HEALTH & ETHNICITY IN ABERDEENSHIRE:
A study of Polish In-Migrants

A report for the Scottish Health Council

June 2007
(revised October 2007)

John G Love
Steve Vertigans
Emilia Domaszk
Konrad Zdeb
Ann P Love
Philip W Sutton

School of Applied Social Studies
Faculty of Health and Social Care
The Robert Gordon University

Contents

Acknowledgements

The present study was commissioned and funded by the Scottish Health Council. We would like to acknowledge the interest and support provided by members of the Scottish Health Council, in particular Rosemary Hill, Development Manager and Fiona Wardell, Assessment and Feedback Manager.

Based mainly on a large-scale survey of Polish people, we would like to acknowledge the commitment and hard work of a large number of individuals, agencies and businesses in Aberdeenshire who helped administer the 'self-completion' questionnaires: Banff Community Centre; Michael Tough, Woodheads, Turriff; Lada Copic, Kate Maclean, Community Learning and Development, Aberdeenshire Council; Milan Copic; Carol Bamburgh, Buchan Education Centre, Wenda Crockatt, Brock Community Centre. We are also grateful to the 'Welcome to Aberdeenshire' Group, especially Kate Rigby and Fiona Stewart.

For helping us to gain an understanding of healthcare in Poland we are grateful to Michal Marek, Dept of Health Insurance; Marciszko Wojciech, Dept. of Health System Organisation; Wiktor Maslowski, Bo ena Piwowar, Centrum ATTIS and special thanks to Marek Red ko, Chancellery of the Prime Minister.

Additional IT support, for the on-line questionnaire, was provided by Jenny Blair, School of Applied Social Studies. Many thanks.

As part of the study a part-time summer scholarship was offered to an Honours year student in the School of Applied Social Studies. We would like to thank Susan Nicolson for the work carried out.

As ever, the study relied upon the support and flexibility of Bill Walker and his team at Graphics and Printing Services (The Gatehouse), The Robert Gordon University. We would like to thank them for their on-going professionalism.

Above all we would like to thank the Polish people who took part in the focus group discussions and survey. Their willingness to become involved was much appreciated.

The Research Team
June 2007

EXECUTIVE SUMMARY

1. Background

In Scotland as a whole, around 2% of the population are from minority ethnic backgrounds, although the distribution of people from such backgrounds is uneven across the country. In Aberdeenshire, out of a total population of 232,850, 1,165 people come from ethnic minority backgrounds, around 0.5 % of the total population. According to the 2001 Census, there are nine main ethnic minority groups in Aberdeenshire, the largest of which is Chinese, comprising around a quarter of the total ethnic minority population of the area (n=277, 24%). The remaining groups are made up of Indians, Pakistanis, other South Asians, Africans, Black Scottish and people from the Caribbean. However, around 29% come from 'other minority ethnic groups'. With respect to the latter, there has been a noticeable influx of people from Eastern Europe, particularly Poland, Lithuania and Latvia following the accession of ten new member states to the European Union on the 1st April 2004. It has been estimated that around 800 migrant workers and their families are now coming to Grampian each month (400 of whom are Polish), if levels of applications for National Insurance numbers are indicative in this respect (NHS Grampian, 2005).

The health needs of migrants is becoming increasingly recognised. As such, the International Organization for Migration's most recent *World Migration Report* (2005) argued that, 'the social and economic costs of neglecting migration health, also as a public health issue, can be immeasurable'. The experience of migration can lead to increased vulnerability to ill health as well as ill health, which arises after arrival. Poorer migrants are often lowly paid, living in damp conditions, badly nourished and exposed to higher risks in working environments yet under-utilise health services. In addition, the stigma generated from wider perceptions of poor migrant health can contribute to an undermining of the benefits of migration. In short, migration *is* a public health issue, which seems likely to endure in an emerging age of migration (Castles and Miller 2003). Finally communication is considered fundamentally important to the health of migrants due to 'language barriers having adverse effects on the accessibility of care, the quality of care received, patient satisfaction and patient health outcomes' (Bischoff 2003).

To help in-migrants settle into Scotland generally and Aberdeenshire in particular the Scottish Executive and a range of national and regional bodies have introduced a range of policies. Within healthcare, NHS Grampian (2005) aims "to make genuine and lasting improvements in the quality of services provided to the local ethnic communities and to make NHS Grampian the leader, for other Health Boards to follow". To this end a range of policies are being implemented. These include, interpretation and translation services, training for NHS Grampian staff to better understand the needs of the local ethnic communities, access and service delivery, racial equality within NHS Grampian, appointments procedures, training procedures, actively promoting health within the ethnic communities and meeting the healthcare needs of recently arrived migrant workers and their families and asylum seekers.

2. Research

The study examined the health status and health behaviours of Polish in-migrants to Aberdeenshire. It sought to find out how well NHS services engage with such Polish people in the local authority area. The intention was to explore how patient and public involvement could be developed meaningfully to ensure that the views of Polish people are actively sought, listened to and acted upon.

The research was guided by the following five research questions:

1. What are the individual needs of Polish in-migrants regarding healthcare and treatment?
2. How should NHS services ensure that Polish in-migrants individual needs are identified respected and responded to?
3. What are the barriers (i.e. structural, policy or attitudinal) to Polish in-migrant workers and their families being involved in decisions about their care and treatment?
4. How should NHS services engage with Polish in-migrants to capture their views and experiences of NHS services?
5. How should NHS services engage with Polish in-migrants to plan changes and improvements in services?

The study combined both qualitative and quantitative methods of investigation. A two-stage approach was adopted, involving the carrying out of two focus groups and a large-scale survey of c.100 Polish people. The latter combined both 'paper-based' and on-line questionnaires.

Fieldwork was carried out between January and April 2007. A mix of local authority personnel, local businesses and individuals from the Polish community with front-line contact with Polish people made available 300 questionnaires. 100 completed questionnaires were returned.

3. Findings

General Profile

In general, the study group comprised an uneven mix of males 52% (n=49) and females 48% (n=46), who ranged in age from 14 years to 59 years, with a mean average age of 29 years. More than a quarter of those surveyed were young people aged 24 years or less (29%, n=29). Half of those surveyed were married or cohabiting (51%, n=49) and around two-fifths of the participants were single - never married (38%, n=37). 8% had been married or cohabited in the past but were now separated or divorced. Just under half of the study group had children (43%, n=42), most having two or more off-spring, and three-quarters of parents shared a household with their offspring (78%, n=31). Three-quarters of participants were currently employed (76%, n=76), with the remainder almost exclusively unemployed (i.e. looking for work) (23%, n=23) Only one person was non-employed and not seeking work.

Health

Around a third of the Polish people surveyed assessed their own general health as 'less than good' (38%). In addition, 14% reported a long-term illness or disability, often related to physical health problems (e.g. back pain), which was limiting in some way for 50% of sufferers.

To put the above findings in context, in the general population as a whole, according to the Scottish Health Survey 2003, only a quarter of people report their health as 'less than good'. Also, two-fifths of people generally report a long-term illness or disability (41% men, 42% women) which is limiting for around three-fifths of sufferers (Scottish Executive, 2005).

As such the findings from the present study suggest that Polish in-migrants suffer disproportionate poor general health but far less long-term (and limiting) illness and disability, than people in the general population.

Asked about their experience of 21 commonly reported 'objective' diseases or conditions, two-thirds of respondents had experienced at least one such condition (65%). On average, they had experience of two such conditions at some stage in their lives, with around a third reporting back trouble (34%) or chronic bronchitis (30%) and a fifth reporting stress (21%).

Participants were more likely to have been treated in Poland than in Scotland for the diseases reported, with chronic bronchitis the most reported disease treated (68%).

Investigation into recent illness (i.e. the subjective experience of pain and discomfort) in the past month, suggested that almost all of the Polish people surveyed had been 'ill' during this time (83%), often with colds/flu, headaches or back pain.

Migrating to Scotland had impacted upon the health of a fifth in-migrants; for 7% their health had improved, for 11% their health had deteriorated. While minor ailments (e.g. colds / flu) improved, psychological wellbeing suffered.

Enquiries about street drug use found that 3% of those surveyed had used street drugs in the past month, while a quarter of respondents (24%) had used street drugs at some point in their lives. There was little or no evidence of drug injecting. To put such findings in context, recent figures from the (sixth) Scottish Crime Survey 2003 (Scottish Executive, 2004), indicate that 5% of all 16 – 59 year olds had used street drugs in the last month. As such the findings of the present study point towards relatively low levels of (recent) street drug use amongst Polish in-migrants.

Use of Health Services

Around three-fifths of those surveyed had registered with a GP (59%), with people aged 25 years+ more likely to have done so. 23% of those surveyed had consulted with a GP in the two weeks prior to the survey; 35% of women and 13% of men.

To put these findings in context, the Scottish Health Survey 2003 found that in the population as a whole, 20% of women and 16% of men had consulted a doctor in the previous two weeks (Scottish Executive, 2005). As such, although less likely to be registered with a GP, Polish in-migrant women appear to make greater (recent) use of GP services, while men under-use such services.

18% of those surveyed had made use of Accident & Emergency services in the past 12 months. A quarter of those surveyed had used some kind of hospital based out-patient service (including emergency services) in the past 12 months (24%).

To put the above findings in context, the 2003 Scottish Health Survey found 35% of men and 37% of women had made use of Accident & Emergency facilities and other hospital based day-patient services in the previous 12 months (Scottish Executive, 2005). As such the present study suggests that Polish in-migrants (in particular men) make less use of hospital based out-patient services than people in the general population.

8% of those surveyed had spent at least one night in hospital as a patient in the past 12 months, 16% of women and 2% of men. In-patient experience was linked to general hospital use.

To put the above findings in context, in the 2003 Scottish Health Survey it was found that 9% of men and 13% of women had stayed in hospital for one night or more in the previous 12 months (Scottish Executive, 2005). Once again, the findings of the present study suggest that

the health behaviours of Polish in-migrants differ from those of people in the general population; female Polish in-migrants make slightly greater use of in-patient hospital services whilst males make less use of in-patient hospital stays.

16% of those surveyed had used health related services in the past six months, mainly for dental appointments and 'smear tests'.

10% of those surveyed had used NHS-24, the nurse-led telephone health advice service, in the previous six months. The most reported use was in respect of advice for a sick child. Women were more likely than men to have used the service.

Experience of Health Services

The most sought after NHS treatments were for physical illness and dental problems, with between a fifth and a third of participants respectively seeking help for such conditions within the previous 12 months.

Access to NHS services was linked to the particular type of condition for which treatment was sought. The conditions most likely to allow easy access to treatment were smoking, accidents and physical illness. Between 45% and 92% of Polish people requiring NHS services for these conditions were able to access treatment. By contrast Polish people's access to NHS dental health services, substance misuse services and sexual health services was more problematic.

There were clear sets of enabling factors as well as potential barriers to NHS service use. Amongst the enabling factors, reported by 90% or more of participants, were Polish people's own knowledge, experience and attitude to using NHS services, as well as the disposition of medical staff.

With respect to the potential barriers to service use, the most reported were waiting lists, appointment systems and the opening hours of services (i.e. GP surgeries closed at weekends). In addition, the financial costs of using (dental) services and language difficulties were highlighted.

Polish patients generally found a range of NHS services useful in meeting their health needs in the previous 12 months. Hospital Accident & Emergency out-patient services (91%) and general hospital in-patient services (90%) were assessed as the most effective services used, by the third of people who had used them. Amongst the half who had used GP services, three-quarters also found them useful (77%).

Across a range of services, around half of the Polish people surveyed felt that their views and opinions were more or less listened to as they underwent treatment through the NHS, in the preceding 12 months. GP services, hospital Accident & Emergency services and general hospital in-patient services were the most reported settings in which Polish people felt that their voices were being heard.

In response to a general question about factors that would make the NHS more useful to Polish people, the three most reported factors were linked to enhanced language services. As such around half of those surveyed called for better Polish translation services and documentation. In addition, around a third of participants called for shorter waiting lists and better appointment systems.

Asked specifically about improvements needed within the NHS, in terms of illnesses needing targeted, policies needing to change and staff attitudes needing to improve, the following was found:

In terms of illnesses requiring prioritisation, the Polish people surveyed identified physical illness (e.g. cancer, heart disease, bronchitis) as the major type of illness requiring attention. Three-fifths suggested that the NHS make this area a priority. In addition, around a third highlighted the need to address mental illness, physical disability and dental problems.

In terms of policies needing attention, the most sought after changes were easier access to dentists and easier registration with GPs, with two-thirds and a half, respectively, of the Polish people surveyed stating such a wish.

With respect to the need to change the attitudes of groups of NHS health workers, the staff seen as most requiring to change were GPs and nurses in GP surgeries. Between a third and a quarter of Polish people surveyed typically called for more sympathy and patience from such NHS staff.

4. Policy Implications

Research does not make health or social policy. However alongside resources and the political will to use them, research can inform decisions at both the strategic and operational levels. The findings from the present study should be understood in this way.

The present study examined the health status and health behaviours of Polish in-migrants to Aberdeenshire and their experiences of healthcare from NHS Grampian. It sought to find out how well NHS services engage with such Polish people in the local authority area and to explore how patient and public involvement could be developed meaningfully to ensure that the views of Polish people are actively sought, listened to and acted upon.

It was the intention that the information gathered and understandings achieved would inform the work of the NHS locally with respect to how best to engage with 'hard to reach' and 'seldom heard' groups. In addition the research sought to inform the Scottish Health Council about how best to support NHS Grampian as it seeks to identify, understand and address these issues, through for example, the development of guidance and standards. NHS Grampian has developed a number of actions designed to improve experiences. This research suggests that migrants are satisfied with many aspects of healthcare in the region but further enhancements could be made in key areas. In particular:

Firstly, the study found that Polish people suffered poorer levels of general health compared with people in the general population. However they were less likely to suffer from long-term (and limiting) illness and disability. **Accordingly, NHS Grampian should take account of such patterns of illness and disease in the planning and delivery of health services. In particular, they should seek to tackle the incidence of back trouble, chronic bronchitis and stress which are relatively highly reported within the study group. Such intervention may preserve the relatively good incidence of reported long-term (and limiting) illness and disability.**

Secondly, notwithstanding the heightened levels of poor general health, the study found that only three-fifths of the Polish in-migrants were registered with a GP practice in the local area. **Accordingly, given the importance of primary care in tackling ill-health and referring patients to specialised secondary care, NHS Grampian should take account of such patterns of registration in the planning and delivery of primary care health services. In**

particular, they should proactively engage with the Polish community in the North East to ensure that they link to GP services. Young people in particular should be encouraged to register.

Thirdly, compared with people in the general population, Polish in-migrants make less use of hospital based out-patient services. Also, their use of hospital in-patient services differs from that of the general population (with men being less likely to be patients and women more likely to be patients). Instead many Poles reported being treated in Poland for different problems including back troubles, chronic bronchitis, stomach disorders and chest complaints. **Accordingly, NHS Grampian should take account such distinctive patterns of health service use in the planning and delivery of health services, the better to meet the requirements of a particularly needy group. Men in particular should be encouraged to use the services available, when in need.**

Fourthly, the study found that Polish people's high levels of need and mixed levels of experience were, in general, met by an appropriate response from NHS services. As such the majority of Polish in-migrants surveyed felt that the NHS was effective in meeting their health needs. **Accordingly, NHS Grampian should build upon the high levels of satisfaction expressed by Polish people to reinforce the valuable work done by staff. In particular it should build upon the positive perception of hospital based services, by the minority who used them.**

Fifthly the study found that Polish people's assessment of NHS healthcare however was both illness and service related. As such, treatments for smoking, accidents and physical illness were more readily available than treatments for NHS substance misuse and dentists. Elsewhere, participants suggested the need to prioritise mental health services. **Accordingly, NHS Grampian should ensure that effective action is taken to improve services to Polish people where necessary. Consideration should be given, in particular, to providing additional mental health services, substance misuse services and dentists.**

Sixthly, the study found clear sets of enabling factors as well as potential barriers to NHS service use. Amongst the enabling factors were Polish people's own knowledge of services, the availability of local services, experience of using services and attitude to using services. In addition, the disposition of medical staff was a factor. In short, the study found that the 'key' to Polish people's satisfaction with services lay in knowing which services were available, a good previous experience and confidence in an interested and caring staff. **Accordingly, NHS Grampian should publicise its services, ensure that 'first contact' with services is positive and offer 'care' as well as treatment.**

Seventhly, with respect to the potential barriers to service use, amongst the most reported were waiting lists, appointment systems in place ,opening hours and a general problem with (the English) language. In addition, the financial costs of using dental services were highlighted. **Accordingly, NHS Grampian should look again at the organisation of both primary and secondary care services, with a view to developing better ways of managing the delivery of treatments. Alongside a reduction in waiting times, extending GP surgery opening hours would be welcomed by Polish people. In addition, extra NHS dentists would promote greater equality amongst a needy and disadvantaged group of patients unable to access private and costly healthcare. Finally, enhanced translation services would assist service engagement generally.**

Finally, the study explored how the views and opinions of Polish in-migrants about the design and delivery of services could best be represented to NHS Grampian. The study found that just over half of the Polish people surveyed felt that their views and opinions had been listened to as they underwent treatment through the NHS, in the preceding 12 months.

Participants identified a straightforward way of seeking their views; consult with them through the systematic collection of opinions and attitudes. **Accordingly, NHS Grampian should proactively seek the views and opinions of Polish people by supporting the use of patient feedback forms in surgeries and clinics and other places where Polish people present for treatment. At the present time, the 'materials' used in such a process (i.e. questionnaires etc.) ought to be in Polish.**

SECTION ONE: INTRODUCTION

1.1 Background

In Scotland as a whole, around 2% of the population are from minority ethnic backgrounds, although the distribution of people from such backgrounds is uneven across the country. In Aberdeenshire, out of a total population of 232,850, 1,165 people come from ethnic minority backgrounds, around 0.5 % of the total population. According to the 2001 Census, there are nine main ethnic minority groups in Aberdeenshire, the largest of which is Chinese, comprising around a quarter of the total ethnic minority population of the area (n=277, 24%). The remaining groups are made up of Indians, Pakistanis, other South Asians, Africans, Black Scottish and people from the Caribbean. However, around 29% come from 'other minority ethnic groups'. With respect to the latter, there has been a noticeable influx of people from Eastern Europe, particularly Poland, Lithuania and Latvia following the accession of ten new member states to the European Union on the 1st April 2004. It has been estimated that around 800 migrant workers and their families are now coming to Grampian each month (400 of whom are Polish), if levels of applications for National Insurance numbers are indicative in this respect (NHS Grampian, 2005).

The needs of Eastern European in-migrants with respect to health and other services is being increasingly recognised, reflecting concerns about levels of ill-health, problematic access to health services and levels of satisfaction with health services among minority ethnic groups living and working in the local area. It has been noted that language difficulties and interpretation provision is a problem, whilst the younger age profile of migrant workers as a group, means that in all likelihood, GP registration is relatively low. Little is known about how best to engage with such communities to ensure that health services are responsive to their needs. Such obstacles and uncertainties can lead to anxieties and misgivings amongst migrants regarding the use of available health services.

1. 2. Health & Ethnicity

The International Organization for Migration's most recent *World Migration Report* (2005) argued that, 'the social and economic costs of neglecting migration health, also as a public health issue, can be immeasurable'. The experience of migration can lead to increased vulnerability to ill health as well as ill health, which arises after arrival. In addition, the stigma generated from wider perceptions of poor migrant health can contribute to an undermining of the benefits of migration. In short, migration *is* a public health issue, which seems likely to endure in an emerging age of migration (Castles and Miller 2003).

Health variability among different ethnic minority communities within Scotland is reflected in differing rates of illness (CSO, 2003) with outcomes following treatment also shown to differ markedly between people from minority ethnic backgrounds and other sections of the population (Mental Health Foundation). Thus, for example, within current public health priority areas, heart disease, diabetes and mental illness are found disproportionately within sectors of the minority ethnic population. In terms of health behaviours, although alcohol consumption is lower among people from minority ethnic groups compared with people in the general population, the use of tobacco is more common amongst certain ethnic minority groups. Use of health services varies too and one recent questionnaire-based report covering 50 migrants in the North East revealed that only 56% had registered with a doctor (de Lima et al 2005). Levels of satisfaction with such services are also lower amongst minority ethnic groups. Also, access to secondary and specialist health services (e.g. general hospital, psychiatric hospital, maternity services) differs from that found among the population as a whole (Centre for Health Studies, 2001).

1.3 Research Study

Research Questions

The present study sought to examine how well NHS services engage with minority groups in Aberdeenshire and explore how patient and public involvement could be developed meaningfully to ensure that the views of all patients, carers and communities are actively sought, listened to and acted on; and treated with the same priority as clinical standards and financial performance.

In particular, the study focused on the experiences of workers from the minority in-migrant Polish community, an emergent group in the area. It was intended that the information gathered and understandings achieved would inform how NHS Scotland can engage with 'hard to reach' and 'seldom heard' groups and how the Scottish Health Council can support this work, through for example, the development of guidance and standards.

The research was guided by the following five research questions:

1. What are the individual needs of Polish in-migrants regarding healthcare and treatment?
2. How should NHS services ensure that Polish in-migrants individual needs are identified respected and responded to?
3. What are the barriers (i.e. structural, policy or attitudinal) to Polish in-migrant workers and their families being involved in decisions about their care and treatment?
4. How should NHS services engage with Polish in-migrant workers to capture their views and experiences of NHS services?
5. How should NHS services engage with Polish in-migrant workers to plan changes and improvements in services?

Process

The study combined both qualitative and quantitative methods of investigation. Accordingly, a two-stage approach was adopted, involving focus groups with Polish in-migrant people in order to identify and understand relevant health beliefs and attitudes, followed by a large-scale survey of the health status and behaviours of Polish in-migrant people. The focus groups were conducted in January and February 2007. The survey was carried out during March and April 2007.

Sample

In the absence of an up-to-date and comprehensive register of Polish in-migrants in Aberdeenshire from which to select a random sample for study, the research adopted a 'purposive' sampling approach, which is commonly used in the study of difficult-to-access populations. In stage one, using knowledge of the local health and social care scene and agency contacts, two focus groups were designed and carried out comprising young men (n=13) and young women (n=12). In stage two, a large-scale survey of 100 Polish in-migrant people was conducted.

Research Instruments

The focus groups were based upon two research instruments. Firstly participants were invited to complete a short proforma that sought to collect basic demographic data (i.e. age, sex, marital status). Secondly, participants were led through a themed discussion that covered the

following five topic areas: health needs, use of health services, barriers to service use, ways of improving services and listening to service users.

The survey was based on a semi-structured (self-completion) questionnaire divided into four main sections. Section A: *About You*, sought classifactory information and information about family background and work experience. Section B: *About Your Health*, explored the areas of general health, long-standing illness and disability, the incidence of disease (based on reported/treated conditions), the experience of illness (based on reported symptoms suffered) and drug use. Section C: *Use of Health Services*, examined registration with GPs, consultation with GPs, use of hospital based A & E and other 'out-patient' services, in-patient stays in hospital and the use of other health related services (including drug and mental health services). Section D: *Experience of NHS Health Services* examined ease of access to treatment for different types of condition, factors which more or less facilitated access to treatment, usefulness of treatment and ways of improving treatment.

The individual questionnaire items comprised a mix of questions designed for the present research, as well as standardised questions employed in studies of health elsewhere. The latter thus enabled comparisons to be made between the study group (i.e. Polish in-migrants to Aberdeenshire) and the wider population.

1.4 Outline of Report

The report is divided into six main sections. In Section One: Introduction, the background to the study is outlined, the research interests described and the methodology used in the study explained. In Section Two: The Study Group, a description of the sample of Polish people who took part in the study is offered in terms of their socio-demographic characteristics. In Section Three: Health, the general health of the study group is described and the experience of disease, illness and drugs is reported. In Section Four: Use of Health Services, the use of GP services, hospital based services and other health related services is examined. In Section Five: Experience of NHS Health Services, ease of access to treatment for different types of condition, factors which more or less facilitated access to treatment, usefulness of treatment and ways of improving treatment are reported on. Finally, in Section Six: Conclusion, an attempt is made to answer the research questions which guided the study. In addition, the policy implications which flow from the study are outlined.

Additional technical note

Throughout the report analyses were carried out according to two main characteristics; sex (men/women) and age (young people aged 16 – 24 years/older people aged 25 years +).

Where an association is indicated in the text (e.g. men are more likely than women to be working) the results are based on the X^2 statistic with a P value of 0.05 or less.

Throughout the report percentages have been rounded up or down and may not add up to 100%. Also, the N within a table may vary depending up the response to the 'control' variable used.

SECTION TWO : THE STUDY GROUP

2.1 Introduction

The present section offers a brief description of the Polish people who took part in the study in terms of their socio-demographic characteristics. To begin with participants are described in terms of their age, sex, marital status, off-spring and employment status. Thereafter, a description of their current area of residence is provided. In order to highlight significant differences within the study group, the findings are analysed by the key characteristics of sex, and age (i.e. 24 years or less vs 25 years +).

2.2 General Profile

In general, the study group comprised an uneven mix of males 52% (n=49) and females 48% (n=46), who ranged in age from 14 years to 59 years, with a mean average age of 29 years[1]. More than a quarter of those surveyed were young people aged 24 years or less (29%, n=29). Half of those surveyed were married or cohabiting (51%, n=49) and around two-fifths of the participants were single - never married (38%, n=37). 8% had been married or cohabited in the past but were now separated or divorced. Just under half of the study group had children (43%, n=42), most having two or more off-spring, and three-quarters of parents shared a household with their offspring (78%, n=31). Three-quarters of participants were currently employed (76%, n=76), with the remainder almost exclusively unemployed (i.e. looking for work) (23%, n=23). Only one person was non-employed and not seeking work.

Differences within the study group suggest that younger people (aged <25 years) were more likely than older people (aged 25 years +) to be single-never married (see table 2.2.1), with almost three-quarters of young people remaining single while around a quarter of older people were in this position . Also, men were more likely than women to be in paid work, with 92% (n=45) men being in employment while less than two-fifths of women (59%, n=27) were similarly engaged (see table 2.2.2) No other systematic differences were found.

Table 2.2.1 Marital Status

	Single – Never Married	*Married / Co-habit*	*Separated, Divorced, Widowed*	*Other*	
	%	**%**	**%**	**%**	**N**
Sex					
Male	**35**	**48**	**10**	**6**	***48***
Female	**39**	**55**	**7**	**-**	***44***
Age-Group					
<25 years	**72**	**21**	**-**	**7**	***29***
25 years+	**24**	**63**	**12**	**1**	***67***
All	**39**	**50**	**8**	**3**	***96***

[1] The study was targeted at adults aged 16 years and older. Two respondents aged 14 years (males) and one aged 15 years (female) replied to the anonymous survey and were included in the subsequent analyses.

Table 2.2.2 Current Employment Status

	Working	*Unemployed*	*Non-employed*	
Sex	**%**	**%**	**%**	**N**
Male	**92**	**6**	**2**	***49***
Female	**59**	**41**	**-**	***46***
All	**76**	**23**	**1**	***95***

2.3 Area of Residence

An attempt was made to gauge the relative prosperity of the backgrounds of in-migrants by reference to Scottish Index of Multiple Deprivation.[2] Accordingly, a postcode analysis was carried out of (known) addresses to establish the proportion living in more or less deprived (or affluent) areas of Aberdeenshire. It should be noted that Aberdeenshire overall is relatively prosperous, ranked eighth amongst Scotland's 32 local (and Island) authorities within the national index of multiple deprivation (Aberdeenshire Council, 2007).

Table 2.3.1 Index of Deprivation / Prosperity

Outward Postcode	% Polish in-migrants	Number of Data-zones	% of Data-zones within 1st Quartile of SIMD rank	Lowest observed Decile number of SIMD	Highest observed Decile number of SIMD	Lowest SIMD rank	Highest SIMD rank
AB23	7	17	0.0%	4	10	2,520	6,174
AB31	9	23	0.0%	7	10	4,309	6,474
AB39	6	20	0.0%	6	10	3,800	6,473
AB43	5	31	6.5%	1	10	642	6,147
AB44	12	5	0.0%	5	7	2,820	4,298
AB45	33	17	0.0%	5	7	2,881	4,385
AB53	8	24	0.0%	5	9	3,071	5,697
AB54	2	21	0.0%	4	10	2,483	5,858
dk	17	-	-	-	-	-	-

As table 2.3.1 shows, few of the Polish in-migrants surveyed were living in areas associated with deprivation. The greatest likelihood of poverty was found in postcode area AB43, around Fraserburgh and Turriff, although even here only 5% (n=4) participants gave an address in this area and, importantly, the area itself covers a wide range of SIMD values, ranging from the poorest (SMD value 642) to the very affluent (SMD value 6147).

[2] The Scottish Index of Multiple Deprivation (SIMD) is a composite measure drawing upon a range of data about income, housing, health, education, employment etc. to derive a score that is then ranked on a scale of 1 (most deprived) to 6505 (least deprived). Information is available at the level of 'data zones'; census output areas with populations of between 500 and 1,000 residents. Data zones can then be ordered equal portions of 10 (i.e. 'deciles'), and subsequently used to divide areas into a hierarchy of the 'most deprived' to the 'least deprived' geographical locations.

SECTION THREE: HEALTH

3.1 Introduction

The present section reports on the health status of the Polish in-migrants surveyed. In particular it describes their present general health, their experience of long-standing illness and disability, their responses to a check-list of specified diseases or conditions, their disclosure of discomfort and suffering and their involvement in the use of street drugs. To begin with participants are described in terms of their self-assessed general health status. Thereafter the experience of long-standing illness and disability (including the nature of the illness or disability and its impact on their lives) is looked at. Next responses to a check-list of 20 common diseases or conditions is described. Following this, participants' disclosures of specific type of pain and discomfort are reported. Finally, participants' use of street drugs, including the incidence of drug injecting and self-assessed problem drug use are described. As previously, findings are analysed by the key characteristics of sex and age (i.e. 24 years or less vs 25 years +).

3.2 General Health and Long-standing Illness and Disability

Participants were asked to assess their own general health in terms of whether they considered it 'good', 'fairly good' or 'not good'[3]. Next they were asked if they suffered from any long-standing illness or disability and if so whether such conditions were mental health, alcohol or drug related. Finally they were asked about the impact of any long-standing illness or disability. In particular they were asked if they found such conditions limiting in any way. The following was found.

As Table 3.2.1 shows, three-fifths of participants regarded their general health as 'good' (61%, n=60), a third assessed their general health as 'fairly good' (34 %, n=34) and a small minority assessed their health as 'not good' (4%, n=4). In total therefore, 38% of the Polish people surveyed considered their own general health as 'less than good'. No systematic differences were found within the study group with respect to the reporting of general health status.

Table 3.2.1 Self-Assessed General Health

	Good	*Fairly Good*	*Not Good*	
	%	**%**	**%**	**N**
Sex				
Male	**65**	**31**	**4**	***49***
Female	**60**	**36**	**4**	***45***
Age-Group				
<25 years	**68**	**32**	**-**	***28***
25 yrs +	**59**	**36**	**6**	***70***
All	**61**	**34**	**4**	***99***

[3] Self assessed health is generally accepted as a good indicator of wellbeing and correlates with diagnosed acute and chronic disease as well as being a good predictor of mortality (Scottish Executive, 2005).

To put the above findings in context, in the general population as a whole, according to the Scottish Health Survey 2003, three-quarters of people report their health as 'good' or 'very good' (74% men, 73% women), around a fifth as 'fair' (18% men, 19% women) and only 8% (of both sexes) as 'bad or very bad' (Scottish Executive, 2005). As such the study group as a whole would appear to suffer disproportionate poor general health.

Table 3.2.2 Long-Standing Illness and Disability

		Total
	%	**N**
Long-Standing Illness/ Disability	**14**	**99**
Physical Only	**86**	**14**
Drug Related	**-**	**14**
Mental Health Related	**7**	**14**
Alcohol Related	**-**	

The study went on to examine the issue of long-standing illness and disability. 14% (n=14) of participants reported having such a condition with physical health problems the most reported conditions suffered (Table 3.2.2). Only one person reported a long-term illness in relation to a non-physical condition and this person suffered from a mental illness. With respect to the physical illnesses suffered, back pain and trouble with eyes were both reported. No systematic differences were found within the study group with respect to long-term illness and disability.

Half of those who suffered from a long-standing illness or disability indicated that such a condition was limiting in some way, with 50% (n=7). The limitations of such conditions were experienced mainly in terms of the distress that the pain caused. Thus a 27 year old woman with a stomach disorder commented '*I feel discomfort at different times of the day*'. Elsewhere a 36 year old man who reported back trouble, remarked, '*I have strong back pain, (through) hard work.*'

To put the above findings in context, two-fifths of people generally report a long-term illness or disability (41% men, 42% women) which is limiting for around three-fifths of sufferers (Scottish Executive, 2005). As such the findings from the present study suggest that Polish in-migrants suffer far less long-term (and limiting) illness and disability than people in the general population.

3.3 Disease

The study went on to examine a further dimension of health and ill-health among the Polish in-migrants surveyed. As such, participants were invited to indicate whether or not they had ever had any of 21 specified (and common) medical conditions. Also, they were asked whether or not such conditions had been treated, either in Poland or in Scotland. Conditions reported as 'untreated' were more likely to be self-diagnosed.

As Table 3.3.1 shows, 19 out of the 21 diseases enquired about had been experienced by the Polish people surveyed. Only lung cancer and stroke were unreported. 12 of the diseases had, for the majority of sufferers, been 'treated' in some way while three conditions had, for the majority, been left untreated. As such, in most cases, it would appear that participants were likely to be reporting on 'medically defined' disease and impairment.

Table 3.3.1 Diseases 'Treated' or 'Untreated'*

Conditions Suffered		
Treated for Majority	**Equally Treated/Untreated**	**Untreated for Majority**
Chronic Bronchitis *'Other' Liver Condition* *'Other' Chest Trouble* *Stomach Disorder* *Heart Trouble* *'Other' Cancer (i.e. not lung cancer)* *Severe Depression/Nervous Illness* *High Blood Pressure* *Stroke* *Migraine* *Back Trouble* *Epilepsy*	*Hepatitis* *Varicose Veins* *Rheumatics / Arthritis* *Diabetes* *Stress*	*Alcohol Problem* *Asthma* *Piles or Haemorrhoids*

**Although asked about, no-one reported having lung cancer*

More than two-thirds of those surveyed reported suffering from at least one of the (21) conditions asked about (65%, n=65). On average, participants reported suffering from two conditions, while around a fifth of all participants reported suffering from three or more conditions at some time (22%, n=22). No differences were found within the study group either in terms of the likelihood of having a disease or in the number of diseases suffered from. As such men were as likely as women and younger (aged <25 years) people were as likely as older people (aged 25 years+) to report having (any number of) diseases.

The study moved on to examine the types of diseases reported. As Table 3.3.2 shows, the most reported condition experienced was back trouble, with around a third of the study group indicating such a problem (34%, n=32). In addition, just under third of participants reported experiencing chronic bronchitis[4] (30%, n=28) and around a fifth reported suffering from stress (21%, n=20) and some kind of stomach or digestive disorder (18%, n=17).

Table 3.2.2 Disease

Condition	%	Likely Sufferers	
		Sex	Age-group
Back trouble	34		older
Chronic Bronchitis	30		younger
Stress	21		
Stomach disorder	18		
Piles or haemorrhoids	10	women	
Heart trouble	10		
Migraine	10		
'Other' Chest trouble	8		

[4] It does seem that bronchitis is more prevalent in Central European countries including Poland (see http://erj.ersjournals.com/cgi/content/abstract/20/4/890), perhaps due to higher levels of air pollution than in Western Europe/America.

Condition	%	Likely Sufferers	Condition
Severe depression / nervous illness	7	women	
Rheumatic trouble or arthritis	6		
Varicose veins	4		
High Blood Pressure	4		
Alcohol problem	3		
'Other' Liver problem	3		
Hepatitis	2		
Diabetes	2		
Epilepsy or fits	2		
Asthma	1		
'Other' Cancer (not lung cancer)	1		
N=	*94*		

Key: older (25 years+),younger (<25 years). The 'N' (number of participants) varied from 91 to 95, with a mode average of 94.

Differences within the study group suggest that young people (<25 years) were more likely than older people (aged 25 year+) to report suffering from chronic bronchitis with 42% (n=12) and 24% (n=16) respectively of each group reporting this to be the case. By contrast, older people were more likely than younger people to report suffering from back trouble, with 41% (n=27) and 19% (n=5) respectively ding so. Elsewhere, women were more likely than men to report suffering from piles or haemorrhoids, with 17% (n=7) and 4% (n=2) respectively doing so. Also, women were more likely than men to report suffering from severe depression or nervous illness, with 14% (n=6) and 2% (n=1) respectively doing so. No other systematic differences were found.

Enquiries about the prevalence of disease amongst the study group closed by asking them about whether or not such conditions had been treated, either in Scotland, Poland or both. The following was found.

Table 3.3.3 Disease and Treatment

Condition	*% with condition*	*% treated*	*Location of Treatment had by sufferers*		
			Scotland	Poland	Both
			%	%	%
Back trouble	34	59	21	68	11
Chronic Bronchitis	30	96	-	100	-
Stress	21	50	30	30	40
Stomach disorder	18	88	7	80	13
Piles or haemorrhoids	10	44	50	25	25
Heart trouble	10	100	10	80	10
Migraine	10	33	33	33	33
'Other' Chest trouble	8	100	12	88	-
Severe depression / nervous illness	7	57	25	50	25
Rheumatic trouble or arthritis	6	50	-	67	33
Varicose veins	4	50	-	100	-

Condition	*% with condition*	*% treated*	*Location of Treatment had by sufferers*		
High Blood Pressure	**4**	**100**	**20**	**80**	**-**
Alcohol problem	**3**	**-**	**-**	**-**	**-**
'Other' Liver problem	**3**	**66**	**-**	**100**	**-**
Hepatitis	**2**	**50**	**-**	**100**	**-**
Diabetes	**2**	**-**	**-**	**-**	**-**
Epilepsy or fits	**2**	**100**	**-**	**100**	**-**
Asthma	**1**	**-**	**-**	**-**	**-**
'Other' Cancer (not lung cancer)	**1**	**100**	**-**	**100**	**-**
N=	***94***				

As table 3.3.3 shows, the likelihood of being treated varied according to the condition suffered. The most likely conditions to be treated were chronic bronchitis, 'other' chest trouble, high blood pressure, heart trouble, 'other' cancer (i.e. not lung cancer), epilepsy or fits and stomach or digestive disorder. Participants were more likely to have been treated in Poland than Scotland for the range of diseases suffered. Treatment in Poland for chronic bronchitis, back trouble and stomach or digestive disorder were the most reported conditions for which help was sought and received.

3.4 Illness

The study sought to examine the issue of illness within the sample of Polish in-migrants surveyed. Unlike the more objective, medically defined condition or pathology of 'disease', illness refers to the subjective experience of pain or discomfort. Often related, although not synonymous, disease and illness allow for a multi-dimensional understanding of health and ill-health.

Table 3.4.1 Illness in Past Month

Symptom	*%*	*Sex*	*Age*
1. Headache	**52**		
2. Cold/Flu	**51**	**women**	
3. Bad Back	**45**		
4. Trouble with Eyes	**26**		
5. Painful Joints	**22**		**older**
6. Indigestion	**22**		
7. Trouble with Teeth	**17**		
8. Trouble with Skin	**17**		
9. Trouble with Ears	**14**		
10. Trouble with Feet	**6**		
11. Palpitations /Breathlessness	**4**		
12. Trouble with periods / menopause	**3**		
N=	***92***		

The 'N' (number of participants) varied from 45 to 95, with a mode average of 92.

Participants were asked about their experience of 12 common illness symptoms over the previous month. The following was found.

More than four-fifths of participants reported experiencing illness symptoms in the previous month (83%, n=83). On average participants experienced three symptoms during this time. There were no systematic differences noted within the study group with respect to the number of illnesses experienced in the past month. As such men were as likely as women and younger people (aged <25 years) as likely as older people (aged 25 years+) to report having an illness.

Looking at the nature of the pain and discomfort experienced, table 3.4.1 shows that the most reported illness symptoms experienced in the previous month were headaches, cold/flu, and back trouble. More than half of participants had suffered from headaches, colds and flu, while more than two-fifths had suffered backache, during this time. In addition, three other illness symptoms were experienced by a fifth or more of the study group; trouble with eyes, joints and indigestion.

Differences in the experience of illness were noted with respect to sex and age. In terms of sex, the findings suggest that women were more likely than men to suffer from colds / flu with around two-thirds of women reporting such symptoms (64%, n=27) compared with around two-fifths of men (44%, n=21). With respect to age, older people (aged 25 years+) were more likely than younger people to report backache, with 29% (n=19) and 11% (n=3) respectively doing so.

By way of closing enquiries about the experience of illness, participants were asked whether migrating to Scotland had impacted upon their health.

As table 3.4.2 shows, for just under three-quarters of participants moving to Scotland had no impact on their health. However the move did impact for at least a fifth of in-migrants, doing so both positively and negatively. With respect to the latter, the impact was felt both in terms of physical health as well as psychological wellbeing. In terms of physical health, the move appeared to be experienced positively, with minor ailments disappearing (i.e. colds and flu) and, in one case, a 'heart condition' improving. Thus a 28 year old man explained '*I do not have heart problems (any more).'* Such perceptions, however, should be understood in the light of the previous reporting of a range of illnesses, which continued to affect most people. Also, several participants reported negative psychological consequences linked to migration. As such feelings of loneliness, isolation, depression and tiredness were reported. Thus a 28 year old woman explained, '*I don't like the seclusion .. I get depressed.'* Another 27 year old woman reported, '*I miss my children.'*, while another 23 year old women confided '*I'm suffering from bulimia and depression which limits my contact with people. Very often I am afraid to go out from home. At times I don't leave the flat for two weeks ..'* Elsewhere a 26 year old man confessed, '*I feel more tired.'*

Finally, a middle-aged man who answered 'don't know' to the question, nevertheless provided insight into the positive impact the move to Scotland had on his health and overall wellbeing. He reflected '*I answered "don't know" because it is in the sphere of my subjective feelings very probably. My health has improved. However, I didn't used to get ill. My opinion is based on how I feel. Before moving out from Poland I used to work in big company owned by government. Constantly, trying to catch running time. Nervous. .... Pressure from (my) boss. Objective difficulties of subordinate personnel are one of the factors, also high level of stress. Coming here and taking up a job in Scotland (Aberdeen, Dyce). (it's a) peaceful job, systematic such that after a month I felt an influx of new …energy and sense of security. Stability is a factor, which influence positively the way I feel about myself and the state of health.'*

Differences within the study group suggest that the move to Scotland impacted more on older people (aged 25 years+) than younger people, with only 64% (n=44) of the former claiming

that the move had no impact upon their health compared with 89% (n=25) of the latter. For such older people the move was generally experienced as having a negative impact upon their health.

Table 3.4.2 Impact Migration on Health

Impact	*%*
No impact	**71**
Yes – health improve	**7**
Yes – health deteriorate	**11**
Don't know	**10**
	100
N=	***98***

3.5 Drug Use

Enquiries into the health status of the Polish in-migrants surveyed closed by exploring the issue of street drug use. In particular, participants were asked about their recent drug use, injecting drugs and problem drug use. The following was found.

Table 3.5.1 Use Street Drugs in Past Month and Ever

Drug Use	*Sex*		*Age-Group*	
	Male	**Female**	**Younger <25 years**	**Older 25 years+**
	%	**%**	**%**	**%**
Use< month	**4**	**2**	**4**	**3**
Ever use	**29**	**21**	**26**	**23**
Ever inject	**-**	**2**	**-**	**2**

Only 3% (n=3) of the study group had used street drugs in the previous month. However 24% (n=22) had used street drugs at some point in their lives. Only one person had injected street drugs, although not recently. Three people considered that their use of street drugs was a problem. No systematic differences were found within the study group with respect to the issue of street drug use.

To put such findings in context, recent figures from the (sixth) Scottish Crime Survey 2003 (Scottish Executive, 2004), indicate that 5% of all 16 – 59 year olds had used street drugs in the last month, while 14% of 16 – 29 year olds had done so. As such the findings of the present study point towards relatively low levels of (recent) street drug use amongst Polish in-migrants.

SECTION FOUR: USE OF HEALTH SERVICES

4.1 Introduction

The present section reports on the use of health services by the Polish people surveyed. As such it examines their use of primary and acute services and explores their use of health related services. To begin with, registration and use of GP services is looked at. Thereafter use of Accident & Emergency services and other hospital based out-patient services is

explored. In addition in-patient hospital use is touched upon, followed by a report of the use of 'check-up services' (i.e. dental checks, cervical screening etc.). Next the use made of a range of health related services (e.g. pharmacists) is documented. Finally, use of NHS-24 is examined.

4.2 Primary Care

Participants were asked firstly about registration with GP services and contact with GPs in the previous two weeks. As table 4.2.1 shows, around three-fifths of participants had registered with a GP in Aberdeenshire. Differences within the study group suggest that older people (aged 25 years+) were more likely than younger people (aged <25 years), to be registered with a GP, with two-thirds of older people having done so (65%, n=45) compared with only two-fifths of younger people (41%, n=12).

Table 4.2.1 Registration with GP in Aberdeenshire

Registration with GP	*%*
Yes	**59**
No	**39**
Don't know	**2**
	100
N=	***99***

Asked about use of GP services in the two weeks prior to the survey, the study found that a quarter of the Polish people had done so (23%, n=23). Differences within the study group suggest that women were more likely than men to have consulted with GP in this time, with a third of women having done so (35%, n=16) compared with 13% (n=6) of men.

To put these findings in context, the Scottish Health Survey 2003 found that in the population as a whole, 20% of women and 16% of men had consulted a doctor in the previous two weeks (Scottish Executive, 2005. Accordingly, the findings from the present study suggest that female Polish in-migrants make greater use of GP services than women in the general population, while male Polish in-migrants are only slightly less likely to have seen a GP recently than their Scottish counterparts. The former finding may imply disproportionately high levels of ill-health amongst Polish in-migrant women.

4.3 Secondary Care

The study moved on to examine participants' use of hospital based Accident & Emergency services, other hospital based out-patient services and in-patient stays.

Participants were asked firstly if they had used hospital based Accident & Emergency services in the last 12 months.

Table 4.3.1 Use of Accident & Emergency < 12 Months

	%
Yes	**18**
No	**82**
	100
N=	***99***

As Table 4.3.1 shows, around a fifth of the Polish in-migrants surveyed had made use of hospital based Accident & Emergency services in the previous year (18%, N=18). No systematic differences were found within the study group with respect to the use of Accident & Emergency services.

Participants were then asked about their use of other (i.e. non Accident & Emergency) hospital based out-patient services in the past 12 months.

Table 4.3.2 Use of 'Other' Hospital Based Out-Patient Services < 12 Months

	%
Yes	**12**
*No **	**88**
	100
N=	***96***

** 'No' includes one respondent who was uncertain about whether or not he had used such services.*

As Table 4.3.2 shows, only a small proportion of the Polish in-migrants surveyed had used 'other' hospital based out-patient services in the previous 12 months (12%, n=11). No systematic differences were found within the study group with respect to the use of 'other' hospital based out-patient services.

Table 4.3.3 Use of All Hospital Based Out-Patient Services < 12 Months

	%
Accident & Emergency + other	**5**
Accident & Emergency only	**13**
'Other' only	**6**
Neither	**76**
	100
N=	***95***

Combining the responses with respect to the use of Accident & Emergency services and other hospital based out-patient services (see Table 4.3.3), the findings suggest that a quarter of the Polish in-migrants surveyed had made use of such provision in the previous 12 months (24%, n=23). 17% (n=8) of men had done so and 34% (n=15) of women had done so, although the difference was not significant.

To put the above findings in context, in the 2003 Scottish Health Survey, 35% of men and 37% of women were found to have made use of Accident & Emergency facilities and other hospital based day-patient services in the previous 12 months (Scottish Executive, 2005). As such the present study suggests that Polish in-migrants (in particular men) make less use of hospital based out-patient services than people in the general population.

Enquiries were then made about participants experience of in-patient stays in hospital in the previous 12 months.

As Table 4.3.4 shows, only a small proportion of the Polish in-migrants surveyed had spent at least one night as a patient in hospital in the past year (8%, n=8). The most likely in-patient stay during this time was as a patient in a general hospital. Differences within the study group suggest that women were more likely than men to have done so, with 16% (n=7) women and 2% (n=1) of men having had this experience.

Table 4.3.4 In-Patient Hospital Stays < 12 Months

	%
No stays in hospital	**92**
General hospital	**8**
Psychiatric hospital	**-**
	100
N=	***96***

To put the above findings in context, in the 2003 Scottish Health Survey it was found that 9% of men and 13% of women had stayed in hospital for one night or more in the previous 12 months (Scottish Executive, 2005). Once again, the findings of the present study suggest that the health behaviours of Polish in-migrants differ from those of people in the general population; female Polish in-migrants make slightly greater use of in-patient hospital services whilst males make less use of in-patient hospital stays.

4.4 Health related Services

Enquiries into the health behaviours of the Polish in-migrants closed by exploring their use of health related services. Participants were asked firstly about their use of 'check-up' services since arriving in Scotland (i.e. dental checks, cervical screening etc.). In addition, they were asked about their use, in the past six months, of a range of services including pharmacists and NHS-24, the nurse-led telephone help-line. The following was found.

Asked about the use of 'check-up' services since coming to Scotland, the study found that 16% (n=16) of participants had made use of such healthcare provision (see Table 4.4.1). The most reported reason for using such services was for dental appointments or 'smear tests'[5].

Table 4.4.1 'Check-up' Services (i.e. dental, cervical 'smear tests')

	%
Yes	**16**
No	**84**
	100
N=	***99***

Additional comments offer insight into this particular health behaviour and highlight reasons why these types of services may be underused. As such, several participants talked about only using services such as dental check-ups or cervical screening in Poland, either doing so before moving to Scotland or waiting until return visits (e.g. holidays) to Poland. Thus a 29 year old woman explained her response to the need for cervical screening, *'I am often in Poland and there I go for examination'*. Similarly another 29 year old woman explained, *'All the most important examinations I did before I arrived here. And now I am planning to do the*

[5] As part of the NHS cervical screening programme, all women (aged 25 years to 64 years) registered with a GP are automatically invited for a smear test periodically. Women are first invited at the age of 25 years and thereafter every three years up to the age of 49 and then every five years until the age of 64 years.

same again on my holiday in Poland.' With respect to dental check-ups, cost was a factor inhibiting use of local dentists. Once again, participants deferred treatment until they could return to Poland, as one 23 year old woman explained, '*.. dentist check-up .. after calculating the costs I decided that I can't afford to have my dental treatment done in Scotland and decided to have it done in Poland..'*

Differences within the study group suggest that women were more likely than men to have 'check-ups' with 28% (n=13) women reporting this to be the case compared with only 2% (n=1) of men.

Enquiries were then made about participants' use of any health related services (e.g. pharmacists). Just under a fifth of those surveyed had made use of such a service in the previous six months (18%, n=18), with pharmacists being the most reported service used. Pharmacists were used for a variety of reasons, including advice on smoking, colds, and haemorrhoids, as well as advice on to deal with a damaged knee. No differences were found within the study group with respect to the use of health related services.

Finally, participants were asked about their use of NHS-24, the 24 hours, nurse-led telephone health advice service.

10% (n=10) of participants had used the service in the previous six months. The most reported use was in respect of advice for a sick child. Differences within the study group suggest that women were more likely than men to have used NHS – 24 with around a fifth of women doing so (20%, n=9) compared with only 2% (n=1) of men.

Table 4.4.2 Use of NHS -24

	%
Yes	**10**
No	**84**
Don't know	**3**
	100
N=	***97***

SECTION FIVE: EXPERIENCE OF HEALTH SERVICES

5.1 Introduction

The final part of the survey (and focus groups) into the health status and health behaviours of Polish in-migrants examined their subjective assessments of using NHS health services. In particular participants were invited to comment upon the ease of accessing NHS treatment, the usefulness of treatments and ways of improving services. The following was found.

5.2 Access to Treatment

To begin with enquiries were made about how easy it was to access NHS treatment for a range of illnesses and health related concerns (i.e. physical illness, mental illness, substance misuse etc.).

Table 5.2.1 Ease of Access NHS Treatment for select conditions < 12 months

Condition	*Very easy / easy*	*Not easy**	*Respondents*	*% of total sample seeking NHS treatment*
	%	%	Total N	%
Smoking	**92**	**8**	**13**	**13**
Accident	**71**	**29**	**17**	**17**
Physical Illness	**45**	**55**	**31**	**31**
Alcohol Problem	**38**	**62**	**8**	**8**
Mental Illness	**36**	**64**	**11**	**11**
Sexual Health	**27**	**73**	**11**	**11**
Drugs	**25**	**75**	**11**	**11**
Teeth or gums	**14**	**86**	**21**	**21**

** not easy referred to 'difficult',' very difficult' and' unsure'*

As table 5.2.1 shows, it was a minority of participants who sought help for any particular condition within the past 12 months. Help with physical illness was the most sought after form of medical assistance alongside specific treatment for dental problems, with between a fifth and a third of people seeking help with such conditions.

Amongst the minority seeking healthcare, there were differential experiences in accessing NHS services linked to the particular type of condition for which treatment was sought. The conditions most likely to allow easy access to treatment were smoking, accidents and physical illness. Between two-fifths and 90% of people requiring NHS services for these conditions were able to access treatment. By contrast access to NHS substance misuse services and Dentists were more problematic.

Table 5.2.2 Factors more or less enabling access to NHS services

Factor	*Made it Easy*	*Made it Less Easy*	
	%	%	Total N
Own knowledge	**92**	**7**	**45**
Own attitude	**99**	**1**	**32**
Previous experience	**94**	**6**	**31**
Appointment system	**61**	**39**	**59**
Location of service	**86**	**14**	**57**
Attitude Medical Staff	**98**	**2**	**45**
Attitude Receptionists	**94**	**6**	**48**
Waiting lists	**60**	**40**	**35**
Opening Hours	**65**	**35**	**37**
Financial costs of using service	**72**	**28**	**32**
Advertising of service	**73**	**27**	**40**
Peer Pressure	**96**	**4**	**25**
Help of family or friends	**100**	**-**	**35**
Religious views	**100**	**-**	**9**

Follow up enquiries about ease of access to NHS treatment, examined a range of factors that were more or less enabling for the Polish people surveyed. Fourteen areas were asked about in the survey and others explored in focus group discussions. They covered both individual

experience and disposition as well as service organisation and delivery. The following was found.

As table 5.2.2 shows, there were clear sets of enabling factors as well as potential barriers to NHS service use. Amongst the enabling factors, reported by four-fifths or more or more of participants, were Polish people's own knowledge, experience and attitude to using NHS services, as well as the disposition of medical staff and receptionists. Also, suitable location assisted service use. In short, knowing which services were available, local services, a good previous experience and confidence in the staff providing the service facilitated engagement. Thus a young Polish mother talked about her very positive experience of a hospital visit in Turriff, highlighting the positive attitude and care of the doctor who treated her children, remarking '*Two years ago I went with my children to a hospital in Turriff. That was during my first month in Scotland. I could not speak English and there was a very nice GP woman there. She spent one and a half hours with us and did not understand me at all ! But she spent so much energy and effort to examine my children that alone she managed to work out what was wrong with them !* Elsewhere, another Polish woman commented upon a different experience of going to a GP in Banff. Confident in the ability of local GPs, she observed, '*Yes, they are knowledgeable, but there is one GP <name> who always thinks there is nothing wrong with you .. but he is nice and kind'*. In addition, it was pointed out in focus group discussions that help with English language translation could facilitate engagement with NHS services. Thus a young Polish women observed, '*It is easy to use the services of the NHS if you have someone who will help you translate.'* The same focus group participants highlighted the value of 'language line', a free telephone interpretation service available in NHS hospitals.

With respect to the potential barriers to service use, the most reported were waiting lists, the appointment systems in place, opening times of services and the costs involved in using services (i.e. dentists). In addition, language barriers were reported. In terms of costs, there was general agreement amongst the men in the 'male focus group' that dental health care was expensive and consequently less accessible. Thus one young man observed '*..the worst situation is with dentists. It is hard to get an appointment. We know there is no subsidy for the cost of the dentist and everyone has to pay. It is very expensive.'* However it was language barriers that were most often commented upon in both the male and female focus groups. Thus one young man observed ' *Yes, English language is a barrier .. the hospital has Language Line but not very medical surgery has.'* Another remarked, '*We think that people working in the NHS are doing their job well. The main barrier is language. People here (in Scotland) will not learn Polish so we will have to learn English.'* In the 'female focus group' similar concerns were expressed, thus one woman recalled her early experience of an NHS GP surgery, noting the difficulties non-English speaking in-migrants posed for reception staff, '*At the beginning the women were terrified when they saw a Polish person come to the desk ..'* However several women noted a change that might be an indication that the language barrier was becoming less of a issue. Thus while one woman commented upon her experience of primary care '*.. if you are managing to speak basic English then in the surgery they do not do anything to help you (but) if they know someone is stuck without English they phone somewhere and try to find someone who can help. Sometimes they use Language Line in hospital but not in the surgery.'* another woman noted '*For the last three months the receptionist has been asking if patients require an interpreting service.'*

5.3 Usefulness of Treatment

The second main interest in examining Polish people's experience of NHS health services was the usefulness of this provision. Accordingly, the Polish people surveyed were asked to assess the value of a range of services, including primary care, hospital based treatments and

specialist services. Such assessments were based on the extent to which these services were able to meet their health needs in the past year. The following was found.

Table 5.3.1 Usefulness of NHS Services

Service	*Useful*	*Unsure*	*Not useful*	
	%	%	%	Total N*
GP practice	77	19	4	53
Accident & Emergency	91	9	-	34
Hospital Out-Patients	83	17	-	24
Substance Related Outpatient Services (e.g. SMS)	73	18	9	11
General Hospital in-patient	90	10	-	31
Psychiatric Hospital in-patient	69	31		13
Dentist	80	10	10	31

** Polish people who had not used a service were excluded from the analysis*

As table 5.3.1 shows, the Polish patients surveyed generally found a range of NHS services useful in meeting their health needs in the previous 12 months. Amongst the most heavily used and reported on (i.e. by a third or more of participants), hospital based services in particular were assessed as worthwhile. There were no systematic differences within the study group with respect to the perceived usefulness of services. As such men were as likely as women and older people (aged 25 years +) as likely as younger people (aged <25 years) to regard the NHS services used as effective.

Comments supporting such an assessment were commonly voiced in the focus group discussions. Thus when asked about the usefulness of NHS services, both men and women were generally of the opinion that the NHS worked well. Thus in the 'female focus group', one woman observed *' NHS treatments are useful, only language is a problem. Treatments are really good; better than in Poland.'* Another young woman amplified the latter point, highlighting the quality of maternity services in Scotland, observing '*The UK NHS services offers treatments the same for everyone and is the same as Poland, except the maternity service is better here. I was surprised how much attention I had during my pregnancy. The nurses here are very knowledgeable; they are acquainted with lots of subjects and areas.'* Another woman remarked, '*In Poland when you are going to give birth you are left alone for the night. That is scary for young girls especially*.'

Elsewhere several men, observed (positive) differences in the treatments offered in Scotland and Poland and thought the Scottish doctors, unlike doctors in Poland, were less likely to prescribe antibiotics, observing '*GPs here do not want to prescribe antibiotics. GPs here are trying to stay away from giving patients antibiotics .. and it is good for us that we are not taking antibiotics'*.

5.4 Improving NHS Services

The survey (and focus groups) closed by exploring ways of improving NHS health services for Polish in-migrants. In particular participants were asked about how attitudes, policies and practices might change within the NHS to better deliver health care. The following was found.

To begin with participants were invited to choose five factors from a list of eleven that would have made a positive difference to their own experience of NHS health services in the

previous 12 months. The factors described a range of organisational arrangements, staff attitudes, new types of service and new ways of accessing services.

Table 5.4.1 Ways of Improving NHS services

*Factor**	*%*
Polish 'Language Line' in all NHS health facilities	**58**
More medical staff able to speak Polish	**53**
Leaflets & documents in Polish	**48**
Shorter waiting lists	**30**
Better appointment systems	**30**
Someone to accompany you to service (i.e. 'buddy')	**25**
More 'female friendly' services	**13**
Better location of service	**10**
Better reception staff attitudes	**5**
Better medical staff attitudes	**3**
Other	
	100
N=	***100***

***** *Participants were invited to state multiple choices*

As table 5.4.1 shows, the three most reported improvements called for were linked to enhanced language services. As such around half of those surveyed called for better Polish translation services and documentation. In addition, around a third of participants called for shorter waiting lists and better appointment systems.

Differences within the study group suggest that women were more likely than men to call for more 'female friendly' services by way of making the NHS more useful, with 20% (n=9) women making such a request compared with only 6 % (n=3) men.

Next the Polish people surveyed were asked about the extent to which their views and opinions had been listened to as they underwent NHS treatment in the previous 12 months.

As table 5.4.2 shows, across a range of services the views and opinions of Polish people were more or less listened to as they underwent treatment through the NHS. GP services, hospital Accident & Emergency services and general hospital in-patient services were the most reported settings in which Polish people felt that their voices were being heard, with more than half of Polish people using these services reporting that their views and opinions had been listened to. By contrast none of the small number of Polish people who had been patients in psychiatric hospital during the past year or used general hospital out-patient services during this time, felt that they had been listened to.

There were no systematic differences found within the study group with respect to the perception that their views and opinions as NHS patients had been listened to. Accordingly men were as likely as women and older people (aged 25 years+) were as likely as younger people (aged <25 years) to feel that they had been listened to or not, during the course of NHS treatment in the previous 12 months.

Table 5.4.2 Views & Opinions listened to <12 months

NHS service	*Listened to*	*Unsure*	*Not listened to*	
	%	%	%	N
GP practice	55	36	9	33
Accident & Emergency	53	42	5	19
Hospital Out-Patients	-	70	30	10
Substance Related Outpatient Services (e.g. SMS)	13	62	25	8
General Hospital in-patient	50	37	13	16
Psychiatric Hospital in-patient	-	75	25	8
Dentist	31	54	15	13

The study closed by inviting the Polish participants to consider ways in which the NHS might change to provide better services to Polish people in the future. In particular, participants were asked to identify improvements in three distinct areas: illness that ought to be prioritised; policies that need to change; and NHS staff attitudes that could improve. They were invited to identify three illnesses, policies and groups of staff attitudes in each of these areas. The following was found.

Table 5.4.3 Future Improvements Sought in NHS – Illnesses & Conditions to Prioritise

Illness / Condition	*%*
Physical illness	60
Mental Illness	37
Physical Disability	35
Problems with teeth & gums	35
Alcohol Problems	26
Drug Problems	26
Other (e.g. female health)	6
	100
N=	*100*

With respect to illnesses that required prioritisation (table 5.4.3), the Polish people surveyed identified physical illness (e.g. cancer, heart disease, bronchitis) as the major type of illness requiring attention, with three-fifths suggesting that the NHS make this a priority. In addition, around a third highlighted the need to address mental illness, physical disability and dental problems. Differences within the study group suggest that women were more likely than men to seek to prioritise physical illness, with two thirds of women calling upon the NHS to do so (70%, n=32), compared with around half of men (49%, n=24). No other systematic differences were found.

In terms of policies needing attention (table 5.4.4), the most sought after changes were easier access to dentists and easier registration with GPs, with two-thirds and a half, respectively, of the Polish people surveyed stating such a wish. Few saw the need to prioritise any of the other policies asked about.

Table 5.4.4 Future Improvements Sought in NHS – Policies

Policies	*%*
Easier access to dentist	**67**
Easier registration with GP	**46**
Easier access to The Substance Misuse Service (SMS)	**16**
Easier access to Alcohol services	**13**
Better hospital discharge procedures	**10**
Other policy (e.g. access gynaecologist)	**9**
	100
N=	***100***

In addition to easier registration with GPs, participants also raised the issue of the opening hours of GP surgeries and suggested Saturday opening might assist those in employment. Elsewhere in the focus groups, women called for a simple but practical improvement that could benefit their children's health. Recalling how children's health was organised in Poland, they called upon the NHS to provide a calendar to mothers to enable them to keep track of childhood inoculations. They explained '*We would like a calendar for children's injections because everyone has them at different times and dates and we are mixed up. In Poland we have more injections for children and we have a calendar.*' There were no systematic differences found within the study group with respect to NHS policies that needed to change.

Finally, with respect to the need to change the attitudes of groups of NHS health workers (table 5.4.5), the staff seen as most requiring to change were GPs and nurses in GP surgeries. As such, and notwithstanding the fact that the majority of the Polish people surveyed felt that their views and opinions had been listened to in primary care (see table 5.4.2) several participants voiced concern about the attitude of some medical staff in GP surgeries. Thus a 28 year old woman complained, '*The GP treated my health problem as a joke and the receptionist could not or did not want to give me an appointment.*' Elsewhere a 21 year old man suggested, '*Receptionists and doctors should have more time and be more patient with their patients. Also, they should be more available..*' Participants called for more sympathy and courtesy from such NHS staff. No systematic differences were found within the study group with respect to perceptions about the need for NHS health workers' attitudes to change.

Table 5.4.5 Future Improvements Sought in NHS – Staff Attitudes

Staff Group	*%*
GPs	**34**
Nurses in GP surgeries	**28**
Receptionists in GP surgeries	**18**
Receptionists in dental surgeries	**17**
Receptionists in hospitals	**11**
Nurse in hospitals (e.g. general, psychiatric)	**11**
Medical staff in hospitals	**7**
	100
N=	***100***

Finally, participants were asked how their views and opinions (about improvements in services) might best be represented. In focus group discussion, participants identified a straightforward way through which their voices might be heard; consult with them through the systematic collection of opinion and attitudes. Such a system was common practice in Poland. Thus in the 'male focus group' participants expressed an interest in being consulted, although they were not sure if this was necessarily effective in bringing about change. Thus one man explained, when asked if his opinion was ever sought within NHS services, '*.. we only give personal information during the (GP) registration process. Also, in hospital this seems to be routine, to ask questions about you, your address and similar .. (but there is no way of giving opinion about treatment from the NHS) .. yes, I would like to, but I am not sure if something like that is available. Do Scottish people have the opportunity of giving such opinions ?'*

Within the 'female focus group', women corroborated the male experience but offered reassurance that patient views could bring about sought after change. They explained as follows, '*No-one ever asks us about our opinion of the service here. In Poland we have an anonymous questionnaire. If we had the possibility here of a questionnaire in Polish for sure we will answer it.'* Additionally, the women then went on to explain how mobilising opinion could be lead to service improvements, explaining how a collective response had helped save local maternity services , '*We proved the strength of our voice two years ago when there was a plan to shut down the maternity ward here (in Banff) .. so many Polish girls arrived in the area that they did not shut down the maternity ward !'*

SECTION SIX: CONCLUSION

6.1 Introduction

The conclusion aims to highlight the main findings of the research by returning to the original research interests that guided the study. As such, it will attempt to answer the following five main questions:

The research was guided by the following five research questions:

1. What are the individual needs of Polish in-migrants regarding healthcare and treatment?
2. How should NHS services ensure that Polish in-migrants individual needs are identified respected and responded to?
3. What are the barriers (i.e. structural, policy or attitudinal) to Polish in-migrant workers and their families being involved in decisions about their care and treatment?
4. How should NHS services engage with Polish in-migrants to capture their views and experiences of NHS services?
5. How should NHS services engage with Polish in-migrants to plan changes and improvements in services?

In addition, the conclusion will reflect upon the findings of the study and suggest possibly policy implications which flow from the research.

6.2 Research Questions Answered

1. What are the individual needs of Polish in-migrants regarding healthcare and treatment ?

The study sought to understand the health needs of Polish in-migrants to Aberdeenshire by adopting a multi-dimensional approach to health. Accordingly health was variously examined in the study through a combination of 'objective' and 'subjective' measures and the use of standardised and study specific questions, all of which were based on self-reporting by the survey participants. As such, no clinical assessments were used in the study. Although such an approach of necessity delimits the findings of the research it is important to acknowledge that any biomedical definition of health is in itself insufficient as health is essentially an amalgam of personal experience and the absence of more measurable abnormality or dysfunction. Further, the 'standardised' (self-report) items used in the study have attained a degree of validity and reliability sufficient to allow us to have confidence in their usefulness as indicators of personal well-being. In short therefore, the measures of health used in the present study were 'recognised', meaningful and practicable and clearly indicative of the health status of the Polish people surveyed. What do such measures tell us?

Based on standardised questions, a third of the Polish people surveyed assessed their own general health as 'less than good' (38%). In addition, 14% reported a long-term illness or disability, often related to physical health problems (e.g. back pain), which was limiting in some way for half of the sufferers (50%). Furthermore, asked about their experience of 20 commonly reported 'objective' diseases or conditions, respondents, on average, indicated experience of two such conditions at some stage in their lives, with around a third reporting back trouble (34%) or chronic bronchitis (30%) and a fifth reporting stress (21%). Investigation into recent illness (i.e. the subjective experience of pain and discomfort) in the past month, suggested that almost all of the Polish people surveyed had been 'ill' during this time (83%), often with colds/flu, headaches or back pain. Finally, enquiries about street drug use found that only a small proportion of those surveyed had used street drugs in the past month (3%), while a quarter of respondents had used street drugs at some point in their lives (24%). There was little or no evidence of injecting street drugs.

To put these findings in context it is instructive to compare them with rates of morbidity in the general population.

Table 6.1 Morbidity Amongst Polish in-migrants and General Population

Condition	***Polish Study Group***	***General Population***
1. General Health – 'less than good'	**38%**	**26-27%**[1]
2. Long-term illness/ disability	**14%**	**41-42%**[1]
3. Limiting long-term illness/disability (among sufferers)	**50%**	**c.60%**[1]
4. Disease prevalence (ever)	**65%**	**-**
5. Disease average number of (20) specified conditions	**2**	**-**
6. Illness prevalence (< month)	**83%**	**-**
7. Illness average number of (12) specified symptoms	**3**	**-**
8. Street drug use past month	**3**	**5**[2]
9. Street drug use ever	**24%**	

Key:1 = Scottish Health Survey 2003, men and women respectively; 2 = Scottish Crime Survey 2003, adults aged 16 – 59 years

As Table 6.1 shows, Polish in-migrants appear to suffer higher levels of general ill-health but less long-term and limiting illness or disability and to use street drugs less than people in the general population. In addition they are likely at some time to have experienced two (medically defined) diseases or conditions and more recently to have suffered from three illness symptoms. In short, the health profile of Polish people surveyed is distinctive and sets them apart from people in the general population. It is characterised by poorer levels of general health, offset by the absence of expected levels of long-term (and limiting) illness / disability and lower levels of drug use.

Polish in-migrants however are not a homogeneous group and differences were noted within the sample with respect to the experience of diseases and (recent) illness (see table 6.2). With respect to gender, women were more likely than men to report suffering from severe depression / nervous illness and piles / haemorrhoids. In addition they experienced greater levels of illness, being more likely to report colds / flu in the previous month. In terms of age, younger people (16-24 years) suffered more from chronic bronchitis By contrast, older people (aged 25 years +) were more likely to suffer back pain.

In sum therefore, the atypical and poorer general health of the Polish in-migrants should be understood as both sex and age defined. As such the complex mix of disease, impairment, illness and psycho-social malaise leaves sub-groups of Polish in-migrants with specific and heightened types of disease and illness. Women are affected differently from men and younger people from older people. All are less well than people generally, but are also less well in their own distinctive ways.

Table 6.2 Health Profile of Polish in-migrants

Health Indices by Likely Sufferers				
Condition	**male**	**female**	**16-24 years**	**25 years+**
General Health				
Long-standing (limiting) Illness / Disability				
Likelihood of 20 specified diseases				
Types of disease		**Severe depression/ nervous illness** **Piles / haemorrhoids**	**Chronic bronchitis**	**Back trouble**
Illness		**Colds/flu**		**Back-ache**
Drug use ever				

2. How should NHS services ensure that that Polish in-migrants' individual needs are identified, respected and responded to ?

To understand how the NHS ought to engage with Polish in-migrants, it is necessary to map out current patterns and levels of service use and to understand the usefulness of such health behaviours to Polish in-migrants themselves. The research sought to do both.

Accordingly, the study explored how Polish in-migrants made use of a variety of NHS health services and health related services. As such it examined registration and use of GP services, use of Accident & Emergency services and other hospital based out-patient services. Also, it reported on the use of in-patient hospital services. Further, it examined the use of 'check-up' services (e.g. dental checks, cervical screening). Finally the use made of a range of health related services (e.g. pharmacists) was looked at. Where possible, the study sought to compare the use of services by Polish people with the use of services by people in the general population. Later, the study examined Polish people's assessments of such service engagement. The following was found.

With respect to primary care services the study found around three-fifths of the Polish people surveyed had registered with a GP (59%). In the two weeks prior to the survey a quarter of respondents overall had consulted a doctor (23%), with 35% of women having done so compared with 13% of men.

As noted earlier, in the general population as a whole 20% of women and 16% of men consulted a doctor in the previous two weeks. The findings from the present study therefore suggest that Polish women make far greater use of GP services than women in the general population, a use that possibly implies greater levels of morbidity.

With respect to acute services, the study found that just under a fifth of the Polish people surveyed had made use of hospital based Accident & Emergency services in the past year (18%). Also, 12% had made use of 'other' hospital out-patient services during this time (39%). In total more a quarter of all the Polish people surveyed had used some kind of hospital based out-patient facility in the last 12 months (24%).

Once again it is possible to put such findings in context by comparing rates of usage of acute services among the study group with health behaviours in the general population. Accordingly among the population at large around a third of people (35% men, 37% women) have made use of Accident & Emergency facilities and other hospital based day-patient services in the previous 12 months. As such, the findings suggest that Polish people again make less use of NHS health services than people generally.

In terms of in-patient hospital stays, the study group found that around only a small proportion of the Polish people surveyed had spent at least one night as a patient in hospital in the past year (8%), with 16% of women having had such an experience compared with only 2% of men. All had been patients in a general hospital during this time. In the general population 9% of men and 13% of women have spent time as a patient in hospital over the past year. Once again, the findings of the present study suggest that the health behaviours of Polish in-migrants differ from those of people in the general population; female Polish in-migrants make slightly greater use of in-patient hospital services whilst males make less use of in-patient hospital stays.

Finally, with respect to the use of 'check-ups' and other health-related services, the study found that 16% of the Polish people surveyed had made use of such services, with dental appointments, 'smear tests' and pharmacists the most reported services used. In addition, 10% had made use of NHS-24, typically for advice about a sick child.

In terms of the value of engaging NHS health services, Polish patients generally found a range of NHS services useful in meeting their health needs in the previous 12 months. Hospital Accident & Emergency out-patient services (91%) and general hospital in-patient services (90%) were assessed as the most effective services used, by the third of people who had used them. Amongst the half who had used GP services, three-quarters found them useful too (77%).

In sum therefore, the study suggests that Polish in-migrants under-use both primary care and secondary care NHS services, including emergency services, being less likely than people in the general population to register with a GP, to use hospital out-patient services or to use hospital in-patient services. Coupled with this under-use of NHS services, there was a positive assessment of the variety of treatments that were engaged with. Accordingly, for the fewer than expected who make use of NHS services, the experience is worthwhile, especially with respect to hospital-based services. As such, the value of the services available needs to be communicated to the wider Polish (in-migrant) community, by the NHS, to effect greater service use.

3. What are the barriers (i.e. structural, policy or attitudinal) to Polish people being involved in decisions about their care and treatment ?

Given the heightened levels of morbidity and under-use of NHS services found amongst the Polish in-migrants in the present study, it was instructive to examine the extent to which Polish people enjoyed equitable access to a range of NHS provision. In particular the study sought to find out whether Polish people faced barriers to service use, either in terms of the ways in which services were organised (i.e. structural and policy factors) or the ways in which they were delivered.

The results of the study suggest that the Polish people surveyed had a differential experience of accessing NHS services linked to the particular type of condition for which treatment was sought. The conditions most likely to allow easy access to treatment were smoking, accidents and physical illness. Between two-fifths and 90% of Polish people requiring NHS services for these conditions were able to access treatment. By contrast Polish people's access to NHS substance misuse services and dentists was more problematic.

Asked about the factors which more or less enabled them to access such services, the study found clear sets of enabling factors as well as potential barriers to service use. Amongst the enabling factors found were Polish people's own knowledge, experience and attitude towards using NHS services, as well as the disposition of medical staff. Knowing which services were available, a good previous experience and confidence in the staff providing the service facilitated engagement

With respect to the potential barriers to service use, the most reported were waiting lists, the appointment systems in place and the costs of using (dental) services. In addition, language barriers were reported. With respect to the latter, there was perception that the situation would improve as greater use was made of 'Language Line', a free telephone interpretation service available in NHS hospitals.

In sum, therefore, the Polish people surveyed were generally able to access NHS services for certain conditions (i.e. smoking, accidents and physical illness.), although access to substance misuse services and dentists was perceived as more difficult. Information, previous experience and confidence in medical staff facilitated engagement, whilst waiting lists, appointment systems, cost (for dental treatment) and language difficulties could deter involvement.

4. How should NHS services engage with Polish people, to capture their views and experiences of NHS services ?

To understand how the NHS might best engage with Polish in-migrants to capture their views and experiences about NHS services, it is important to understand how Polish people currently experience NHS services. Accordingly, the study sought to find out whether or not Polish people's views and opinions were already recognised within the NHS services they used.

Across a range of services, the views and opinions of Polish people were more or less listened to as they underwent treatment through the NHS, in the preceding 12 months. GP services, hospital Accident & Emergency services and general hospital in-patient services were the most reported settings in which Polish people felt that their voices were being heard. Just over half of Polish people using these services reported that their views and opinions had been listened to.

By contrast none of the small number of Polish people who had been patients in psychiatric hospital during the past year or used general hospital out-patient services during this time, felt that they had been listened to.

In sum therefore, if the responsiveness and interest found in certain GP surgeries, hospital out-patient services and hospital in-patient services were replicated more widely across other NHS services, Polish people's views and opinions about health and healthcare would be better recognised within the NHS. A key dimension of such responsiveness would, at least initially, include the use of the Polish language, both in verbal and written communication.

5. How should NHS services engage with Polish people, to plan changes and improvements in services ?

The study closed by exploring how the NHS might engage with Polish in-migrants in order to improve future service provision. Participants were asked to identify improvements in three distinct areas: illness that ought to be prioritised; policies that need to change; and NHS staff attitudes that could improve. In addition, they were asked about the processes through which their views might best be represented.

In terms of the improvements required in NHS services, and with respect to illnesses requiring prioritisation, the Polish people surveyed identified physical illness (e.g. cancer, heart disease, bronchitis) as the major type of illness requiring attention. Three-fifths suggested that the NHS make this area a priority. In addition, around a third highlighted the need to address mental illness, physical disability and dental problems.

In terms of policies needing attention, the most sought after changes were easier access to dentists and easier registration with GPs, with two-thirds and a half, respectively, of the Polish people surveyed stating such a wish.

With respect to the need to change the attitudes of groups of NHS health workers, the staff seen as most requiring to change were GPs and nurses in GP surgeries. Between a third and a quarter of Polish people surveyed identified these groups of staff. Participants called for more sympathy and patience from such NHS staff.

Finally, asked how their views and opinions (about improvements in services) might best be represented, participants identified a participants identified a straightforward way through which their voices might be heard; consult with them through the systematic collection of opinion and attitudes. Such a system was common practice in Poland.

6.3 Policy Implications

Research does not make health or social policy. However alongside resources and the political will to use them, research can inform decisions at both the strategic and operational levels. The findings from the present study should be understood in this way.

The present study examined the health status and health behaviours of Polish in-migrants to Aberdeenshire. It sought to find out how well NHS services engage with such Polish people in the local authority area and to explore how patient and public involvement could be developed meaningfully to ensure that the views of Polish people are actively sought, listened to and acted upon.

It was the intention that the information gathered and understandings achieved would inform the work of the NHS locally with respect to how best to engage with 'hard to reach' and 'seldom heard' groups. In addition the research sought to inform the Scottish Health Council about how best to support NHS Grampian as it seeks to identify, understand and address these issues, through for example, the development of guidance and standards. What does the research imply ?

Firstly, the study found that Polish people suffered poorer levels of general health compared with people in the general population. However they were less likely to suffer from long-term (and limiting) illness and disability. **Accordingly, NHS Grampian should take account of such patterns of illness and disease in the planning and delivery of health services. In particular, they should seek to tackle the incidence of back trouble, chronic bronchitis and stress which are relatively highly reported within the study group. Such intervention may preserve the relatively good incidence of reported long-term (and limiting) illness and disability.**

Secondly, notwithstanding the heightened levels of poor general health, the study found that only three-fifths of the Polish in-migrants were registered with a GP practice in the local area. **Accordingly, given the importance of primary care in tackling ill-health and referring patients to specialised secondary care, NHS Grampian should take account of such patterns of registration in the planning and delivery of primary care health services. In particular, they should proactively engage with the Polish community in the North East to ensure that they link to GP services. Young people in particular should be encouraged to register.**

Thirdly, compared with people in the general population, Polish in-migrants make less use of hospital based out-patient services. Also, their use of hospital in-patient services differs from that of the general population (with men being less likely to be patients and women more likely to be patients). Instead many Poles reported being treated in Poland for different problems including back troubles, chronic bronchitis, stomach disorders and chest complaints. **Accordingly, NHS Grampian should take account such distinctive patterns of health service use in the planning and delivery of health services, the better to meet the requirements of a particularly needy group. Men in particular should be encouraged to use the services available, when in need.**

Fourthly, the study found that Polish people's high levels of need and mixed levels of experience were, in general, met by an appropriate response from NHS services. As such the majority of Polish in-migrants surveyed felt that the NHS was effective in meeting their health needs. **Accordingly, NHS Grampian should build upon the high levels of satisfaction expressed by Polish people to reinforce the valuable work done by staff. In**

particular it should build upon the positive perception of hospital based services, by the minority who used them.

Fifthly the study found that Polish people's assessment of NHS healthcare however was both illness and service related. As such, treatments for smoking, accidents and physical illness were more readily available than treatments for NHS substance misuse and dentists. Elsewhere, participants suggested the need to prioritise mental health services. **Accordingly, NHS Grampian should ensure that effective action is taken to improve services to Polish people where necessary. Consideration should be given, in particular, to providing additional mental health services, substance misuse services and dentists.**

Sixthly, the study found clear sets of enabling factors as well as potential barriers to NHS service use. Amongst the enabling factors were Polish people's own knowledge of services, the availability of local services, experience of using services and attitude to using services. In addition, the disposition of medical staff was a factor. In short, the study found that the 'key' to Polish people's satisfaction with services lay in knowing which services were available, a good previous experience and confidence in an interested and caring staff. **Accordingly, NHS Grampian should publicise its services, ensure that 'first contact' with services is positive and offer 'care' as well as treatment.**

Seventhly, with respect to the potential barriers to service use, amongst the most reported were waiting lists, appointment systems in place ,opening hours and a general problem with (the English) language. In addition, the financial costs of using dental services were highlighted. **Accordingly, NHS Grampian should look again at the organisation of both primary and secondary care services, with a view to developing better ways of managing the delivery of treatments. Alongside a reduction in waiting times, extending GP surgery opening hours would be welcomed by Polish people. In addition, extra NHS dentists would promote greater equality amongst a needy and disadvantaged group of patients unable to access private and costly healthcare. Finally, enhanced translation services would assist service engagement generally.**

Finally, the study explored how the views and opinions of Polish in-migrants about the design and delivery of services could best be represented to NHS Grampian. The study found that just over half of the Polish people surveyed felt that their views and opinions had been listened to as they underwent treatment through the NHS, in the preceding 12 months. Participants identified a straightforward way of seeking their views; consult with them through the systematic collection of opinions and attitudes. **Accordingly, NHS Grampian should proactively seek the views and opinions of Polish people by supporting the use of patient feedback forms in surgeries and clinics and other places where Polish people present for treatment. At the present time, the 'materials' used in such a process (i.e. questionnaires etc.) ought to be in Polish.**

References

Aberdeenshire Council (2007) *Aberdeenshire Statistics, Scottish Index of Multiple Deprivation*
http://www.nhsgrampian.org/nhsgrampian/files/GPBookletFeb07.pdf

Blaxter, M (1990) Health & Lifestyles London: Routledge

Castles, S and Miller, M. (2003) *The Age of Migration: International Population Movements in the Modern World*. London: Palgrave.

Chief Scientist Office. (2003) Research Matters: Newsletter of the Chief Scientist Office: Issue 20 Spring 2003.
http://www.show.scot.nhs.uk/cso/Publications/ReMat20/rm20-00.htm

Centre for Health Studies, Warwick University. (2001) 'Systematic Review of ethnicity and health service access for London' in *Commission for Racial Equality Research : Health Care Statistics*.
http://www.cre.gov.uk/publs/cat_health.html

De Lima, P., Jentsch, B and Whelton, R. (2005) *Migrant Workers in the Highlands and Islands: Research Report*. UHI Policyweb & National Centre for Migration Studies.

Information Services Division (ISD, Scotland) (2006) Drug Misuse Statistics Scotland 2006
http://www.drugmisuse.isdscotland.org/about.htm

Mental Health Foundation. http://www.mentalhealth.org.uk

NHS Grampian. (2005) *NHS Grampian Race Equality Scheme 2005 – 2008*.
http://www.nhsgrampian.org/nhsgrampian/files/Race%20Equality%20Nov%202005.rtf

Scottish Executive (2001) 'The Scottish Health Survey 1998'
http://www.sehd.scot.nhs.uk/scottishhealthsurvey/sh8-00.html

Scottish Executive (2004) 'The Scottish Crime Survey 2003'
http://www.scotland.gov.uk/Publications/2004/12/20379/48077

Scottish Executive (2005) 'The Scottish Health Survey 2003'
http://www.scotland.gov.uk/Publications/2005/11/25145024/50251

Scottish Executive (2006) *Scottish Index of Multiple Deprivation*
http://www.scottishexecutive.gov.uk/News/Releases/2006/10/17104536