

# Caring for refugees in general practice: perspectives from the coalface

Rebecca Farley<sup>A,B,D</sup>, Deborah Askew<sup>A,C</sup> and Margaret Kay<sup>A</sup>

<sup>A</sup>Discipline of General Practice, The University of Queensland School of Medicine, Level 8, Health Sciences Building, Building 16/910, Royal Brisbane and Women's Hospital, Herston, Qld 4029, Australia.

<sup>B</sup>Inala Primary Care, 64 Wirraway Parade, Inala, Qld 4077, Australia.

<sup>C</sup>Inala Indigenous Health Service, 64 Wirraway Parade, Inala, Qld 4077, Australia.

<sup>D</sup>Corresponding author. Email: [r.farley1@uq.edu.au](mailto:r.farley1@uq.edu.au)

**Abstract.** This qualitative research project explored the experiences of primary health care providers working with newly arrived refugees in Brisbane. Data from 36 participants (20 general practitioners, five practice nurses and 11 administrative staff) involved in five focus groups and four semi-structured interviews were analysed. The results indicated that despite difficulties, providers are committed and enthusiastic about working with refugees. The flexibility of the general practice setting enables innovative approaches. The establishment of a specialised refugee health service in Brisbane has improved providers' capacity to deliver refugee health care. However, most practices continue to feel isolated as they search for solutions, and the need for greater supports and a more coordinated approach to care were emphasised. The themes of communication, knowledge and practice and health care systems encapsulated the factors that influence health care providers' ability to care for refugees and provide a framework for improving available supports. Australian primary health care is currently undergoing great change, which provides an opportunity to make significant gains in the provision of care for refugees and other minority groups within our community. As health care reforms are implemented it is essential that they are responsive to the expressed needs of health care providers working in these areas.

**Additional keywords:** Australia, primary health care, qualitative research.

Received 27 May 2012, accepted 25 November 2012, published online 21 December 2012

## Introduction

Each year ~13 500 refugees settle in Australia (Department of Immigration and Citizenship 2011). They experience higher rates of physical and psychological problems than other migrants, resulting from deprivation of resources, exposure to trauma and torture and poor access to health care before arrival (United Nations High Commissioner for Refugees 2002; Smith 2006; Victorian Foundation for Survivors of Torture 2012; Sheikh *et al.* 2009). These issues can be exacerbated in the early resettlement period, when refugees frequently experience unemployment, discrimination and lack of family and social supports (United Nations High Commissioner for Refugees 2002; Davidson *et al.* 2004; Sheikh-Mohammed *et al.* 2006; Sheikh *et al.* 2009). It is not uncommon for refugees to have multiple, complex health problems at the time of arrival but, with sensitive, intensive 'catch-up' care in the early resettlement period, most issues can be addressed (United Nations High Commissioner for Refugees 2002).

In Australia, most refugee health care is provided in primary care, yet few studies have explored the experience of these providers (Johnson *et al.* 2008; Sypek *et al.* 2008). A 2008 South Australian study highlighted the difficulties faced by general

practices when caring for newly arrived refugees, with some general practitioners (GPs) questioning whether private practice was the most appropriate setting for providing this care (Johnson *et al.* 2008). The authors concluded that a specialised refugee health service providing initial assessments for refugees before referral to community general practices might represent a better system (Johnson *et al.* 2008).

Currently each Australian state and territory has a different model for the provision of initial refugee health services (Smith 2006; Woodland *et al.* 2010). In 2009, Queensland established a specialised refugee health service, Refugee Health Queensland (RHQ), to provide health assessments and support to newly arrived refugees before referral to local general practices for ongoing care (Queensland Health 2008; Kay *et al.* 2010). The present study explored the experiences of general practices working within this new model, focusing on the barriers and enablers they continue to experience in providing care to refugees.

## Methods

### *Approach, setting and sampling strategy*

This qualitative research project involved purposive sampling, with RHQ staff identifying six general practices that had been

referred newly arrived refugees within the preceding 6 months. These practices were advised of the project by the senior medical officer at RHQ, and provided consent for one of the researchers (RF) to contact them and provide further information. RF attended each of these practices to discuss their involvement in the project.

Following each meeting, practices were contacted by telephone to further clarify their involvement in the project. To gain a whole-of-practice perspective, GPs, administrative staff (AS) and practice nurses (PNs) were invited to participate. Practices agreeing to participate were provided with information sheets, confidentiality agreements and consent forms and either focus groups or semistructured interviews were organised at a time suitable for the majority of staff.

### *Data-collection techniques*

Data collection occurred between November 2009 and May 2010. Focus groups were held during staff lunch breaks and lunch was provided by the researchers. Sessions were half an hour to an hour in length. Informed consent from each participant was obtained before the commencement of each group.

In addition to focus groups, semistructured interviews were conducted with participants for whom time constraints prevented participation in focus groups. In addition to facilitating involvement, these interviews enabled the researchers to determine whether additional issues emerged during interviews when compared with the data previously collected. If further issues did emerge, it would indicate the need to conduct further interviews with the participants involved.

RF facilitated all focus groups and conducted the semistructured interviews. A standard introduction and interview schedule, informed by the literature, was used to stimulate conversation and prompt discussion (Krueger 1998). Questions explored the barriers and enablers experienced when providing refugee health care and the resources providers felt would assist them in this task. Sessions were audio recorded and transcribed in full at the time of the focus group or interview. RF and MK took notes. Participants were provided with de-identified transcripts and given the opportunity to make additional confidential comments.

### *Analysis*

Key themes were identified using inductive thematic analysis and NVivo software was used to assist with data management (NVivo qualitative data analysis software Version 9, QSR International Pty Ltd, www.qsrinternational.com, verified 19 December 2012). Analysis was iterative and data collection ceased when no new issues emerged, suggesting data saturation (Hansen 2006). RF and MK read each transcript and independently coded data, identifying a preliminary list of themes. RF produced a refined list of major themes and subthemes; MK endorsed these themes. Because similar themes were identified during the focus groups and interviews, the data were considered comparable and therefore analysed together.

Ethics approval was granted by the Mater Health Services Human Research Ethics Committee (1415E).

### **Results**

All six practices participated in the study, with a total of 36 participants: 20 GPs, five PNs and 11 AS. All practices were

mainstream, urban general practices located in areas where refugees had been settled. The practices had a mixed-patient population, with refugee care being integrated into their usual practice. Five focus groups were conducted. Semistructured interviews were conducted with a practice manager and two GPs from the sixth practice where time constraints prevented a focus group occurring, as well as with a practice manager from a practice where a focus group had occurred.

Our results indicated that despite the difficulties faced when providing refugee health care, there is enthusiasm and commitment towards this work among providers. They spoke of how the flexibility of the general practice setting enables them to be innovative in their approach to caring for refugees, but could also be somewhat isolating. As providers discussed the barriers and enablers they experienced when caring for refugees, the themes of communication, knowledge and practice and health care systems emerged as an effective framework for capturing their descriptions of the factors that influence their ability to care for newly arrived refugee patients.

### *Providers' perceptions of their patients and their work*

The commitment of participants toward working with refugees was driven by a complex mix of diverse factors. Providers described patient characteristics, 'I find them an absolute pleasure, very nice, very courteous...' (1C, male GP, Focus group 1), feelings of social responsibility, '... certainly from our experience, we come from overseas as well, so we try to help...' (2E, male GP, Focus group 2) and the intellectual stimulation involved in caring for refugee patients:

*They are just really nice, interesting people... You learn about different cultures... You learn different medicine... certainly a lot of the tropical medicine we wouldn't see much of in Brisbane.* (6A, female GP, Interview 3)

The enthusiasm amongst providers was evident as they described their experiences working with refugees:

*When they come in to me... we have chats... 'Where did you come from?' I have got a map and they come and [they] show me, particularly the kids come and show me where they are from. I tend to ask them what it was like... sometimes they divulge; sometimes they don't... it just depends what they have been through...* (4A, female PN, Focus group 4)

*I think the rewards would be them coming back for follow up. I think that is the reward we get, which means they are slowly learning we need to go back.* (2C, male GP, Focus group 2)

Despite this enthusiasm, difficulties were acknowledged. As one provider stated:

*The other side of things, of course, is that it can be quite difficult. You're working through interpreters and cultural differences and trying to understand people. There is a lot of somatisation in these patients and that can become really frustrating because they just come with a pain that you investigate and, as soon as that is investigated, they have another pain. You just don't really feel you are getting*

*anywhere and they get frustrated and you do as well. (6C, female GP, Interview 3)*

One provider went as far as to state:

*If you are talking about it being rewarding, I wouldn't think so. Sometimes you spend a whole afternoon here, trying to sort out things. (2E, male GP, Focus group 2)*

### *The general practice setting*

The flexibility of the general practice setting enabled providers to act on their commitment to provide refugee health care, allowing them to be responsive and innovative in their approach to caring for refugees and also providing flexibility in the hours they work. Providers demonstrated a willingness to provide the time necessary to respond to their patients' needs and the flexibility of the general practice setting allowed for this.

*The main challenge is the time that it takes. With vaccinations for instance, I know for a fact that I have to wait half an hour after I end the clinic for my patients to turn up, because they will turn up half an hour after I am supposed to have left. If I sit and wait, I know they will come, so you just have to be prepared to do that. (5B, female GP, Focus group 5)*

While the flexibility offered by the general practice setting positively impacted on providers' ability to care for refugees in some ways, in others it contributed to feelings of being isolated and under resourced. As outlined previously, the themes of communication, knowledge and practice and health care systems emerged as a framework for capturing health care providers' descriptions of the factors that influence their ability to care for refugees within this setting and provide a framework for improving available supports.

### *Communication*

Participants described communication difficulties as one of the most significant barriers to refugee health care. They described difficulty in caring for patients with limited or no English-language skills and high rates of illiteracy. They also identified the enormous impact that cultural differences had on communication.

*The barrier, is always the language (and) interpretation of what you are saying ... they have a different culture, so their cultural perception of symptoms and what they mean ... trying to interpret the difference between a bloated abdomen and a painful abdomen, just becomes an impossible task ... (4E, male GP, Focus group 4)*

Interpreter services were an important enabler of refugee health care but were also time consuming, often unavailable and sometimes of questionable reliability.

*The interpreters don't interpret what you say and they give their own opinion ... Sometimes ... they have a five-minute conversation, but you are not getting what they really said. (3B, female PN, Focus group 3)*

When interpreters were not available, providers used family and friends, which enabled communication but raised concerns about confidentiality and safety. Providers also recognised that

interpreter services do not overcome the impact of cultural difference on effective communication.

Participants had tried to reduce these barriers. Some had developed sufficient language skills to greet their patients; others used pictures and diagrams. Many practices developed systems to accommodate interpreters, including longer appointments and careful planning to ensure availability of appropriate interpreters. They described the value of currently available external supports, including language classes, translation and interpreting services, and specialised refugee health services, particularly in the area of mental health. However, participants emphasised the need for a broader health care system that supports the work of individual practices and these support services.

### *Knowledge*

Participants described deficiencies in their knowledge of refugee health care as limiting their ability to effectively care for patients. They discussed uncertainties around clinical and cultural knowledge, the services available and how the broader system worked, particularly as it pertained to refugee health.

Refugees were described as presenting with complex, unfamiliar conditions that providers felt they lacked the skills and expertise to manage effectively. This included both acute and chronic diseases, such as schistosomiasis, malaria, sickle cell anaemia and thalassaemia, but more importantly included social and psychological complaints. Many participants expressed their uncertainty when caring for victims of past trauma or torture and described limited knowledge of resources available to assist.

*My problem is my lack of familiarity with ... schistosomiasis and all those infectious diseases ... They seem to have a lot of problems, particularly psychological problems ... very traumatised ... that makes them much more difficult ... (5B, female GP, Focus group 5)*

The isolation providers felt as they attempted to address these knowledge deficiencies was evident. One provider described her search for immunisation information before the establishment of RHQ by stating:

*Even when we called ... the [Division of General Practice] ... they didn't know how to guide us ... I think we didn't have a guideline ... I think I used South Australia's guideline because ... that was the one that I was able to download ... (2B, female GP, focus group 2)*

Another described 'Googling' for information:

*... I just searched. I Googled 'customs and traditions for this country' ... we can ... work with that in regards to health care, and try to incorporate it ... (2C, male GP, Focus group 2)*

Those that were aware of available support organisations found them to be of great value, but discussed that they were often underfunded and consequently limited in the support they were able to offer. They perceived information evenings, print and Internet resources to be important, but found them difficult to access. Providers acknowledged the value of clinical support provided by organisations such as RHQ, discussing how the provision of an initial health assessment, investigations, an

immunisation schedule and management plan assisted them in overcoming knowledge gaps.

*From my point of view, as practice nurse, [catch up immunisations] run quite smoothly, because Refugee Health [Queensland] has worked out the catch up immunisation schedule and the transfer of information has been very smooth. (1A, female PN, Focus group 1)*

#### *Practice and health care systems*

Participants felt that significant gains had been made to the refugee health care system, with the establishment of a specialised service. One provider working in the field for some time described thinking, '... fantastic, finally' (6B, female AS, Interview 2). Another stated, '... having the health service (RHQ) has just revolutionised (refugee health care) ... it just made perfect sense' (3D, female GP, Focus group 3). However, providers described the broader Australian health care system as providing limited support and flexibility in terms of caring for this population, not allowing for the time and complexity involved.

The complexity of the health care system itself proved challenging for both patients and providers.

*Knowledge of the Australian health system ... You have to make an appointment ... go to the doctor ... get a script ... go to the chemist ... the chemist fills it out, but then you need to make another appointment ... they don't understand. (4A, female PN, Focus group 4)*

These factors were exacerbated by the fact that many providers working in this field have trained overseas and are yet to fully understand the Australian health care system themselves, particularly as it pertains to refugee health. As one provider stated:

*We are doctors from other countries, trying to understand the [Australian] health system ... I am taking care of refugees while getting to be oriented on refugee health ... (2B, female GP, Focus group 2)*

Individual practices had developed more flexible systems to accommodate their refugee patients, going to great lengths to advocate for these patients in the broader health care system. However, they were concerned that the complex, resource-intensive and time-consuming nature of caring for refugees would impact on their ability to both care for other patients and remain viable in a mainstream general practice setting. Caring for refugee patients takes resources and time away from other patients and currently Medicare does not allow providers adequate remuneration.

Providers felt isolated in their search for solutions and called for greater support. The value of support services available within the current system, including settlement agencies, programs for survivors of torture and trauma, language classes, translating and interpreting services and case workers, were all discussed. In particular, the establishment of RHQ had facilitated their capacity to deliver refugee health care.

However, the need for greater support and a more coordinated, cohesive approach to refugee health care was emphasised. Specific suggestions included greater access to caseworkers who could assist refugees in navigating the complexity of the health care system and greater availability of interpreter services across

all health services, including allied health providers and pathology and radiology providers. Adequate remuneration for the time and complexity involved for all health care providers involved in refugee health care was considered important.

#### **Discussion**

Our results indicate that despite difficulties, there is enthusiasm and commitment among providers toward working with refugees. The flexibility of the general practice setting enables providers to be innovative in their approach to caring for refugees. However, most practices continue to feel isolated as they search for solutions. The themes of communication, knowledge and practice and health care systems encapsulate the factors that influenced health care providers' ability to care for refugees and provide a framework for improving available supports (Table 1).

The present study was designed to capture the voices of different staff members and the interactions between their different roles. Involvement of GPs, PNs and AS in the focus groups enabled this. However, personal relationships and potential power differentials in the workplace may have impacted on individuals' perceived freedom to express their opinions, particularly if it differed from the dominant opinions being expressed. Careful facilitation and observation of the group dynamics in each focus group suggested that all participants contributed equally and no divergent opinions were expressed when participants were given opportunity to provide confidential feedback. While it may be expected that staff with different roles (GP, PN, AS) would have raised distinct issues, this was not generally the case. Their varied experiences may have altered their emphasis on specific issues, but participants' comments generally complemented the perspectives of other participants with different roles in the practice. The interactions seen in the focus groups reflected a team approach to refugee health, with individual members intensely aware of each other's roles and the issues they were confronting.

Two researchers (RF and MK), including the interviewer, work in refugee health. A potential advantage of a health practitioner with knowledge in refugee health care facilitating sessions is the shared understanding of the specific environment, which may reduce barriers between the researcher and the research participants (Hansen 2006; Howes *et al.* 2010). The researchers were aware of the potential for influencing data collection and interpretation. A clear statement of the role of the researchers was included in the preamble and an interview guide was used to minimise this impact on data collection (Hansen 2006). To encourage reflexivity, the researchers met regularly to discuss and reflect on data and analysis. They were encouraged to reflect critically on how their views and differing perspectives were influencing interpretation of data (Finlay 2002). Another researcher working outside the field (DA) helped ensure objectivity in this process.

The use of purposive sampling ensured that participating practices had experience in caring for refugees within the new model of care, maximising the richness of the data available and enabling a detailed descriptive exploration of the issues (Hansen 2006). In future studies, a broader range of practices, including practices that declined to accept referrals from RHQ, could be



**Table 1. Framework for understanding and addressing the factors that influence health care providers' capacity to deliver quality refugee health care**

Theme	Issue	Recommendation
Communication	Limited English-language skills among refugees	Increase range of resources available in languages other than English Support English education for refugees Support providers in understanding the linguistic backgrounds of their patients
	Limited literacy (reading and writing) among refugees	Consider the importance of literacy in English education for refugees Improve availability and quality of visual resources Raise awareness of refugees' limited literacy among providers
	Concerns regarding quality and availability of interpreter services among providers	Increase interpreter service availability across all health care sectors (including allied health) Improve medical interpreter training
	Impact of cultural difference on effective communication between refugees and providers	Provide information for providers regarding cultural differences in communication and the impact this can have on a consultation
Knowledge	Limited knowledge among providers regarding refugee health issues	Provide focussed education and training around important refugee health issues, including: <ul style="list-style-type: none"> <li>• Common refugee presentations</li> <li>• Cultural awareness</li> <li>• The settlement process and available supports</li> <li>• Local refugee health services and supports</li> <li>• Models of refugee health care and how they fit into the broader health care system</li> </ul>
	Difficulty among providers in accessing available education and training resources, through lack of awareness and practical limitations, such as time constraints	Improve dissemination of resources, ensuring that multimodal (online, face-to-face and print) education and training resources are readily available and adequately advertised
	Uncertainty among providers in managing refugees with mental health issues, including torture and trauma	Provide mental health training for providers, particularly in relation to caring for victims of past torture and trauma Improve supports available to providers working in this area, through access to trained psychologist and bicultural workers Enhance psychologists' access to interpreters
	Poor health literacy among patients	Provide appropriate education for refugees to improve health literacy (e.g. education sessions organised through settlement agencies or incorporated into English classes)
Systems	Practices feel isolated within the broader health care system	Provide initial refugee health care in a specialised refugee health setting and ensure effective communication and support at the time of referral and beyond. This may include: <ul style="list-style-type: none"> <li>• Health assessments</li> <li>• Initial investigations</li> <li>• Immunisation schedules</li> <li>• Management plans</li> <li>• Useful resources</li> </ul> Provide a forum for the exchange and transfer of experiences, information and resources between providers working in this area
	Limited understanding among providers of the health care system as it pertains to refugee health	Provide focussed education and training for providers, regarding the health care system as it pertains to refugee health care
	Limited funding available for refugee health services and support organisations	Identify and adequately resource relevant support organisations
	Inadequate time, flexibility and resources available to provide complex care	Consider methods to adequately remunerate providers (e.g. Medicare payments when interpreters are used)
	Compromised care and increased costs related to patients' difficulties navigating the complex health care system, resulting in missed appointments, tests and failed follow up	Provide case workers with appropriate training to assist in coordinating care Provide education for refugees around health care within the Australian health care system

recruited to provide a broader perspective. This study focussed on urban practices and it is acknowledged that the rural setting adds complexity (Sypek *et al.* 2008). These data only capture the provider perspective; further information from the refugee patient's perspective of care provided using this model would complement this study.

Through providers' perceptions of their work we saw the commitment, enthusiasm and good will that exists toward working with refugees. Our findings highlighted the importance of patient characteristics, feelings of social responsibility and intellectual stimulation as influencing primary health care providers' involvement in refugee health care and suggested that

the flexibility of the general practice setting facilitated this involvement. These findings are supported by a recent study conducted by Stevenson *et al.* (2011) that explored attitudes to work and professional satisfaction, as well as strategies to promote resilience among health care providers working in more challenging conditions.

Stevenson *et al.* (2011) identified that doctors were motivated by the belief that helping a disadvantaged population is the 'right thing' to do and were often sustained by a deep appreciation and respect for the population they served, an intellectual engagement with the work itself, and the ability to control their own working hours. The authors concluded that if organisations wished to increase numbers of medical staff or increase the work commitment of staff in areas of social disadvantage, they needed to consider strategies such as supporting doctors to work part-time and allowing experienced doctors to mentor more novice doctors, modelling for them patient-appreciative approaches, and reinforcing the personal and intellectual pleasures of working in these fields.

While the general practice setting allowed providers the flexibility to respond innovatively to the needs of their refugee patients, it also meant that many providers felt somewhat isolated and under resourced. Lack of coordination and the isolation of those working in this setting can exacerbate many of the problems experienced by health care providers caring for refugees (Phillips *et al.* 2011).

Providing insights into the experiences of providers caring for newly arrived refugees, this research builds on the body of literature that focuses on the refugee perspective. Australian and overseas literature has highlighted language and cultural differences, distrust of health professionals, a lack of health information, poor understanding of the health care system, an often-undertrained workforce and financial limitations as impacting on refugees' ability to access health care (Finney Lamb and Smith 2002; Davidson *et al.* 2004; Murray and Skull 2005; Sheikh-Mohammed *et al.* 2006; Henderson and Kendall 2011). These issues were mirrored in the comments of providers, as they discussed the barriers they experienced in providing care, highlighting the way in which patients and health care providers are struggling to overcome these issues together.

Consistent with previous recommendations, the value of a specialised refugee health service was identified (Adams *et al.* 2004; Benson and Smith 2007; Johnson *et al.* 2008). However, while current supports are of great value, many providers are not aware of available resources and in some instances the necessary resources simply do not exist. Along with the need for further resources, the importance of improved knowledge exchange and transfer regarding available resources and a more cohesive approach to refugee health care was emphasised. The themes of communication, knowledge and practice and health care systems provide a framework for understanding and addressing the factors that influence health care providers' capacity to deliver quality refugee health care (Table 1). Further research, with a broader focus, exploring the experiences of providers working in the different models of refugee health care across Australia will

inform these recommendations further and will assist in the development of an evidence-based model of care (Kay *et al.* 2010; Woodland *et al.* 2010).

There is emerging interest in improving the way in which refugees are cared for throughout Australia. The Refugee Health Network of Australia was recently established. This national collaboration of over 140 refugee health service providers (GPs, nurses, specialists, public health practitioners, academics and policymakers) throughout all states and territories hopes to overcome some of the barriers highlighted in this study, allowing for greater communication and dissemination of information to various stakeholders (Phillips *et al.* 2011). The Refugee Health Network of Australia supplements discipline-specific groups, including the Royal Australian College of General Practitioners, National Faculty of Specific Interests Refugee Health Special Interest Group, and builds on state-level networks in Victoria and South Australia (Phillips *et al.* 2011). It is hoped that these groups will provide a much-needed forum for collaboration and communication between practitioners, policy-makers and researchers, to support the work of individual primary health care providers.

Australian primary health care is currently undergoing great change (Department of Health and Ageing 2010; Department of Health and Ageing 2011). Under national health reform, the Australian Government states that it is aiming to shift health services from hospital to primary care (Department of Health and Ageing 2011). This affords the opportunity to make significant gains in the way in which we care for refugee patients and other minority groups within our community. As health care reforms are implemented, it is essential that they are responsive to the needs of patients and health care providers working in these areas. By giving voice to their collective experience, this project has begun to identify the needs of health care providers working with newly arrived refugee patients in Queensland. It acknowledges the benefits of Queensland's current model of refugee health care and offers constructive guidance regarding the support required to further improve delivery of quality care to refugees.<sup>1</sup>

### Conflicts of interest

RF and MK are members of the Refugee Health Network of Australia and the Royal Australian College of General Practitioners National Faculty of Specific Interests Refugee Health Special Interest Group. Since completing data collection and analysis RF has gone on to work clinically at Refugee Health Queensland for 1 day per week.

### Acknowledgements

The authors acknowledge Dr Megan Evans (Clinical Director at the time of project completion), Sarah Greal (Statewide Coordinator at the time of project completion) and the staff at Refugee Health Queensland, Mater Health Services, Brisbane for their support in the preparation of this paper. The authors also acknowledge General Practice Education and Training and the Royal Australian College of General Practitioners Family Medical Care, Education and Research Grant for their assistance in funding this study.

<sup>1</sup>The model of refugee health care in Queensland has changed to no longer include a medical assessment in a specialised refugee health service. The new model offers refugees a comprehensive nursing assessment before they are linked with a GP in the community to complete the medical component of the refugee health assessment.

## References

- Adams KM, Gardiner LD, Assefi N (2004) Healthcare challenges from the developing world: post-immigration refugee medicine. *British Medical Journal* **328**, 1548–1552. doi:10.1136/bmj.328.7455.1548
- Benson J, Smith M (2007) Early health assessment of refugees. *Australian Family Physician* **36**, 41–43.
- Davidson N, Skull S, Burgner D, Kelly P, Raman S, Silove D, Steel Z, Vora R, Smith M (2004) An issue of access: delivering equitable health care for newly arrived refugee children in Australia. *Journal of Paediatrics and Child Health* **40**, 569–575. doi:10.1111/j.1440-1754.2004.00466.x
- Department of Health and Ageing (2010) 'A national health and hospitals network for Australia's future: delivering the reforms.' (Commonwealth of Australia: Canberra) Available at [http://www.yourhealth.gov.au/internet/yourHealth/publishing.nsf/Content/DeliveringTheReforms/\\$FILE/DeliveringTheReforms.pdf](http://www.yourhealth.gov.au/internet/yourHealth/publishing.nsf/Content/DeliveringTheReforms/$FILE/DeliveringTheReforms.pdf) [Verified 21 May 2012]
- Department of Health and Ageing (2011) 'Improving primary health care for all Australians.' (Commonwealth of Australia: Canberra) Available at [http://www.yourhealth.gov.au/internet/yourHealth/publishing.nsf/Content/improving-primary-health-care-for-all-australians-toc/\\$FILE/Improving%20Primary%20Health%20Care%20for%20all%20Australians.pdf](http://www.yourhealth.gov.au/internet/yourHealth/publishing.nsf/Content/improving-primary-health-care-for-all-australians-toc/$FILE/Improving%20Primary%20Health%20Care%20for%20all%20Australians.pdf) [Verified 21 May 2012]
- Department of Immigration and Citizenship (2011) 'Fact sheet 60 – Australia's refugee and humanitarian program.' (Commonwealth of Australia: Canberra) Available at <http://www.immi.gov.au/media/fact-sheets/60refugee.htm> [Verified 21 May 2012]
- Finlay L (2002) Outing the researcher: the provenance, process and practice of reflexivity. *Qualitative Health Research* **12**, 531–545. doi:10.1177/104973202129120052
- Finney Lamb C, Smith M (2002) Problems refugees face when accessing health services. *NSW Public Health Bulletin* **13**, 161–163. doi:10.1071/NB02065
- Hansen E (2006) 'Successful qualitative health research: a practical introduction.' (Allen & Unwin: Sydney)
- Henderson S, Kendall E (2011) Culturally and linguistically diverse peoples' knowledge of accessibility and utilisation of health services: exploring the need for improvement in health service delivery. *Australian Journal of Primary Health* **17**, 195–201. doi:10.1071/PY10065
- Howes F, Hansen E, Williams D, Nelson M (2010) Barriers to diagnosing and managing hypertension – a qualitative study in Australian general practice. *Australian Family Physician* **39**, 511–516.
- Johnson D, Ziersch A, Burgess T (2008) I don't think general practice should be the front line: experiences of general practitioners working with refugees in South Australia. *Australia and New Zealand Health Policy* **5**, 20.
- Kay M, Jackson C, Nicholson C (2010) Refugee health: a new model for delivering primary health care. *Australian Journal of Primary Health* **16**, 98–103. doi:10.1071/PY09048
- Krueger R (1998) 'Developing questions for focus groups.' (Sage Publications: Thousand Oaks)
- Murray SB, Skull SA (2005) Hurdles to health: immigrant and refugee health care in Australia. *Australian Health Review* **29**, 25–29. doi:10.1071/AH050025
- Phillips CB, Smith MM, Kay M, Casey S (2011) The Refugee Health Network of Australia: towards national collaboration on health care for refugees. *The Medical Journal of Australia* **195**, 185–186.
- Queensland Health (2008) 'Queensland Refugee Health Service. Service plan. Executive summary.' (Queensland Government: Brisbane) Available at [http://www.health.qld.gov.au/multicultural/health\\_workers/QHHS\\_exe\\_summ.pdf](http://www.health.qld.gov.au/multicultural/health_workers/QHHS_exe_summ.pdf) [Verified 21 May 2012]
- Sheikh M, Pal A, Wang S, MacIntyre C, Wood N, Isaacs D, Gunasekera H, Raman S, Hale K, Howell A (2009) The epidemiology of health conditions of newly arrived refugee children: a review of patients attending a specialist health clinic in Sydney. *Journal of Paediatrics and Child Health* **45**, 509–513. doi:10.1111/j.1440-1754.2009.01550.x
- Sheikh-Mohammed M, MacIntyre C, Wood N, Leask J, Isaacs D (2006) Barriers to access to health care for newly resettled sub-Saharan refugees in Australia. *The Medical Journal of Australia* **185**, 594–597.
- Smith MM (2006) Refugees in Australia: changing faces, changing needs. *The Medical Journal of Australia* **185**, 587–588.
- Stevenson AD, Phillips CB, Anderson K (2011) Resilience among doctors who work in challenging areas: a qualitative study. *The British Journal of General Practice* **61**, e404–e410. doi:10.3399/bjgp11X583182
- Sypek S, Clugston G, Phillips C (2008) Critical health infrastructure for refugee resettlement in rural Australia: case study of four rural towns. *The Australian Journal of Rural Health* **16**, 349–354. doi:10.1111/j.1440-1584.2008.01015.x
- United Nations High Commissioner for Refugees (2002) 'Refugee resettlement: an international handbook to guide reception and integration.' (UNHCR: Geneva) Available at <http://www.unhcr.org/4a2cfe336.html> [Verified 21 May 2012]
- Victorian Foundation for Survivors of Torture (2012) 'Caring for refugee patients in general practice: a desk-top guide.' 4th edn. (Victorian Foundation for Survivors of Torture: Melbourne) Available at <http://refugeehealthnetwork.org.au/learn/guides/> [Verified 5 December 2012]
- Woodland L, Burgner D, Paxton G, Zwi K (2010) Health service delivery for newly arrived refugee children: a framework for good practice *Journal of Paediatrics and Child Health* **46**, 560–567. doi:10.1111/j.1440-1754.2010.01796.x