Rites of passage: improving refugee access to general practice services

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Background

Refugees in Australia experience barriers in accessing healthcare services. The aim of this study was to analyse the factors influencing Afghan refugees' access to general practice.

Methods

A qualitative study on a single general practice in south-east Melbourne in 2013 was conducted. Data were collected using individual, semi-structured interviews and field observations. Data were analysed thematically and informed by the Penchansky and Thomas concept of access.

Results

The general practice utilised multiple strategies to improve access for refugees. Nevertheless, persistent barriers included language and cultural differences at reception, difficulties with transport to the practice, long wait times and the cost of care.

Discussion

This case study highlights the benefits of providing affordable, co-located, culturally responsive services with integrated interpreter and settlement agency support. Increasing the use of interpreters and translated materials at reception, and improving the coordination of patient transport assistance could enhance refugees' access to general practice.

Refugees are individuals who reside outside the country of their nationality because of the fear of persecution. They are unable or unwilling to avail themselves of the protection of that country.[1] Australia has resettled over 750,000 refugees and humanitarian entrants since 1945, including 20,019 in 2012–13.[2–4]

Refugees are at risk of complex physical, mental and social problems, which can contribute to poor health outcomes and difficulties in fully engaging the Australian society.[5–7] Quality primary healthcare services are an important part of addressing these needs.[8]

The Australian government's policy supports refugees' access to general practice as the 'first point of contact' for health problems. It also acknowledged general practice as the main gateway for referral to the rest of the healthcare system.[9–11] The Humanitarian Settlement Services Program provides intensive settlement support services to all refugees during the first 6–12 months after arrival. It includes education, orientation and assistance to attend local health services and transition to independence.[12,13]

International literature has described some of the barriers refugees experience in accessing primary care. However, little empirical evidence has been published in the Australian context,[14–18] and a better understanding of the difficulties refugees experience in Australia is required.[19] We therefore sought to undertake an in-depth investigation on the factors influencing refugees' access to general practice services at an urban general practice in Australia.

Methods

The research was designed to be a qualitative case study focusing on a general practice as the unit of analysis, using field observations and semi-structured interviews. The study was set in south-east Melbourne in the Cities of Greater Dandenong and Casey, which receive an estimated one-twelfth of Australia's refugee intake each year.[18] The largest proportion of recent refugee arrivals in these two regions is from Afghanistan.[18,20]

We sought to recruit an accredited, multidisciplinary, general practice with an interest in refugee health that had a high case load of recently arrived Afghan refugees. Three highly eligible practices were identified through consultations with the South Eastern Melbourne Medicare Local and AMES Settlement (provider of settlement, education/training and employment services for refugees and newly arrived migrants in Victoria). The practices were sent invitations to participate in the study and one agreed to participate.

Participants consisted of practice staff, settlement workers and adult Afghan

refugees. With the assistance of the practice manager, we recruited clinical, reception and management staff who were experienced in working with Afghan refugees. AMES Settlement managers assisted with recruiting settlement workers, and Afghan refugees who attended the practice and had lived in Australia for up to 5 years.

Three authors conducted individual, semi-structured, face-to-face interviews with participants and were assisted by an accredited, on-site, Dari interpreter where appropriate. The interviews focused on the 'lived experiences' of accessing the general practice (refugees), providing services to Afghan refugees (practice staff) and supporting Afghan refugees to attend the practice (settlement workers). Data were complemented by 2 hours of field observations looking into the interaction between Afghan refugees and reception staff. These observations were made by the sociologist.

Professionally transcribed audio recordings and observation notes were inductively coded and thematically analysed using the Penchansky and Thomas concept of access (*Table 1*).[21] Perspectives were compared and contrasted to identify convergent and divergent themes. Analysis was conducted by the research team, which comprised two academic general practitioners (GPs), a sociologist and a medically qualified Afghan refugee from the local community. A written summary of the findings was checked for accuracy through formal discussions with key members of each participant group.

The study was approved by the Monash University Human Research Ethics Committee (reference number CF12/0545-2012000214).

Results

The large, privately owned, bulk-billing practice was located on a major road with good access to public transport. The practice employed 19 GPs (five had a strong interest in refugee health and most worked part-time) and four practice nurses. All practice staff received training in cultural responsiveness and interpreter use; one counsellor was from Afghanistan and one GP spoke Afghan languages. The practice also provided on-site pathology, pharmacy, psychology, dentistry, allied health, Chinese medicine and specialist medical services. The practice had a long history of assisting refugees.

Seventeen participants were recruited. The six practice staff included two GPs, one practice nurse, one receptionist, one practice manager and one bicultural Afghan counsellor. The five settlement workers included three community guides and two case managers. The six Afghan refugees included five ethnic Hazara and one Tajik (mid-twenties to mid-forties in age; equal gender distribution). All refugees spoke Dari, had very low levels of English language proficiency and had lived in Australia for 1–3 years.

Although the practice used many strategies to improve access, there were still ongoing problems with language barriers, cultural responsiveness, transport difficulties, appointment waiting times and cost.

Language barriers

The refugees experienced significant difficulties in making appointments at the reception because of their low proficiency in the English language.

> 'The main problem was that because I don't speak the language I couldn't even make an appointment with them' (refugee).

Although the reception staff received training in using formal interpreters, this was utilised infrequently. The multilingual Afghan counsellor provided assistance with making appointments, but only when available. The GPs at the practice used the government-funded Translating and Interpreting Service (TIS National), a telephone interpreter service, during the consultations.

The study found many refugees used informal interpreter strategies. They often sought assistance from family, friends or members of the Afghan community in the reception area, or called for assistance by telephone. The practice staff expressed concerns about the accuracy and acceptability of these informal interpreting strategies. The settlement workers were equally concerned, and encouraged the refugees to ask for a formal interpreter when required. However, they acknowledged this was not always the case.

Written-language barriers also contributed to problems with appointments. While the reception staff provided appointment cards, reminder SMS messages and recall letters in English, it was not always understood

Table 1. The Penchansky and Thomas concept of access[21]

Accessibility – The relationship between the location of supply and the location of clients (eg client transport resources, travel time, distance, cost of travel)
Availability – The relationship of the volume and type of existing services (and resources) to the clients' volume and types of needs (eg adequacy of supply of physicians, facilities, specialised programs)
Accommodation – The relationship between the manner in which the supply resources are organised to accept clients and the clients' ability to accommodate to these factors and the clients' perception of their appropriateness (eg appointment systems, hours of operation, walk-in facilities, telephone services)
Affordability – The relationship of prices of services and providers' insurance or deposit requirements to the clients' income, ability to pay, and existing health insurance (eg client knowledge of prices and perception of worth relative to total cost)
Acceptability – The relationship of clients' attitudes about personal and practice characteristics of providers to the actual characteristics of existing providers, as well as provider attitudes about acceptable personal characteristics of clients (eg consumer reaction to provider age, sex or ethnicity; consumer reaction to type of facility; provider willingness to serve certain types of clients)

by the Afghan refugees as they preferred verbal reminders over written reminders. The settlement workers were able to facilitate this by telephone, but this was only available during the initial stages of settlement.

Cultural responsiveness

There were variations in the way the staff responded to the unique challenges faced by Afghan refugees. Staff who were refugees, or had previously worked in a developing country, found these experiences to be helpful in providing services with empathy and patience.

The refugees and settlement workers appreciated the friendly and respectful behaviour of the practice staff and described responsiveness to their individual needs as the primary consideration in choosing to see a particular GP. The refugees needed to feel that the GP listened and took their health complaints seriously. Some were willing to travel long distances, or wait a long time, to see their preferred GP. Some settlement workers suggested an even greater degree of cultural responsiveness would be helpful.

Transport difficulties

All participant groups expressed difficulties that many refugees experience with transport when attending the practice. Refugees who did not have a driver's licence, or had limited access to a private vehicle, had to use public transport or walk. This was difficult for refugees with physical or mental disabilities, the elderly, and families with infants and young children. Many relied on the assistance of family, friends and settlement workers to attend the practice.

> 'Initially we had some problems especially when we did not have our own transportation. We had to take the bus to the train station and then to the [clinic]. Since we were not familiar with the area, sometimes [we] got lost or missed the station that we were supposed to get off at. Then we had to switch buses again or walk long distances' (refugee).

The refugees and settlement workers explained female Afghan refugees were also constrained by cultural expectations which required a close male relative accompany them when in public.

> 'Especially for women [it] is difficult because women are very reliant on their husband or their sons or their brothers, and usually they don't get enough attention to do the things by themselves' (settlement worker).

The practice staff were found to have provided information about public transport options, but were not able to provide practical transport assistance. The settlement workers educated the refugees on how to travel to the practice and provided practical assistance for attending initial appointments. However, they were not always available or aware of appointment details.

The co-location of general practice, pathology, pharmacy and counselling services was strongly endorsed by refugees and settlement workers. Service co-location reduced the difficulties associated with travelling to multiple sites. The participant groups were generally satisfied with the wide range of services offered on site or within walking distance.

Appointment waiting times

Several refugees expressed dissatisfaction with long appointment waiting times. This often caused difficulties with competing priorities such as attending English language classes. As a result, some had to leave the practice without seeing a GP.

> 'The average waiting time was around 45 minutes. Some patients objected angrily that people who had arrived after them were seen by a GP [before them], and one patient left after waiting 45 minutes' (independent, non-participant observer).

Practice staff explained the extended waiting times could be the result of a number of issues. For example, when refugees were early or late to their appointments, or showed up at the practice without appointments and had to wait until a doctor was available. They explained that some refugees chose to wait to see their usual doctor rather than see any available doctor. The GPs explained that waiting time increases when multiple family members present during a single appointment, when a refugee had complex health issues and when an interpreter was required.

To address this, the practice decided to conduct refugee health assessments and assist multiple family members over a series of staggered appointments. They communicated these issues with settlement workers who provided refugees with education about correct appointment-making procedures and timely attendance. Nevertheless, concerns about waiting times remained.

Cost

There was a consensus from all participants that refugees struggled to afford out-of-pocket healthcare costs. Providing fee-free services at the practice through the use of Medicare rebates, healthcare card entitlements and additional cash assistance from settlement agencies was essential.

> 'I don't believe that any of our clients in the area would use a GP that was not going to bulk bill because they can't afford the cost' (settlement worker).

While the practice generated most of its income through Medicare consultation rebates, the staff also provided additional assistance with making appointments, appointment reminders and education on using the service. These non-clinical activities did not attract government reimbursement and were constrained by funding limitations.

Discussion

Our in-depth case study and triangulated perspectives gave important insights into some of the unique challenges faced by refugees in accessing general practice services in Australia. As evident in other countries,[14] refugees found challenges in the language, transport to the practice and appointment waiting times.

While the practice used a number of strategies to address language and cultural

differences, our findings highlighted a need for reception staff to make greater use of formal interpreter services to assist in making appointments, and translate written materials for appointment reminders. There is currently little literature on the use of interpreters in the Australian general practice reception settings, and further research would be beneficial.

While many of the refugees lived in close proximity to the practice, the findings found a need for additional transport assistance. There was a need to better communicate transport requirements and coordinate practical assistance between refugees, families, settlement workers and practice staff. The co-location of multiple health services reduced the need to travel to multiple sites. Existing literature on refugee primary healthcare models supports integrated approaches.[22,23]

Long waiting times were a problem for Afghan refugees despite the practice's well-established appointment system. While education on how to make and attend appointments was provided, transport difficulties and language barriers also contributed to this problem. This is consistent with the wider literature on the inter-related nature of multiple factors influencing access.[24]

The capacity of staff at the practice to address issues of access was limited by government funding. This suggests a need to review the way general practice funding policies support non-clinical client assistance activities, and a need to further examine solutions in partnership with settlement agencies and refugee communities.

Limitations

Our case study provided an in-depth understanding of the determinants of access for Afghan refugees at a large, bulk-billing, urban general practice, but the generalisability of our findings is uncertain. Other factors may have an impact on the experience of access for other refugee groups in different settings in Australia.

Conclusions

Refugees' access to the general practice services was improved through providing affordable, co-located, culturally responsive services with interpreter and settlement agency support. General practice access could potentially be enhanced by increasing the use of interpreters and translated materials for making appointments at reception and by improving the coordination of client transport assistance.

Implications for general practice

Improve refugee access to general practice services:

- Provide multiple, affordable, culturally responsive health services in one location as much as possible.
- Use credentialed interpreters and translated materials at reception to assist refugees with appointments. Fee-free interpreter services for receptionists can be obtained through TIS National (www.tisnational.gov.au). An appointment reminder translation tool is available through the New South Wales Refugee Health Service (www.swslhd.nsw.gov.au/refugee).
- Coordinate appointment and transport needs with settlement workers to assist refugees in attending the appointment. Local Humanitarian Settlement Services' contact details can be found at www.dss.gov.au/our-responsibilities/settlement-and-multicultural-affairs/programs-policy/settlement-services/settlement-services-locator

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References

1. United Nations High Commissioner for Refugees. The 1951 Convention relating to the status of refugees and its 1967 Protocol. Geneva: UNHCR, 2011.
2. Department of Immigration and Citizenship. Refugees and Humanitarian Issues: Australia's response. Canberra: DIAC, 2011.
3. Department of Immigration and Border Protection. Fact sheet 20 - Migration Program planning levels. Canberra: DIBP, 2013. Available at www.immi.gov.au/media/fact-sheets/20planning.htm [Accessed 18 November 2013].
4. Department of Immigration and Border Protection. Fact sheet 60 – Australia's Refugee and Humanitarian Program. Canberra: DIBP, 2013. Available at www.immi.gov.au/media/fact-sheets/60refugee.htm [Accessed 18 November 2013].
5. Harris M, Zwar N. Refugee health. Aust Fam Physician 2005;34:825–29.
6. Gardiner J, Walker K. Compassionate listening: Managing psychological trauma in refugees. Aust Fam Physician 2010;39:198–203.
7. Foundation House. Promoting Refugee Health: A guide for doctors, nurses and other health care providers caring for people from refugee backgrounds. 3rd edn. Melbourne: Foundation House – The Victorian Foundation for Survivors of Torture, 2012.
8. Milosevic D, Cheng I-H, Smith MM. The NSW Refugee Health Service: improving refugee access to primary care. Aust Fam Physician 2012;41:147–49.
9. The Royal Australian College of General Practitioners. Becoming a GP in Australia: What is a GP? Melbourne: RACGP, 2013. Available at www.racgp.org.au/becomingagp/what-is-a-gp [Accessed 26 November 2013].
10. Department of Health. Medicare Benefits Schedule (MBS) Health assessment for refugees and other humanitarian entrants. Canberra: DoH, 2013. Available at www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare_mbsitem_refugees [Accessed 26 November 2013].
11. Benson J. Early health assessment of refugees. Aust Fam Physician 2007;36:41–43.
12. Department of Immigration and Border Protection. Fact sheet 66 – Humanitarian Settlement Services Program. Canberra: DIBP, 2013. Available at www.immi.gov.au/media/fact-sheets/66hss.htm [Accessed 18 November 2013].
13. AMES Settlement. Services we provide. Melbourne: AMES Settlement, 2013. Available at www.ames.net.au/humanitarian-settlement-services/services-we-provide.html [Accessed 15 March 2014]

14. Cheng I-H, Drillich A, Schattner P. Refugee and asylum seeker experiences of general practice services in countries of resettlement: A literature review. Brit J Gen Pract 2014;in press.
15. Jackson-Bowers E, Cheng I-H. Meeting the primary health care needs of refugees and asylum seekers. Primary Health Care Research Information Service: Research Roundup, 2010;16.
16. Spike EA, Smith MM, Harris MF. Access to primary health care services by community-based asylum seekers. Med J Aust 2011;195:188–91.
17. Clark A, Gilbert A, Rao D, Kerr L. 'Excuse me, do any of you ladies speak English?' Perspectives of refugee women living in South Australia: Barriers to accessing primary health care and achieving the Quality Use of Medicines. Aust J Prim Health 2014;20:92–97.
18. Cheng I-H, Russell GM, Bailes M, Block A. An evaluation of the primary healthcare needs of refugees in south east metropolitan Melbourne. Report to the Refugee Health Research Consortium. Melbourne: Southern Academic Primary Care Research Unit, 2011.
19. Raven M. Patient experience of primary health care. Adelaide: Primary Health Care Research and Information Service, 2013.
20. South Eastern Region Migrant Resource Centre. Afghan people in south east Melbourne: Perspectives of a migrant and refugee community. Melbourne: SERMRC, 2009.
21. Penchansky R, Thomas JW. The concept of access: Definition and relationship to consumer satisfaction. Med Care 1981;19:127–40.
22. Russell G, Harris M, Cheng I-H, et al. Coordinated primary health care for refugees: A best practice framework for Australia. Report to the Australian Primary Health Care Research Institute. Melbourne: Southern Academic Primary Care Research Unit, 2013.
23. Feldman R. Primary health care for refugees and asylum seekers: A review of the literature and a framework for services. Public Health 2006;120:809–16.
24. McLaughlin CG, Wyszewianski L. Access to care: Remembering old lessons. Health Serv Res 2002;37:1441–43.

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