

# Refugee Health and Wellbeing: A policy and action plan for Queensland 2017– 2020

## Evaluation Report

Report prepared by:  
Dr Ignacio Correa-Velez, Adjunct Associate Professor  
School of Public Health and Social Work,  
Queensland University of Technology

Ms Shanti Kadariya, Research Assistant

Report prepared for:  
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Mater Misericordiae Ltd  
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## Executive summary

This report presents the findings of the evaluation of the *Refugee Health and Wellbeing: a policy and action plan for Queensland 2017–2020*. The evaluation aims to assess the impact of the introduction of the *Policy and Action Plan* on the healthcare experience of people from refugee backgrounds settling in Queensland.

The evaluation uses a before and after design (phase I: July to October 2018; phase II: December 2019 to February 2020) and a mixed-method approach which included: (i) a patient experience quantitative survey with recently arrived adults from refugee backgrounds (63 respondents in phase I; 69 in phase II); (ii) a patient experience semi-structured qualitative interview with a cohort of refugee background families (53 were interviewed in phase I; 47 in phase II); and (iii) an online survey with services and stakeholders (69 respondents in phase I; 54 in phase II). Surveys and interviews with people from refugee backgrounds were conducted by trained refugee-background peer researchers. Ethics approval was obtained from the Mater Misericordiae Human Research Ethics Committee.

## Findings

Overall, the analysis of the data collected indicates that the *Refugee Health and Wellbeing Policy and Action Plan for Queensland 2017–2020* has had a positive contribution to the healthcare experience of people from refugee backgrounds settling in Queensland. The following can be concluded in relation to the five key principles which underpin the Policy and Action Plan:

### **Collaboration and partnerships**

The ‘services and stakeholders experience surveys’ reported good levels of collaboration and partnerships, with a trend towards increasing involvement of stakeholders’ in RHNQ activities, and in partnering with other agencies to improve refugee health outcomes. Over time, there was a significant increase in the percentage of referrals services and stakeholders received from Queensland Health/HHS, other government agencies, non-government organisations, settlement services, and refugee community representatives.

Collaboration and partnerships contribute to coordination of care for people from refugee backgrounds. Although there was a decrease between phase I and II in the percentage of ‘patient experience survey’ respondents who reported having a healthcare professional coordinating their care, this could be partially explained by the significantly shorter period of time phase II respondents had been in Australia, compared to phase I respondents.

### **Cultural responsiveness**

Data from the ‘patient experience surveys’ showed a significant increase over time in the proportion of respondents who had been offered an interpreter when visiting a GP and a dentist, and a trend towards an increase in the provision of interpreters when visiting a medical specialist and a hospital emergency department. ‘Patient experience interview’ respondents valued being assisted by interpreters during appointments, and some reported an improvement, between phase I and II, in the quality of communication between health professionals and patients, the cultural awareness of health services, and the provision of interpreters. Similarly, services and stakeholders reported a significant increase in the provision of qualified interpreters, and a trend towards an increase in the proportion of organisations having a language service or interpreter policy, and in the language diversity of their staff.

However, important gaps in interpreting services remain in other healthcare settings such as pharmacies where provision of interpreters is almost non-existing. High levels of distress and dissatisfaction are experienced by clients from refugee backgrounds when qualified interpreters are not made available during healthcare consultations.

### **Consumer and community voice**

Data from the 'services and stakeholders survey' reported moderate to high levels of engagement of refugee background consumers and communities in service planning, development and/or evaluation. Importantly, there was a significant increase in the percentage of respondents whose services had monitored the needs of people from refugee backgrounds. Some of the strategies included formal and informal consultations with patients and community representatives.

### **Continuous improvement**

Just over half of stakeholders in both phases had attended a refugee health training or education session in the previous 12 months, with the majority stating they had applied the knowledge and skills learned. Importantly, healthcare practitioners' participation in refugee health clinical training increased significantly between phase I and phase II. There was also a trend towards increasing access and use of RHNQ resources by stakeholders, and development by services of local health strategies or programs to support people from refugee backgrounds.

Data on patients' country of birth, preferred language and interpreter requirements were collected by over 80% of services, while a lower proportion collected data on ethnicity and date of arrival in Australia. The stakeholders survey showed a moderate increase over time in the proportion of services collecting data on date of arrival and a small increase in the collection of preferred language, interpreter requirements, and ethnicity.

### **Clinical excellence**

Overall, the majority of respondents had mostly positive experiences visiting healthcare professionals and services. When asked about their experiences visiting general practitioners, there was a significant increase over time in the proportion of respondents who reported having a mostly positive experience. Respondents valued the support provided by case workers from the settlement services when navigating the healthcare system, feeling welcomed and respected by healthcare staff, the quality of care received, and having access to dental care and medications. In both phases, general practices and case workers from settlement services were the top sources of advice and guidance in relation to accessing healthcare services in Australia.

### **Other issues that require further consideration**

Of concern are the barriers that some respondents continue to experience such as limited knowledge of the Australian healthcare system, long wait to get appointments with medical specialists and public dental clinics (sometimes while in pain), increasing out of pocket expenses when accessing prescribed medications, and lack of affordability of private dentists.

Similarly, the healthcare experiences of families from refugee backgrounds living in regional areas are impacted by lower availability of GPs, mental health, medical specialists and dental services; limited interpreter services; long wait for appointments and elective surgery; limited transport; and out of pocket expenses.

Stakeholders also identified the need to address the health and social needs of asylum seekers, the barriers people from refugee backgrounds face while trying to access the National Disability Insurance Scheme (NDIS) and some of the gaps in regional areas described above.

### **Recommendations**

1. A Refugee Health and Wellbeing Policy and Action Plan beyond 2020 is needed to sustain the achievements of the 2017-2020 Policy and Action Plan and support the COVID-19 pandemic recovery of refugee communities
2. Greater focus on the social and environmental determinants of refugee health
3. Addressing the health and social needs of asylum seekers
4. Building capacity of services in regional areas
5. Enhancing care coordination

6. Expanding the successful strategies used to address language barriers and provide interpreter services in other healthcare settings
7. Addressing the substantial barriers people from refugee backgrounds face while trying to access the NDIS
8. Creative delivery of training on refugee-informed and culturally-safe care across the different Hospital and Health Services

## Background

In April 2017, the Hon Cameron Dick, then Minister for Health and Ambulance Services, launched the *Refugee Health and Wellbeing: a policy and action plan for Queensland 2017– 2020* (Queensland Health, 2017), which articulates a shared vision and common purpose for refugee health in Queensland and promotes a state-wide approach to improving the health and wellbeing of refugees.

This report presents the findings of the evaluation undertaken to assess whether or not the Policy and Action Plan have enabled five key principles:

- Collaboration and partnerships
- Cultural responsiveness
- Consumer and community voice
- Continuous improvement
- Clinical excellence

The evaluation comprised two phases of data collection: (i) phase I, between July and October 2018, and (ii) phase II, between December 2019 and February 2020.

## Evaluation Objectives

The primary objective of the evaluation is to describe the impact of the introduction of the *Refugee Health and Wellbeing: a policy and action plan for Queensland 2017 – 2020* on the healthcare experience of people from refugee backgrounds settling in Queensland.

The secondary objectives of the evaluation are:

- To identify current barriers and enablers to access health services for people from refugee backgrounds; and
- To develop recommendations for future policy development and services improvement

## Evaluation Methods

### Design

This mixed-methods evaluation used a before and after design (phase I – July–Oct 2018; phase II – Dec 2019–Feb 2020) and involved the collection of data through:

- Quantitative survey with recently arrived refugee background participants (Patient experience survey)<sup>1</sup>;
- Semi-structured qualitative interviews with refugee background families (Patient experience qualitative interview)<sup>2</sup>; and
- Survey with services and other stakeholders (Services and stakeholders experience survey)<sup>3</sup>

### Participants

The evaluation involved two groups of participants:

- Adults from refugee backgrounds (18+ y/o) living in the greater Brisbane metropolitan area, Toowoomba, and Cairns

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<sup>1</sup> Before and after cross-sectional analysis

<sup>2</sup> Cohort design

<sup>3</sup> Before and after cross-sectional analysis

- Services and other stakeholders located in Queensland that work with refugee background individuals, families and communities

## Ethics Approval

Ethics approval was obtained from the Mater Misericordiae Human Research Ethics Committee (HREC/17/MHS/143).

## Patient Experience Survey

### *Inclusion and exclusion criteria*

Eligibility to the patient experience survey included: any recently arrived (within two years) adult (18+ y/o) living in Queensland who came to Australia under the Refugee and Humanitarian Program, or had a refugee like experience in their country of origin, and had received health care services in Queensland. Adults who did not have the capacity to provide informed consent to participate, or who were highly dependent on medical care were not eligible.

### *Recruitment and sampling*

In phase I and phase II, a random sample of patients from refugee backgrounds was identified through the Mater Integrated Refugee Health Service (MIRHS) database (Brisbane). All new refugee arrivals in Brisbane are recorded in the MIRHS. In Brisbane, the patient experience survey included participants from the five most common countries of origin. In regional areas (Toowoomba and Cairns), recently arrived refugee background participants were identified through local refugee settlement services.

### *Data collection*

In phase I, trained refugee peer researchers were given the contact details of the patient experience survey participants, provided them with all relevant information, and administered the survey either by phone or in person. Peer researchers spoke the same language of participants. The same process was repeated in phase II.

The patient experience survey was adapted from the annual Australian Bureau of Statistics (ABS) Patient Experience Survey (Australian Bureau of Statistics, 2017). The ABS survey collects data on access and barriers to a range of health care services. For the purpose of this evaluation, only general practitioners, medical specialists, dental professionals, hospital admissions, and emergency department visits were included. A copy of the Patient Experience Survey is available in the Appendix. On the basis of data collection experience in phase I, a few changes were made to the questionnaire in phase II.

## Patient Experience Qualitative Interview

### *Inclusion and exclusion criteria*

Eligibility for the patient experience qualitative interview included: any adult (18+ y/o) living in Queensland who came to Australia under the Refugee and Humanitarian Program, or had a refugee like experience in their country of origin, and had received health care services in Queensland. Adults who did not have the capacity to provide informed consent to participate, or who were highly dependent on medical care were not eligible. People under 18 years of age were not included as direct participants, but their experiences were captured through the information provided by their parents or guardians.

### *Recruitment and sampling*

In phase I, each trained refugee peer researcher recruited a convenience sample of 4-5 families from refugee backgrounds through their own ethnic community networks. Where possible and to ensure a diverse range of perspectives regarding health care services use, peer researchers sought at least

50% of participants to be people who had arrived in Australia within the past 2 years. The remaining 50% may have lived in Australia for a longer period of time.

### **Data collection**

Peer researchers who spoke the same language as the participants conducted the semi-structured interviews in both phases. The interviews aimed to investigate the health care experiences of participants and their family members. Most interviews took place in participants' homes. For the follow up interviews in phase II, the same families were approached and interviewed. An outline of the semi-structured patient experience qualitative interview is included in the Appendix.

## **Services and Stakeholders Experience Survey**

### **Inclusion and exclusion criteria**

People who were on the Refugee Health Network Queensland (RHNQ) mailing list or who was engaged in the provision of health services to people from refugee backgrounds in Queensland was eligible to participate in the services and stakeholders experience survey (phases I and II).

### **Recruitment and sampling**

In phase I and phase II, all people included in the RHNQ mailing list were sent an email with information about the anonymous survey and a link to access it (SurveyMonkey®). In addition, public invitations were issued via existing stakeholders and other external networks (e.g. Primary Health Networks, Settlement LACs) for other individual engaged in the provision of health services to people from refugee backgrounds in Queensland who were not linked to the RHNQ.

### **Data collection**

The anonymous online survey (SurveyMonkey®) included questions about access to and participation in training, innovative models of care, referral patterns and collaboration between stakeholders, existing barriers and opportunities for coordination of care. A copy of the Services and Stakeholders Experience survey is included in the Appendix.

## **Data analysis**

Descriptive statistics have been used to analyse the quantitative data. The Patient Experience Survey has been analysed by sex while the Services and Stakeholders Experience Survey has been analysed using four primary role categories: (i) health care practitioner; (ii) settlement/health promotion practitioner; (iii) manager/supervisor; and (iv) other (e.g. refugee community representative, interpreter, project officer, and researcher). Comparisons of proportions between phases have been conducted using MedCalc<sup>4</sup>. MedCalc uses the "N-1" Chi-squared test as recommended by Campbell (2007) and Richardson (2011).

Thematic analysis was used to analyse the qualitative data obtained from the Patient Experience Qualitative Interviews.

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<sup>4</sup> [https://www.medcalc.org/calc/comparison\\_of\\_proportions.php](https://www.medcalc.org/calc/comparison_of_proportions.php)

## Results

### 1. Patient Experience Survey

#### *Respondents characteristics*

Sixty-three and 69 individuals from refugee backgrounds participated in the patient experience survey in phase I and phase II respectively. When stratified in terms of sex, 39 respondents (62%) in phase I and 40 (58%) in phase II were males. In phase I, the top countries of birth were Syria (n=21%), followed by Afghanistan (17%) and Iraq (16%) (Table 1.1). In Phase II, the majority of respondents were born in Iraq (29%), followed by Syria (26%), Congo (14%) and Democratic Republic of Congo (14%).

Table 1.1 Respondents' country of birth, by phase

Country of birth	Phase I (n=63)	Phase II (n=69)
Syria	21%	26%
Afghanistan	17%	—
Iraq	16%	29%
Bhutan	13%	—
Eritrea	13%	6%
Democratic Republic of Congo (DRC)	8%	14%
Congo	6%	14%
Nepal	3%	—
Iran	1.5%	—
Pakistan	1.5%	—
Ethiopia	—	7%
Sudan	—	3%

#### *Demographic characteristics by sex*

The demographic characteristics of respondents in both phases by sex are shown in Table 1.2. Respondents in both phases had a mean age of 39.9 years. Phase II respondents had been in Australia for a shorter period of time (1 year on average) compared to Phase I respondents (1.7 years on average) ( $p < 0.001$ ). There were no statistically significant differences in level of education, English language ability and self-reported general health status between phase I and phase II respondents. Compared to male respondents, female respondents in phase I were more likely to have no formal education or primary education only. Phase I male respondents and Phase II female respondents reported better levels of health status.

Table 1.2 'Patient experience survey' respondents' demographic characteristics by sex (Phases I and II)

Characteristics	Phase I			Phase II		
	Female (n=22)	Male (n=39)	Total (n=63)	Female (n=29)	Male (n=40)	Total (n=69)
Age in years (mean ± SD)	40.6 ± 15.5	39.5 ± 13.2	39.9 ± 14.0	38.7 ± 11.3	40.8 ± 10.7	39.9 ± 10.9
Years in Australia* (mean ± SD)	2.4 ± 1.7	1.2 ± 0.5	1.7 ± 1.3	0.9 ± 0.4	1.1 ± 0.3	1.0 ± 0.3
Education						
None/primary school	13 (54.2%)	10 (25.6%)	23 (36.5%)	11 (37.9%)	13 (32.5%)	24 (34.8%)
Secondary/high school	5 (20.8%)	13 (33.3%)	18 (28.6%)	8 (27.6%)	11 (27.5%)	19 (27.5%)
College/trade/University	6 (25%)	15 (38.5%)	21 (33.3%)	10 (34.5%)	16 (40.0%)	26 (37.7%)
No response	-	1 (2.6%)	1 (1.6%)	-	-	-
English language ability						
Very well/well	8 (33.3%)	15 (38.5%)	23 (36.5%)	6 (20.7%)	15 (37.5%)	21 (30.4%)
Not well/not at all	16 (66.7%)	24 (61.5%)	40 (63.5%)	23 (79.3%)	25 (62.5%)	48 (69.6%)
General health status						
Excellent/very good/good	15 (62.5%)	31 (79.5%)	46 (73.0%)	22 (75.9%)	27 (67.5%)	49 (71.0%)
Fair/poor	9 (37.5%)	8 (20.5%)	17 (27.0%)	7 (24.1%)	13 (32.5%)	20 (29.0%)

\* p<0.001

### Long term health conditions

Thirty-one percent of respondents in phase I and 25% in phase II reported having at least one health condition that was likely to last longer than 6 months (not significant). Compared to males, female respondents were more likely to have a long term health condition in phase I (43.5% vs. 23.7%) but less likely in phase II (17% vs. 25%). Arthritis was the most commonly reported chronic health condition in phase I while cardiovascular disease was the most common condition in phase II (Table 1.3).

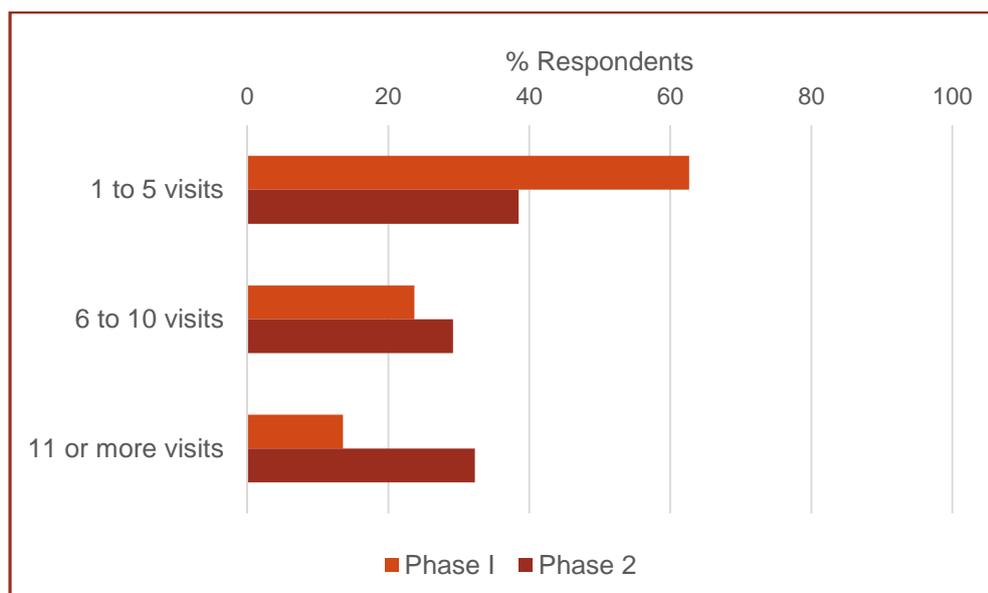
Table 1.3: List of the most common chronic conditions experienced by the respondents in phase I and phase II

Chronic condition	Phase I	Phase II
Arthritis	9.5%	-
Asthma	1.6%	1.4%
Cardiovascular disease	7.9%	15.3%
Diabetes	4.8%	6.8%
Long term injury	3.2%	3.4%
Mental health problems	3.2%	3.4%
Others (Ulcer, neck and lower back problems, liver condition)	8.2%	5.1%

### Experiences with General Practitioners

Overall 94% of respondents had visited a general practitioner (GP) in the previous six months in phase I (59 respondents) and phase II (65 respondents). Among them, all female and 90% of male respondents had visited the GP in both phases. A comparison of the number of visits for both phases is shown in Figure 1.1. Phase II respondents were significantly more likely to report a higher number of visits to a GP than phase I respondents ( $p=0.014$ ).

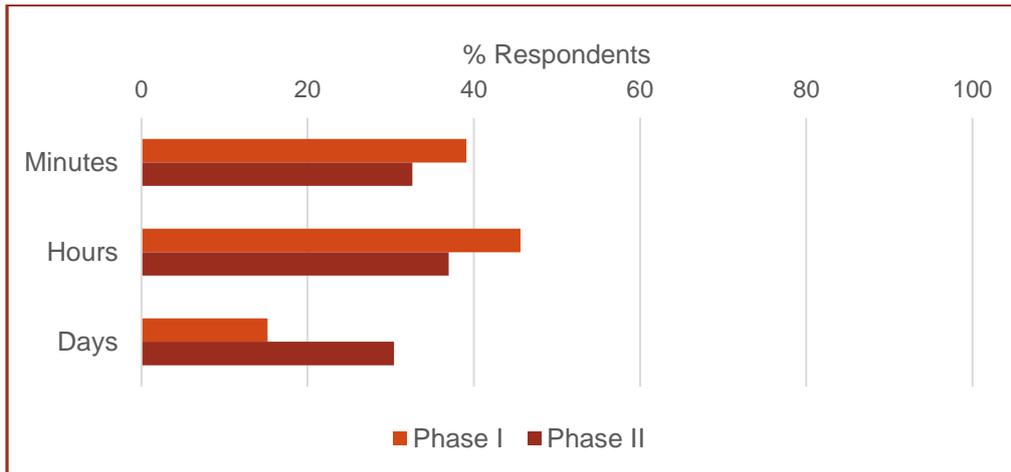
Figure 1.1: Number of visits to a GP in the last six months, by phase



### Visits to GP for urgent medical care

Figure 1.2 compares the time spent between booking the appointment and visiting their GP between phase I and phase II respondents. The majority of respondents in both phases were seen by a GP within minutes or hours of making an appointment when they required urgent medical care. Although 30% of phase II respondents, compared to 15% in phase I, were seen by a GP within days, this difference was not statistically significant ( $p=0.084$ ). Compared with male respondents, female respondents were more likely to report that they were seen within minutes of making an appointment, in both phases.

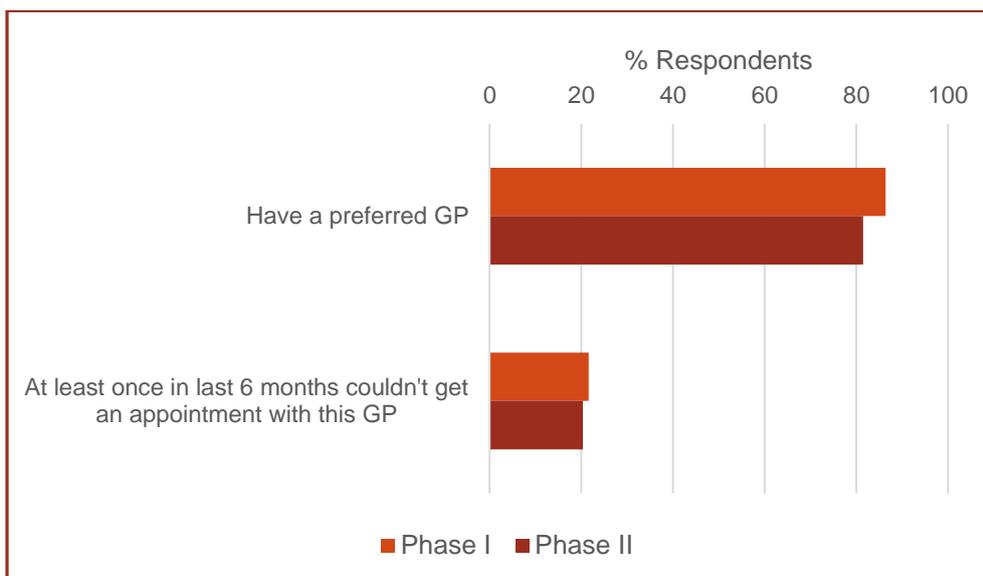
Figure 1.2: Length of time between booking and appointment for urgent medical care and being seen by a GP, by phase



### Have a preferred GP

In the six months previous to the survey, 86 percent of respondents in phase I and 82 percent in Phase II had a GP they preferred to see (Figure 1.3). Female respondents in phase I were more likely to have a preferred GP than male respondents (96% vs. 80%), whereas in phase II, male respondents were more likely to have a preferred GP than female respondents (86% vs. 76%). Twenty-two percent of respondents in phase I and 20 percent in phase II had not been able to get an appointment with their preferred GP at least once in the previous six months.

Figure 1.3: Preferred GP, by phase



### Reasons for not seeing a GP when needed

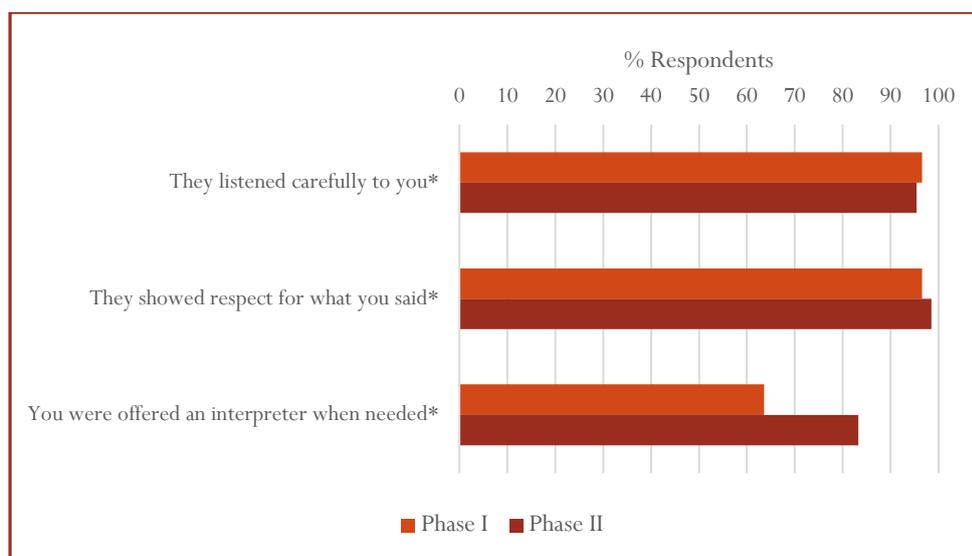
Among the respondents who said they could not get an appointment with a GP when needed, in the previous six months, the main reason in both phase I and phase II was long waiting time.

### Quality of services provided by GPs

As shown in Figure 1.4 most of the respondents in both phases stated that their GPs always/often listened to them: phase I (97%) and phase II (95%). Similarly, almost all of them reported that their GP showed respect for what they said: phase I (97%) and phase II (99%).

Regarding provision of interpreting services when visiting a GP, there was a statistically significant increase in the proportion of respondents who were offered an interpreter when they needed it, from 63.6% in phase I to 83.3% in phase II ( $p=0.043$ ). The increase was greater among female respondents.

Figure 1.4: Quality of services provided by GPs in the last six months, by phase



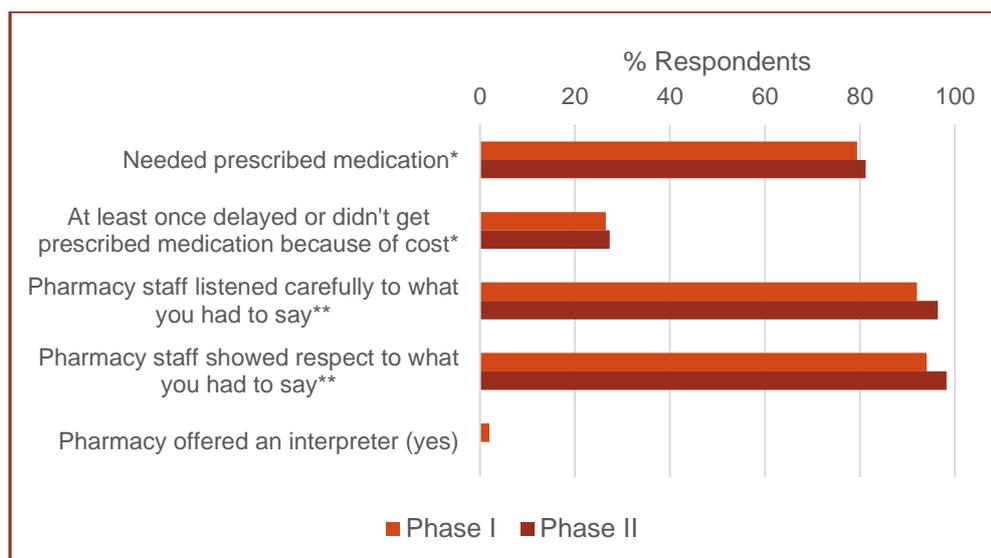
\*Response: Always/Often

### Experiences with medication and pharmacies/chemists

There were no statistically significant differences regarding respondents' experiences with medication and pharmacies between phase I and II (Figure 1.5). Fifty (79.4%) respondents in phase I and 56 (81.2%) respondents in phase II needed prescribed medication at some point in the previous six months. Female respondents were more likely than male respondents to report they needed prescribed medication in the previous six months (87.5% vs. 74.4% in phase I and 86.2% vs. 77.5% in phase II). In the previous six months, about one quarter of respondents in both phases reported a delay in getting, or being unable to get a prescribed medication due to cost. Over 90% of respondents in both phases felt that the pharmacy staff listened to them carefully and showed respect towards them.

Regarding provision of interpreters, only one respondent in phase I and none in phase II were offered an interpreter when needed while seeking service from a pharmacy.

Figure 1.5: Experiences with medication and pharmacies/chemists, by phase

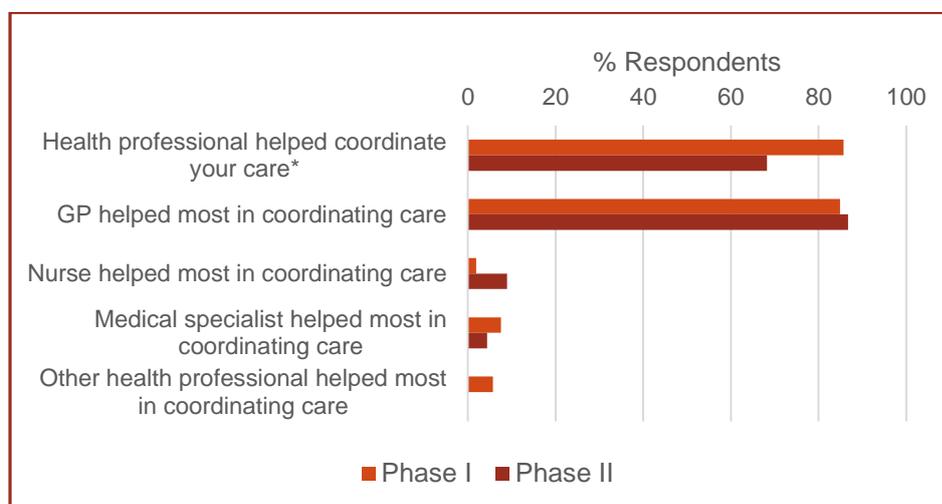


\*In the last six months; \*\*Always/often

### Care coordination

Respondents' experiences with care coordination are summarised in Figure 1.6. Overall, there was a statistically significant decrease in the number of respondents who stated that a health professional had helped them to coordinate their health care; from 86% in Phase I to 68% in phase II ( $p=0.019$ ). General practitioners were the most common health professionals coordinating care in both phases (85% in phase I and 81% in phase II).

Figure 1.6: Coordination of care, by phase

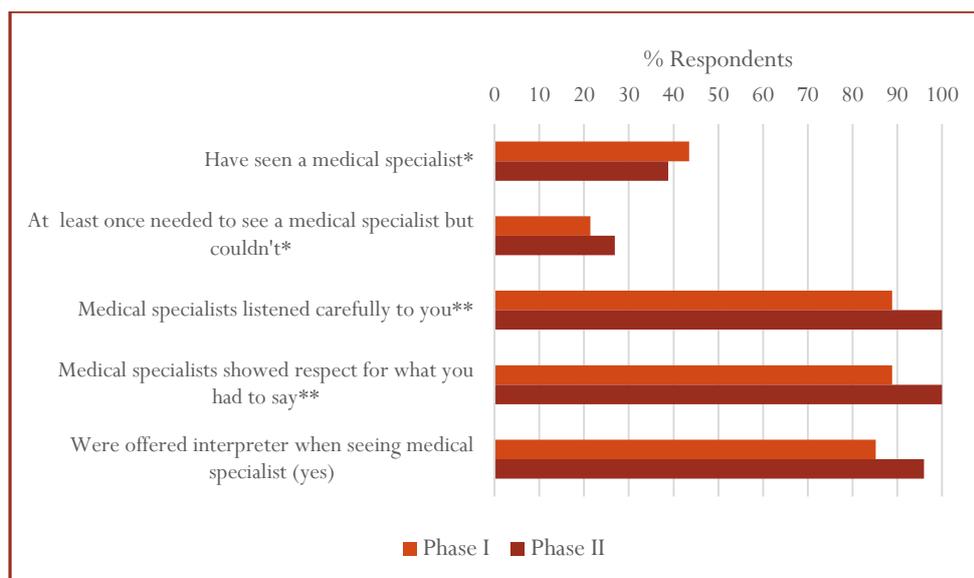


\* In the last six months

### Experiences with medical specialists

As shown in Figure 1.7, 43.5% of respondents in phase I and 38.8% in phase II had seen a medical specialist in the previous six months. In both phases, female respondents were more likely than male respondents to report that they had visited a specialist in the previous six months. About one in five phase I respondents and one in four phase II respondents needed to see a medical specialist in the previous six months but could not (not statistically significant difference).

Figure 1.7: Experiences with medical specialists, by phase



\*In the last six months; \*\*Always/Often

In both phases, the most common reason for not being able to see a specialist when needed was 'waiting time too long'. Cost was identified by 8% and 25% of respondents who could not see a specialist in phase I and II respectively.

Overall, compared to phase I respondents, phase II respondents were more likely to feel that medical specialists had listened to them and showed respect for what they had to say, but this difference was not statistically significant. Likewise, 85% of respondents in phase I and 96% in phase II were always or often offered an interpreter when they saw a medical specialist (not statistically significant difference).

In both phases, the medical specialists most commonly visited by respondents in the previous six months were obstetrician/gynaecologists and cardiologists.

### Experiences with dental professionals

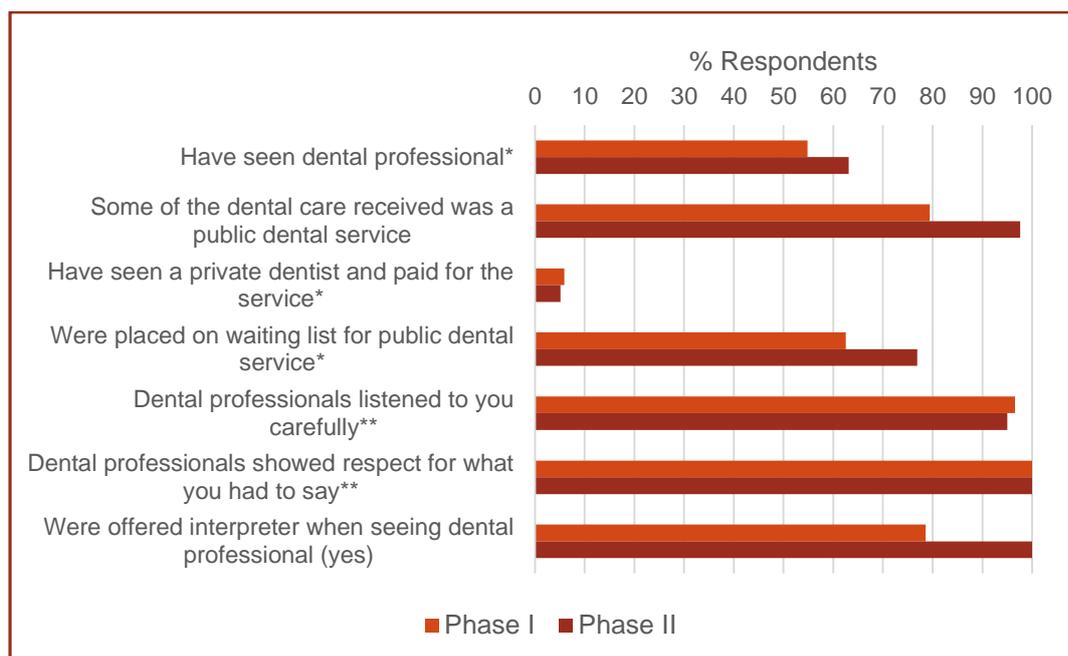
Figure 1.8 illustrates respondents' experiences with dental professionals in both phases. Fifty-five percent of respondents in phase I and 63% in phase II had seen a dental professional in the previous six months (no major differences between males and females).

There was a statistically significant increase in the proportion of respondents who had received some of the care in a public dental service (from 79.4% in phase I to 97.6% in phase II;  $p=0.012$ ). A similar proportion of respondents in both phases had seen a private dentist and paid for the service (6% in phase I and 5% in phase II).

Compared to phase I respondents, a greater proportion of phase II respondents had been placed in a waiting list for public dental services (not significant;  $p=0.177$ ). Similarly, phase II respondents were more likely than phase I respondents to state that at least once they could not go (38.2% of those who saw a dentist in the last six months in phase I vs. 52.5% in phase II;  $p=0.222$ , not significant). The most common reasons in both phases were cost and wait time too long.

More than 90 percent respondents in both phases stated that dental professionals had listened to them carefully and showed respect for what they had to say. There was statistically significant increase in the proportions of respondents who were offered an interpreter when they needed it while visiting a dentist (from 78.6% in phase I to 100% in phase II;  $p=0.004$ ).

Figure 1.8: Experiences with dental professionals, by phase

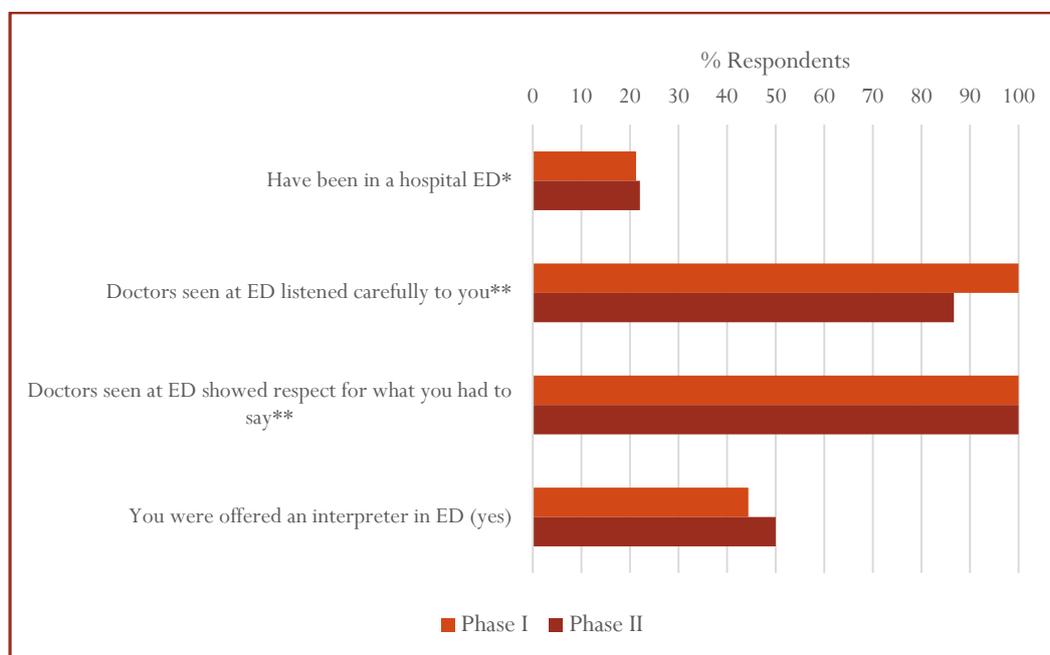


\*In the last six months; \*\*Always/Often

### Experiences with Emergency Departments

Respondents' experiences with hospital emergency departments (ED) are shown in Figure 1.9. Approximately one in five respondents in both phases had been in a hospital ED in the last six months, with no differences between males and females.

Figure 1.9: Experiences with hospital emergency departments, by phase



\*In the last six months; \*\*Always/Often

The most common reason for visiting the ED in both phases was 'taken by ambulance or the condition was very serious'.

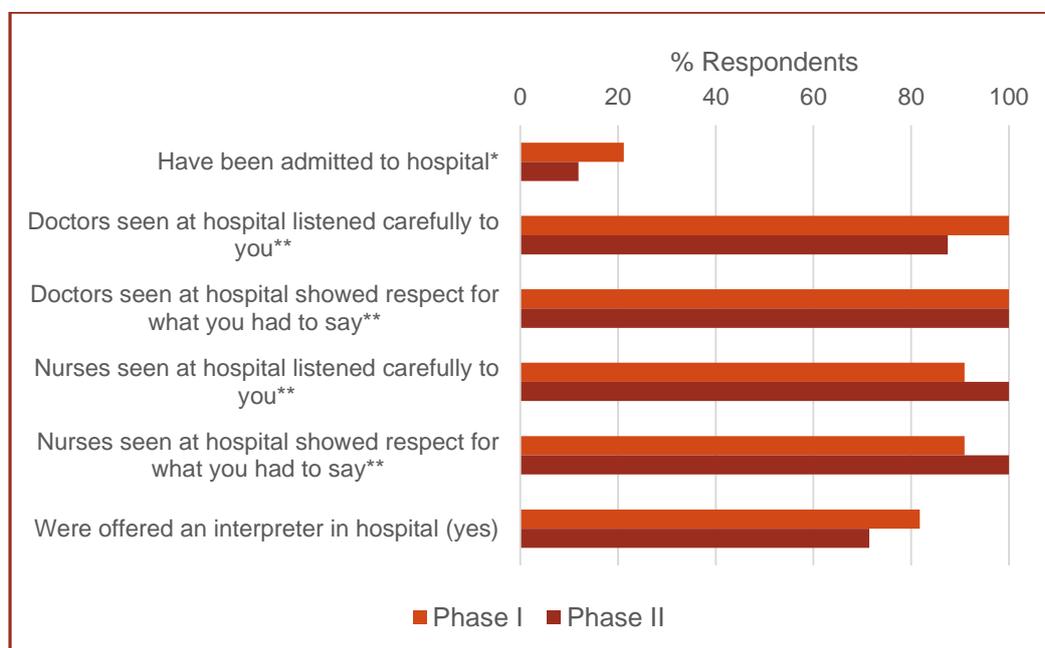
Overall, a high proportion of phase I and phase II respondents who had been to the hospital ED reported that doctors listened to them carefully and showed respect for what they had to say. Forty-four percent of phase I respondents and 50% of phase II respondents were offered an interpreter when visiting ED (not statistically significant difference).

### Experiences with hospital admissions

Respondents' experiences with hospital admissions in the previous six months are illustrated in Figure 1.10. A smaller proportion of phase II respondents had been admitted to hospital (21.2% in phase I vs. 11.9% in phase II;  $p=0.171$ , not significant). Females in phase I were more likely than males to have been admitted to hospital (not significant) but the proportion was similar between male and female phase II respondents.

Overall, respondents in both phases were highly satisfied with the way doctors and nurses in the hospital listened to them and showed respect for what they had to say. Among the respondents who had been admitted to hospital, 82% in phase I and 71.4% in phase II were offered an interpreter (not statistically significant difference).

Figure 1.10: Experiences with hospital admissions, by phase



\*In the last six months; \*\*Always/Often

### Patient experiences with health services – comparison with Australian population

Table 1.4 below compares respondents' experience with health services with those of the overall Australian population in 2017–2018 for phase I (Australian Bureau of Statistics, 2018) and 2018-2019 for phase II (Australian Bureau of Statistics, 2019). This comparison needs to be taken with caution as data from the overall Australian population relate to persons 15 years and over, and over the previous 12 months.

Table 1.4: Experience of health services – comparison between survey respondents and the overall Australian population (Australian Bureau of Statistics, 2018, 2019)

Experience of health services	Phase I		Phase II	
	Respondents from refugee backgrounds (18+ years – over last 6 months)	Overall Australian population (15 years and over – last 12 months)	Respondents from refugee backgrounds (18+ years – over last 6 months)	Overall Australian population (15 years and over – last 12 months)
Saw a general practitioner	94%	84.3%	94%	82.8%
Received a prescription for medication	79.4%	69.7%	81.2%	67.4%
Saw a medical specialist	44%	37.4%	38.8%	35.5%
Saw a dental professional	55%	50.1%	63.1%	49.0%
Visited hospital emergency department	21.3%	14.3%	22.1%	13.8%
Admitted to hospital	21.2%	12.5%	11.9%	12.8%

### **Patient Experience Survey – Summary of Findings**

Sixty-three (62% males) and 69 (58% males) individuals from refugee backgrounds participated in the patient experience survey in phase I and phase II respectively. The top countries of birth were Syria, Afghanistan and Iraq in phase I, and Iraq, Syria, Congo and Democratic Republic of Congo (DRC) in phase II. Phase II respondents had been in Australia for a significantly shorter period of time compared to Phase I respondents. There were no statistically significant differences in level of education, English language ability, self-reported general health status, and overall prevalence of long term health conditions between phase I and phase II respondents.

Between phase I and phase II there was a statistically significant increase in the proportion of participants who reported a higher number of visits to a GP, had been offered an interpreter when visiting a GP and a dentist, and who had received some of the dental care in a public dental service. There was also an increase in the proportion of participants who had been offered an interpreter when visiting a medical specialist and a hospital emergency department, and a decrease among those who were admitted to hospital, but these differences were not statistically significant. Only one respondent in phase I and none in phase II were offered an interpreter while seeking service from a pharmacy.

Overall, there was a statistically significant decrease in the number of respondents who stated that a health professional had helped them to coordinate their health care. This difference may be explained by the significantly shorter period of time phase II respondents had been in Australia, compared to phase I respondents.

## 2. Patient Experience Qualitative Interviews

### Participants characteristics

Semi-structured qualitative interviews were conducted with families from refugee background by trained peer researchers. Fifty-three families were interviewed in phase I and 47 (88.7%) were interviewed in phase II. In phase I, primary respondents were 29 (55%) females and 24 (45%) males, with a mean age of 41.8 years (SD=12.5; Median=38 years; range=21 to 67 years). The average number of family members was 4.3 (SD=1.8; Median=4; range 1 to 9 members) in phase I and 4.5 (SD=1.7; Median=4; range 1 to 8 members) in phase II. Table 2.1 shows the countries of origin of primary respondents in phase I and phase II.

Table 2.1: Patient experience qualitative interviews – Primary respondents' country of origin

Country of origin	Phase I (n=53)	Phase II (n=47)
Afghanistan	8 (15.1%)	8 (17%)
Iraq	8 (15.1%)	8 (17%)
Rwanda	5 (9.4%)	4 (8.5%)
Bhutan	4 (7.5%)	4 (8.5%)
Burma (Myanmar)	4 (7.5%)	4 (8.5%)
Burundi	4 (7.5%)	4 (8.5%)
Eritrea	4 (7.5%)	4 (8.5%)
Liberia	4 (7.5%)	4 (8.5%)
Somalia	4 (7.5%)	4 (8.5%)
South Sudan	4 (7.5%)	4 (8.5%)
Syria	4 (7.5%)	0
Total	53 (100%)	47 (100%)

### First healthcare appointment after arriving in Australia

At the phase I interview, respondents were asked about their first healthcare appointment after arriving in Australia. Overall, the experience was described as positive by 89% of respondents, negative by 4%, and as a mixed experience by 7% of respondents. Respondents valued being supported by case workers from the settlement services, feeling welcomed and respected by healthcare staff, undergoing comprehensive health assessments, and being assisted by interpreters during the appointments. Difficult experiences included language barriers, lack of interpreters, and limited understanding of the Australian healthcare system.

### Having a regular general practitioner

There was a decrease in the proportion of respondents who reported that they and/or their families had a regular GP, from 92% in phase I to 85% in phase II but this difference was not statistically significant. Some of the reasons given for not having a regular GP included a preference to have a regular medical centre but not necessarily a preferred GP, and the convenience of booking appointments with the nearest GP available. For some respondents, in particular those living in regional areas, their regular GP had left the medical centre.

### Experiences with general practitioners

Ninety-four percent of respondents in phase I and 91% in phase two reported that they and/or their families had visited a GP in the previous six months.

When asked about their experiences visiting general practitioners (GPs), there was a statistically significant increase in the proportion of respondents who reported having a mostly positive experience (79% of respondents in phase I and 93% in phase II;  $p=0.048$ ). In both phases, respondents valued that their GP was an experienced and friendly healthcare professional, who listened carefully, was respectful, and provided a thorough assessment and quality care. Some respondents also highlighted the kindness of other general practice staff, the availability of interpreters, having a GP who spoke the same language, the convenient location of the practice, and the availability of (Medicare) bulk billing.

#### Family 15

Phase I: "There was an interpreter there and it was easy to understand the process. We did not have to pay anything as it was all covered by Medicare"

Phase II: "A phone interpreter helped me understand what the doctor was saying. My GP referred me to a specialist quickly and I did not have to wait for long"

A number of difficulties were reported by some respondents in both phases including language barriers, unavailability of or dissatisfaction with interpreters, and dissatisfaction because their regular GP was not available or because they did not receive the expected treatment or service (e.g. no referral to a specialist, no prescribed medication, no tests or further investigations).

#### Family 5

Phase I: "Everything was good. Alongside my long lasting illnesses, recently I also had kidney problem and was advised to have urine test, and then Ultrasound and MRI"

Phase II: "Not good, I have had a lower back and leg problem for a long time and there isn't a clear diagnosis. I was first told that it is due to degenerated discs and now the GP says the problem is not because of discs and not serious, and that I will be alright after a few sessions of physiotherapy. Now I am on waiting list for physiotherapy"

#### Family 8

Phase I: "In general, I always have good experience with my regular GP but this one was different and I felt like I wasted my time. I believed that this GP was going to help me straight away because I thought it was an easy thing but turns out that it was not as easy as I had expected. I felt bad and very upset because I thought why this GP did not include me and tell me what the process was or find another solution to address this issue. I realised that every GP is different and finding a good one is always difficult especial if you don't speak English very well. I think communication was an issue or possibly this GP did not have enough time to see me. I wish he told me what was going on or at least told me to come back next time when he has time available"

Phase II: "I have seen a big change in the GP compared to the previous visit [interview]. So far I have had an amazing experience with the GP"

### Experiences with specialists

Sixty-two percent of respondents in phase I and 55% in phase II reported that they and/or their families had seen a specialist over the previous six months.

Overall, the majority of respondents in both phases reported positive experiences with their visits to specialists. Respondents valued that specialist and other staff were welcoming and reassuring, the quality of the care received including good communication, and the availability of interpreters.

#### Family 1

Phase I: "I had consultation experience with a mouth specialist from Logan hospital. It was very helpful because the specialist was really friendly and explained to me what she had done and what she was going to do for me, through an onsite interpreter. Before she checked me she asked for my permission first and made me feel comfortable"

Phase II: "My specialist from hospital booked onsite interpreter for me, so it was a big help. Sometimes I needed to see other doctors from other departments. My specialist referred me to another clinic. So, I could easily arrange appointments with other clinics if needed"

Some respondents also reported difficulties when visiting specialists including long wait to get appointments or in the clinic, lack of availability of qualified interpreters or dissatisfaction with the quality of interpretation, out of pocket expenses, lack of continuity of care (i.e. different specialist at each visit), and dissatisfaction with the care received.

#### Family 20

Phase I: "There was a waiting period for the Gynaecologist to take a biopsy operation from April until now. This is medically unacceptable, because a biopsy is generally performed whenever there is doubt of a serious hidden thing to be revealed (like cancer for example), and waiting six months to do the biopsy is not helpful, the disease will not wait, it can proceed to a dangerous irreversible condition and this is not for the benefit of the patient. The patient will be worried all this time about his condition. This will affect him emotionally and mentally and his life negatively"

Phase II: "After a brain surgery of my wife one and a half years ago, there were some complications. Her right eye didn't move or open properly, and the jaw was paralysed. She received some sessions with the physio, but it wasn't helpful, and the specialist mentioned that she needs an operation to correct the damage. She has been waiting for one year now without getting an appointment for the operation. This impacted her mental health severely, and she attempted to commit suicide more than once just because of how she looked. The specialist didn't follow-up with her at all. They were only able to see her if she had a major accident, like falling or fainting. She also reported that the specialist cancelled her appointments more than once at the last minute, which was very hard for the family as the son takes time off TAFE to get her to the appointment. When we ask them the reason, the reply was usually that either the doctor has other operations to do, or that he is just too busy and unavailable"

### **Experiences with dentists**

Seventy-four respondents in phase I and 51% in phase II reported that they and/or their families had visited a dentist over the past six months.

Positive experiences with dentists were reported by 71% of respondents in phase I and 75% in phase II (not significant). Respondents valued having access to a dental service (as some had never been to a dentist before), the quality of care and service received, the welcoming and caring attitudes of the dentists and clinic staff, the availability of interpreters, and the shorter waiting time in private dental clinics.

#### Family 19

Phase I: "They always provide me an interpreter"

Phase II: "They made a few appointments for me to get my tooth cleaned, and to try to slow down the progression of gum disease. I always had an onsite interpreter; they explained the situation clearly. I understood more what the problem was and I was also informed what to expect regarding waiting list for the denture"

Some of the difficulties reported by respondents in both phases when visiting a dentist included long wait for an appointment (sometimes while in pain) and limited treatment options in public clinics, lack of affordability of private dentists, poor communication and no interpreter provided, and dissatisfaction with the care received.

#### Family 19

Phase I: "My front teeth was wobbly and need to be extracted. But the waiting list for denture is around a year. I will try to keep them as long as I can till I get called for an appointment"

Phase II: "I was in so much pain that I needed to take pain killer on a regular basis. After a while the medicine wasn't working and the pain was unbearable. I went to the dentist and they said they could not do any other treatment apart from extracting my teeth, as there was no hole need to be filled. They removed eight remaining back teeth all at once and that was pretty much what I had left. Now I can't eat normal food, it is a problem. Two years passed since they put my name on the waiting list to get denture and my understanding is that I have to wait for two or more years. I tried to get it done privately, however the cost was too much that I couldn't afford to pay it. We had a quote from few places; it would cost me from \$1500 to \$3000 for just one side denture"

#### Family 26

Phase I: "The dentist there can't treat many cases (even fillings are sometimes difficult for them to perform). In any difficult case, they offer the option of extraction because it is easier for them"

Phase II: "Language was the only difficulty. As mentioned before, phone interpreters need to improve their services"

### **Experiences with pharmacists**

All respondents in phase I and 87% in phase II reported that they and/or their families had visited a pharmacist at least once over the previous six months.

The proportion of respondents who reported positive experiences with pharmacists increased over time, from 88% in phase I to 95% in phase II but this difference was not statistically significant. Overall, respondents valued easy access to medication, friendliness of pharmacy staff, useful information provided by pharmacists, affordability (subsidised medications) and choice (between brand and generic medications), prompt service, and convenient location.

#### Family 3

Phase I: "My experience at the pharmacy has been relatively positive. The system in Australia is straightforward. All I needed is a medical transcript, and the rest is taken care of. The staff hand me medications, and demonstrate how I should consume them"

Phase II: "My pharmacists are very young, and there are a few people my age. My visits were always very positive and engaging, thereby enhancing my overall experience"

Difficult experiences with pharmacists were reported by some participants. Some of these experiences included language barriers and no interpreter offered, costly medication, the requirement to have a prescription from the doctor, and unhelpful pharmacy staff.

#### Family 8

Phase I: "I always take the script and hand it to the pharmacist and after that, I just have to wait. The pharmacists never ask me whether I need an interpreter or if I understand the medications regime. I gave my script to the pharmacist, she did not explain anything or even ask me to keep waiting. I just had to wait. If you don't have prescription from the doctor, it is always hard to know what is available for you and the environment is not very welcoming. For example: my doctor prescribed some medications and I went to the pharmacy to collect them, they explained the medications but because I don't understand much English, and I don't know how to read I was

taking two tables instead of taking one and I did not know how the medicine was to be stored. Later when my friends looked at medication box she told me that I was supposed to take one tablet early morning in empty stomach and keep this medication in the fridge. It was so difficult for me to understand all this because they did not explain to me in my language. There is limited information about interpreter at the pharmacy”

Phase II: “I have had a good experience with pharmacy when it comes to the staff members explaining things in a respectful way [...] The issue is that some pharmacists explain to me what they are giving me even though I don’t understand much, but some others don’t explain too much. Sometimes the GP explains to me what medications he has prescribed and how to use them. Otherwise the pharmacists only give the medicines to me. Moreover, they don’t even ask me whether I need an interpreter even if the situation is obvious. For example: when they ask me any question I just say “yes, yes”. I don’t understand much what they say to me but I just nod my head and say okay. Also when the pharmacist noticed that I don’t understand much, they said “oh, it’s, okay it’s okay” and gave me medications. I found this very scary but I don’t know what to do. The only problem comes when it comes to interpreter availability at the store. It is very difficult to see whether there is interpreter service there. I don’t even know whether there is interpreter at the pharmacy at all which is very dangerous for non-English speaking clients”

### **Experiences with hospitals**

Seventy-five percent of respondents in phase I and 81% in phase II reported that they and/or their families had been to a hospital over the previous six months.

Seventy-seven percent of those who had been to a hospital in phase I and 71% in phase II reported having a positive experience (not significant). Respondents valued the timely service, the professionalism, caring attitude and cultural competence of hospital staff, comprehensive assessment and quality care received, the availability of interpreters, the accessibility and affordability of hospital services.

#### **Family 11**

Phase I: “Doctors and staff from the hospital looked very well after me during my delivery time. I had suffered too much pain, so my sister informed them and they gave me pain relief medication. In the ward, they came and checked me and the baby from time to time. The doctors came and checked me and explained to me about the “do’s and don’ts” with the help of an interpreter. They gave me breakfast, lunch and dinner as well. They called an interpreter for me and gave me instructions before discharge. Physiotherapist, paediatrician and gynaecologist came to see me and my baby, then checked us to make sure we were okay before being discharged from the hospital. All hospital staff were also very friendly and smiled to me. That was very helpful. All services are free of charge and that was helpful to us too”

Phase II: “The hospital called an interpreter for me, so that was very helpful. I did not need to pay money for my treatment so that was also a big help. All hospital services were free and all medication was free at the hospital. All staff were very friendly and tried to help me”

Some respondents reported difficult experiences with hospitals such as long waiting time in emergency departments, language barriers and lack of interpreters, feeling ignored and isolated, cost of parking, and transport difficulties due to long distance between home and hospital.

#### **Family 4**

Phase I: “Language difficulty was a problem. When I needed to go to toilet there was no one to provide support. Interpreter was provided only when the doctors needed to communicate with me”

Phase II: “Language always comes as a difficult part. My surgery was carried out in Townsville hospital but my transport including the escort’s (family members) was arranged by the hospital. However, my relatives had to travel a long distance to see me and bring home-cooked food for me. I wish I had the surgery in Cairns”

### **Best sources of advice and guidance to access healthcare services in Australia**

General practices and case workers from settlement services were the best two sources of advice and guidance in relation to accessing healthcare services in Australia, as stated by respondents in both phases (Table 2.2).

Table 2.2: Best sources of advice and guidance to access healthcare services in Australia by phase\*

Source of advice and guidance	Phase I	Phase II
General practitioner and staff from medical centre	68%	68%
Case worker / settlement service	51%	36%
Community members, friends and neighbours	32%	34%
Family members	15%	23%
Bicultural healthcare worker	8%	—
Others (church, health information sessions, interpreters, specialists and hospital staff, children’s school, TAFE, internet, Centrelink)	23%	6%

\* Respondents could nominate more than one source of advice and guidance

“Most of the time my GP has been a very helpful person. I always ask my GP if I have any question. Sometimes I ask my GP for further information. He has been very supportive and able to help me with more information if needed”

“The best person I used to get advice and guidance from in terms of accessing the health services was my case manager from XXX. She was very helpful in explaining a lot of the services I was entitled to and what my rights were. She helped explain to me how to access the buses, trains and the clinic where I go to see my GP”

“Community members are the ones who give us information. For example: we did not know that we were able to change GP other than the one we have been linked with when we first came here”

### **Improvements in the health care system over the past year**

Respondents were asked whether they had seen any improvements in the healthcare system over the previous year. There were mixed responses. Some reported improvements in the communication between health professionals and patients, cultural awareness of health services, use of interpreters, and overall standards of care.

“In terms of improvement of healthcare, I will mention one single thing that has been very much progressive in Queensland. It is the communication between patients from CALD backgrounds and health and allied health professionals. The level of cultural awareness has improved due to the improved cultural communication awareness.”

“I have seen so much improvement in my GP and other services. All health care providers are very happy to see us. They are very caring and show us respect. For instance, my GP used to use Google translate before instead of offering an interpreter, but nowadays he always offers us an interpreter. Even if the interpreter is not physically available, he tries to use phone interpreter all the time.”

Other respondents had not seen improvements and were dissatisfied with the long waiting time for appointments (for specialists and public dental services in particular), limited availability of some health professionals, and increasing out of pocket expenses.

“No I haven’t seen any improvements. For the improvement to be noticed I would like to see one of the biggest issues facing many Australian citizens. That is to shorten the waiting list for specialist service or elective surgery. This is getting even worse hence I see no improvement.”

“Private health cover cost has actually jumped up and some medications have become very expensive for people who don’t have health cards. Some pathology tests and procedures such as iron infusion are not fully covered by Medicare anymore.”

“No improvement was observed in the health system for the past year. Generally, the professionals are all busy, and the waiting time is too long. Even when you go to the emergency department, you have to wait for a long time. There are not enough doctors, specialists, and other medical staff in Brisbane to accommodate the growth in population.”

### **Experiences in regional areas**

Some respondents living in regional areas identified a number of issues that impacted on their overall healthcare experience including lower availability of GPs, having to change GPs regularly as doctors frequently transferred to other medical centres, lack of interpreter services, limited availability of mental health services and some medical specialists, long wait to get appointments with specialists and for elective surgery, difficulties accessing dental services, limited transport options to attend health appointments, and out of pocket expenses for prescribed medications.

### **Patient Experience Qualitative Interviews – Summary of Findings**

Fifty-three families from a variety of ethnic backgrounds were interviewed in phase I and 47 (88.7%) were interviewed in phase II. At phase I, 85% of families lived in the greater Brisbane metropolitan area, while 15% lived in regional towns (Toowoomba and Cairns).

Overall, the majority of respondents had mostly positive experiences visiting healthcare professionals and services. When asked about their experiences visiting general practitioners (GPs), there was a statistically significant increase between phase I and II in the proportion of respondents who reported having a mostly positive experience. Respondents valued the support provided by case workers from the settlement services when navigating the healthcare system, feeling welcomed and respected by healthcare staff, the quality of the care received, having access to dental care and medications, and being assisted by interpreters during the appointments.

Some of the difficulties experienced by respondents included language barriers, lack of availability of interpreters or dissatisfaction with the quality of interpretation during some consultations, limited knowledge of the Australian healthcare system, long wait to get appointments with specialists and public dental clinics or when visiting hospital emergency departments, out of pocket expenses (e.g. medication), lack of continuity of care when visiting specialists in public hospitals, long wait for dental appointments (sometimes while in pain), and lack of affordability of private dentists.

Some respondents reported improvements between phase I and phase II in the quality of communication between health professionals and patients, cultural awareness of health services, use of interpreters, and overall standards of care. Other respondents had not seen improvements and were dissatisfied with the long waiting time for some appointments, limited availability of some health professionals, and increasing out of pocket expenses.

Some respondents living in regional areas identified a number of issues that impacted on their healthcare experiences such as limited availability of GPs, medical specialists and dental care, lack of interpreter services, long wait times for some appointments and elective surgery, limited transport and out of pocket expenses for prescribed medications.

### 3. Services and Stakeholders Experience Survey

#### Respondents characteristics

Sixty-nine respondents in phase I and 54 in phase II completed the Services and Stakeholders Experience online survey. Table 3.1 shows respondents' area of work and primary role. Compared to phase I, in phase II there was a greater proportion of respondents working in HHS/other hospital and general practice, and a smaller proportion working in Queensland Health, the non-government community sector, and as private providers. Regarding primary role, in phase II there were more managers/supervisors and fewer settlement/health promotion practitioners than in phase I. These differences however were not statistically significant ( $p>0.05$ ).

Table 3.1 Services and Stakeholders Experience Survey respondents' area of work and primary role

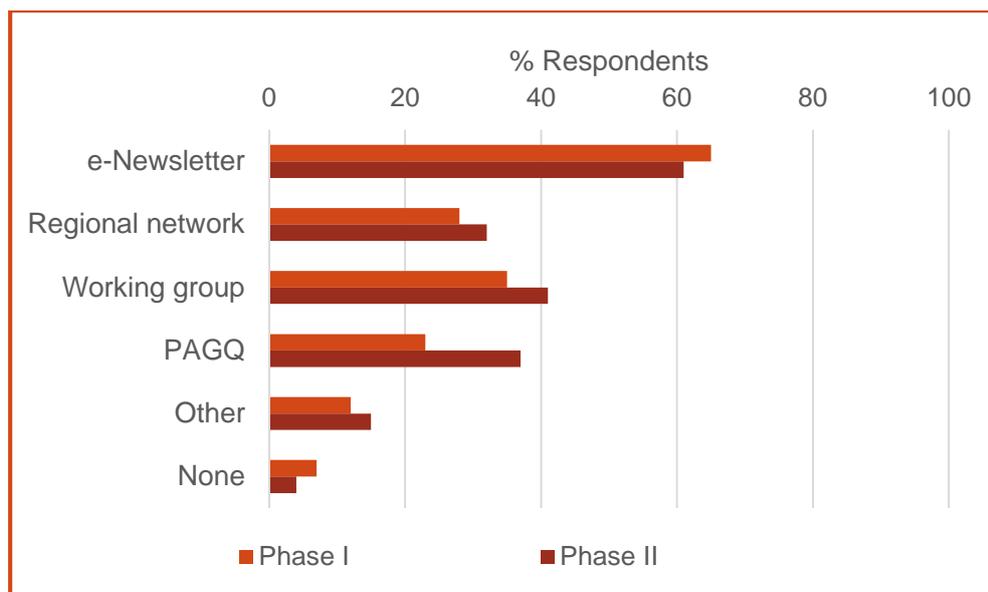
Area of work	Phase I (n=69)	Phase II (n=54)
Hospital and Health Services/other hospital	19%	26%
General practice	14%	26%
Queensland Health	14%	9%
Non-government community sector	13%	7%
Settlement service	12%	13%
Refugee community	7%	6%
Private provider	6%	—
Primary Health Network	4%	4%
Other government agency	3%	4%
Other area of work <sup>1</sup>	7%	6%
<b>Primary role</b>		
Healthcare practitioner	39%	39%
Settlement/Health Promotion practitioner	22%	9%
Manager/Supervisor	20%	30%
Other primary role <sup>2</sup>	19%	22%

<sup>1</sup> Other area of work: refugee health service, secondary/tertiary education sector, Refugee Health Network Queensland; <sup>2</sup> Other primary role: refugee community representative, interpreter, administrator, policy officer, volunteer

#### Level of involvement in Refugee Health Network Queensland (RHNQ)

The level of involvement of respondents in different activities of the RHNQ in both phases is shown in Figure 3.1. Over 90% of respondents in both phases were involved in at least one RHNQ activity. Overall, compared to phase I respondents, there was a greater proportion of phase II respondents involved in the regional network, working groups, the Partnership Advisory Group (PAG), and other activities, although these differences were not statistically significant.

Figure 3.1: Level of involvement in RHNQ, by phase

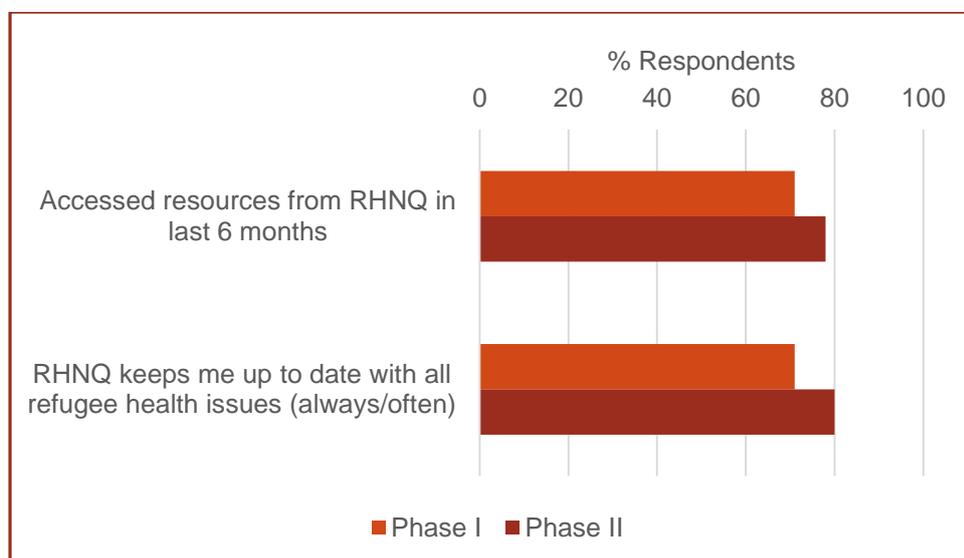


PAGQ: Partnership Advisory Group (Refugee Health Network Queensland)

### Access of resources from RHNQ

As shown in Figure 3.2, there was an increase in the proportion of respondents who reported accessing the resources of the RHNQ in the last six months (from 71% in phase I to 78% in phase II), and also those who reported that the RHNQ always/often kept them up to date with all refugee health issues (71% in phase I, 80% in phase II), but these differences were not statistically significant.

Figure 3.2: Access of resources from RHNQ, by phase



### Partnering with other agencies to improve refugee health outcomes

Sixty-eight percent or respondents in phase I and 74% in phase II reported partnering with other agencies to improve refugee health outcomes (not statistically significant difference).

These partnerships included collaborations between healthcare practitioners (e.g. GPs, specialists, refugee nurses, other allied health professionals), settlement services (e.g. Access Community

Services, Multicultural Australia, Centacare), Primary Health Networks, Hospital and Health Services (HHS) Queensland Health, Inala Community House, ECCQ, QPASTT, WWG, Queensland Transcultural Mental Health Centre, Harmony Place, Mater Hospital (MIRHS), Maternity and Child Health, Aged Care Assessment Teams, Transition Care Program, Red Cross, Cairns Local Network, disability services, Local Area Collaboratives, Partnership Advisory Group and Clinical Advisory Group (RHNQ), TAFE, QUT Health Clinics, Logan Health Day, RAILS, Northern Australia Primary Health Ltd (NAPHL), Hub Community Centre, Amparo Advocacy, Belong (Acacia Ridge Community Centre), refugee community leaders networks, interpreters and universities. Examples of these collaborations are shown below.

#### Phase I

“MIRHS nurse visits every week and we do refugee health assessments. Attempting to get other agencies involved to provide improved health outcomes to our patients... e.g. want to do a My Health for Life program for CALD” [Healthcare practitioner]

“Run preventative health information sessions for refugees in partnership with Refugee Health Nurse” [Settlement/Health promotion practitioner]

“Mater provides us with nurses; we collaborate with MDA and Access regarding new services. We cross-promote activities occurring at the Hub Community Centre. We refer patients to QPASTT, Amparo, ECCQ, WWG and Belong for programs they are funded to deliver” [Manager/Supervisor]

“Partner with settlement agencies, non-profits, health services in research and program delivery” [Other primary role]

#### Phase II

“Joint activities including advocacy at all levels, health education, health navigation, community engagement, clinical education, research” [Healthcare practitioner]

“Co-location with Mater for new arrival screening. Provision of 31% of our doctors’ time using interpreters last quarter. CALD specific mental health services. Working with neighbourhood and other groups around better health and social care provision. Research into CALD health” [Manager/Supervisor]

“Strengthening relationships between interpreter services from different HHS and link with CALD communities and NGOs” [Other primary role]

### **Local health strategies to support people from refugee backgrounds**

Fifty-nine percent of respondents in phase I and 70% in phase II reported that their service had developed a local health strategy or program to support people from a refugee background (not statistically significant difference). Some examples of these strategies are shown below.

#### Phase I

“Caring for pregnant mums from a refugee background” [Healthcare practitioner]

“Assessing newly arrived refugees along with the refugee nurses” [Healthcare practitioner]

“Educate refugees about lifestyle and health” [Healthcare practitioner]

“A refugee health protocol” [Healthcare practitioner]

“A book with a plan to assist a cohesive approach” [Healthcare practitioner]

“Refugee health ready practice” [Healthcare practitioner]

“Strong clinical guidelines for managing refugee clients” [Healthcare practitioner]

“[...] a refugee nurse from the West Moreton region to assist newly arrived clients with health assessments and appointments coordination” [Settlement/health promotion practitioner]

“Refugee health referral pathways developed” [Settlement/health promotion practitioner]

“Working with National Settlement Standards and local health services” [Settlement/health promotion practitioner]

“Fund refugee health nurses and AHP [Allied Health Professionals] access to TIS” [Manager/supervisor]

Phase II

“A medical clinic to provide primary care for patients without Medicare and those with Medicare” [Healthcare practitioner]

“BSPHN has been working to enhance the health and health literacy of refugees within the local area and supporting other PHNs to do the same” [Healthcare practitioner]

“Formed a refugee health interest group in the area” [Settlement/health promotion practitioner]

“Many clinics have arisen as a direct result of need from CALD patients. HepReach service is an example” [Manager/supervisor]

“All staff has had to be educated on using TIS and other methods of communication. Nursing team were also required to participate in some online refugee health care webinars” [Manager/supervisor]

“WMH Cultural Diversity Action Plan” [Manager/supervisor]

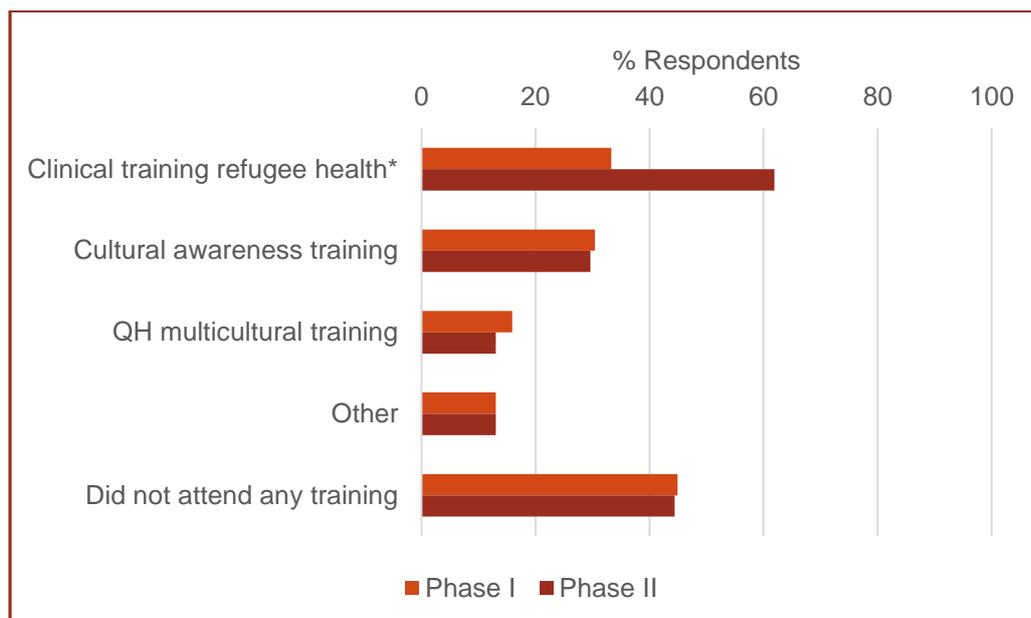
“Improving patient booking and reminder systems, engaging interpreters, identifying when an interpreter has been engaged and training” [Manager/supervisor]

“Funds to Non-Government organisations to support vulnerable people seeking asylum” [Other primary role]

### Refugee health training/education

Attendance to training and education sessions among respondents in both phases is shown in Figure 3.3. About 55% of respondents in both phases had attended at least one training and education session. Among healthcare practitioners, participation in clinical training in refugee health increased from 33% in phase I to 62% in phase II (p=0.051; borderline significant).

Figure 3.3: Attendance to refugee health training or education in the last 12 months, by phase



\*Healthcare practitioners only

### Application of knowledge and skills

Eighty-six percent of respondents in phase I and 93% in phase II who had attended training in the previous 12 months reported having applied the knowledge and skills learned from the training (not significant difference). Some examples are stated below.

#### Phase I

“Being aware of the clients’ culture and using interpreters more efficiently” [Healthcare practitioner]

“I became more aware about refugee health issues” [Healthcare practitioner]

“Disease profile of refugees, torture and trauma awareness, changes to mental health” [Settlement/health promotion practitioner]

“Helped patients access services, applied knowledge re: NDIS, culturally sensitive sexual health and reproduction” [Settlement/health promotion practitioner]

“Referring to services, advocating with mainstream services” [Settlement/health promotion practitioner]

“Using telephone interpreters to discuss sensitive topics” [Settlement/health promotion practitioner]

“Effort to become more culturally inclusive” [Manager/supervisor]

#### Phase II:

“Talking to parents about speech and language development in children of refugee background” [Healthcare practitioner]

“Refugee health assessment and website for resources” [Healthcare practitioner]

“Better able to understand the refugee perspective and use resources to gain more knowledge” [Healthcare practitioner]

“Insights developed around community expectations, improved cultural awareness” [Healthcare practitioner]

“Increased knowledge related to malaria management - what to do post arrival” [Settlement/health promotion practitioner]

“Cultural sensitivity and application to education events” [Manager/supervisor]

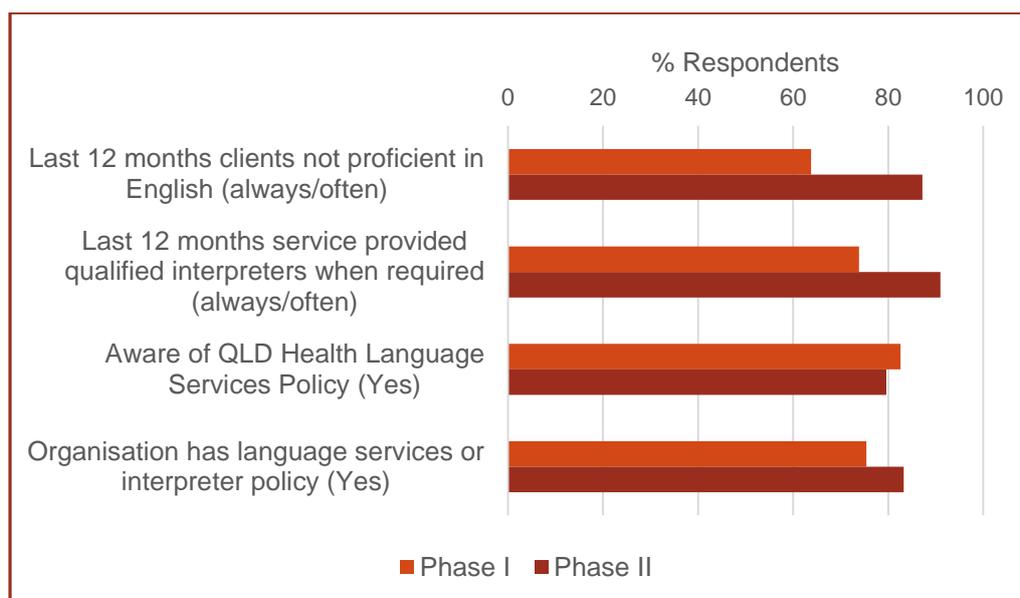
“The use of appropriate language in resource development” [Other primary role]

“More knowledge about up-to-date health info/ how to communicate with other community people/ how to distribute health message to your own community/ how to access other services.” [Other primary role]

### Language issues

Stakeholders were asked a number of questions related to the English language proficiency of their patients/clients, provision of interpreter services, and language policies. Figure 3.4 shows the breakdown of responses by phase. There was a statistically significant increase in the proportion of respondents whose clients were always/often not proficient in English (from 63.8% in phase I to 87.2% in phase II;  $p=0.005$ ), and the proportion of respondents whose service always/often used a qualified interpreter for patients not proficient in English (from 73.9% in phase I to 91% in phase II;  $p=0.025$ ).

Figure 3.4: Language issues related to patients/clients from refugee backgrounds, by phase



Some of the reasons for not always/often using qualified interpreters are stated below. These included lack of availability of interpreters for some languages, variable quality of interpreters, clients' preference for having family or friends as interpreters, and availability of bilingual staff in the services.

**Phase I**

“One in seven of our consultations uses an interpreter. We use hundreds of interpreters every week. We often find XXX interpreters to be of poor quality, doing household tasks whilst doing interpreting by phone, or not available as they are such small language groups. We believe that XXX pays the lowest amount, hence the more experienced interpreters move from XXX to other providers. With the lack of compulsory health care training required of interpreters there is hugely variable quality and ability to really rely on interpreters. This needs to be addressed” [Manager/supervisor]

“Occasionally XXX cannot provide an on-site interpreter, we then use phone interpreter which is not optimal for our cohort (aged/frail/disabled)” [Manager/supervisor]

“Not available Rohingya or Oromo language” [Healthcare practitioner]

“Some patients prefer to use family or friends as interpreter - this is not our preferred option though” [Manager/supervisor]

**Phase II**

“Our staff speak the language of our clients” [Manager/supervisor]

“On the very rare occasion that despite all our efforts we have been unable to access an appropriate interpreter and the matter was urgent. On these occasions we would manage risk as best we could and ensure a follow up appointment with an appropriate interpreter was booked to clarify any issues” [Healthcare practitioner]

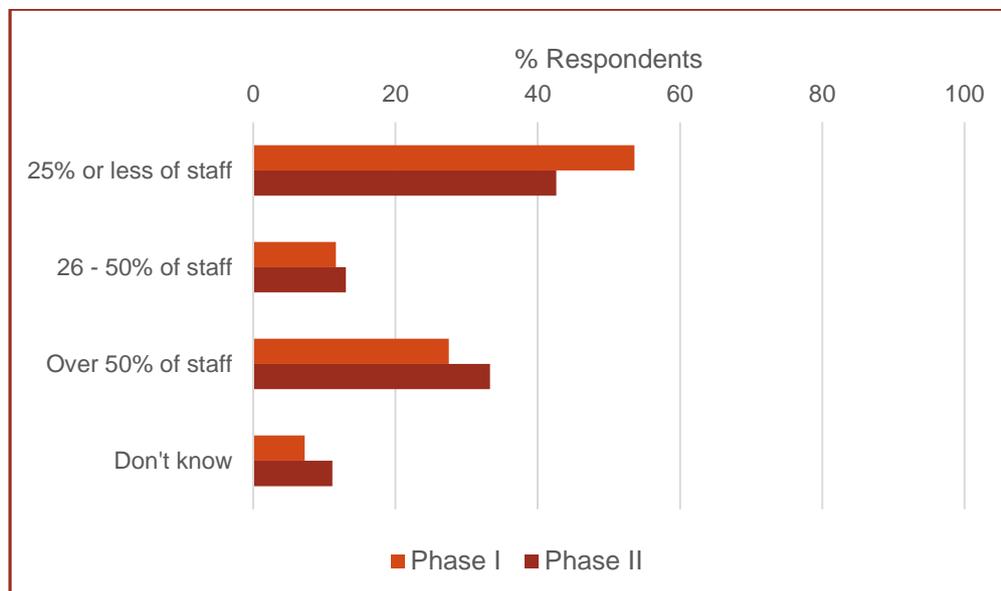
“Often a non-accredited interpreter is the only option we have as there are limited accredited interpreters in most languages especially in emerging languages eg: Kurdish kurmanji or African language groups” [Other primary role]

There was also an increase in the proportion of respondents whose organisation had a language services or interpreter policy (75% in phase I, 83.3% in phase II) but this difference was not statistically significant. Overall, about 80% of respondents in both phases were aware of Queensland Health Language Services Policy.

### Language diversity of staff

The proportion of staff in the respondents' teams, who spoke a language other than English as their first language is shown in Figure 3.5. Overall, there was an increase in the language diversity of staff in respondents' teams between phase I and phase II, although not statistically significant.

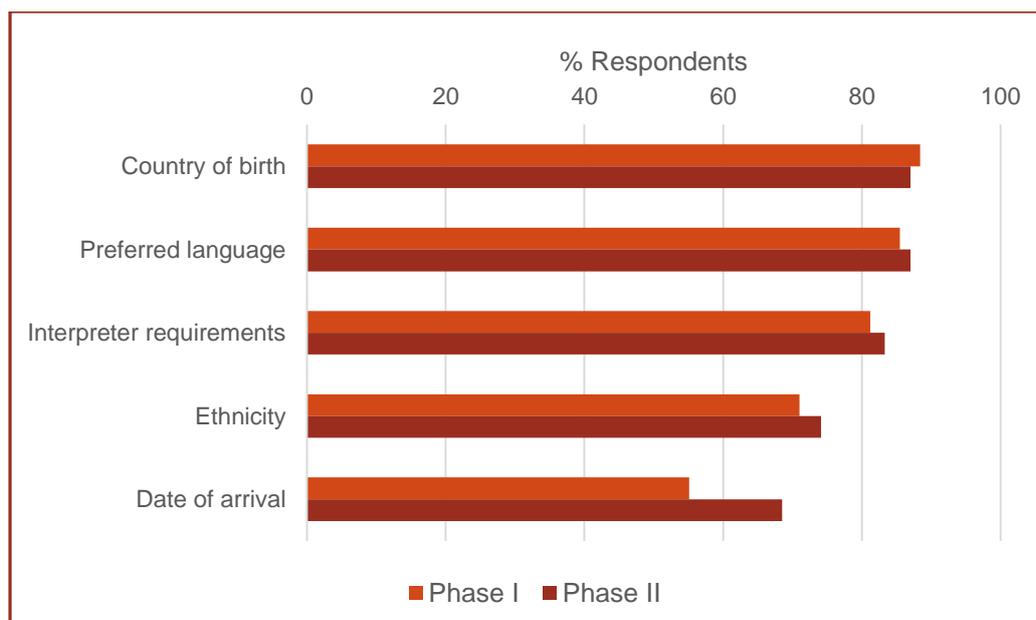
Figure 3.5: Percentage of staff in respondents' teams speaking a language other than English as their first language, by phase



### Collection of refugee-relevant demographic data

Figure 3.6 illustrates the refugee-relevant demographic data collected by respondents' services in phases I and II. More than 80% of services in both phases collected country of birth, preferred language and interpreter requirements. Overall there was a small increase in the proportion of services collecting preferred language, interpreter requirements and ethnicity, and a moderate increase in date or arrival, but these changes were not statistically significant.

Figure 3.6: Demographic data collected, by phase



### Referrals from and to other agencies and providers

The percentage of referrals received often/sometimes by respondents' services from a variety of agencies and providers (where applicable) in both phases are shown in Figure 3.7. Overall, there was a statistically significant increase in the percentage of referrals received from Queensland Health/HHS ( $p < 0.001$ ), non-government organisations ( $p = 0.003$ ), other government agencies ( $p = 0.019$ ), settlement services ( $p < 0.001$ ), and refugee community representatives ( $p = 0.036$ ).

Figure 3.7: Percentage of respondents' services who often/sometimes received referrals from these agencies and providers, by phase

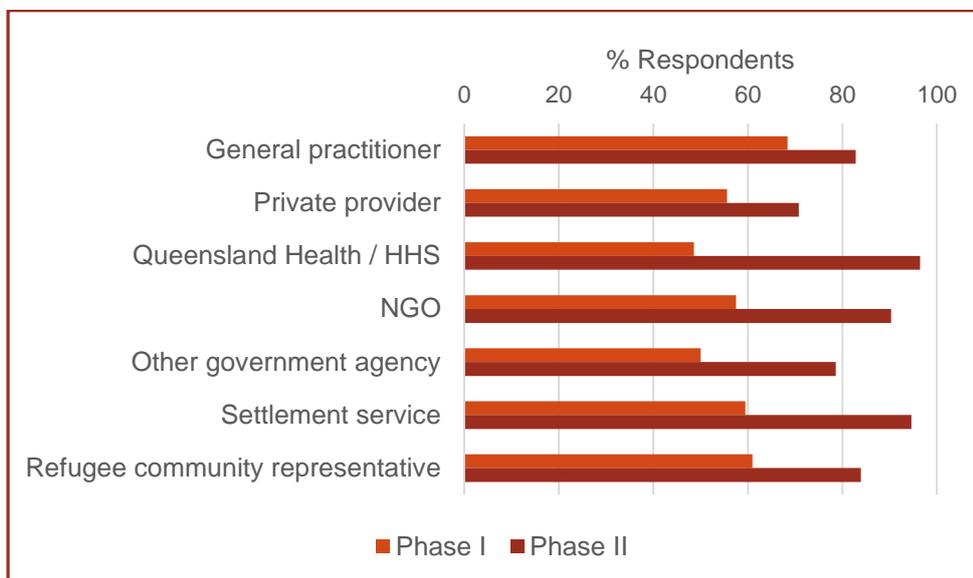
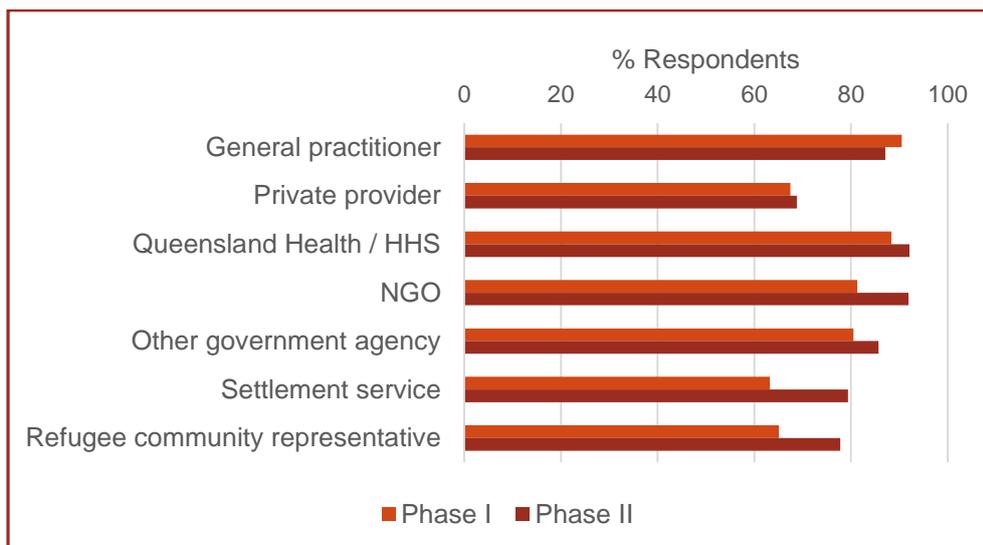


Figure 3.8 shows the percentage of referrals respondents' services often/sometimes made to other agencies and providers. Overall, between phase I and phase II there was an increase in the percentage of referrals made to Queensland Health/HHS, NGOs, other government agencies, settlement services, and refugee community representatives, but these were not statistically significant.

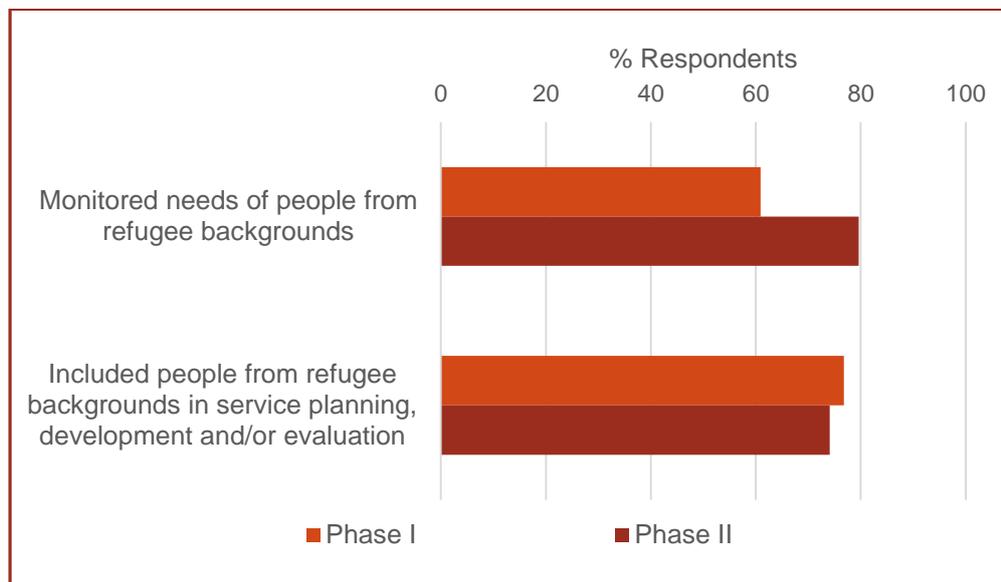
Figure 3.8: Percentage of respondents' services who often/sometimes made referrals to these agencies and providers, by phase



### Monitoring the needs of people from refugee backgrounds and including them in service planning, development and/or evaluation

As shown in Figure 3.9, between phase I and phase II there was a statistically significant increase in the percentage of respondents who stated that their services had monitored the needs of people from refugee backgrounds, from 61% in phase I to 80% in phase II ( $p=0.027$ ). Over 70% of respondents in both phases reported that their services had included people from refugee backgrounds in service planning, development and/or evaluation over the previous 12 months.

Figure 3.9: Percentage of respondents' services who monitored needs of and included people from refugee backgrounds in service planning, development and/or evaluation, by phase



Some examples of how services had monitored the needs of people from refugee backgrounds are stated below.

#### Phase I:

“Community consultation, mapping, needs assessment” [Settlement/health promotion practitioner]

“Through case plans, anecdotal, meetings with leaders, feedback from other services” [Manager/supervisor]

“Constant feedback received through our ongoing work with people from refugee backgrounds” [Settlement/health promotion practitioner]

“GP reviewing referrals. Follow ups with patients seen us” [Healthcare practitioner]

“Monitor interpreter needs” [Healthcare practitioner]

“On a frequent basis: look at cohorts’ health literacy and needs in general and by assessing individuals needs fully soon after arrival. Nursing and medical assessment” [Healthcare practitioner]

“As part of research evaluation” [Other primary role]

“Our usual service planning and monitoring processes” [Manager/supervisor]

“We track new arrival numbers, ages and genders, no show rates at the service, other non-medical support needs” [Manager/supervisor]

#### Phase II

“Work in partnership through local networks to monitor access to services, feedback from the

providers, immunisation records, and feedback from other clinicians” [Healthcare practitioner]

“Monthly consultation with the people’s representatives” [Manager/supervisor]

“Through engagement with the Refugee Health Advisory Group and informal feedback from patients” [Manager/supervisor]

“Through 3-month and six-month review, case meetings, team meetings, and consultations with leaders” [Settlement/health promotion practitioner]

“Through the reporting arrangement for funding provided to NGOs to support vulnerable people seeking asylum” [Other primary role]

“Convening a series of CALD data roundtable to understand and address CALD community’s health needs” [Other primary role]

“Very active data collection and publishing of peer reviewed articles on comparative health outcomes as well as running community consultation forums and involving patients in evaluation” [Other primary role]

Fifty-one percent of respondents in phase I and 44% in phase II reported that their services had engaged with a university for refugee health research (not statistically significant difference).

### **Issues that could be addressed by the RHNQ in the future**

The most common issues stakeholders believed could be addressed by the RHNQ included language barriers and interpreter services; health literacy for refugee communities; better funding of programs and financial support for some services; service gaps in regional areas including better access to primary health care and mental health services; addressing the health and social needs of asylum seekers; NDIS access for clients with disability; continue enhancing collaboration, communication and information sharing between services; cultural responsiveness and greater cultural diversity of workforce; additional training for healthcare staff; and continuing advocacy for better collection of refugee-related data. Some examples of these gaps as reported by respondents are stated below.

#### **Phase I**

“Advocating for Qld oral health to use TIS so that clients can independently make/modify/ cancel appointments” [Settlement/health promotion practitioner]

“Sustainable funding for the sector; ongoing improvement with interpreter training and recruitment” [Healthcare practitioner]

“*More research in health literacy*” [Settlement/health promotion practitioner]

“More health information in the language of the refugee eg, hand-outs. I can access information, however, due to our printers, I cannot print anything as it doesn’t print in any legible language. If there was a way that we could order resources, that would be great” [Healthcare practitioner]

“Have allied health and mental health providers communicate, in writing, regarding what happens with the patients we refer to them. Communication back is very poor – they want everything from the GP and give nothing in return. We need to treat our patients holistically. How can we do this when we do not know what is happening with the psychologist, psychiatrist, etc.” [Healthcare practitioner]

“Private general practice URGENTLY needs additional financial support to provide high quality care to refugees, similar to our ATSI population” [Healthcare practitioner]

“Need for culturally responsive mental health services in Cairns” [Settlement/health promotion practitioner]

#### **Phase II**

“More translated resources for Kurdish kurmanji speaking people” [Settlement/health promotion

practitioner]

“Advocacy for private pathology and radiology labs to use interpreters. Ensuring that all refugees who have a health assessment are given their paperwork to have. Support GPs to ensure that all vaccines are put into AIR – including travel vaccines. Support health literacy education for refugees” [Healthcare practitioner]

“Pandemic education for non-English speakers, with images for those who are illiterate” [Manager/supervisor]

“Poor relationships between refugee health service providers reduces availability and quality of services available to people from a refugee background” [Other primary role]

“Keep advocating for funding improvements so that people from refugee background have more access to navigators and linkages to services and people to help them access services they need” [Other primary role]

“Increase participation of people with refugee experience in planning, setting strategies and responses” [Manager/supervisor]

“Advocacy/support for people in Ipswich/Gatton/Goodna – appears to be a large population including asylum seekers and some engaged clinicians that need greater support. Collaboration with/advocacy to QHealth regarding support for primary care and mental health services working with asylum seekers without Medicare (...) Advocacy around housing/social support for asylum seekers” [Healthcare practitioner]

“Refugee Health Network Qld should advocate and support for better health support for refugees in regional areas (...) More regional GP clinics should be ready to take care of client health needs. There is a shortage of health services like GP & mental health support for the clients and a negative attitude with lot of GP clinics to service our clients as they have to use interpreters” [Manager/supervisor]

“Workarounds for NDIS and access to functional assessments/OT/Physio reports. Any ideas/access on short term loans of medical aids, low cost or free” [Healthcare practitioner]

### **Services and Stakeholders Experience Survey – Summary of Findings**

Sixty-nine respondents in phase I and 54 in phase II completed the Services and Stakeholders Experience online survey. Compared to phase I, in phase II there was a greater proportion of respondents working in HHS/other hospital and general practice, and a smaller proportion working in Queensland Health, the non-government community sector, and as private providers.

Overall, between phase I and phase II, there was an increase in stakeholders' involvement in RHNQ activities, access to RHNQ resources, partnering with other agencies to improve refugee health outcomes, and development of local health strategies or programs to support people from a refugee background, although these differences were not statistically significant. Overall participation in training was similar in both phases, but healthcare practitioners' participation in refugee health clinical training increased significantly over time. There was also a statistically significant increase in the percentage of respondents whose services had monitored the needs of people from refugee backgrounds.

There was a statistically significant increase in the proportion of services whose clients were always/often not proficient in English, and in the provision of qualified interpreter by those services. There was also an increase in the proportion of stakeholders whose organisation had a language services or interpreter policy, and in the language diversity of respondents' teams, although these difference were not statistically significant.

More than 80% of services in both phases collected country of birth, preferred language and interpreter requirements. Overall there was a small increase over time in the proportion of services collecting preferred language, interpreter requirements and ethnicity, and a moderate increase in date or arrival, but these changes were not statistically significant.

Regarding referral, there was a statistically significant increase in the percentage of referrals stakeholders' received from Queensland Health/HHS, non-government organisations, other government agencies, settlement services, and refugee community representatives.

Stakeholders identified a number of issues that RHNQ should continue addressing. These included language barriers; health literacy; better funding of programs and financial support for some services; service gaps in regional areas; addressing the health and social needs of asylum seekers; NDIS access; continue enhancing collaboration, communication and information sharing between services; cultural responsiveness and greater cultural diversity of workforce; additional training for healthcare staff; and continuing advocacy for better collection of refugee-related data.

## Limitations of the evaluation

A number of limitations should be acknowledged. The evaluation uses a combination of before and after cross-sectional (patient experience survey; services and stakeholders experience survey) and cohort (patient experience qualitative interviews) designs. This combination aimed to address some of the shortcomings of cross-sectional only designs, such as the inability to make causality assumptions. Also, the evaluation did not include control groups, and the sample size of surveys prevents robust analysis of inter-group differences (e.g. settlement location, country of birth). There are practical and financial limitations when conducting evaluation of interventions in community settings, more so with vulnerable populations.

The phase I data were collected between July and October 2018, one year after the Policy and Action Plan were officially launched. It is difficult to ascertain whether or not some of the findings shown in phase I were the result of actions/strategies already implemented prior to the data collection.

There was a low response rate for the Services and Stakeholders survey in both phases. As the survey was conducted online and it was anonymous, it is not possible to ascertain the proportion of respondents in phase II who also participated in phase I. Although these samples may not be representative of the broader population of services and stakeholders, respondents in both phases were from a range of areas of practice including HHS/other hospital, general practices, Queensland Health, non-government community sector, and settlement services. However, some of the differences in responses between phase I and II may be due to the greater proportion of respondents in phase II who worked in HHS/other hospitals and general practices, and also those who were managers or supervisors.

## Conclusions

Overall, the analysis of the data collected indicates that the *Refugee Health and Wellbeing Policy and Action Plan for Queensland 2017–2020* has had a positive contribution to the healthcare experience of people from refugee backgrounds settling in Queensland. The following can be concluded in relation to the five key principles which underpin the Policy and Action Plan:

### **Collaboration and partnerships**

The 'services and stakeholders experience surveys' reported good levels of collaboration and partnerships, with a trend towards increasing involvement of stakeholders' in RHNQ activities, and in partnering with other agencies to improve refugee health outcomes. Over time, there was a significant increase in the percentage of referrals services and stakeholders received from Queensland Health/HHS, other government agencies, non-government organisations, settlement services, and refugee community representatives.

Collaboration and partnerships contribute to coordination of care for people from refugee backgrounds. There was a decrease between phase I and II in the percentage of 'patient experience survey' respondents who reported having a healthcare professional coordinating their care. This might

be partially explained by the significantly shorter period of time phase II respondents had been in Australia, compared to phase I respondents.

### **Cultural responsiveness**

Data from the 'patient experience surveys' showed a significant increase in the proportion of respondents who had been offered an interpreter when visiting a GP and a dentist, and a trend towards an increase in the provision of interpreters when visiting a medical specialist and a hospital emergency department. 'Patient experience interview' respondents valued being assisted by interpreters during appointments, and some reported an improvement, between phase I and II, in the quality of communication between health professionals and patients, cultural awareness of health services, and the provision of interpreters. Similarly, services and stakeholders reported a significant increase in the provision of qualified interpreters, and a trend towards an increase in the proportion of organisations having a language service or interpreter policy, and in the language diversity of their staff.

However, important gaps in interpreting services remain in other healthcare settings such as pharmacies where provision of interpreters is almost non-existing. High levels of distress and dissatisfaction are experienced by clients from refugee backgrounds when qualified interpreters are not made available during healthcare consultations.

### **Consumer and community voice**

Data from the 'services and stakeholders survey' reported moderate to high levels of engagement of refugee background consumers and communities in service planning, development and/or evaluation. Importantly, there was a significant increase in the percentage of respondents whose services had monitored the needs of people from refugee backgrounds. Some of the strategies included formal and informal consultations with patients and community representatives.

### **Continuous improvement**

Just over half of stakeholders in both phases had attended a refugee health training or education session in the previous 12 months, with the majority stating they had applied the knowledge and skills learned. Importantly, healthcare practitioners' participation in refugee health clinical training increased significantly between phase I and phase II. There was also a trend towards increasing access and use of RHNQ resources by stakeholders, and development by services of local health strategies or programs to support people from a refugee backgrounds.

Data on patients' country of birth, preferred language and interpreter requirements were collected by over 80% of services, while a lower proportion collected data on ethnicity and date of arrival in Australia. The stakeholders survey showed a moderate increase in the proportion of services collecting data on date of arrival and a small increase in the collection of preferred language, interpreter requirements, and ethnicity.

### **Clinical excellence**

Overall, the majority of respondents had mostly positive experiences visiting healthcare professionals and services. When asked about their experiences visiting general practitioners, there was a significant increase over time in the proportion of respondents who reported having a mostly positive experience. Respondents valued the support provided by case workers from the settlement services when navigating the healthcare system, feeling welcomed and respected by healthcare staff, the quality of care received, and having access to dental care and medications. In both phases, general practices and case workers from settlement services were the top sources of advice and guidance in relation to accessing healthcare services in Australia.

### **Other issues that require further consideration**

Of concern are the barriers that some respondents continue to experience such as limited knowledge of the Australian healthcare system, long wait to get appointments with medical specialists and public

dental clinics (sometimes while in pain), increasing out of pocket expenses when accessing prescribed medications, and lack of affordability of private dentists.

Similarly, the healthcare experiences of families from refugee backgrounds living in regional areas are impacted by lower availability of GPs, mental health, medical specialists and dental services; limited interpreter services; long wait for appointments and elective surgery; limited transport; and out of pocket expenses.

Stakeholders also identified the need to address the health and social needs of asylum seekers, the barriers people from refugee backgrounds face while trying to access the National Disability Insurance Scheme (NDIS), and some of the gaps in regional areas described above.

## Recommendations

### **1. A Refugee Health and Wellbeing Policy and Action Plan beyond 2020**

The good progress made by the *Refugee Health and Wellbeing Policy and Action Plan 2017–2020* in improving the healthcare experience of people from refugee backgrounds needs to be sustained. A new Policy and Action Plan beyond 2020 is needed, and it should build on the processes, strategies and activities that have shown a positive impact as described in this evaluation report. Although the five principles of the 2017–2020 Policy and Action plan still apply, a new policy should have a stronger focus on the social and environmental determinants of health (including strategies to support the COVID-19 pandemic recovery of refugee communities), addressing the health and social needs of asylum seekers, building capacity of health services in regional areas, strengthening care coordination, continue improving the availability of interpreter services, and reducing barriers for people from refugee backgrounds with a disability to access the National Disability Insurance Scheme (NDIS).

### **2. Greater focus on the social and environmental determinants of refugee health**

Good progress has been made in addressing some of the downstream determinants of refugee health such as referral pathways and access to refugee-informed and culturally-safe primary healthcare services. A stronger preventative approach should include some of the upstream and midstream determinants such as health literacy (including COVID-19 pandemic and mental health literacy) for refugee communities, promoting healthy behaviours, better access to health services in regional areas, and advocacy to address the impact of immigration policies on asylum seekers and refugees.

### **3. Health and social needs of asylum seekers**

Asylum seekers continue to be impacted by harmful immigration policies. Greater efforts are needed to enhance service coordination to address their health and social needs, including adequate referral pathways.

### **4. Building capacity of services in regional areas**

Sustained efforts are required to enhance service access and the capacity of healthcare services in regional areas to provide refugee-informed and culturally-safe care to people from refugee backgrounds. These efforts may include increasing the number of refugee health nurses in regional areas. The refugee health nurse model of care has shown positive outcomes in improving access, quality of care and care coordination in healthcare settings (Au, Anandakumar, Preston, Ray, & Davis, 2019; McBride, Russo, & Block, 2016).

### **5. Care coordination**

Sustained efforts are needed to enhance care coordination for patients from refugee backgrounds using a variety of models (Joshi et al., 2013) including refugee health nurses.

## **6. Language services**

The evaluation has found positive progress on addressing language barriers and providing adequate interpreting services in some healthcare settings. Successful strategies should be maintained and greater efforts made in addressing the limited availability of interpreter services in a number of settings such as pharmacies and private pathology services among others.

## **7. Refugees with disability and the NDIS**

Specific strategies are required to address the substantial barriers people from a refugee background with a disability face while trying to access the NDIS (Federation of Ethnic Communities Council of Australia, National Ethnic Disability Alliance, Refugee Council of Australia, & Settlement Council of Australia, 2019; Victorian Foundation for Survivors of Torture, 2019).

## **8. Training for healthcare professionals**

Continuous practice improvement and clinical excellence require refugee-informed and culturally-safe healthcare sector development. More creative ways of engaging with and delivering training to healthcare professionals and services using a variety of technologies should be considered. This could include developing a depository of resources that can be used across the different Hospital and Health Services (HHS).

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