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Understanding vulnerability in primary health care

Overcoming barriers to
consumer transitions
through the primary health
system

Virginia Lewis, Geraldine Marsh, Francine Hanley,
Jenny Macmillan, Lyn Morgain, Kate Silburn, Libby
Kalucy, Judith Dwyer, Jason Rostant, Cathy Mead

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Australian Institute for Primary Care and Ageing

La Trobe University

Victoria 3086 Australia

T 61 3 9479 3924

F 61 2 9479 5977

E v.lewis@latrobe.edu.au

www.latrobe.edu.au/aipca

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Background

POLICY CONTEXT

Population health data provides an insight into the factors that may contribute to some people being vulnerable to poorer health, including a range of well-recognised socio-demographic characteristics—an important component of what is described as the social determinants of health. Other characteristics associated with poor health outcomes are identified through analysis of patterns of utilisation of different kinds of health care, (e.g., potentially avoidable presentations for hospital services). These characteristics may include past experiences—such as whether someone arrived in Australia as an immigrant or refugee—or current life circumstances—such as whether someone is currently homeless—as well as a range of co-morbid conditions—such as whether someone has a mental illness; and a range of social, economic and environmental factors. These various factors and characteristics lead to the notion of groups of people in the population being “vulnerable” to poor health.

Policy responses to addressing the health needs of population groups who are identified as “vulnerable” often involve the development and delivery of programs and services specific to that group. This may include setting up special services targeting particular populations, providing programmatic funding to existing services to address particular population groups, or offering incentives to “mainstream” services to provide care to people from these population groups. Primary health care in particular, as the first level of contact individuals, families and communities have with the Australian health care system, is seen as important in addressing the needs of vulnerable population groups.

Given the growing demands on the primary health care system, it is important that specialist services for target groups are not only provided when required, but that they continue to be viable and able to respond to new demands. Programs that are successful in targeting and engaging vulnerable populations in a health care system can find themselves in the position of not keeping up with demand because of their own success.

While governments and policy advisers predominantly deal with populations, health professionals and services work with individuals; there are differences in understanding the concept of “vulnerability” and in implementing an appropriate health system response at each level. Across the primary health care system, there need to be policies, procedures and strategies to ensure that appropriate kinds and levels of service are provided to individual consumers. Specialist comprehensive primary health care (CPHC) programs and services need strategies that encourage and support people who may no longer need their targeted model of care to make the transition to mainstream primary care to manage their ongoing health, thus increasing the opportunities for other vulnerable consumers to have access to care that is appropriate to their level of need.

Policy in practice

Community Health Services (CHSs) in Victoria play an important role in the primary health system as a platform for the delivery of comprehensive primary health care. They operate from a social model of health and acknowledge the social, environmental and economic factors that affect health, as well as the biological and medical factors. There are 62 CHSs that operate as part of public health services (including rural or metropolitan public hospitals and health services) and 38 that are independent registered community health centres (CHCs) operating as companies limited by guarantee: thirty-six CHCs manage GP clinics. GPs in CHCs are remunerated in different ways, including being staff on a fixed annual salary or a salary with incentives which the CHC generates through billing the Medicare Benefit Scheme (MBS) according to activity; being contractors who receive a proportion of the MBS activity payments billed by the CHC; being private businesses charging activity to the MBS and renting space from the CHC; or a mix of models. Community Health Program

activities funded through the state government give priority to populations with particular health needs, including in particular disadvantaged populations with the poorest health and greatest economic and social disadvantage. Through a statewide demand management framework health services in CHCs are prioritised for the following population groups: Aboriginal and Torres Strait Islander people; people with an intellectual disability; refugees and people seeking asylum; homeless people and people at risk of homelessness; and people with a serious mental illness.

The Western Region Health Centre (WRHC) is a large community health centre in the inner city of Melbourne with a catchment that includes a high proportion of people with characteristics that are likely to increase their vulnerability to poor health. The WRHC provides primary medical care (with 14 salaried GPs filling 8 equivalent full-time (EFT), positions, including several doctors training to become specialists (registrars)), primary health care (including health promotion, allied health services and a range of targeted programs), an integrated oral health service, mental health services and a range of community services such as legal and housing support.

WRHC has a commitment to reflection, research, evaluation and quality assurance in order to implement and support best practice aimed at ensuring the best possible outcomes for clients. Through this partnership with the Australian Institute of Primary Care & Ageing, La Trobe University and other mechanisms, WRHC has been exploring the issue of how to ensure sustainability of a service delivery model that has a particular focus on meeting the needs of individuals and groups that may be among the most disadvantaged in communities. The purpose of the project was to focus on refugees as a case study for understanding how quality cost-effective patient-centred primary health care can be delivered over the longer term.

LITERATURE REVIEW

A rapid literature review was undertaken to explore current evidence about issues associated with transferring clients from specialised primary health care services to mainstream primary care.

Studies that explore transitions in care generally focus on transitions from one sector (e.g., acute or specialist care) to another (e.g., primary care), and are primarily related to improving those transitions through developing and establishing referral procedures and practices, including improving communication for the exchange of accurate and appropriate information (e.g., Chan et al. ¹).

There has been some recognition of the system-level problem of how to balance targeted and mainstream services to meet the needs of specific population groups. In considering care for multi-cultural communities, Fuller² noted that “universal healthcare services appeal because they appear to deliver equal health care to all, but they actually systematically advantage “those whose values most closely fit with the dominant social norms”. Fuller noted that ethnic-specific services ensure access for people who may otherwise not receive their care through the universal system, but observed that, as a model, “it could not meet all of the health needs of all people from ethnic minorities, especially in locations where numbers are low. Fuller’s proposed strategy to address the problem was increased participation by ethnic minorities in the processes of the health system, a strategy that has been used extensively in the community health service model.

The problem of ensuring sustainability to appropriate CPHC at WHRC is an access issue, in that appointments for newly settled refugees to see the practitioners who have the necessary skills and experience to take on these complex cases are not always available. Access has been theorised in different ways, but commonly focuses on individuals – in terms of their help-seeking behaviour and individual outcomes, including satisfaction as well as health³⁻⁴.

The Institute of Medicine (IOM) defines access as “the timely use of personal health services to achieve the best possible outcome”. The IOM model of access⁵ describes the outcomes of equity of service (all individuals receive adequate care without difficulty) and health status, which includes one or more of four health outcome indicators: morbidity, mortality, well-being, and functional ability as a consequence of use of services (visits and procedures) mediated by four factors (appropriateness, efficacy, provider quality, patient adherence). Barriers to access (structural, financial and personal) will affect use of services.

Another influential framework developed in the 1980s by Penchansky⁶⁻⁷ measures access using five domains—availability, accessibility, accommodation, affordability, and acceptability—which overlap with each other to some degree. The overall outcome is client satisfaction with each domain.

Another approach describes access in terms of supply and demand, where access to primary care is a product of supply factors and demand factors⁸: supply factors include the location, cost, and appropriateness of services, while demand factors include the health, knowledge, attitudes, and behaviours of the population.

Andersen’s “Behavioural Model for Health Services Use” has evolved over the past twenty years^{4,9}. In its most recent iteration, the model stresses that contextual characteristics (predisposing – demographic, social and beliefs; enabling – health policy, financing, and organisation; and need – environmental and population health indices) and individual characteristics (predisposing – demographic, social and beliefs; enabling – financing and organisation; and need – perceived and evaluated) are the most important determinants for understanding health behaviours (personal health practices, process of medical care and use of personal health services). Perceived health, evaluated health and consumer satisfaction will be a consequence of health behaviours mediated by contextual and individual characteristics.

It is notable that most of the popular models focus on outcomes at the level of the individual consumer, rather than in terms of a sustainable cost-effective system. Some theories consider that the appropriateness of services relative to need is a key element of access.^{8,10} This approach recognises issues around providing care of “equal quality” to different populations, particularly those who do not have access to care that is consistent with their cultural and linguistic background, or people who are more vulnerable to poor health for other reasons. The concept of equity is a special challenge for models of access. In proposing a model for delivering health care to refugees, Le Feuvre¹¹ argued that any specialist service should have the goal of full integration of the refugee into normal general practice following completion of the period of specialist care, and that this means that the nature and quality of the services they receive at this point should be the same as for any other consumer– “no better than those to which the local population has access”.

A final area of the literature providing potential insight to the current research question is around demand management. Literature about managing demand recognises that waiting lists are a common and serious problem for many health services.^{12,13} A common response is to introduce triage or prioritisation systems for managing demand, allocating patients to categories based on different factors relevant to specific conditions or service types (e.g., mental health services,^{14,15} outpatient clinics^{16,17}). The effectiveness of prioritisation systems has been called into question, with subjectivity undermining reliability,^{18,19} particularly for outcomes other than identification of the most urgent categories.

Research around transfer of care between primary care providers is less common, although there has been growth in the idea of the “specialist GP” internationally since the early 2000s. The “General Practitioner with Special Interests” (GPwSI) service delivered within Primary Care Trusts (PCTs) was developed as part of the UK Government’s NHS Plan 2000, with the main goal to reduce waiting lists for medical specialists. While there have been some claims that GPwSIs can reduce waiting lists for specialist services through referrals from generalist GPs to GPwSIs^{20,21}, there is also evidence that they cost more than the

equivalent hospital based clinics and they may generate increased demand^{21,22}. Weighed against possible reductions in cost efficiency are improved patient access and broadly similar health outcomes to those in secondary care²¹. Referral mechanisms and procedures for the GPwSI services vary across PCTs, and no information about referral practices was found in the refereed literature; however, an evaluation of the original pilot projects²⁰ reported the “discharge” rate of patients back to the original referring GP was around 70-80%.

In Australia, where the primary health system is primarily delivered through private general practice services, there is no formal scheme for strategic commissioning of GPs with special interests; however, the Royal College of General Practice (RACGP) is moving towards greater recognition of general practitioners with specific interests through the establishment of The National Faculty of Specific Interests (NFSI) since 2008. The NFSI is charged with, “‘recognising the additional interest and expertise held by general practitioners in selected areas of general practice’ and facilitating GP members practising in these areas to ‘promote the area of specific interest and to share and develop related knowledge and materials’”.²³

In discussions about introducing a more systematic approach to GPwSIs in Australia, there has been concern that it may exacerbate the current GP workforce shortage, or be anti-competitive. Wilkinson, Dick and Askew²⁴ argue that the separation of core components of general practice into specialist or stand-alone GP services (e.g., travel medicine, skin cancer, women's health), leads to a loss of generalist skills across the system, fewer GPs working in less well-remunerated areas, as well as issues with standards of care and training. Spurling and Jackson²⁵ argue that GPwSI offer great potential benefits to patients, particularly with appropriate support from Colleges, government and training and accrediting bodies.

The “Primary Care Amplification Model” is an example of a model of specialised multi-disciplinary clinics, including an “advanced skill GP” focused on particular health issues. Operating in Queensland, a state that does not have an active community health sector, a “Beacon” practice is established with an “expanded clinical capacity” to deliver health care for specific conditions, such as chronic disease.²⁶ The beacon practice receives referrals from private GPs who recognise the need for the service. Patients are discharged to the care of their usual GP once clinical targets have been achieved, or following the 12 month review “if there is no evidence of possible improvement”. Other states have similar programmatic time-limited service delivery models for chronic disease and the consumer continues to receive care for other health issues from their referring GP. More recently, the model has been extended to initial health care for refugees,²⁷ where the beacon practice is designed to fulfil a similar role to other specialist refugee health services around Australia, and the referral pathway is from the comprehensive PHC service to mainstream PHC. The extent to which some of the issues experienced by similar programs will be present for this model of care is not yet described in the literature.

The literature recognizes the role of consumers, practitioners, health services and systemic factors in determining access to care. The simplest organising framework to use to guide empirical study of the issues associated with the transfer of care for vulnerable consumers within the primary health care system is to recognise the potential impact of experiences and factors at a number of different levels, including:

- > Consumers – exploring individual characteristics and socio-demographic factors that determine need and influence help-seeking behaviour and choices
- > Primary Health Care practitioners – recognising the potential for different roles of generalist and specialist providers to affect access and sustainability
- > Health services (including community or private GP clinics) – exploring systems for assessing need and managing demand, including procedures for referral and transfer of consumers

- > System- level – recognising how policy drivers and finance arrangements may support appropriate care, or may provide incentives for inappropriate care.

CASE STUDY

There is a significant and growing demand for health care for refugees in Australia. Changes to Commonwealth immigration policy in 2012 have resulted in Victoria experiencing its biggest increase in settlement by people from refugee backgrounds (“refugees”) and those seeking asylum in 30 years. The number of refugees settling in Victoria has increased from an average 4,000 over recent years to around 7,400 people per annum in 2012, in addition to approximately 1,330 family members of refugees through a special initiative under the Family Migration Program. Additionally, around 660 asylum seekers are currently settling in Victoria every month²⁸.

Refugees and asylum seekers are considered a “vulnerable” group because “most have experienced traumatic events such as physical and psychological trauma or torture, deprivation and prolonged poverty, periods in immigration detention and poor access to health care prior to arrival. As a result, many refugees have multiple and complex physical and psychological health problems on arrival, including high levels of avoidable illness and associated mortality.”²⁹ The Australian government has developed policy and programs to ensure that most health problems experienced by refugees receive health care and support in the early periods of settlement.

The primary health care response to refugees varies across jurisdictions in Australia, with some states or regions dependent on GPs in private practice to provide initial health assessments using standard MBS items. Most jurisdictions have some kind of dedicated refugee health service or program to address complex physical or mental health conditions of some consumers, and to provide a level of support to GPs in private practice. State-funded community health centres in Victoria take a lead role in providing and supporting primary health care services, including providing general practice services in some instances. CHSs are well-positioned to deliver services to refugees because of their close relationship with their community and their ability to connect people with a broad range of other health and human services.

The Victorian Refugee Health Nursing Program

There are several specialised components of the state-funded refugee health system in Victoria designed to assist the mainstream health system to better respond to the needs of refugees, including the Refugee Health Nurse Program (RHNP).²⁹ The RHNP began in 2005 in response to the poor health and complex health issues of arriving refugees. It aims to: increase refugee access to primary health services; improve the response of health services to refugees’ needs; and enable individuals, families and refugee communities to improve their health and wellbeing.

The program operates in areas where data demonstrate high numbers of newly arrived refugees settle and employs community health nurses with expertise in working with culturally and linguistically diverse and marginalised communities to provide a coordinated health response to newly arrived refugees. One element of the program is focused on developing referral networks and collaborative relationships with general practitioners and other health providers.

The state wide Refugee Health Nursing Program Facilitator is employed to: increase CHS’ responsiveness to refugees’ needs by providing organisational development, advice and support to agencies; provide secondary consultation to refugee health nurses; and contribute to, and actively promote, the professional development of refugee health nurses.

Primary Health Care for refugees in the Western Region Health Centre

As part of their service-wide model of care for refugees, WRHC employs nurses funded by the Refugee Health Nurse Program to support GPs to provide health services to newly-arrived refugees. The Refugee Health Nurses (RHN) secure primary medical services through the WRHC GP clinic in the first instance; however, private GP clinics are being utilised more frequently as part of the primary medical care response to new arrivals because of limited capacity within WRHC. The RHN will facilitate appointments, including organizing for assistance to travel to the GP and arranging interpreters where required. The GP and RHN work together to complete the refugee health assessment, which usually requires three to four visits.

The WRHC model for providing initial primary medical services to refugees through the WRHC GP clinic is intended to be a time-limited approach offering intensive wrap-around support during a refugee's first 12 months in the community. The model assumes that there will be appointments available in any week to take on newly arrived refugees for the initial health assessment and to ensure appropriate referrals are made to other services. The model also assumes that, over time, clients will establish long-term management of their health care including making choices about their ongoing PHC. This may mean that a client continues to attend the GP clinic at WRHC or that they transfer to other "mainstream" or "community" general practices (where both of these terms generally mean "private" GPs). If they continue to attend WRHC, it is intended that they receive the same high quality PHC as that provided for any other consumer of the service, but not additional levels of care as part of a "refugee health program". Transition to an alternative PHC provider is likely to be particularly appropriate as people move away from the immediate geographic area.

The capacity of WRHC to provide the initial primary medical care to new arrival refugees is limited in part because some consumers have maintained their initial care relationship with WRHC GPs over a significant period of time (in some cases 10 years), including having ongoing priority access and access to longer consultations. WRHC has noted³⁰ that this may occur even when the circumstances and needs of the individual have changed, and in some cases in spite of their relocating to more distant suburbs or areas. While continuity of care is a general principle of best practice³¹ maintenance of "targeted" or "specialist" care to consumers who may no longer need it severely limits the capacity of a service to respond to newly emerging need (in this case, the large numbers of new refugees coming in to the area who clearly require the intensive specialist program including initial primary medical care). Staff in WRHC are aware of the issues with demand; however, there has not necessarily been consensus about, or commitment to, implementation of potential strategies and solutions.

The purpose of this case study was to explore the barriers to the transfer of clients within primary health care and, if possible, propose strategies to overcome them in order to support smooth transitions for consumers from "specialist" CPHC services to mainstream services (in particular, but not exclusively, private GPs) that can provide quality cost-effective patient-centred PHC over the longer term.

The research questions, expressed in general and in relation to the case study of refugee health, were:

- > What can consumers do to facilitate their own transitions through the primary health system, to ensure they receive care appropriate to their level of need and potential vulnerability to poor health?
 - o How do refugee consumers experience and understand PH care from the time of their arrival in Australia to longer term residency?
- > How can health care providers support clients to receive different levels or kinds of care according to their need without compromising on quality?

- How do health professionals working to deliver and support health care to refugees understand the concept of “vulnerability”, and how is this reflected in their practice with refugees?
- > How can health services support smooth transitions through the health system for clients who may require enhanced primary health care in times of high need?
 - How does the health service manage the type and extent of PHC service delivery over time for refugees?
- > What aspects of the health system facilitate or inhibit appropriate changes in the level or kind of primary health care offered to consumers according their level of need at a particular time?

Methods

A Project Advisory Group (PAG) including all Chief Investigators and Associate Investigators was established to support discussion and decision-making. The PAG met by teleconference in addition to having ongoing email communication.

A Reference Group was established including research team members and staff from the Western Region Health Centre (WRHC) and the State Wide Refugee Nurse Facilitator (RHNP). WRHC staff included two refugee health nurses, the manager of the RHNP, the manager of the primary health care service (WRHC general practice), and a general practitioner. There was no WRHC consumer representative on the reference group, as this would have required selecting one community/cultural group over others which may have led to misrepresentation of the purpose of the study; however, WRHC staff sought advice from the members of different refugee communities at various points in the study to support design and implementation. An information flyer was developed by the Reference Group and used to promote awareness of the study within the WRHC.

Ethics approval was provided by the La Trobe University Human Research and Ethics Committee.

DATA COLLECTION

Consumer interviews

Recruitment lists were generated as follows:

- > The WRHC refugee program staff generated a list of names and telephone numbers of consumers who were recently arrived refugees (i.e., who have been in Australia for a minimum of six months and maximum of 10 years) and had attended the centre for their initial refugee health checks.
- > WRHC general practitioners generated a list of names and telephone numbers of potential participants without reference to any specific criteria except that the individuals were known to have arrived in Australia as refugees recently (a minimum of six months and maximum of 10 years).
- > The WRHC general practice manager generated a list of names and telephone numbers of consumers with refugee backgrounds whose files had been requested by general practitioners from other clinics, and/or whose details were transferred to a new practitioner within the past 10 years.
- > The WRHC general practice manager generated a list of names and telephone numbers of current consumers of the Vitamin D clinic who had refugee backgrounds, particularly those who lived further away from WRHC and who may be not using other services. (The Vitamin D clinic is one of the specialist services provided for

people from a refugee background so provided a convenient point of contact for recruitment.)

With the use of accredited interpreters where required (generally as indicated by the WRHC staff member who was facilitating recruitment), a research team member made contact with potential participants and explained the purpose, objectives and data collection procedures. Participants were offered a \$40 shopping voucher and/or compensation for the costs associated with travelling to the interview.

The study originally aimed for a sample of 40 consumers, based on a 2x2 matrix of “current/former use of the WRHC general practice service”, and “proximity of current residency to WRHC”. While recruitment of consumers who currently used the WRHC general practice clinic was successful, there were significant difficulties recruiting consumers who were former clients of the service. Ultimately 17 consumers, who had arrived in Australia as refugees were interviewed. Interviews were undertaken through an interpreter (face-to-face or telephone, independent of the WRHC) where required or requested by the participant. Interviews took between 15 and 60 minutes and participants’ responses were audio-recorded where consent was given.

The semi-structured interviews included questions to guide the focus of interviews; however, participants were free to direct the conversation as they liked. The interview questions explored how participants came to be aware of the services at WRHC, what they liked about WRHC services and whether they used other health services.

WRHC staff interviews

Face-to-face interviews were undertaken with 10 WRHC staff (members of the Refugee Health Program, the state wide facilitator for the RHNP who is located at WRHC and program managers) and six WRHC GPs. The interviews went for between 40 to 60 minutes and interviews were audio recorded where consent was given.

The semi-structured interviews included questions to guide the focus of interviews; however, participants were free to direct the conversation as they liked. The interview questions explored service provision to vulnerable clients and staff experiences of transferring clients, including: expectations they had of continuity of care to be provided; potential indicators that may help to identify when transfer is appropriate; perceived barriers and facilitators to people with refugee-like experiences receiving good quality health care in a setting other than WRHC.

Private GP interviews

The study design included telephone interviews with private GPs, including: those who had received clients referred by WRHC RHP; those who were identified as currently providing care to former WRHC RHP clients – without active referral; and GPs who had declined to accept referred clients in the past when approached by WRHC RHP. The design was based on the assumption that there was an active referral process and records would be available to identify these GPs. In practice, WRHC was unable to identify GPs to whom they referred clients. An alternative method for recruiting GPs was therefore developed.

Through the WRHC and with assistance from the Medicare Local, a list of GPs or clinics who potentially serviced refugees was provided. In total 27 medical practices were contacted by phone seeking to interview GPs regarding their experiences of providing primary health care to consumers who arrived in Australia as refugees. Most were rung repeatedly and many were also emailed with further details of the project. No GPs responded to an email sent out by the Medicare Local; however, six GPs responded to phone contact and agreed to be interviewed, with two working in the same clinic.

Semi-structured interviews were conducted by telephone or in-person according to the preference of the GP. The interviewer did not ask for any information about specific clients but explored GPs’ experiences of receiving, referring and caring for refugee clients,

including strategies that could be used to make the process smooth and satisfactory for all stakeholders (clients, referring GP and receiving GP).

Additional data

In addition to the interviews described above, interviews were undertaken with a RHN from a different community health centre and a nurse working with refugees who was not part of the RHNP. These interviews aimed to explore different experiences with working with refugees and alternative policies and procedures to those in place at WRHC RHP.

Documentation regarding the RHNP and its operation at WRHC was also reviewed by the study team. This included an external evaluation conducted in 2009, a review of the service model conducted in 2012, as well as documentation associated with the program and WRHC more generally. An interview with the research team conducted by a consultant commissioned by WRHC to further develop their refugee service model in mid-2013 provided additional opportunities to reflect on the validity of the emerging findings of the study with another external, independent source.

DATA ANALYSIS

The analysis of the interview data was guided by analytic induction which supports the identification of patterns or themes through the application of a conceptual lens. The basis for the conceptual lens was the framework developed from the initial literature review, initial and ongoing consultation with key stakeholders including the PAG, and through ongoing discussion among the research team. Data was then analysed with the benefit of this external reference point, which magnified the salience of patterns that otherwise might not be identified. Analytic induction thus provided “directions along which to look”.³²

Results

CONSUMERS

Participants

The 17 refugees interviewed came from the Sudanese (n=10), Tibetan (n= 4), Iranian (n=1), Sri Lankan (n=1), and Ethiopian (n=1) communities. There were 10 female and seven male participants. Eleven participants were currently accessing their primary health care from WRHC GPs only; two were current clients at WRHC and had tried other GPs in the past; three were using other GPs in addition to WRHC GPs; and one was no longer receiving any primary health care from WRHC.

Location of residence

Most of the refugees interviewed for this study lived in the western region of Melbourne; however, some interviewees came from the local government areas of Yarra and Banyule. Table 1 below lists the distance travelled by the participants from their place of residence to attend services at the WRHC.

Table 1: Distance in kilometres of consumers’ residence from WRHC

	Within 1 km	1 – 8 kms	9 – 15 kms	16 – 40 kms
No. of Consumers	5	3	5	4

Source of initial referral

The source of the initial referral to the WRHC, as recalled by the respondents, included settlement services (n=5), a personal visit from a refugee health nurse (which would generally be initiated by a referral from settlement services) (n=5) and by friends or relatives (n=6). One refugee was a young person when first arriving and did not know the source of the referral given to her family.

Expectations of care

Expectations of services following arrival in Australia

The refugees interviewed were asked to describe the expectation they had of the services they would receive from WRHC when they first arrived in the country. Responses varied across the group. Fourteen interviewees said that they were sick when they arrived and that they sought health checks and tests for detection /diagnosis and medical or other treatment. Four reported that part of their expectation was for their family members (i.e. spouse and/or children) to receive treatment. One interviewee sought dental services and three said that they had sought referrals for specialist medical services.

Expectations of duration of care

Interviewees were asked about their expectations on the duration or permanence of the services they received from GP providers at the WRHC when they first arrived in the country. Thirteen consumers reported that they had expected the GPs at WRHC would remain as their ongoing provider for health services. One commented, “they are good doctors – why would I stop?” Of the four interviewees who noted that they did not expect WRHC to remain as their main health provider, three had been in Australia 5 – 10 years, and the fourth was a new arrival (since 2011) and did not know if WRHC would continue as the main health provider in the future. Table 2 below outlines the number of years that the interviewees had been attending a GP provider at WRHC.

Table 2: Years attending a GP provider at the WRHC

	Since 2011	3 – 5 years	5 – 10 years	10 or more years
No. of Consumers	5	3	5	4

Choosing a principal GP

Interviewees were asked to speak about the clinic they go to for their ‘everyday things’. The aim of the question was to determine the reasons behind preferences for one clinic over others if people attended more than one clinic. All interviewees identified WRHC as the main place they go to for a GP; however, 10 were using other GP services most often, commenting that this was for minor issues. The reasons given by interviewees for going to a different clinic were related to the geographical proximity to the family home or cultural familiarity (and a shared language in particular) with the staff at a different clinic. Cultural familiarity enabled ‘talk’ within the health interactions, but neither proximity nor cultural familiarity alone guided the interviewees’ choices over their preferred GP provider. Overall, interviewees reported that GPs at alternative clinics:

- > did not provide interpreters when needed
- > had a different manner - which was very business-like and not easy to talk to
- > limited the content that could be discussed in health interactions – by focusing only on the presenting problem - and either did not ask information about medical history or did not provide adequate time for the refugees to explain why they had come.

A number of refugees who were seeing another GP commented that they were reluctant to tell WRHC staff about their use of different services. When prompted to explain the reasons why they would continue with both services, interviewees reported the following.

1) Reminder notices

Some reported that the receipt of reminder notices for checkups in the mail from WRHC bring them back to WRHC even when they are satisfied with other GPs.

2) The quality of the health interactions

GPs at other clinics were seen as secondary choices by 10 of the interviewees who continued to maintain a clinical relationship with a preferred GP at WRHC. A range of explanations were given for this, but generally responses were around the quality of health interactions in alternative practices, including poor communication skills.

And when I go there [to a different clinic] to see the GP...he not work with me well because some time I don't understand English well. But I understand that GP English [WRHC staff] more than others. Because she knows how I speak English and then she knows how to explain to me, how I must to understand, what the GP mean and what I mean...Good listening and understanding the English I'm talking about. My English is broke and sometimes I'm sick and I didn't get better – sometimes I try to explain to the GP – and the GP didn't try to explain to me...because some they speak faster. That is very difficult for catching all the words. If we don't catch all the word we don't know what they're talking about. With a good GP they must understand the broken English. When they understand the broken English they appreciate you and they approach you to say anything you want and catch what you mean...

3) The thoroughness of treatment

Interviewees also commented on the quality of health interactions from the point of view of thoroughness.

Because if we go to the [other] clinics...the GPs just write some notes but do nothing. My husband went to the GP at the other [general] clinic – he has wounds inside. The GP just said “open your mouth” but he did nothing. They didn't do any other check, nothing...

They see me for as long as I want and organise everything my family needs...

Good ones see you a long time, give you medicine and tests, send you to other special doctors – no cost...

Interviewees were of the view that WRHC staff were better GPs: “Even if we have to wait 2 or 3 three days - we keep going there”. When one interviewee was prompted to explain why she thought the other clinics did things differently, her understanding was that:

...he didn't know me and didn't know my family very well – [I] feel scared that maybe they give child medicine that will make problems for the child ... My GP [at WRHC] does different things.

4) The importance of continuity

For other interviewees, long-term relationships started with WRHC staff when they did their initial health assessment. Through this process they became familiar with WRHC staff and had greater confidence in their clinical skills. Understanding and empathy were also important:

(They) understand my story ... I don't want to explain my story to too many people.

The GP needs to understand what has happened to my family and why my health is bad. They should speak [my language] or use a good interpreter... from [my country who] understands me and my family, [and] knows our troubles and [the troubles of] all the people in our community...If I go to another GP I worry that they won't understand my health problems and not look after me and my family. The nurses also listen and help me. Do they have nurses at other [clinics]?

Interviewees were aware that their medical history could be shared between health providers but some were of the view that “not everything is written in the patient notes”.

The GP at [WRHC GP clinic] is totally aware of my [circumstances and medical condition] – anything that is wrong with me the GP knows. If I start seeing another GP I would have to start all over – explaining. This GP [at WRHC] knows everything...

Lack of continuity was reported to create ongoing frustration:

The GPs need to know how to use an interpreter, be very skilled in diagnosing problems, listen to patient and look at all of the person's health problems. GP must talk to patient to understand their history and write it all down...I don't want to have to repeat my story and health problems all the time. When I went to hospital they asked me all the same questions ...why didn't they ask my GP? They need to be compassionate and really listen to patient...must understand [our] problems and what has happened to the refugees. GPs need to do ...diagnosis of [whole person] not just one health problem. Make sure we get the services needed to make us better. GPs need to spend time with the whole family, to hear story and write it all down. Shouldn't have to always repeat story, GPs should share the information.

Engaging with a new GP

1) Getting information from WRHC staff to assist finding a new GP

Two refugees interviewed reported that WRHC staff suggested they try a GP closer to their home; however, finding a new and suitable GP appeared to be a challenge and the respondents could not describe whether or how the WRHC staff assisted them to find an alternative GP.

I asked one of the GPs here (WRHC) “Can I see the nearest clinic?” She said if you find one, ask first, and if they agree, you can go there”. But I forgot to do that.

If we moved far away and had to try a new clinic, we don't know how to find one that is the best. So we would go to the GP that received our records ... We would trust that the new GP is the best...I have no idea what would help me pick a new GP....

...[P]eople who move away from the area should be helped to find other GPs near where they live. [New] GPs need to understand refugee, new people... I couldn't afford to go to other GPs and they don't know my stories. [WRHC GPs] look after me.

2) Getting information from community contacts, friends or family to find a new GP

Eight interviewees had tried different clinics without WRHC encouragement, and had received contact information about new GPs from community contacts, friends and/or relatives. Communication was a key factor in selecting a GP, so gathering advice from other community members was important. One participant noted that staff at WRHC clinic gave her friend the name of a new GP (#1). However GP #1 did not understand the patient's

problem and referred her to a different GP - GP #2. In this case, the process did not lead to a positive outcome, as the participant reported that GP #2 did not explain the medical problem very well. In another case the interviewee sought a GP from the same cultural-linguistic community to get clearer and more accurate health information.

It was not easy communicating to the WRHC GPs with interpreters over the phone. The WRHC GP used an x-ray /ultrasound to explain my heart condition and the [telephone] interpreter could not see what the GP was pointing to...I [still] didn't understand what my condition was. Then I had to go to the hospital...and the GP there spoke to me in [my language] and explained to me my problem. So then my friends told me about going to a GP in [a suburb 23kms away] who spoke [my language]...

My uncle helped me find a new doctor – you need someone to help you – can't do it on your own.

Although finding a new GP who can use one's own first language was preferred, geographical distances, the need to book an appointment one or more days in advance and upfront costs all affect access.

[Q: what advice would you give?] I would tell them to go to GP who understood refugee problems, spent lots of time with them and listened to their story. The GP needs to understand our story, what is wrong. There has to be an interpreter. [The service] must be free. If other refugees use the GP that means she must be a good GP.

HEALTH SERVICE STAFF

Participants

Ten members of staff from the health service took part in face-to-face semi-structured interviews, including members of the RHNP, the Family Mental Health workers, and managers of the RHNP, GP clinic, and general programs.

Understanding “vulnerability”

Differences in the level or type of service provided to clients

All the interviewees believed that some clients, including refugees, required more “intensive” services than other clients; however, describing the point at which clients could be considered to be less “vulnerable” and return to some kind of “care as usual” was a vexed question that interviewees were unable to answer.

In the case of refugees as a group, many of the interviewees reported that before arriving in Australia most of their clients had not had access to health services; therefore, it took a lot of time to sort out the treatments and services they required. In addition, their low levels of health literacy and poor understanding of the health system created problems for them that could only be overcome with the assistance of the RHNs.

I see myself as a detective: I investigate the needs of the client, find the right services for them then link them into the service. It takes lots of investigation.

I assist newly arrived refugees access services and navigate the health system. This includes: maternal and child health, Medicare, health assessments, specialist care, explaining how health system works, accessing interpreters, dentists, allied health, eye care, linking with housing, social work and transport services, how to navigate transport system to attend appointments. It is a very intensive time and they need a lot of assistance. This settles down after a couple of months.

While agreeing that some clients require intensive support and facilitated access to a wide range of services, two of the interviewees were unsure whether there should be specific health programs for groups of people on the basis of shared demographic characteristics e.g. refugees as a group.

I am unsure whether there needs to be a separate program for refugees; there are many vulnerable people in the community who also have complex health issues.

Refugees present to WRHC with multi-layered complex problems requiring the involvement of many different specialties. We have other vulnerable clients who also have complex issues and require similar levels of care.

The majority of interviewees reported that many refugees had unrealistic expectations about what health services could do for them: "Not all health concerns can be 'fixed' by GPs". There can be a significant gap between expectations of health services and the reality of what is available and the health outcomes possible. They felt clients also needed to take personal responsibility for their health, and that this could be facilitated by health care providers continually re-iterating what is and isn't possible.

There is too much doctor shopping, people looking for the magic medicine. Health services are not an infinite resource.

Determining a point of transition in care

Refugees are given priority access to services through community health centres in Victoria as part of the funding agreements they have. This includes access to dental, allied health, counselling, and general practice services. This priority status is not required to be reviewed or changed, no matter how many years a refugee has lived in Australia nor their level of need. There is no definition of when someone should no longer be considered a refugee: they are given ongoing priority access to state funded services.

One interviewee described vulnerable refugee families she had worked with in another organisation who had received intensive targeted support in the first six to twelve months after their arrival in Australia. They subsequently moved from the intensive support system to independently managing their access to health care.

There is no end date for withdrawal of our assistance in the refugee health program. I would like this to be clarified. How do we determine when someone requires less specialist services? It doesn't change. This determines level of service access.

On the [health service client] computer...system, once a person is noted as a refugee it remains that way.

Some of the factors that interviewees believed affected the level of need for enhanced services and support among clients with a refugee background in general included: complexity of health issues, length of stay in Australia, employment status (and income), access to accommodation, literacy level, ability to navigate the service system, and competency in spoken English.

Health service sustainability to provide enhanced primary health care to vulnerable clients

Health Service policies and procedures to support appropriate care

Interviewees highlighted that vulnerable people present with complex multi layered problems which require involvement of many different services and professionals and they grappled with how the systems and procedures in the health service could help to determine when these more vulnerable clients become less vulnerable and can be transferred to less intense service provision.

Processes and procedures to support a routine and standard review of the level of need of clients were seen as appropriate, but generally lacking. A few of the interviewees supported the introduction of care plans to ensure an integrated coordinated approach and ongoing assessment of levels of care a client requires: “This would distribute service access based upon client need, not professional needs”.

Maybe it is some services a person may need less of. A coordinated review of a client’s health status, by the staff at WRHC involved in their care, could help make this decision.

All clients at WRHC should have a care plan to ensure there is a coordinated response to the client’s needs. At the moment it is disjointed care. E.g. allied health may refer client to a service only to find GP has already done this. The ‘squeaky door’ used by some clients could be addressed.

Coordinating primary health services

Interviewees considered that the service does not have clearly documented processes and procedures about the way the RHNP and the general practice clinic should work together in the long term. The general practice clinic and the general practitioners were seen by interviewees as being very autonomous in how they worked. The RHNP and WRHC management reported they had limited influence over the access of newly arrived refugees to the GP clinic. There were also no agreed policies or procedures around transferring clients from the WRHC GP clinic to private GPs.

It would be really helpful if we had a list of recommended GPs and other health services which have experience in providing care for refugees

The majority of interviewees believed that when a client relocated to a suburb outside WRHC’s geographic catchment they had the right to continue seeing the WRHC GPs, and that continuity of care was an important characteristic of good quality PHC. At the same time, however, the staff believed that GPs at WRHC should ask patients who had moved out of the area whether they were seeing another GP and, if so, acknowledge to the patient that it is OK if they want to have them as their primary GP. Interviewees did not believe that this was routine practice, based on what consumers told these interviewees.

Financial sustainability

Interviewees reported that the low level of financial reimbursement to general practitioners for the additional time required to provide medical care for patients with complex needs may provide a disincentive for providing comprehensive care and using interpreters for refugees, particularly in private practice but also for CHCs.

Managers of general practice clinics (whatever the business model or governance of the service) have to consider how to ensure ongoing financial sustainability of services.

Attributes of a good refugee primary care service

Health professional characteristics

All interviewees believed that the general practice clinic at WRHC offered a very high standard of primary health care to patients with refugee backgrounds. The GPs at WRHC were reported to be very experienced and skilled in helping refugees. They spent extra time listening to patients’ stories and unravelling their health concerns and understood their multi-layered complex issues which required specialist services. In addition they had vast experience in using interpreters.

Refugees with more complex needs tend to be referred [*by settlement services*] to WRHC for their health assessments rather than private GPs. This

is because our GPs are experienced in working with refugees: they provide longer appointments and refer to specialist WRHC services.

Most refugees don't speak English when they arrive in Australia and require an interpreter. Using interpreters often makes an appointment with a health professional more complex and time consuming. Explaining medical terms and providing health advice is difficult enough if the person has poor health literacy, the involvement of an interpreter adds to this difficulty and requires a lot of time.

It is very important that a patient understands a diagnosis and the advice I am giving them. In some instances the interpreter has difficulty understanding and explaining what I have told the patient. I often need to repeat what I have told the patient, this takes time.

I need to allow enough time in appointments with refugees to use an interpreter and 'unpack' the issues, it is also important to determine the expectations of the patient.

Service characteristics

Based on their professional experience and observations, as well as interactions with consumers, interviewees described a number of factors that contribute to the quality of primary health care:

- > A particular challenge for refugees is the underutilisation of interpreters by health care providers, as language barriers can result in miscommunication, misdiagnosis, and lack of appropriate follow-up. There is also a perceived under-supply of health-trained interpreters: interpreters who lack relevant training or experience may not know the appropriate words required for delivery of medical care.
- > The level of financial reimbursement to general practitioners for the additional time required to provide medical care for patients with complex needs may provide a disincentive for providing comprehensive care and using interpreters. Managers of general practice clinics (whatever the business model or governance of the service) have to consider how to ensure ongoing financial sustainability of services.
- > The extent of relevant clinical and cultural knowledge of primary health care practitioners and other staff in general practices affects access to appropriate primary care. Ideally, general practice staff should have some familiarity with the health needs and problems common to refugees from different countries of origin, and have some understanding of the cultural characteristics that may impact on help-seeking, interactions in consultations, adherence to treatment regimes, and uptake of referrals to other services.
- > A whole-of-practice approach is required to successfully provide services to vulnerable people such as refugees. This requires the up-skilling of practice managers, practice nurses, reception staff and GPs to understand refugee cultural and health issues, use interpreter services well, and understand how refugee settlement is organised. Refugees need to feel welcome at a GP practice and the receptionist has a key role to play through the way they interact with patients; access to care is strongly influenced by how that patient feels about attending the practice.

HEALTH SERVICE GENERAL PRACTITIONERS

Participants

Six WRHC GPs who provided care to clients who had arrived in Australia as refugees took part in face-to-face semi structured interviews. All interviewees had refugee patients who regularly attended the medical clinic. Some GPs interviewed had been seeing their refugee

patients and their families for over 6 years and they reported that the majority of refugees they saw used WRHC GPs as their primary GP. (GPs in WRHC are salaried – the WRHC bills the MBS for eligible activities to contribute to the salaries.)

Understanding “vulnerability”

Differences in the level or type of service provided to clients

All interviewees were very committed to providing health care to refugees and for most it was a reason for them working at WRHC. Some expressed a preference for working with refugees from particular countries or cultural groups. The GPs reported having a close working relationship with the WRHC Refugee Health Program; they were in regular contact with the RHNs and mental health workers and this enabled a more coordinated approach to patient care. Most refugee patients' initial contact with the medical service was for their refugee health assessment; prior to this the refugees had usually met with the RHN at the centre or their home.

In addition to assessing the refugees' health needs, the GPs reported assisting refugees navigate the health system, organising specialist, mental health and allied health appointments and ensuring recommended treatments were followed. Considerable time was also spent explaining the medical treatment, how to take medications (in some instances how to fill a script) and what changes to expect due to the treatment.

I oversee all their health needs, help them navigate the health system and assist in improving their health literacy.

They have been through the trauma of war, dislocation, family deaths, persecution and most have never seen a GP before – they require intensive care which takes lots of time.

The GPs reported that the care they provided to refugees differed from that provided to other service users. Refugees presented at the medical centre with many overlapping long-term health problems and respondents said it took many visits to the clinic to start unravelling their needs. They felt that the refugees were vulnerable, often traumatised, with mental health problems and/or with other complex health issues such as chronic disease. All interviewees believed that due to their complex health issues, most refugees required intensive health care and access to many WRHC services such as dental, mental health, podiatry, and physiotherapy services, particularly during the period of their initial settlement.

The GPs reported that they generally allocated extra time to 'listen to the refugee's story' and understand their health and social issues. This required a different level of consultation to that provided to other patients. Longer consultation times were also required as the majority of refugees didn't speak English when they arrived in Australia and required interpreters. GPs reported they were often told by refugees that they appreciated the way they tried to understand their situation and spent time listening to them.

The consultations I have with refugees are longer. Their presenting issues are often very complex and using an interpreter takes lots of time, particularly if the interpreter doesn't understand the questions I ask the patient.

Refugees' health literacy is often very poor, I have to spend a lot of time explaining treatments, how to take medication and what they should expect from the treatment. I need to ensure they have a realistic idea about what medication will do for them and their role in caring for their own health.

One GP however commented that refugees were just one of the vulnerable groups they see at WRHC.

We have lots of other vulnerable clients who also have complex health needs – we must make sure they don't fall under the radar.

Determining a point of transition in care

Responses varied when asked whether the health care or the way it is provided to refugees changed over time. They reported that there could be change in the services required but in the majority of cases the level of care required by refugees doesn't decrease; it is the type of care that changes. Once the urgent health concerns were addressed, the GP could focus on more complex issues. For most GPs the level of care they provided did not change.

The care becomes less urgent- patients may present with infections, diabetes etc. Once the urgent issues are addressed we can concentrate on other areas including mental health and management of chronic conditions.

Some changes occur when some of the patient's health issues are addressed, refugees have complex issues which require long term treatment. Mental health problems are common.

As they access other health services the time they need with me may reduce, this is often due to them no longer requiring an interpreter.

Some GPs expressed concern that some refugees had an unrealistic view of what the health system could do for them and may have expected a 'magic cure' for all health problems. In addition GPs often had to spend time reiterating how the health system worked, in order to address patients' frustration about access to services.

It is difficult to get new arrivals to understand that GPs and health professionals can't always fix all their problems. (This) may result in GP shopping.

It is important GPs don't take on a paternalistic role; patients need to be taught how to take responsibility for their health as health services can't always fix everything.

Health service sustainability to provide enhanced primary health care to vulnerable clients

Coordinating primary health services

The GPs primarily referred refugees to services within the WRHC such as dental, allied health and counselling. None had referred a client to another GP outside WRHC. They did however refer patients to external health services if the service wasn't available at WRHC, such as medical specialists. The WRHC medical clinic practice manager could not recall receiving a request from a private GP for a patient's file nor had a refugee patient requested that their file be transferred to another clinic. She was not aware of patients moving to other medical clinics.

The RHNs and GPs were aware that the refugees referred to WRHC by settlement services and Adult Multicultural Education Services (AMES) through their triage system usually had higher levels of need than those referred to private GPs. While they felt this was appropriate, because of the additional resources available through the WRHC RHNP, some respondents considered that one of the reasons they needed to provide additional non-medical services to patients was a lack of consistency in the quality of case management provided by other services. They observed a high turnover of staff in organisations providing these services, and felt that the level of understanding of the health system among some case managers was poor.

Attributes of a medical practice able to provide care to refugees

There was general consensus amongst GPs about the attributes required by a medical practice if it is to provide good care to refugees. The attributes included:

- A whole of practice approach including cultural sensitivity exhibited by all staff in the practice.
- A ‘welcoming clinic’ including reception staff who are the ‘gate keepers’ and influence how a patient feels at initial contact with the practice.
- All staff are skilled and confident in using interpreters. In addition they know how to access interpreter services.
- GPs and practice nurses are aware of potential health issues e.g. trauma, mental health, Vitamin D levels, infectious diseases.
- Staff are aware of how the refugee program operates in Victoria including settlement services and other services refugees can access.
- Empathy and consideration of refugees’ circumstances – they are often illiterate; they may not have had access to health services in their country/camp; have poor health literacy and are unfamiliar with the Australian health system.
- Flexible appointments.
- Access to longer consultations

PRIVATE GENERAL PRACTITIONERS

Participants

Six respondents took part in telephone or face-to-face semi-structured interviews. All of those interviewed had provided services to refugee patients, with most working with refugees for a significant period of time – from five to fifteen years. Only one GP had recently commenced seeing refugees. All of those interviewed had undertaken refugee health checks, varying in number from under ten to hundreds over a number of years, with most reporting that the number per week/month can fluctuate significantly. The GPs interviewed were all in private practice remunerated through direct billing of eligible activity to the MBS.

Understanding “vulnerability”

Differences in the level or type of service provided to clients

Most interviewees believed that patients with refugee backgrounds did require a different level or type of service, and longer time for consultations. Additional time was required for the tasks involved in the initial refugee health checks such as tests and immunisations as well as the time taken due to the use of interpreters. Although the interpreter service was reported to work well, it was noted that there were sometimes delays in getting interpreters and that their use extended consultations.

The kind of care that was reportedly provided recognised common refugee experiences; most interviewees commented on the psychological trauma associated with being a refugee and noted that counselling was frequently required. Some GPs said that they referred to specialist health services such as Foundation House (for counselling) and to dental services, and one commented that he tried to find language-appropriate private psychologists (although this was increasingly difficult). Most commented that they undertook counselling and case work that they would not do for other patients, and some commented that this was not really a GP role. Most of the GPs interviewed said that they could handle

most of the issues raised in caring for refugees themselves, and they did not refer to other GP services.

Some GPs reported that although the counselling they provided was time-consuming and included addressing welfare issues such as assisting with accommodation or filling out forms that they did not do with other patients, they believed there was no one else who would do it. The GPs assessed the quality of caseworkers allocated to refugees, who might otherwise have undertaken this work, as varying from very unsatisfactory to capable.

One GP expressed the view that many of his patients who had refugee backgrounds did not require special services and were capable of negotiating the health system themselves. The patients with refugee backgrounds that this GP was seeing were mostly from his own language and cultural background and tended to be better educated and resourced than some others.

Determining a point of transition in care

Several of the GPs interviewed were asked to comment on how refugees might make the transition to different levels of care. Several suggested that the initial triage undertaken by settlement services should recognise that some refugees require more support than others and direct consumers to different primary care providers on this basis. This is supposed to be current practice, but clearly not all providers are aware of this.

Another GP reflected on the change in vulnerability over time

Usually after five years they have sufficient English and can explore other GPs – or they have physically moved – but they are still vulnerable before that.

Several GPs commented on the potential consequences of not transferring clients from a specially targeted comprehensive primary health care service to more usual care, including creating dependency and providing services that are not really part of general practice:

There is a danger of creating dependency at community health – they promise the world but don't have the resources. Also they refer them around internally and block access for others

They [*refugee clients*] don't need a GP to give them a lot of what they need – attention, help with forms...

An understanding at the start that the service is for a limited time would help.

Two GPs suggested that refugees should receive their complete health checks, including appropriate immunisations, before they enter the community. They believed this process would better protect the community against potential public health risks. If the information was systematically documented and forwarded to the patient's GP this would result in community-based GPs have a preliminary knowledge of current health status and need. They stated that this approach could also save money, through ensuring that there is less duplication of services, and fewer unnecessary services provided. The process would also mean less vulnerable refugees such as young men who may not have any particular health issues, and were frequently 'no shows' for health checks and follow-up appointments, would not be required to access GP services unnecessarily.

Health service sustainability to provide enhanced primary health care to vulnerable clients

Coordinating primary health services

Most GPs reported that the refugees they saw were referred directly from settlement services. Refugee patients also came through family connections or other community members. Only one GP reported that he had received referrals from WRHC and this had

been some time ago. Some GPs, however, commented that they would not be aware if their patient had come from WRHC – they “just deal with what comes through the door”. Several GPs commented that they would be happy to have more refugees referred to them, including from WRHC, in spite of the financial and other issues associated with their treatment.

Some GPs commented that it was common for the refugees not to have any documentation with them when they came to the clinic, with one reporting that they needed to have their receptionist check with Medicare before treatment to make sure that he would not be repeating tests that had already been done and that he would then not be paid for. (He also commented that this caused further delays). Others reported that refugee patients had come with documentation from previous providers.

A number of those interviewed commented on the high level of mobility of their refugee patients. Relocating over time was common and, “they don’t usually ask (for a referral), they just disappear.” No GPs routinely referred their refugee patients to other GPs, for instance when they moved to another area: it was left to the refugee to find a new GP. Some did however report sending the new GP the patient’s paperwork if they were notified.

In one instance a GP commented that he contacted another private clinic when he became aware that his patients of a particular language group were moving there because a GP at the clinic spoke their language. He offered to provide case summaries but the GP never followed up on this offer.

When discussing providing care for refugees more generally, one GP commented that migration and release from detention can come in waves and GPs should be part of the consultation and planning process for this to ensure better coordination; however, there is a lot of pressure to see patients and there is not time to attend meetings to be consulted.

Financial sustainability

Most private GPs interviewed reported that seeing refugees was not financially viable in the long term, despite the fact that they provided care to refugees and expressed the intent to go on doing so. Refugees were frequently “no shows” – with one reporting this was the case in half of the appointments made. Refugees were reported to be complex patients and required longer consultations than could be billed. Cultural issues, lack of support services and illiteracy added to the difficulties of seeing refugees.

Attributes of a medical practice able to provide care to refugees

GP characteristics

Most interviewees believed that private GPs, including themselves, were committed to providing care to patients with refugee backgrounds because they were “passionate about refugee health”. They described this as having empathy and dedication to patients with these experiences, rather than just seeking a financial return for their time (though recognising that there had to be some limits to this). A number commented on the danger of ‘burning out’. Another GP stressed how rewarding it was working with refugees and that GPs, particularly registrars, should be encouraged to provide care for refugees as they would get unique experiences.

Some interviewees considered that GPs (and other health professionals) require specific training and support in order to be able to provide care to patients with refugee backgrounds. This should include information about resources and services that are available to help refugees, and how to access them. The need for cultural sensitivity was also stressed. Some GPs also believed that health providers need specific training to cope with the emotional demands of caring for refugees in order not to be overwhelmed by the complexity of their needs.

Specialist services can be good and have a place, but training can also help utilise mainstream services. (Students) do aboriginal health in training – you should also do refugee health and then others might not be put off by it.

It was suggested by one GP, and supported by another, that one-to-one training/mentoring, where a private GP could observe for a half day another private GP who was identified as showing good practice in refugee health, was preferable to the current training being provided in group sessions.

Service characteristics

Client experiences of different GPs

Several GPs stressed the importance of using reliable interpreters with one outlining a strategy he used for improving the efficiency of the use of interpreters. Appointments for patients were made based on pre-determined specific language days (e.g., a 'Burma day') when the Burmese refugees would be given appointments and a Burmese interpreter would be booked for the day or half-day. He reported that this was more efficient and tended to improve attendance rates.

Based on their professional experience and observations, as well as interactions with consumers, interviewees described a number of factors that contribute to the quality of primary health care:

- > One GP commented that most of the refugees he saw hadn't seen other GPs in private practice; they have only seen them in the camps. This concerned him, as not all of the potential public health threats (e.g., contagious diseases) had been identified and treated prior to entering the general community.
- > One GP reported that most patients complained that other GPs don't spend the time with them that they needed or that they try to deal with them without interpreters.
- > One GP spoke at length about his perception that most private GPs won't do the intensive work involved in working with refugees – "most churn them through in the minimum time". He commented that AMES appeared to support this approach and preferred these clinics for referral although some may be unscrupulous. The GP reported that he believed some clinics charge for services that they don't do and some may over service patients – sending them for multiple tests that are unnecessary. The patients may like the attention from the latter but it uses taxpayer's money to no effect. Another GP also seriously questioned the quality of care some GPs provided including that some were not Fellows of the College of GPs and that some did not use interpreters.

Quality [of primary care generally available to refugees] varies – I hate to think about certain GPs' behaviour.

I'd rather seek treatment from the dustman than some of my colleagues!

System Issues in transferring clients within primary care

References to system factors and issues beyond those experienced in individual general practice were limited.

Vulnerable groups tend to access primary health care outside normal hours, and after hours GP coverage is third world at best!

OTHER INFORMANTS

Interviews were undertaken with two other professionals involved in delivery of refugee health care in the community health sector; one employed through the RHNP in a CHC with GPs on staff, and one employed through the Home And Community Care (HACC) program

in a CHC without in-house GPs, where refugee clients are referred to local private GPs with whom a relationship has been established. The interview questions focused on access to services for refugees and any policies or processes used for transferring vulnerable clients such as refugees from specialist/higher level care to mainstream care, including primary health care.

Government Policy

Both interviewees referred to the Victorian Department of Health Community Health Priority Tools³³ as a key policy document guiding their service provision to refugees and other vulnerable groups. This document stipulates that certain groups, including refugees, homeless people, Aboriginal or Torres Strait Islander people and others, are high priority clients for Victorian community and women's health services and a generic tool has been developed to refine the prioritising of their access to services. There is no cut-off point once clients are categorised as high priority. If an individual does not meet the criteria for high priority using the generic tool "(they) will have their level of priority determined through the relevant clinical priority tool or tools, or through a comprehensive assessment where required".

The removal of an MBS item for refugee health checks was reported by one interviewee as impacting on service provision to refugees. It was no longer possible to clearly identify the number of refugee health checks that had been undertaken from the health service's data as the various components are indistinguishable from other clients having the same tests; and costs associated with providing comprehensive primary health care to refugees were no longer fully covered.

Access

Neither interviewee reported difficulties with access to services at their health centres for either refugees or other service users. The centre without GPs worked with mainstream private GPs who used interpreters and bulk billed. Although the interviewee reported that the centre experienced some problems with follow-up, the process for access appeared smooth; however, this interviewee commented that establishing the relationship with the GPs had been difficult and it was an on-going process to extend to other GPs.

The informant from the CHC with on-site GPs noted that, if refugees moved location, they were unlikely to return to the health centre primarily because of poor transport in the area. In this case the nurse would contact a refugee health nurse in the area to which the client had relocated seeking recommendations regarding PHC services in the new area to which they could refer. The CHC particularly encourages the refugee to find a local GP if they have small children and to take their health record with them. Both interviewees reported that unless they were relocating, most refugees stay with the health centre or the GP clinic they have been referred to.

Transfer to less intensive service

The centre using private GPs had not been operating a refugee program for very long and they were still developing policies and procedures. The other centre reported that although it did not have a policy, it did have a process for reviewing refugee clients; however, this was described as more a quality control mechanism than a review of clients for the purposes of transfer to lower intensity or other services. The process was described as follows.

In the fourth month after engagement with the service the client is told they will be reviewed by the refugee health nurse after 12 months. At twelve months they are sent a letter and receive a phone call asking them to attend a review. About a third of clients attend. It is hoped that by then an interpreter will not be required but one is used if necessary to ensure they understand. The review checks that what the client needed to be done including immunizations and checks has been done and that there are no outstanding issues. If they do not attend the review but are still using services at the centre the nurse alerts the team at

the centre that a review is due and they link her with the client. If clients have left the area or are no longer attending the centre, they are not followed up for review. The review does not check the vulnerability of the client and the interviewee stated that the level of vulnerability was determined by the client – the more empowered they are, the less likely they are to need her and to see her. She commented that the role of the RHN was to teach the client the necessary health knowledge and to empower them to use the health system.

If you do what you should do well then there shouldn't be a problem with demand.

Support workers

Having a facilitator or conduit between agencies, such as a refugee health nurse who knows the health system and health needs, was reported to be vital for assisting refugees to navigate the health system and maintain their health. Case workers from settlement agencies were reported often to be inexperienced and not health trained, and to have heavy case loads: their capacity to prioritise health issues was therefore reported to be limited.

Discussion

This qualitative study explored issues related to the delivery of primary health care services to vulnerable consumers, with a particular focus on how to ensure an appropriate level of care is provided over time in a cost-efficient way.

The research used primary health care for refugees as a case study of a vulnerable group and examined their use of primary health care services. Consumers who are described as “vulnerable” are likely to have complex needs that are time-consuming to deal with in a PHC setting, and refugees are no exception; however, although community health service managers and some GPs in private practice (i.e. self-managed services) expressed concerns about the financial viability of providing services to refugees, there did not appear to be a systematic approach to ensuring services continue to be directed to those who are most vulnerable. Neither did there seem to be general acceptance of the need to transfer patients to less intensive services when vulnerability changes.

All of the interviews in the present study—with consumers, WRHC staff (including nurses, GPs and managers), and private GPs who currently provide care to refugees— reveal a wide range of reasons influencing whether or not consumers make the transition from CPHC to more mainstream PHC. The research questions and framework for the study considered barriers that may be present across four levels of the health care system: from consumers as users of care, to health professionals providing care, health service managers implementing local systems and policy at the state and national level.

SUMMARY OF KEY FINDINGS

Consumers

The research asked the question:

- > How do refugee consumers experience and understand PH care from the time of their arrival in Australia to longer term residency?

The study recognised that consumers are entitled to select their own PHC provider, and it was clear that consumers of WRHC interviewed for this study valued the quality of the service they received. Some reported this as the reason for continuing to attend WRHC even if they moved away from the geographic area.

The study demonstrated that the consumers who arrived in Australia as refugees were no different to others in the community in their attitude towards continuity of care: once they established a valued relationship with their health care provider they were likely to continue to use them even if they moved house, provided they could continue to access them through

adequate transport and timely appointments. They often reported using an additional PHC provider near to where they live for more routine health issues, which may mean that the original organisation continues to provide care for the more complex, and potentially costly, needs.

If consumers changed provider, the advice of friends and family was important when identifying a new provider. It is notable that the factors that emerged as important for choosing and maintaining care for consumers with a refugee background reflect those that are generally reported in the literature³⁴ for any individual, including:

- > Ability to communicate with the health professional – preferably through sharing a language, but through effective use of interpreters if necessary
- > Ability to connect with the health professional – the perception that the health provider understands the individuals’ experiences and expresses empathy
- > The perceived level of knowledge, skill and experience the doctor has of physical and mental health conditions relevant to the individual
- > Cost – the affordability of the care
- > And, all other things being equal or acceptable, geographic proximity.

Health providers, including GPs

The research asked the question:

- > How do health professionals working to deliver and support health care to refugees understand the concept of “vulnerability”, and how is this reflected in their practice with refugees?

One of the strongest themes that emerged from interviews with all health providers was the level of personal commitment they had towards the care of refugees as a population group. Most GPs expressed a particular interest in refugees and refugee health and they described a level of care that was beyond typical PHC, including addressing non-health related issues and providing practical support. There were, however, differences in the attitudes of some providers towards refugees from different countries: that is, they recognised sub-categories within the overall population category of “refugee”, and they expressed preferences for providing care to refugees from some communities over others. These preferences did not appear to relate to the provider having particular cultural knowledge or the ability to speak specific languages. This suggests that the personal preference of the GPs, even among those who provide care to refugees, is a key and often unacknowledged driver of access.

Most GPs interviewed, in private clinics and the CHC, reported providing additional services to refugee consumers compared with the level of care provided to other consumers, resulting in them spending more time with their refugee clients. Most of the GPs did not refer to the question of whether giving some refugees priority access or longer appointments created difficulties with access for others, particularly those more recently arrived.

Providers considered that continuity was an important factor in providing quality PHC, and valued the ability to provide ongoing care to consumers; however there were differences in the extent to which the different informants recognised the potential to have to change the level of care provided to refugees over time. Many private GPs and some community health managers acknowledged that providing CPHC services to individual refugees over the long term was unlikely to be financially viable, and recognised the need to “ration” the more intensive CPCH.

We suggest that GPs need to take responsibility for ensuring that consumers understand the nature of the PHC they are receiving, including whether it is more comprehensive than usual care, and whether there is a time limit to the level of care. In the context of a managed health service (whether a private practice or clinic within a broader health service), a policy

and procedures reflecting the level of care provided and for how long should be developed and the GPs should then be guided by organisational policy over personal preference.

Many of the informants, including consumers, described a lack of consistency in the quality of services provided to refugees in mainstream PHC services, although there was also a general lack of awareness of the alternative PHC service options available for consumers among the GPs in both settings. The GPs did not consider there were limitations in their capacity to respond effectively to all the issues that may arise for their clients, and did not believe they generally needed to refer vulnerable clients to other services. While this assessment may have been accurate, it is important that providers of care to vulnerable consumers are aware of all of the health and community service support options available, and refer appropriately.

Ongoing training and professional development for GPs is clearly important in ensuring an appropriate level of skill and knowledge across the PHC sector to meet the needs of refugees. This includes knowledge of common health issues for different community populations, practising with cultural and linguistic sensitivity (including using interpreters effectively where necessary), and having knowledge of the service system to which clients can be referred for emerging needs and how to use it.

Health Services

- > How can health services manage the type and extent of PHC service delivery over time for refugees?

The study identified several concerns for WRHC associated with providing health care to refugees, many of which were reflected by the private GPs. These included the cost of providing CPHC, including: a high proportion of 'no shows' and long consultations; the costs of using interpreters; inefficient use of GPs' time on non-health related matters (such as completing forms that could be done by other services or providers); costly duplication of services through inadequate documentation or communication between service providers; and 'doctor shopping' by consumers, which represents a poor use of resources and undermines treatment adherence or effectiveness.

From the health service perspective it is important to recognise that the concept of 'transitioning' refugees (or other vulnerable groups) from 'specialist' or 'targeted' CPHC services to 'mainstream' PHC services does not have to mean that they move from a particular practice or clinic with which they are satisfied. It should not be assumed that 'transitioning' requires a change of location or care provider and certainly not a loss of choice of provider for the consumer. It may be that the same provider continues to be used but that the intensity of the PHC service and related support is reduced as the client becomes less vulnerable to poor health and more empowered to navigate the health system, including developing other social supports for themselves. It should also be recognised, however, that many providers could find it difficult to change the intensity of care provided over time, in part because of patient expectations, and health services may need to support them to adhere to the transitory nature of the program.

The study also demonstrated how important it is for health service managers to recognise the impact that the personal preferences of staff will have on implementation of models of care and, through this, consumers' access to services. Health service managers need to communicate the rationale underlying programs and models of care, and directly address personal preferences where they are a barrier to meeting the needs of the community.

Evidence from across the groups of informants suggested a range of strategies that should be in place to manage the type and extent of PHC service delivery over time, including:

- > Efforts need to be made to manage patient expectations at the onset. This involves placing greater emphasis on communicating the short-term duration of the initial period of CPHC service—through the phases of comprehensive health assessment

and referral to other services to a point of stabilising health—from the first point of contact and regularly (without making the consumer feel insecure).

- > Routine review of health status and factors that contribute to vulnerability to poorer health at least after 12 months in the service and earlier if that appears appropriate, with notice given in advance of the review, and a clear purpose and intent described. The review would provide an opportunity to ensure the service response has been appropriate, including treatments provided, medications (and that scripts had been filled and taken), and referrals (and that appointments had been made and were attended). The review should establish whether clients are still living in the area and whether they are receiving PHC from other providers or would like assistance to identify another provider.
- > Part of the review should include a more nuanced assessment of vulnerability, in which “refugee status” does not automatically provide for ongoing priority access to services. There are existing tools used for initial triage of refugees or asylum seekers and a standard Initial Needs Identification tool used across Victoria that include relevant questions for ongoing routine assessment. Factors that could be considered as part of a revised tool include financial circumstances (including employment), residential status, language skills, mental health status, social supports and the complexity of health issues.
- > Depending on the outcome of the review and assessment of vulnerability, priority access to services may be removed and the client would have the same access to the appointment system within the service as other consumers. If the review indicates the client is still vulnerable, further reviews should be undertaken at six monthly intervals.

Health system

- > What aspects of the health system facilitate or inhibit making appropriate changes in the level or kind of PH care offered to consumers according their level of need at a particular time?

In a context of limited resources and high demand for services, the Victorian Department of Health developed the Community Health Priority Tools to identify where programmatic funding should be directed. The generic priority tool categorises consumers into identifiable population groups for the purposes of priority access as “these groups include people with the poorest health status and the greatest economic and social need for service as well as those with complex care needs that require a coordinated team approach.”³³ The generic priority tool is to be used “as a first step in determining the priority of access for clients”. A second component, the clinical priority tool “prioritises clients on the basis of their clinical presentation”.

While population health data supports the generalised assumption behind the application of a generic priority tool at the level of a service or program, this kind of population-based approach to resource allocation can lead to inappropriate provision of services. The informants in the study noted that, within the priority groups identified in the generic tool used by WRHC, individual vulnerability may vary significantly particularly over time and hence so will their need for priority access. For example, some refugees may be illiterate or have little education in their own countries, no experience of health services and no understanding of English. Others may be highly educated, possibly speak English and have a much greater capacity to negotiate the Australian health system and access support services. While some priority groups in the generic tool can capture a change in circumstances for a consumer, for example from homeless to no longer homeless, membership of other priority groups such as Aboriginal or Torres Strait Islander does not change over time. The current study highlights the difficulties associated with using membership of the group “refugees” as a permanent category for the purpose of prioritising

access to care. Refinement of these tools for ongoing assessment of priority status may support a more appropriate approach to managing access over the longer term.

Current capacity building and system-level support for the broader PHC sector in Victoria come through the state-funded RHNP in particular, in most cases working in collaboration with Medicare Locals (and before them, Divisions of GP). The focus of this work is on building skills to work with refugees, including how best to work with interpreters and being aware of the likely health issues that consumers may present with, as well as linking GPs to relevant specialist services and support networks to which they may need to refer clients. Identifying GPs with an interest in providing care to people with refugee backgrounds has also been an element of the work of the RHNP, and of other organisations with a special interest in refugee health; however, there is no evidence of a systematic approach to use of the care options identified.

POLICY & PRACTICE IMPLICATIONS

The study aimed to consider the implications of its findings at different levels, in particular, seeking to answer the following questions:

- > What can consumers do to facilitate their own transitions through the primary health system, to ensure they receive care appropriate to their level of need and potential vulnerability to poor health?
- > How can health providers support clients to receive different levels or kinds of care according to their need without compromising on quality?
- > How can health services support smooth transitions for clients who may require enhanced primary health care in times of high need through the health service and system?
- > What aspects of the health system facilitate or inhibit making appropriate changes in the level or kind of PH care offered to consumers according their level of need at a particular time?

Consumers

Health literacy is recognised in policy and practice as a key factor that influences access to care for all consumers. An important part of reducing an individual or group's vulnerability to poor health is to provide information and support to increase their capacity to act for themselves and to navigate the health system and self-manage health conditions where appropriate.

Both state/territory and Commonwealth governments currently recognise the importance of health literacy in policy; however, strategies and mechanisms to increase literacy in consumers who are vulnerable to poor health need to be designed with the specific needs of different populations in mind. Increasing health literacy also requires ongoing strategies and multiple sources of messages, not one-off messages that are not reinforced by health practitioners. For example, a powerpoint presentation about the Australian health system is available for refugees and they are given other materials that have been developed to assist with improving health literacy; however, if the messages in these materials are not repeated and reinforced across multiple sources, they are unlikely to have much impact on the beliefs and attitudes of individual consumers.

Consumers who have little experience of the health system, by virtue of their recent arrival in Australia or their past limited access, also need to understand what the characteristics of usual PHC are. Having expectations of the mainstream PHC system based on specially targeted CPHC service models may lead to later dissatisfaction and potentially undermine future help-seeking. It is important that consumers using the Australian health system are aware of its limitations, including understanding the dangers (and waste) associated with

'doctor shopping', unnecessary duplication of tests and the potential dangers of polypharmacy.

Health providers, including GPs

Development of a mechanism to assist GPs to assess their interests, capabilities and skills to provide care to consumers vulnerable to poor health for different reasons and, if required, seek appropriate training or information about services for appropriate referrals could improve the quality of care provided in mainstream services. The RACGP's current approach, through the Faculty of Specific Interests including Networks to support GPs, provides one strategy for promoting greater awareness of what is required to deliver care across different groups. The specialist services concerned with different kinds of vulnerability that exist at the national, statewide or regional level also offer support, including training, for health practitioners. Study participants noted the potential to encourage direct training to GPs in specialist areas, and recommended one to one mentoring, and clinical placements that target CPHC for vulnerable consumers.

At the same time, the study demonstrated that many of the issues considered to be particular to the experience of providing a PHC response to refugees in fact reflect very general principles of person-centred care or 'people and family centred care' as described by the National Health and Hospitals Reform Commission³⁵ including being: responsive to individual differences, cultural diversity and preferences of the people receiving care; easy to navigate; and provided in the most favourable environment. Promoting the principles of person-centred practice would support care for vulnerable consumers broadly across the PHC system, regardless of the population category or specific disease or health condition of an individual.

Health Services

Health services are required to identify need at the level of individual clients in order to ensure appropriate access to services, particularly those that are more costly. While population categories provide an initial broad level of identification of need, in order to ensure that scarce specialist resources are directed to where they are required most it is necessary to assess other characteristics and to repeat this assessment regularly over time.

- > Further development of a generic priority tool to regularly assess individual vulnerability to poor health on the basis of known characteristics, experience and circumstances, that is implemented by an experienced professional—but not necessarily the consumer's treating GP—would help to differentiate those for whom specialist services are required, and the precise nature of the required services/supports.
- > Any tool that assesses vulnerability should clearly recognise those needs that relate to specific issues or conditions as well as any other forms of complexity or vulnerability and the variable nature of the extent of vulnerability over time in order to ensure appropriate targeting of services. For example, consumers with refugee experiences from particular countries may be likely to have specific medical conditions or other health needs that require specific knowledge or expertise, while for other consumers, a person's refugee experience may be incidental to many of their needs, and another non-refugee-specialist provider with good cultural competencies and capacities could suitably address their needs.
- > At an organisational level, health services (whether they are private GP clinics, community organisations or specialist services) need to be able to direct their staff to behave consistently with internal policies and procedures. For some health professionals, this may represent a challenge to their sense of professional autonomy; however, promoting an understanding of the impact of individual practitioner decisions on system-level access to care may contribute to greater

compliance. While it may be a challenge to personal preferences of some practitioners, the underlying assumption of the health care system is that access to care should be equitable in relation to need for all consumers over the long term: determined by a valid and objective assessment of need at an individual level.

- > Clients of specialist comprehensive PHC services should be systematically reviewed at least after 12 months in the service and earlier if appropriate. This should be explained to the client on entering the service with further notice given in advance of the review. Consumers who are identified as being able to make the transition to less intensive or comprehensive PHC should be supported to understand that this represents normal access. Support to identify alternative providers should be offered as part of the “discharge” from the CPHC service.

Health policy & system

In order to address the often complex needs of consumers vulnerable to poor health, there need to be systems to support coordination and referral across the health and community services systems at a local level. Each jurisdiction has responsibility for supporting local level system coordination, and different mechanisms are in place across Australia. At the national level, there is significant effort going into development of service directories for better referral practice and e-Health solutions to support better information sharing.

Medicare Locals (MLs) provide the strongest current mechanism to coordinate efforts to improve access to appropriate PHC for vulnerable consumers at a local catchment level, as long as they work in collaboration with existing networks of relevant health and community services, NGOs, local government and community groups. MLs have a core objective to identify the health needs of local areas and develop locally focused and responsive services to address any gaps or access issues. They have capacity to work with their local provider networks and communities to assess population data, with a focus on potentially vulnerable groups, and to map existing services in order to develop targeted strategies or programs to address unmet need. MLs also have a core objective to improve the patient journey through developing integrated and coordinated services (including through supporting better links between GPs and existing services) and to provide support to clinicians and service providers to improve patient care (including through resourcing and training).

At a policy level, there are two key findings from the study that warrant further investigation and consideration:

- > While population-level health and service utilisation statistics provide a broad guide to vulnerability within the community, a more nuanced understanding of the concept is needed, based on recognition that an individual’s vulnerability to poor health or poor access to care may change over time.
- > Access to PHC is influenced greatly by the individual skills, knowledge and interests of GPs, and the study confirmed that some GPs will choose to deliver care that goes beyond what they can be fully compensated for financially. The RACGP is recognising and supporting GPs with specific interests through its Faculty, with the intent of providing resources and approved professional development. The way in which the skills of these GPs can best be used within the PHC system is not clear. The more formal and structured UK approach to harnessing personal interest through the GPwSI services may not apply in the Australian system because of the very different approaches to organisation and financing. Medicare Locals may represent a mechanism by which the potentially underutilised asset of specific skills and knowledge of GPs could be assessed and used more strategically to support the care of consumers who need some degree of enhanced PHC without the intensity of specialist services.

CONCLUSION

The current research is a small, qualitative study; however, the findings from the interviews with different informants were consistent and highlighted concerns regarding access to and the sustainability of services for vulnerable groups and a common set of barriers in relation to the transition of consumers through levels of care in the primary health care system. As with the rest of the community, it is reasonable that people from vulnerable groups are able to choose their health care provider; however limited resources within the health sector make it unrealistic and unfair to continue to provide more expensive comprehensive primary care when that care is no longer required. A number of strategies were identified that could be implemented at different levels in the PHC system to address some of the issues raised.

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