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Lindsey Ross

Catherine Harding  
*University of Notre Dame Australia*, Catherine.Harding@nd.edu.au

Alexa Seal  
*University of Notre Dame Australia*, alexa.seal@nd.edu.au

Geraldine Duncan  
*University of Notre Dame Australia*, geraldine.duncan@nd.edu.au

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# **Improving the management and care of refugees in Australian hospitals: a descriptive study**

Lindsey Ross <sup>1,3</sup>  
Catherine Harding <sup>2</sup>  
Alexa Seal <sup>2</sup>  
Geraldine Duncan <sup>2</sup>

<sup>1</sup>The University of Notre Dame Australia, School of Medicine, Sydney, 160 Oxford Street, Darlinghurst, NSW 2010, Australia.

<sup>2</sup>The University of Notre Dame Australia, School of Medicine, Rural Clinical Sub School, P.O. Box 5050 Wagga Wagga, NSW 2650, Australia.

<sup>3</sup>Corresponding author. Email: Lindsey.ross1@my.nd.edu.au

## Abstract

**Objectives:** The aim of the study was to investigate healthcare provider perceptions of the impact of refugee patients at two public hospitals, one rural and one urban, in designated refugee resettlement areas. Healthcare professionals' views regarding improvements that could be made in this area were also sought.

**Methods:** Two page anonymous questionnaires containing demographic, quantitative and open-ended questions were distributed to 150 healthcare providers at each research site.

**Results:** Response rates were 50% and 49% at the rural and urban sites respectively. Refugees were seen at least monthly by 40% of the respondents. Additional support was requested by 70% of respondents. Confidence was associated with being born overseas ( $p=0.029$ ) and increased time working with refugees ( $r_s=0.418$ ,  $p<0.001$ ). Only 47% of respondents felt confident managing social and psychological needs of refugees. Midwives saw refugees more than nursing and allied healthcare staff combined and this was significant at the rural hospital ( $p<0.001$ ). Rural respondents reported that working with refugees enhanced their practice ( $p=0.025$ ), although felt

significantly less confident ( $p<0.001$ ) than urban respondents. Themes that arose regarding barriers to care included: language and cultural barriers, paucity of knowledge and issues accessing available services including appropriate **interpreters**, Medicare eligibility and patient factors including lack of patient trust in government systems. Desire for support was more pronounced in the rural setting ( $p=0.001$ ).

Conclusions: Refugees were seen frequently in both settings and most respondents requested additional support highlighting that caring for refugees in Australian hospitals is a significant challenge. Additional support and education should be targeted to those helping refugees most frequently, particularly midwifery services, to reduce barriers to care.

**For Articles authors are asked to provide, in addition to an abstract, three short paragraphs answering these questions:**

**1. What is known about the topic?**

Refugees are a vulnerable group often with complex health needs. These needs are often unmet because of issues including language and cultural barriers.

**2. What does this paper add?**

Refugees were seen frequently in the two public hospital settings involved in this study and most often by midwifery services. Healthcare professionals require more support, more information about available services and better access to interpreter services. These issues were more pronounced in the rural setting where very limited research exists.

**3. What are the implications for practitioners?**

Implementing additional support and education regarding refugee health needs could increase knowledge and confidence when managing refugees, reducing barriers to care and improving quality of care.

## **Introduction**

Each year, 13,750 refugees are granted protection in Australia<sup>1</sup>, 30% of whom resettle in NSW<sup>2</sup>. Refugees, by definition, are unable to return to their home country owing to a well-founded fear of persecution<sup>3</sup>. Refugees have frequently encountered torture and trauma, and have interrupted access to health services, poor living conditions and many other factors that impact upon their physical and psychological health<sup>4</sup>. These factors may lead to complex presentations to hospitals and primary care settings<sup>5</sup>. Refugees attempting to access healthcare in Australia face language, cultural and geographical barriers<sup>6</sup> and there is currently no consistent model of healthcare delivery in Australia<sup>4</sup>.

Nursing, midwifery and allied healthcare staff have an important role caring for refugees in the hospital setting. To appropriately serve the refugee population, healthcare professionals should have an adequate understanding of healthcare system arrangements relevant to refugees and feel confident to manage this unique patient group. It has been shown previously that doctors have limited knowledge of services available to assist with refugee care<sup>7</sup> and that serious gaps in refugee patient care exist<sup>8</sup>.

There is limited information regarding attitudes and experiences of nurses, midwives and allied healthcare staff with refugees in Australia<sup>8,9</sup>, particularly in the rural setting. This study explored the views of nurses, midwives and allied healthcare staff in both a rural and an urban hospital setting. These particular research sites were chosen, as both are designated refugee resettlement areas in NSW<sup>10</sup>.

The urban general hospital had 160 beds, situated in Western Sydney with the highest proportion of humanitarian entrants per capita in NSW<sup>11</sup>. The rural referral hospital had 220 beds and approximately 950 refugees residing in this area. Although comparatively small, the refugee population in this area has risen dramatically over the past decade<sup>12</sup>.

This descriptive study aimed to determine the frequency with which nursing, midwifery and allied healthcare staff encounter refugee patients in two public hospitals, how confident they are working with refugees, the effect on their work and any differences between the rural and urban settings. The study also sought the views of healthcare professionals as to improvements that could be made in this area.

## Box 1. Information regarding Humanitarian entrants and Medicare eligibility

### Definitions<sup>3</sup>

- **Refugees** are people who have been forced to flee their homes by conflict or persecution. They are unwilling or unable to avail themselves of the protection of their own government, and must seek protection in another country.
- **An asylum seeker** is a person who has sought protection as a refugee, but whose claim for refugee status has not yet been assessed.
- Every refugee has at some point been an asylum seeker.
- Asylum seekers who are found to be refugees are entitled to international protection and assistance. Those found not to be refugees, nor in need of any other form of international protection, can be sent back to their country of origin.

### Medicare arrangements<sup>10,13</sup>

- All refugees have permanent residency and are Medicare eligible.
- Some asylum seekers have Medicare rights. Others, who are Medicare ineligible, are eligible to obtain assistance under federally funded initiatives e.g. **Asylum Seekers Assistance Scheme (ASAS)**. Some asylum seekers are also excluded from receiving assistance under ASAS.
- In NSW public hospitals, a fee waiver is available for Medicare ineligible asylum seekers for certain health services including emergency care, some elective surgery, some ambulatory and outpatient care, maternity services and mental health services.
- Eligibility can be confirmed through the Medicare inquiry line (132 150).

### Humanitarian Programme<sup>1</sup>

- Refugees are granted protection in Australia through the Humanitarian Programme. The onshore component provides options for people applying for protection after arrival in Australia. The offshore component contains two categories of permanent visas. These are:
- **Refugee:** For people who are subject to persecution in their home country, who are typically outside their home country, and are in need of resettlement. The Refugee category includes the Refugee, In-country Special Humanitarian, Emergency Rescue and Woman at Risk visa subclasses.
- **Special Humanitarian Programme (SHP):** For people outside their home country who are subject to substantial discrimination amounting to gross human rights violations, and immediate family of persons who have been granted protection in Australia. Applications must be supported by a proposer who is an Australian citizen, permanent resident or eligible New Zealand citizen, or an organisation that is based in Australia.

### Interpreter services<sup>14,15</sup>

- Within the Australian public hospital system there is free access to professional interpreters.
- Translating and Interpreting Service (TIS) interpreters can be utilised when the patient is accessing a Medicare rebatable service with a doctor, the staff operating under the doctor's supervision or with pharmacists.

## **Methods**

A questionnaire was developed based on the work of Duncan *et al.*<sup>16</sup> after review of the literature and consultation with healthcare professionals working with refugees. Questions regarding social aspects of healthcare, barriers to care and suggestions for improvement in the system of care were added. Stratified purposeful sampling and opportunistic sampling were used<sup>17</sup> and 150 questionnaires were distributed at each site. Heads of department were contacted prior to distribution of the anonymous questionnaire and participant information sheet. Questionnaires were distributed via unit managers. Although allied healthcare staff differed slightly across sites, those represented included physiotherapy, dietetics, social work, occupational therapy and psychology.

## **Ethics**

Ethics approval was obtained from human research ethics committees (HRECs) of Western Sydney Local Health District, Murrumbidgee Local Health District and The University of Notre Dame Australia.

## **Data analysis**

SPSS (Version 22, IBM Corp., Armonk, NY) was used for analysis at a significance level of  $\alpha=0.05$ . To compare categorical variables between groups chi-square ( $\chi^2$ ) was used or Fisher's exact test (FET) whenever the assumptions of the chi-square were not met. Student's t-test was used to compare continuous variables between groups. Spearman's Rho ( $r_s$ ) and Pearson's  $r$  ( $r$ ) were used for correlations. Responses to some Likert-type questions were dichotomised into two categories (e.g. from very disruptive, disruptive and not disruptive into disruptive and not disruptive) for the purpose of analysis. NVivo (Version 10, QSR International Pty Ltd) software facilitated analysis of open-ended questions.

## Results

Of the 150 questionnaires distributed per hospital, 50% (n=75) and 49% (n=74) were returned at the rural and urban sites, respectively. Demographic characteristics between hospital settings were similar (Table 1). More urban respondents were born overseas [ $\chi^2(1, N=141)=17.343, p<0.001$ ]. More rural staff had <5years clinical experience (40.5% vs. 28.2%;  $\chi^2(1, N=145)=2.455, p=0.117$ ). More urban staff had worked with refugees for >10years ( $p=0.029$ ).

Table 1. Demographic characteristics of all respondents

		<b>Overall n/N (%)</b>	<b>Rural n/N (%)</b>	<b>Urban n/N (%)</b>	<b>p value</b>
<b>Age (years <math>\pm</math>SD)</b>		38.6 $\pm$ 11.9 SD	37.3 $\pm$ 10.9 SD	40.1 $\pm$ 12.8 SD	0.183
<b>Sex</b>	Female	125/149 (83.9)	64/75 (85.3)	61/74 (82.4)	0.630
<b>Supervisor</b>	No	90/140 64.3)	45/74 (60.8)	45/66 (68.2)	0.363
<b>Clinical experience (years)</b>	<1 year	18/145 (12.4)	6/74 (8.1)	12/71 (16.9)	0.108
	1-<5 years	32/145 (22.1)	24/74 (32.4)	8/71 (11.3)	0.002
	5-10 years	31/145 (21.4)	16/74 (21.7)	15/71 (21.1)	0.942
	>10 years	64/145 (44.1)	28/74 (37.8)	36/71 (50.7)	0.119
<b>Place of birth<sup>^</sup></b>	Australia	89/141 (63.1)	58/73 (79.5)	31/68 (45.6)	<0.001
<b>Australian graduate</b>	Yes	121/145 (83.4)	63/74 (85.1)	58/71 (81.7)	0.577
<b>Department</b>	Nursing	77/149 (51.7)	35/75 (46.7)	42/74 (56.8)	0.218
	Midwifery	29/149 (19.4)	19/75 (25.3)	10/74 (13.5)	0.068
	Allied Health	43/149 (28.9)	21/75 (28)	22/74 (29.7)	0.816
<b>Frequency of seeing refugee patients</b>	Daily	7/144 (4.9)	1/75 (1.3)	6/69 (8.7)	0.092*
	Weekly	21/144 (14.5)	6/75 (8)	15/69 (21.7)	0.019
	Monthly	26/144 (18.1)	20/75 (26.7)	6/69 (8.7)	0.005
	Rarely	67/144 (46.5)	38/75 (50.7)	29/69 (42)	0.301
	Never	6/144 (4.2)	3/75 (4)	3/69 (4.4)	>0.999*
	Uncertain	17/144 (11.8)	7/75 (9.3)	10/69 (14.5)	0.338
<b>How long have you worked with refugee patients for?</b>	<1 year	32/134 (23.9)	11/66 (16.7)	21/68 (30.8)	<0.001
	1-<5 years	39/134 29.1)	23/66 (34.8)	16/68 (23.5)	0.149
	5-10 years	39/134 (29.1)	25/66 (37.9)	14/68 (20.6)	0.028
	>10 years	24/134 (17.9)	7/66 (10.6)	17/68 (25)	0.029

n = no. of staff giving each response. N = no. of staff who answered question; \*Fisher's exact test whenever the assumptions of the chi-square were not met; ^Australia vs. Overseas



The average age of nursing and midwifery respondents was 39.8±11.3years and for allied health respondents was 35.6±12.8years. There was a female predominance within allied health respondents. Nursing and midwifery respondents were predominately female (90.6%). Overall, 36.9% of nursing and midwifery respondents were born overseas.

Table 2 outlines the attitudes and experiences of staff caring for refugees at least monthly. In the rural setting, refugees were reported as seen at least monthly by 36% of respondents and 39% in the urban setting. More rural than urban staff reported that working with refugees enhanced their practice [ $\chi^2(1, N=49)=5.024, p=0.025$ ]. Around 40% of respondents in both settings found working with refugees disruptive to their practice [ $\chi^2(1, N=50)=0.333, p=0.564$ ].

Most rural midwife participants (94.1%) saw refugees at least monthly compared to 21.6% of nursing and allied health combined [ $\chi^2(1, N=68)=28.03, p<0.001$ ]. This pattern was similar for urban midwives (77.8% vs. 40%; FET  $p=0.082$ ). There was a positive correlation between frequency of encountering refugees and increasing disruption to practice ( $r_s=0.256, p=0.006$ ). There was also a positive correlation between frequency of seeing refugees and enhancing practice ( $r_s=0.361, p<0.001$ ).

Table 2. Attitudes of staff caring for refugees at least monthly

		Overall n/N (%)	Rural n/N (%)	Urban n/N (%)	p value
<b>Does working with refugees disrupt your practice?</b>	Disruptive	20/50 (40.0)	11/25 (44.0)	9/25 (36.0)	0.564
	Not disruptive	30/50 (60.0)	14/25 (56.0)	16/25 (64.0)	
<b>Does working with refugees enhance your practice?</b>	Enhances	37/49 (75.5)	23/26 (88.5)	14/23 (60.9)	0.025
	Does not enhance	12/49 (24.5)	3/26 (11.5)	9/23 (39.1)	

n = no. of staff giving each response. N = no. of staff who answered question

For all respondents, confidence in general was associated with being born overseas [ $\chi^2(1, N=134)=4.756, p=0.029$ ] but not country of graduation (FET  $p=0.452$ ). Rural respondents were less confident than urban respondents [ $\chi^2(1, N=141)=8.626, p=0.003$ ]

and this remains true for those caring for refugees monthly or more frequently [ $\chi^2(1, N=52)=10.884, p=0.001$ ] (Table 3). Approximately 50% of respondents reported feeling confident managing psychological and social aspects of care. Increasing time worked with refugees was positively correlated with confidence in general ( $r_s=0.418, p<0.001$ ), psychological aspects of care ( $r_s=0.178, p=0.044$ ), and medical/physical concerns ( $r_s=0.209, p=0.018$ ), however, not for social aspects of care ( $r_s=0.173, p=0.053$ ).

Table 3. Confidence levels of staff caring for refugees at least monthly

		<b>Overall n/N (%)</b>	<b>Rural n/N (%)</b>	<b>Urban n/N (%)</b>	<b>p value</b>
<b>Confidence in general</b>	Confident	43/52 (82.7)	17/26 (65.4)	26/26 (100)	0.001
	Not confident	9/52 (17.3)	9/26 (34.6)	0/26 (0)	
<b>Confidence with medical/physical concerns</b>	Confident	46/51 (90.2)	23/24 (95.8)	23/27 (85.2)	0.427*
	Not confident	5/51 (9.8)	1/24 (4.2)	4/27 (14.8)	
<b>Confidence with psychological concerns</b>	Confident	24/51 (47.1)	12/24 (50)	12/27 (45.5)	0.692
	Not confident	27/51 (52.9)	12/24 (50.0)	15/27 (55.5)	
<b>Confidence with social concerns</b>	Confident	29/51 (56.9)	13/24 (54.2)	16/27 (59.3)	0.714
	Not confident	22/51 (43.1)	11/24 (45.8)	11/27 (40.7)	
<b>Confidence with understanding of immigration terminology<sup>#</sup></b>	Confident	46/54 (85.2)	22/27 (81.5)	24/27 (88.9)	0.704*
	Not confident	8/54 (14.8)	5/27 (18.5)	3/27 (11.1)	
<b>Request for more support</b>	Yes	43/51 (84.3)	21/24 (87.5)	22/27 (81.5)	0.844*
	No	8/51 (15.7)	3/24 (12.5)	5/27 (18.5)	

n = no. of staff giving each response. N = no. of staff who answered question; \*Fisher's exact test whenever the assumptions of the chi-square were not met; <sup>#</sup>Immigration terminology: 'refugee', 'asylum seeker' and 'overseas visitor'

More rural staff requested additional support [ $\chi^2(1, N=132)=10.518, p=0.001$ ] (Figure 1). In the rural setting a similar proportion of Australian-born (82.4%) and overseas-

born staff (84.6%) requested more support. However, at the urban hospital, 74.2% of Australian-born staff wanted more support versus 36.7% of overseas-born staff [ $\chi^2(1, N=61)=8.703, p=0.003$ ]. Increasing age was positively correlated with increased confidence in general ( $r=0.206, p=0.020$ ) but not for other domains. Confidence levels in all domains and request for more support were similar between genders. Respondents who reported they were not confident in general requested more support [ $\chi^2(1, N=131)=9.431, p=0.002$ ].

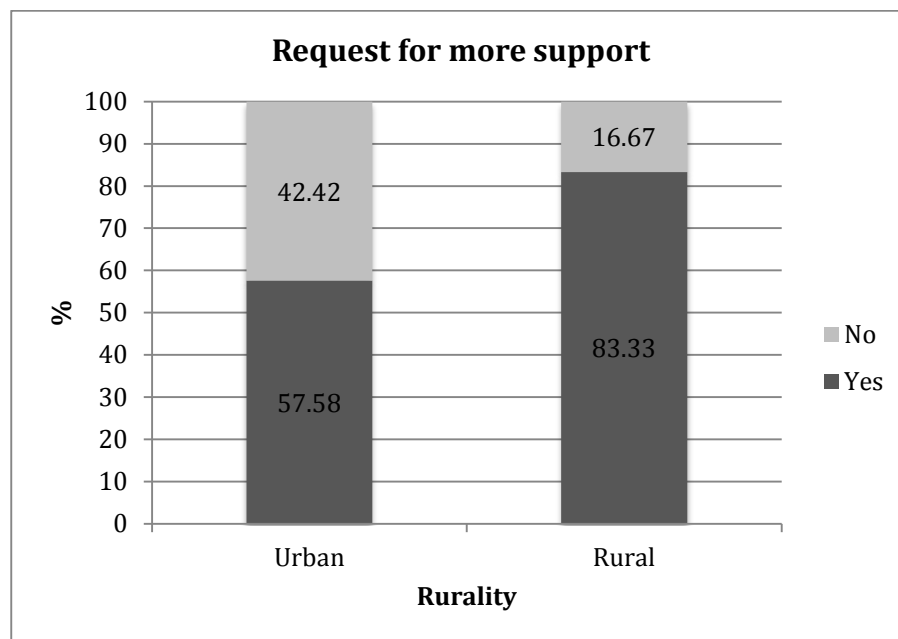


Figure 1. Request for further support when working with refugee patients (all respondents)

Thematic analysis was undertaken and themes that arose regarding barriers to care included language and cultural barriers, paucity of knowledge and issues accessing available services including appropriate interpreters, Medicare eligibility and patient factors including lack of patient trust in government systems.

## **Discussion**

Approximately 40% of the respondents reported at least monthly contact with refugees and over 70% requested additional support, suggesting that managing refugees in the public hospital system is both a considerable issue and a challenge. Western Sydney, with the larger refugee population than in rural NSW, reported similar rates of caring for refugees, perhaps due to greater rural midwifery responses within this study. Ninety-four per cent of rural midwifery participants saw refugees at least monthly compared to 21.6% of nursing and allied health combined. Reproductive healthcare is a priority for refugee women as they have high birth rates and use of birth services<sup>18</sup>. The average age of refugees entering Australia is 22 years<sup>19</sup> and many have frequent contact with midwifery services<sup>18</sup>.

Study respondents from each discipline were similar in age, gender and birthplace to the national workforce<sup>20-22</sup> increasing generalisability and transferability to the national context. The majority of rural respondents were Australian-born (79.5%). This suggests that even though the rural refugee population is smaller than Western Sydney, a patient from a culturally and linguistically diverse background may be more evident in the rural setting compared to the culturally diverse Western Sydney. More staff in the rural setting reported <5 years of clinical experience, supporting the well-documented challenges of retaining staff rurally<sup>23-25</sup>. This results in attrition of healthcare workers with specialised knowledge treating refugees<sup>25</sup>, and an overall more inexperienced workforce.

### **Impact on work**

Of those seeing refugees at least monthly, 75.5% of respondents reported that working with refugees enhanced their practice. The overwhelming message was the altruism in the work. Many responses reported that involvement in refugee healthcare helps to broaden one's understanding, experience and scope of practice and increases cultural awareness. This was more pronounced in the rural setting [ $\chi^2(1, N=49)=5.024, p=0.025$ ]. Working with refugees was reported as disruptive to practice by 40% of staff. In the context of the present study, the researchers wanted to gauge the effect on the working day of the healthcare professionals (eg whether disruptions, such as unforeseen delays, were an issue for respondents). Most reported disruptions were associated with increased demands on the healthcare professionals to meet the particular needs of the

patients, and that aspects of providing appropriate care can be inherently time consuming due to the difficulties outlined below, not due to the patients themselves.

Difficulties identified by participants included “*language barriers*”; a “*lack of trust in government systems and healthcare staff*”; “*cultural differences*” [including discussion of domestic violence and gender roles] and the need to arrange additional services such as interpreters. The present study supports the need for additional services for staff members working with refugees. Other studies also found that, despite some difficult aspects, most staff involved in refugee healthcare reported substantial rewards, enabling a sense of accomplishment and satisfaction with their work<sup>16</sup>.

Although many respondents felt positively about working with refugees, prejudice still existed. One respondent expressed frustration that “*refugees are paid more than veterans in Australia!*” Although this is a quote from only one respondent, when extrapolated to the national context, such attitudes could be problematic, potentially affecting quality of care. Refugees are considered permanent residents and eligible for financial support that is equivalent to, not greater than, that available to Australian citizens<sup>26</sup>.

#### Request for more support

Although many staff reported being confident carrying out their professional role, the majority of respondents requested additional support (Figure 1). This was more pronounced in the rural setting [ $\chi^2(1, N=132)=10.518, p=0.001$ ] where services are limited. Those seeing refugees infrequently also requested support; implying recognition of health service needs to relieve the extra workload associated with rising numbers of refugees. The medical profession recently expressed this concern, as the number of complex cultural cases is rising, placing greater demands on time and resources<sup>27</sup>.

In general, overseas-born staff reported greater confidence than Australian-born staff [ $\chi^2(1, N=134)=4.756, p=0.029$ ]. Personal experiences of the respondents may contribute to greater understanding that facilitated their ability to manage refugees confidently, or, they may have received different education regarding refugee health. In the rural setting a similar proportion of Australian-born (82.4%) and overseas-born

staff (84.6%) requested more support. However, at the urban hospital, 74.2% of Australian-born staff wanted more support versus 36.7% of overseas-born staff [ $\chi^2(1, N=61)=8.703, p=0.003$ ]. This finding suggests that further support for all staff would be welcomed, particularly for Australian-born healthcare staff.

Needs identified by healthcare professionals included multilingual documents regarding health topics and conditions, education surrounding available services, Medicare eligibilities, cultural awareness and patient experiences prior to arrival in Australia. A literature review by Joshi *et al.*<sup>28</sup> found that cross-cultural communication training underpinned the capacity for many healthcare staff to provide appropriate care in conjunction with bilingual healthcare workers and interpreters. In the urban setting, easier access to bilingual healthcare workers and interpreters was reported, which reflected the lower desire for additional support and overall higher confidence. Schulz *et al.*<sup>29</sup> demonstrated that accessing interpreters via videoconference in the rural setting was preferred by doctors and refugees alike over telephone interpreters, and are more readily available than on-site interpreter services. Furthermore, obtaining interpreter services out of hours was reported as challenging in the rural setting, particularly within midwifery. This compounded difficulties in gaining consent for procedures and general patient management. The experiences of women prior to migration including rape, female genital mutilation and other forms of sexual exploitation have major implications for reproductive health needs<sup>18</sup> and make the need for a culturally sensitive care paramount. Of concern, a recent Australian study reported poor access and utilisation of professional interpreters might contribute to adverse perinatal outcomes<sup>8</sup>.

Previous research documents the lack of equitable access to health services, particularly for refugees in rural Australia, due to the low staff numbers and poor retention of healthcare staff, causing a fragile rural health infrastructure<sup>25</sup>. Poor retention of staff is associated with a lack of continued professional development<sup>30</sup>, therefore providing the education identified as needed in this study could impact positively on rural retention rates.

### Medicare eligibility

Not all respondents understood that refugees have full access to Medicare. Confusion was evidenced by comments including “*Medicare eligibility and charging patients*”

and “*not covered under public health costs*” were reported as barriers to care. Furthermore, despite 80% of urban respondents reporting that they were confident with immigration terminology, a lack of knowledge regarding Medicare eligibilities was demonstrated by comments including “*we never see refugees in this department because all patients need to have had an ACAT [aged care assessment team] assessment and therefore have a Medicare card*” were raised. This lack of knowledge may have resulted in an underestimate of the frequency of refugee patient encounter, helping to explain the reported similar rates of encountering refugees between the two settings, despite the refugee population being substantially higher in Western Sydney. Further education is needed to reduce barriers to healthcare and is supported by research identifying that doctors also require further education surrounding Medicare eligibilities<sup>7</sup>.

#### Access to services

Mental health problems are prevalent amongst refugees<sup>31</sup> and 47% of respondents working with refugees at least monthly reported being confident managing psychological aspects of care, mainly by referring to appropriate services when a need is identified. Interestingly, there was a perceived shortage of psychological services in both settings and it was reported that refugees were not accessing the rural community psychology service, located within the hospital. This service, in conjunction with existing services, could be very helpful and suggests that referral pathways can be improved. It may also highlight barriers to obtaining psychological assistance from within the refugee community. Low mental health literacy amongst refugees has been suggested as a contributing factor to not seeking psychological care<sup>31</sup>, warranting further research to assist development of culturally sensitive health promotion and intervention.

Many respondents (50.7%) reported rarely or never seeing refugee patients, implying that refugees are not accessing healthcare services. This has been previously reported and explanations include fear of being judged by the treatment provider, fear of hospitalisation, logistical difficulties and lack of awareness of available services<sup>32</sup>. Community education regarding the Australian healthcare system may assist in reducing such barriers. The treating GP could provide an invaluable medium for education. A Sydney based study found that many refugee families were regularly

accessing GP services but 15 of 34 refugee families interviewed did not know where to seek healthcare in Australia and 7 out of 34 families had not been able to access healthcare when needed<sup>5</sup>. This suggests that some patients know how to successfully access care, while many do not.

Previous literature has reported that up-skilling of hospital staff is necessary in order to improve healthcare provisions to refugees<sup>10,33</sup>. It seems that this is yet to be achieved. The NSW Refugee Health Service offers tailored training for healthcare providers<sup>34</sup>, which could be beneficial at both research sites. While the contributions from the participants in this study will depend on their professional roles, they can support refugees by becoming patient advocates and addressing practical barriers to accessing healthcare<sup>35</sup>. In order to do this effectively, more education is clearly needed surrounding healthcare arrangements that could be beneficial for refugees.

### Limitations

This study has enabled the opinions of a significant number of healthcare workers to be represented. Although the demographics of respondents were consistent with the national workforce data, it was a relatively small, purposeful sample and therefore results may be influenced by the potential for bias and not be representative. A larger study exploring other sites may elicit further needs. This study did not formally stratify allied healthcare staff and future research in this area might better decipher needs of individual healthcare professions.



## **Conclusion and recommendations**

Although confidence levels do not necessarily equate to poorer or better quality of care, there is certainly a perceived gap in confidence and a need for further training and education. This study provides insight into changes that could be implemented to improve the management of refugees in Australian hospitals.

Up-skilling of staff could be achieved by increasing education about refugee and asylum seeker groups during tertiary training, education sessions from The NSW Refugee Health Service and production of practical materials outlining services and supports available. Additional research is required to establish whether refugees feel their health needs are being met and to explore reasons for the relative lack of confidence amongst Australian-born staff and the rural staff compared to the overseas-born and rural staff.

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