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Reconceptualising specialisation: integrating refugee health in primary care

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Abstract. People from a refugee background have significant unmet health needs including complex physical and psycho-social presentations. They can experience low trust, unfamiliarity with the health system and reliance on family and friends to access care. To address these needs, Australia has specialised refugee health services in each state and territory. The majority of these services transition patients to primary care, but this transition, although necessary, is difficult. Most primary care and specialised health professionals share a high degree of commitment to refugee patients; however, despite best efforts, there are gaps. More integrated health services can start to address gaps and promote continuity of care. A previous study has described 10 principles that are associated with successful integration; this paper references five of those principles (continuum of care, patient focus, geographic coverage, information systems and governance) to describe and map out the outcomes of an integrated model of care designed to deliver specialist refugee health in primary care. The Co-location Model is a partnership between a refugee health service, Primary Health Networks, a settlement agency and general practices. It has the potential to deliver benefits for patients, greater satisfaction for health professionals and gains for the health system.

Keywords: delivery of health care: integrated, minority health, organisation: innovation, patient-centred care, primary health care.

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Introduction

This paper describes a model of healthcare integration that is based on a successful partnership between a specialist refugee health nursing service, Primary Health Networks (PHNs), a settlement support agency and 13 general practices. The 10 principles proposed by Suter *et al.* (2009) for successful health system integration have been used as a framework for understanding the success of this model, with a specific focus on five of the principles and how they have been applied to develop a partnership-focussed refugee health model in primary care (Suter *et al.* 2009). The principles of: comprehensive services across the continuum of care, patient focus, geographic coverage, information systems and governance, have guided the integration strategies and processes to achieve some significant patient benefits for humanitarian entrants and greater health professional satisfaction.

Policy and service context

The Australian Refugee and Humanitarian policy is to resettle 18 750 people annually (see https://www.refugeecouncil.org.au/recent-changes-australian-refugee-policy/). It should be noted that although the term 'refugee background' is used to describe people who have refugee-like experiences, the model described in this paper relates only to newly arrived refugees under the Australian Government Humanitarian Settlement Program (HSP) and not asylum seekers. Asylum seekers experience significant barriers associated with their migration journey and Government policy and often rely on charitable organisations for support. By contrast, humanitarian refugees arrive with permanent protection visas and are assisted under the HSP by the Department of Home Affairs contracted settlement services. HSP service providers support clients to achieve outcomes including education, English, employment, physical and mental health and well-being (see https://immi.homeaffairs.gov.au/settling-in-australia/humanitarian-settlement-program). Humanitarian entrants are Medicare eligible and have Centrelink support including Health Care Cards for additional benefits like subsidised medicines and oral health. HSP providers are required to address the health needs of new arrivals, including linkage to a specialist refugee health service or general practice in the first 28 days' post arrival for a comprehensive health assessment. To incentivise primary care, GPs receive targeted funding under the Medicare Benefit Schedule (MBS), to provide a one-off comprehensive refugee health assessment in the first 12 months' post arrival. GPs have access to free interpreting under a government-funded service, TIS National (Translating and Interpreter Service). Although Australia has an impressive investment in refugee resettlement

services, there are complexities in terms of an integrated healthcare response.

In the absence of a national refugee health framework, local responses have been developed. All refugee health services rely on State government funding. In Brisbane, the Mater Refugee Health Service was funded in 2008 by the State Department of Health to facilitate standard initial health assessments, healthcare coordination and linkage to ongoing primary care in a general practice. However, as noted extensively in the literature, there are significant barriers to primary care receiving refugee patients despite primary care being well placed to promote health equity and patient-centred care (World Health Organization (WHO) and United Nations Children's Fund (UNICEF) 2018).

To overcome these barriers and to build connection to local general practices, Mater Refugee Health significantly reshaped its approach. The Mater Integrated Refugee Health Service (MIRHS) now provides specialist nursing support in community-based general practices. This model has improved some key outcomes for patients and has the potential for greater health professional satisfaction and health system improvements.

Review of the literature

Although the health systems and refugee services in other resettlement countries like the UK, Canada and USA differ significantly from Australia, there are benefits in exploring the available local and international literature given underlining common principles.

For example, UK-based Le Feuvre (2001) noted that:

> Two principles should underpin the provision of primary health care to refugees: (a) that refugees should have the same access to quality primary care services as the local population; and (b) any specialist service should have the goal of full integration of the refugee into normal general practice.

Although the principles cited by Le Feuvre (2001) are supported in the literature, there is considerable discussion about how full integration should be achieved.

The literature documents clear evidence that people from a refugee background have significant health needs on arrival (Harris 2018) and note the 'multilayered' barriers to accessing health care including cultural, communication, financial and health literacy challenges (Russell *et al.* 2013; Manchikanti *et al.* 2017; Taylor and Lamaro Haintz 2018).

It has been established that although primary care is well placed to promote high-quality patient-centred care, the complexity of refugee health needs can be difficult to manage comprehensively in this setting (Russell *et al.* 2013).

Robertshaw *et al.* (2017) described challenges in accessing primary health care for refugees across three domains – healthcare encounter (trusting relationship, communication, cultural understanding, health and social conditions, time); healthcare system (training and guidance, professional support, connecting with other services, organisation, resources and capacity); and the asylum and resettlement situation.

Primary care services currently engaged in the delivery of care to people from refugee backgrounds report being isolated as they search for solutions to the complex issues patients present to them (Farley *et al.* 2014).

Specialist refugee health services have been established in Australia to improve the health of humanitarian migrant groups. However, refugees on family sponsored visas receive reduced settlement support and new arrivals may only see a GP in the community who may not be as familiar with refugee health. Furthermore, as noted by Harris (2018), there are systemic integration challenges between general practice and state-funded community health and hospital services. These services are also challenged by the complexity of care needed, the chronicity of health concerns and poor service coordination across different sectors (Joshi *et al.* 2013). There is also concern that failure to address these challenges and effectively link refugees to primary care may lead to lower standards of care and less preventative care (Harding *et al.* 2019).

Improved integration of health services is cited as a strategy to address complexity both in Australia (Kay *et al.* 2010; Zwi *et al.* 2017; Harris 2018) and in the international literature (McMurray *et al.* 2014; Miller *et al.* 2014; Javadi *et al.* 2017). Models to achieve such integration in the refugee health context include implementing a team-based structure (Ghorob and Bodenheimer 2015), recognising and valuing both the formal and informal communication between healthcare providers exemplified by the complex adaptive structure (Gill *et al.* 2017; Phillips *et al.* 2017), facilitation of interdisciplinary care (Lane *et al.* 2017), engaging health system navigators (McMurray *et al.* 2014) and utilising and dispersing specialist expertise through the creation of 'beacon practices' (Kay *et al.* 2010; Kohler *et al.* 2018). Co-location with primary care colleagues had mixed reports to support integration (Bonciani *et al.* 2018). A Canadian study of co-location of community-based services in primary care reported significantly enhanced integration (Isaacs *et al.* 2013). All models grapple with the importance of relationship and communication flow.

There is strong support in the literature for the importance of health service integration, but it is relatively silent about how that is best achieved. The systematic review undertaken by Suter *et al.* (2009) acknowledged a paucity of information relating to evaluations of integration-related initiatives, meaning there is 'little guidance for planners and decision-makers on how to plan and implement integrated health systems'. Suter *et al.* (2009) noted that there is no 'one size fits all' for successful integration, but highlighted 10 principles that were consistently presented as key elements for successful integration in the reviewed literature. These are grouped as follows:

(1) Comprehensive services across the care continuum
(2) Patient focus
(3) Geographic coverage and rostering
(4) Standardised care delivery through inter-professional teams
(5) Performance management
(6) Information systems
(7) Organisational culture and leadership
(8) Physician integration
(9) Governance structure
(10) Financial management.

Practice innovation

Primary care is well placed to enable patient-centred integrated care for this patient population in Australia; however, extra support is required. Humanitarian entrants benefit from a comprehensive health assessment on arrival, but require support to access primary care, receive quality (patient-informed) assessment and coordinated referrals to other health services (e.g. tuberculosis (TB) services, oral health, mental health services). This patient cohort faces additional challenges of language, culture, health literacy and health system knowledge. Theoretically, any general practice should be able to deliver quality care. In reality, there are challenges faced by both patients and clinicians as outlined above. There are also financial risks for practices as the MBS does not adequately remunerate for the amount of time required to address complex needs (Calder *et al.* 2019), particularly when there is no provision within the MBS for the additional time required for consultations with interpreters.

A model of service delivery (the Co-location Model), drawing on the elements of the Best Practice Framework for Australia (Russell *et al.* 2013), has been developed by Mater Refugee Health and is described here. It draws together the key skills and perspectives of several partners including the Mater Refugee Integrated Refugee Health Service (MIRHS), the PHNs, the refugee settlement service and general practices. The partnership draws on the:

- specialist nursing assessment skills of refugee health nurses (employed by MIRHS);
- clinical and psychosocial skills of GPs and accessibility of general practice;
- settlement expertise of the HSP provider (including decisions about where people are to be housed);
- resourcing and coordination by the PHNs;
- capacity-building agenda for primary care services by the PHNs;
- the commitment to operational governance by a partnership between general practices, nursing services and the settlement service.

The outcomes

The principles for successful integration proposed by Suter *et al.* (2009) provide a useful framework for mapping the outcomes of the Co-location Model. The partnership brings together input from a complex web of social services and health services, against a background of particular cultural, historical and political experience. The five most relevant principles proposed by Suter *et al.* (2009) were chosen to map the progress of the model. The provided case study further illustrates the effect of the model on a refugee family's health journey (Box 1).

Comprehensive services across the continuum of care

The MIRHS Co-location Model has been delivering care to newly arrived refugees in Brisbane since 2013. In 2018, MIRHS nurses co-located across 13 general practices and saw 784 patients. On average, patients visited the practice four times in the first 6 months post arrival in Australia. MIRHS nurses delivered 1916 activities in general practice. At the end of 6 months, practices reported up to 98% retention of patients.

MIRHS has implemented a patient tracking sheet in each practice, for the use by MIRHS nurses, in addition to the practice electronic medical record. The tracking sheet is held in a cloud-based application that meets the privacy requirements of the Mater Hospital's Information Privacy, Confidentiality and Information Security Policies. This tracking sheet is updated at each visit by the Mater refugee health nurse and enables continuity of care over the initial 6 months' health journey. The tracking sheet records dates of key indicators identified by MIRHS as being baseline expectations for every patient who has a comprehensive health assessment: date of completion of refugee health assessment, pathology tests, referrals to TB, oral health and completion of catch-up immunisations and other relevant preventative health checks. It is accessible to all MIRHS nurses, meaning that if MIRHS nurses or patients move between practices, the spreadsheet enables continuity of care by providing an at-a-glance means of checking patients' progress against a series of expected clinical interventions, as detailed above. It also facilitates a quality audit of MIRHS to ensure equitable service across different practices.

The engagement of patients with their local primary care practice is established early in the settlement period. With this connection established, patients are well able to access their local general practice for all their future care needs and are supported by a refugee skilled practice team including MIRHS nurses to access tertiary care where required. Patients who experience barriers to accessing care can be linked to social supports, mental health, disability support services and additional settlement support.

Patient focus

The Co-location Model was conceptualised to enable patients easy access to high-quality care in their own neighbourhood. It contrasts with alternative models of centralised specialist refugee health centres, as those models have not been able to demonstrate sustained capacity building of primary care in the place where people live.

The capacity building focus of the model has linked people to a conveniently located medical centre or practices identified by patients, including practices with language concordant doctors, which have been enabled to provide culturally appropriate services. General practices in this partnership:

- engage interpreters as required for all patients with limited English and are TIS (Translating and Interpreting Service) registered
- have access to regular training offered by the partnership that focusses on key issues (clinical, cultural, age-specific) that refugee background patients bring to primary care
- have developed and use effective culturally appropriate reminder and recall systems
- are cognisant of the legal, administrative and logistical complexities of settlement, particularly in the first 6 months after arrival
- are cognisant of the effect of trauma on the psychosocial presentation of patients and clear about the range of community supports available to them.

Box 1. The Kasongo Family: health journey[A]

Lucille Kasongo (42 years) arrived in Australia in April 2019 on a refugee Women at Risk visa. She was accompanied by five dependants aged 2–13 years. Originally from Congo, Lucille and her older children had been living in a refugee camp in Tanzania for the past 7 years. Lucille's two youngest children were born there. Lucille's preferred language is Kiswahili and she has limited English.

Pre-arrival in Australia:

- The settlement agency (SA) referred the Kasongo family to Mater Integrated Refugee Health Service (MIRHS) and provided a unique 'Health Identifier' that enabled MIRHS clinicians to access and review the family's overseas medical checks on a secure Department of Home Affairs portal.
- This information indicated the family had no chronic health concerns but one child (Marie) had had an ear infection before departure.

On arrival in Australia:

- Co-location Model partner representatives (i.e. SA, Primary Health Network (PHN) and MIRHS) met to discuss key issues affecting the family's ability to effectively access healthcare services including accommodation and settlement needs.
- The Kasongo family was linked with a 'refugee friendly GP practice' with a co-located MIRHS nurse, 1 km from their house.
- The MIRHS administration team liaised with this practice and the SA, booking health assessment appointments for each family member. These appointments were booked during the family's third week in Brisbane with consideration of other settlement priorities. MIRHS electronic ally forwarded patient details and clinical files, including language spoken to enable an interpreter to be booked by the practice.
- An additional appointment was made for Marie during her first week in Brisbane for review of her ear symptoms.

Health assessment and ongoing care:

- **First routine appointment:** Lucille and her children attended their local GP practice. The SA provided a cultural support worker to assist in getting to and registering at the practice. Lucille and Marie had met their GP during the appointment to review Marie's ear symptoms. This was the first appointment for the rest of the family. During this appointment they met their treating team including their MIRHS nurse, practice GP and administration staff. A comprehensive refugee health assessment was commenced including nursing and GP consultations, with a focus on building health literacy and trust between the family and their healthcare team. This assessment included migration history, a full medical history, physical examination and relevant investigations including recommended initial screening investigations for people from refugee backgrounds and development of a management plan.
- **Second appointment:** (1 week later) the family were reviewed by their healthcare team, including a discussion of pathology results and ongoing management with their GP. In collaboration with Lucille and her family, the GP and MIRHS nurse developed a longer-term management plan. This plan included management of any ongoing health concerns as well as preventative health activities, including catch-up immunisations, referrals for tuberculosis, hearing and vision screening, dental care, linkage with child and mental health services, and ongoing health literacy and promotion activities. Copies of these plans were offered to Lucille.
- **Subsequent visits:** The family returned for four further visits in their first 6 months, seeing their GP and MIRHS nurse at each appointment. Nursing appointments focused on ensuring preventative health activities including catch up immunisations were completed and that patients were well engaged with services they had been referred to and able to access additional supports as required. This focus was essential to ensuring each component of the management plan was addressed. Throughout this time the team continued to build trust and health literacy critical to long-term patient outcomes. The family attended additional appointments for emerging health needs as required.

Key outcomes:

- Lucille was supported to overcome known challenges in accessing care in the early resettlement period by an integrated framework of support services experienced in navigating the legal, administrative and logistical complexities of this period and the impact of trauma and psycho-social factors on accessing healthcare services
- In the longer term, Lucille was enabled to build a trusting relationship with a geographically accessible general practice that provided culturally appropriate care, where she and her family received comprehensive high-quality care
- Individual partner organisations (MIRHS, SA, PHN and GP practices) worked collaboratively to optimise resources, building knowledge, skills, capacity and understanding across the sector.

[A]Fictional case study drawing on experiences from real patients of the MIRHS service; any resemblance to any individual is purely coincidental.

Geographic accessibility

The geographic settlement location of newly arrived refugee patients is a decision made by the settlement service. The partnership meets regularly to discuss early identification of new locations and subsequently identifies and visits general practices in these areas to assess interest and suitability against the refugee ready checklist (see http://www.refugeehealthnetworkqld.org.au/wp-content/uploads/2016/11/Refugee-Health-Ready-Practice-Checklist-V3.6.pdf, accessed 27 October 2020). Key to the Co-location Model is the practice's capacity to physically accommodate a MIRHS nurse and agree to the governance structure outlined below. The Co-location Model is underpinned by the partnership's well-timed responses to build capacity in practices in emerging settlement suburbs. Responses have included creating one-off 'pop up' practices in refugee settlement areas, providing primary care in the home and monitoring the total number of referrals to any one practice to avoid burn-out.

Information systems

The integration of refugee health in primary care requires timely sharing of patient information between services. The settlement service flags potential arrivals and refers patients to MIRHS to be linked to primary care for a comprehensive health assessment. These referrals are discussed weekly by the partnership to decide a best management plan, including which practice to refer to, based on any pre-arrival health issues, geographic accessibility and any other preferences expressed by settlement services or the patients themselves (e.g. gender and/or language concordance of treating GP, family member attends practice).

MIRHS coordinates, through secure messaging with the practice, transfer of patient information from the pre-arrival medical and any on-arrival health information (home visit assessment). The first appointment is booked by MIRHS and the settlement service arranges cultural support workers to build patients' transport skills to attend the appointment. All subsequent appointments are managed between the practice and patient. To minimise patients missing appointments, the MIRHS nurse provides health literacy support, informs the settlement service of future appointments and, if required, advocates for additional cultural worker support and ensures the practice has arrangements to provide culturally appropriate reminders to patients.

Governance structure

An essential element of governance of the Co-location Model is the principle of partnership. This is borne out through:

- bi-annual policy and advisory group meetings of the senior program officers of the PHN (primary care component), general practice (GPs and practice staff) and Mater Refugee Health (nursing and senior management)
- monthly operational meetings with partners, including the settlement operation team for problem solving, quality assurance and identification of trends.

The clinical governance of the Co-location Model is further embedded in legal Working Together Agreements (WTA) signed between the general practice and MIRHS. The WTA provides clear articulation of the roles and responsibilities of the respective services and employees involved; MIRHS nurses are professionally indemnified by the Mater Hospital, but work under the clinical governance of the GP. The WTAs are unique to each practice and reflect the flexibility of this model, but are underpinned by a commitment to continuous improvement, data sharing and research collaboration. They identify the rate of referral acceptable to the practice, notes particular requirements of that practice and the length of time the agreement will remain in place with consideration to the fluctuations in numbers of arrivals and locations of settlement. The WTA also establishes the MIRHS nurses' adherence to patient confidentiality at the practice and endorses their access to practice software, so that their notes are included in the patient's electronic medical record within the practice.

Conclusion

An assessment of the effectiveness of the Co-Location Model was undertaken by mapping its adherence to the principles proposed by Suter *et al.* (2009) for successful integration. The Co-location Model endorses the assumption that 'primary care is essential to the delivery of high-quality, ongoing care to people of a refugee-like background across the life cycle'. In doing so, it effectively attends to five of the key principles essential to achieve integration articulated by Suter *et al.* (2009):

(1) Comprehensive services across the care continuum
(2) Patient focus
(3) Geographic coverage and rostering
(4) Information systems
(5) Governance structure

Thus, patients have access to a geographically accessible general practice, which also provides culturally appropriate care, takes into account the complexities of settlement for families in the first 6 months' post arrival and establishes relationships conducive to care across the life cycle. The continuity of care offered in the general practice, with a dedicated refugee health nurse, builds trust and opportunities to promote and develop health literacy, which in turn supports good settlement.

Practices in locations of high settlement benefit from the additional support and skills of a co-located refugee health nurse. The partnership approach with PHNs and MIRHS provides an easily accessed one point-of-call for practices. Building both clinical and administrative capacity is essential and underpins sustainable practice utilising the available MBS rebate. It has been established that the initial 6 months' post arrival can be challenging (Au *et al.* 2019) and the additional time the MIRHS nurse is able to provide support in terms of both health system navigation (access) and health literacy (management) is critical to positive patient outcomes in a time-poor general practice context.

There are significant benefits for other culturally and linguistically diverse patients as a result of the Co-location Model, including access to interpreters, culturally appropriate reminder and recall systems, increased integration of psychosocial issues in the health context and cross-culturally skilled clinicians.

Above all, the Co-location Model is overseen by a clearly articulated partnership framework. With its complementary roles, it provides transparency, facilitates problem-solving and system review and enables the 'complex and nimble' responses necessary to meet the changing needs of patients and service providers. The partnership also facilitates a range of non-clinical expertise (such as administrative support) to support the delivery of specialist work within a general practice.

This paper describes a Co-location Model that places a specialist nurse within a generalist health service and the multiple supportive factors that contribute to its effectiveness. We have established that there are significant benefits for patients in terms of completion of health assessments, immunisation and linkage to a geographically convenient practice that engages interpreters or has language concordant health professionals. MIRHS nurses and GPs involved in the model have expressed satisfaction in being able to provide ongoing care to patients. MIRHS nurses who co-locate over several years in the same general practice have noted that seeing families still attending the practice and thriving is professionally rewarding. During the annual or bi-annual practice visits, GPs and practice staff have expressed appreciation not only for the additional in-practice support, but also the information sharing and resources that improve practice efficiency. There is a need to further evaluate the model and, in particular, assess the effect of the partnership in generating sustained health system improvements. Further investigation of the Co-location Model also needs to be undertaken using peer researchers to better understand the qualitative nature of those benefits in the health encounter for both refugee patients and clinicians and to also determine aspects of the model that contribute to sustainability and transferability.

Conflicts of interest

The authors declare no conflicts of interest.

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References

Au M, Anandakumar AD, Preston R, Ray RA, Davis M (2019) A model explaining refugee experiences of the Australian healthcare system: a systematic review of refugee perceptions. *BMC International Health and Human Rights* **19**, 22. doi:10.1186/s12914-019-0206-6

Bonciani M, Schäfer W, Barsanti S, Heinemann S, Groenewegen PP (2018) The benefits of co-location in primary care practices: the perspectives of general practitioners and patients in 34 countries. *BMC Health Services Research* **18**(1), 132. doi:10.1186/s12913-018-2913-4

Calder R, Dunkin R, Rochford C, Nichols T (2019) Australian Health Services: too complex to navigate. A review of the national reviews of Australia's health service arrangements. Australian Health Policy Collaboration (AHPC), Policy Issues Paper No. 1. AHPC, Melbourne, Vic., Australia.

Farley R, Askew D, Kay M (2014) Caring for refugees in general practice: perspectives from the coalface. *Australian Journal of Primary Health* **20**(1), 85–91. doi:10.1071/PY12068

Ghorob A, Bodenheimer T (2015) Building teams in primary care: a practical guide. *Families, Systems & Health* **33**(3), 182–192. doi:10.1037/fsh0000120

Gill G, Stocks N, Powell K, Laurence C, Aylward P, May E (2017) Supports and hindrances to the integration of co-located services in multiple models of primary health care delivery Integration in co-located primary health care services. *International Journal of Integrated Care* **17**(5), A95. doi:10.5334/ijic.3400

Harding C, Seal A, Duncan G, Gilmour A (2019) General practitioner and registrar involvement in refugee health: exploring needs and perceptions. *Australian Health Review* **43**(1), 92–97. doi:10.1071/AH17093

Harris MF (2018) Integration of refugees into routine primary care in NSW, Australia. *Public Health Research & Practice* **28**(1), e2811802. doi:10.17061/phrp2811802

Isaacs S, Valaitis R, Newbold KB, Black M, Sargeant J (2013) Brokering for the primary healthcare needs of recent immigrant families in Atlantic, Canada. *Primary Health Care Research and Development* **14**(1), 63–79. doi:10.1017/S1463423612000229

Javadi D, Langlois EV, Ho S, Friberg P, Tomson G (2017) Intersectoral approaches and integrated services in achieving the right to health for refugees upon resettlement: a scoping review protocol. *BMJ Open* **7**(8), e016638. doi:10.1136/bmjopen-2017-016638

Joshi C, Russell G, Cheng I-H, Kay M, Pottie K, Alston M, Smith M, Chan B, Vasi S, Lo W, Wahidi SS, Harris MF (2013) A narrative synthesis of the impact of primary health care delivery models for refugees in resettlement countries on access, quality and coordination. *International Journal for Equity in Health* **12**(1), 88. doi:10.1186/1475-9276-12-88

Kay M, Jackson C, Nicholson C (2010) Refugee health: a new model for delivering primary health care. *Australian Journal of Primary Health* **16**(1), 98–103. doi:10.1071/PY09048

Kohler G, Holland T, Sharpe A, Irwin M, Sampalli T, MacDonell K, Kidd N, Edwards L, Gibson R, Legate A (2018) The newcomer health clinic in Nova Scotia: a beacon clinic to support the health needs of the refugee population. *International Journal of Health Policy and Management* **7**(12), 1085–1089. doi:10.15171/ijhpm.2018.54

Lane R, Russell G, Bardoel EA, Advocat J, Zwar N, Davies PGP, Harris MF (2017) When colocation is not enough: a case study of General Practitioner Super Clinics in Australia. *Australian Journal of Primary Health* **23**(2), 107–113. doi:10.1071/PY16039

Le Feuvre P (2001) How primary care services can incorporate refugee health care. *Medicine, Conflict, and Survival* **17**(2), 131–136. doi:10.1080/13623690108409567

Manchikanti P, Cheng IH, Advocat J, Russell G (2017) Acceptability of general practice services for Afghan refugees in south-eastern Melbourne. *Australian Journal of Primary Health* **23**(1), 87–91. doi:10.1071/PY16020

McMurray J, Breward K, Breward M, Alder R, Arya N (2014) Integrated primary care improves access to healthcare for newly arrived refugees in Canada. *Journal of Immigrant and Minority Health* **16**(4), 576–585. doi:10.1007/s10903-013-9954-x

Miller BF, Petterson S, Burke BT, Phillips RL, Jr, Green LA (2014) Proximity of providers: colocating behavioral health and primary care and the prospects for an integrated workforce. *The American Psychologist* **69**(4), 443–451. doi:10.1037/a0036093

Phillips C, Hall S, Elmitt N, Bookallil M, Douglas K (2017) People-centred integration in a refugee primary care service: a complex adaptive systems perspective. *Journal of Integrated Care* **25**(1), 26–38. doi:10.1108/JICA-10-2016-0040

Robertshaw L, Dhesi S, Jones LL (2017) Challenges and facilitators for health professionals providing primary healthcare for refugees and asylum seekers in high-income countries: a systematic review and thematic synthesis of qualitative research. *BMJ Open* **7**(8), e015981. doi:10.1136/bmjopen-2017-015981

Russell G, Harris M, Cheng I-H, Kay M, Vasi S, Joshi C, Chan B, Lo W, Wahidi S, Advocat J, Pottie K, Smith M, Furler J (2013) Coordinated primary health care for refugees: a best practice framework for Australia. Southern Academic Primary Care Research Unit, Melbourne, Vic., Australia.

Suter E, Oelke ND, Adair CE, Armitage GD (2009) Ten key principles for successful health systems integration *Healthcare Quarterly* **13**(Sp), 16–23. doi:10.12927/hcq.2009.21092

Taylor J, Lamaro Haintz G (2018) Influence of the social determinants of health on access to healthcare services among refugees in Australia. *Australian Journal of Primary Health* **24**(1), 14–28. doi:10.1071/PY16147

World Health Organization (WHO), United Nations Children's Fund (UNICEF) (2018) A vision for primary health care in the 21st century: towards universal health coverage and the Sustainable Development Goals. WHO/HIS/SDS/2018.X. WHO, Geneva, Switzerland.

Zwi KJ, Woodland L, Kalowski J, Parmeter J (2017) The impact of health perceptions and beliefs on access to care for migrants and refugees. *Journal of Cultural Diversity* **24**(3), 63–72.