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Letter to the Editor

The Refugee Co-Location Model may be useful in addressing refugee barriers to care. What do refugees think?

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Abstract. Co-location of services for refugees may be beneficial in addressing barriers to care. This model of care involves support for a specialist refugee nurse service with general practice, as well as developing partnerships with settlement support agencies and Primary Health Networks. We consider published literature on refugee perceptions of co-location, different models of care, upcoming research and priorities in the area.

Keywords: models of care, service delivery, underserved populations, minority, regional, remote, disparity, multidisciplinary.

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We read with great interest Sackey *et al.*'s (2020) integrated model of healthcare to deliver specialist refugee services in primary healthcare settings, published in Volume 26 Issue 6 of the *Australian Journal of Primary Health*. The Co-location Model, as described by Sackey *et al.* (2020), involves support for a specialist refugee nurse service with general practice, as well as developing partnerships with settlement support agencies and Primary Health Networks (PHNs), to deliver care for refugees. This model of care has been in place for some years in South East Queensland, comparable to other models of care in Victoria, but sparse in regional settings, despite ongoing focus of the Australian Government to resettle refugees in these regions (Department of Social Services 2018). Co-location of services may be a model of care more suited to regional settings than centralised specialist refugee health centres that are readily accessible in metropolitan settings (Milosevic *et al.* 2012).

Co-location of services in primary health is important. It breaks down accessibility barriers, where access to specialist resources dedicated for refugee health, such as on-site interpreting, psychiatry, and counselling, and infectious disease specialists, can all be utilised in a multi-disciplinary setting to enhance communication and continuity of care. Services play important roles in addressing familiarity and promoting information sharing practices for refugees (Au *et al.* 2019), which can be enhanced with co-located services. In addition, access to on-site interpreting may be particularly useful for specialist and allied health services, as they currently do not have free access to the Translating and Interpreting Service, which is only freely available to general practice.

Refugee perceptions of co-location of services have been described in some papers. Cheng *et al.* (2015), Owens *et al.* (2016) and Valibhoy *et al.* (2017) described refugee and settlement worker perceptions, favouring the co-location of different healthcare services to avoid the necessity of multiple trips, difficulty with transport and navigating the healthcare system. McBride *et al.* (2017) described the Monash Health Refugee Health and Wellbeing Service Model (MHRHW), comprising of primary health care, co-located specialist tertiary services, refugee health nurses, allied health and capacity-building secondary consultation staff. Users of the service regarded the ability to attend multiple services at the one site as an important benefit. We wonder how these models of co-location differ between states, how they adapt to specific contexts and how outcomes might differ.

We believe the success of the Co-location Model will rely strongly on the commitment of general practitioners and PHNs to refugee health. Presently, there is no nationally coordinated policy on refugee health. Addressing refugee health has largely been left to responsibilities of the states and community interventions. However, the role of government would be to promote, coordinate, and incentivise this commitment to refugee health. Refugee health nurses, community health workers, PHNs and settlement organisations can also play significant roles in building capacity of service organisations that are committed to refugee health (Timlin *et al.* 2020; Wei *et al.* 2021). A recently published pragmatic stepped-wedge cluster randomised trial, the OPTIMISE study, demonstrated modest increases in the proportion of 14 633 refugee patients undergoing comprehensive health assessment from 31 general practices in metropolitan Sydney and Melbourne. Facilitators from local health services worked with private practice teams to improve the organisation and delivery of services to refugees. This model of capacity

building through outreach facilitation in primary health settings is an interesting framework and may be applicable in regional or remote settings where permanent co-location may be more challenging to implement. However, more information is needed on whether longer-term or more intensified partnerships would have greater impacts (Russell *et al.* 2021). Service provider barriers to delivery of refugee healthcare have been well described in the literature and will need to be addressed, such as issues of renumeration, interpreting and training support (Johnson *et al.* 2008; Farley *et al.* 2014; Harding *et al.* 2019).

Indeed, any model of care will need to adapt to regional contexts with different refugee profiles. Adapting to the language and cultural needs of different refugee communities requires careful consideration. Fostering partnerships between organisations and private practices will require time. Local barriers will also need to be addressed.

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Data availability statement

Data sharing is not applicable as no new data were generated or analysed during this study.

Conflicts of interest

Robyn Preston is an Associate Editor with the *Australian Journal of Primary Health*. The authors declare no other conflicts of interest.

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