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**Review**

# How can healthcare professionals address poor health service utilisation among refugees after resettlement in Australia? A narrative systematic review of recent evidence

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**Abstract.** This systematic narrative review of qualitative studies examined health service barriers and facilitators in Australia for refugees after resettlement. Twelve qualitative studies published between 2006 and 2017 involving more than 500 participants were included in the review. Approximately half of all participants were healthcare professionals. A meta-synthesis approach was used to compare and combine findings from across studies. Few facilitators were identified. Barriers to accessing health services were commonly attributed to refugees, but several barriers were associated with healthcare professionals and health services. Barriers attributed to healthcare professionals included gaps in knowledge and skills; poor cultural competency; poor communication skills; and time constraints. Understanding such barriers is the first step in developing strategies to overcome them. The skills and knowledge of healthcare professionals are important to facilitating access to healthcare among this vulnerable population.

**Additional keywords:** access to healthcare, asylum seeker, health-seeking behaviour, service access.

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## Introduction

As a signatory of the 1951 Refugee Convention, Australia is one of 26 countries participating in the United Nations High Commissioner for Refugees (UNHCR) resettlement program (Koser 2015) taking ~14 000 refugees every year under its Humanitarian Program with additional special provision places (Department of Immigration and Border Protection 2017). Under this resettlement program, ~83 000 people have settled in Australia over the last 5 years (Department of Home Affairs 2019). Nationalities making up the program vary over time, but several countries appear consistently in recent years (Department of Immigration and Border Protection 2017). Australia has taken an extra 12 000 Syrian refugees since 2013 (United Nations High Commissioner for Refugees 2016).

Large resettlement numbers within short time periods can create particular challenges for health service providers unfamiliar with the particular physical and psychological stresses refugees face. Resettlement can also bring new difficulties in accessing services for refugees (Morris *et al*. 2009; Shawyer *et al*. 2017). In Australia, despite high levels of satisfaction with the quality of healthcare services available among refugees, many families experience difficulties in accessing timely services (Cheng *et al*. 2015*a*; Szajna and Ward 2015).

A recent overview of nine systematic reviews (Parajuli and Horey 2019), including more than 200 published articles, looked at global barriers and facilitators to health service use by refugees after resettlement. Three broad barriers were identified: those relating to refugees; those relating to health services; and those relating to the context of resettlement. Common refugee-related barriers were language; cultural and health beliefs; low literacy; refugee experiences; financial constraints; employment and physical health issues (O'Mahony and Donnelly 2010; Colucci *et al*. 2014; Hadgkiss and Renzaho 2014; Bellamy *et al*. 2015; Cheng *et al*. 2015*a*; Szajna and Ward 2015; Hoffman and Robertson 2016; Robertshaw *et al*. 2017; Taylor and Lamaro Haintz 2018). Health service-related barriers included lack of cultural competency; lack of knowledge about refugee health issues; difficulties working with interpreters; and time constraints (Szajna and Ward 2015; Robertshaw *et al*. 2017). Barriers in the context of resettlement included the type of health system and its flexibility; the location of services; and transport accessibility. Fewer facilitators were identified. Facilitators included continuity of care; contextualising needs; healthcare professional attitudes; and providing information about the roles of healthcare professionals (O'Mahony and Donnelly 2010; Colucci *et al*. 2014).

The nine systematic reviews included in the overview incorporated studies from developed countries with different health systems.

**What is known about the topic?**

- Barriers to accessing health care by refugees are commonly attributed to refugees themselves.

**What does this paper add?**

- Barriers related to healthcare professionals and health services that can be attributed to poor accessibility of health services by refugees were common across different studies and refugee populations.

The main aim of this narrative review was to examine Australian studies to identify any barriers and facilitators affecting the health service use of refugees in Australia. A secondary aim was to consider how healthcare professionals could address poor health service utilisation among refugees after resettlement in Australia.

## Methods

A systematic narrative review of qualitative studies, or qualitative meta-synthesis, involves a systematic approach to synthesising findings from qualitative research and using an analytical process where findings of included studies are aggregated and interpreted as a whole (Hsieh and Shannon 2005). There are four stages: searching, screening, data extraction and analysis (Moher *et al*. 2010).

The search strategy was devised with the help of a senior university librarian and the use of the STARLITE approach, a standard for reporting literature searches (Booth 2006; Table 1).

Seven electronic databases were searched for studies published in English between 2006 and 2017. The 10-year limit was to ensure that studies reflected contemporary refugee policy in Australia. The searches were conducted twice (1 July 2017 and 21 December 2017), with search results imported into EndNote (EndNote X8, Clarivate Analytics, Philadelphia, PA, USA) and duplicates removed. Titles and abstracts were screened for potential inclusion, and full-text articles identified for retrieval. The inclusion criteria were applied independently by two authors, with discrepancies resolved by discussion. Reference lists of included articles were scanned, and Google Scholar used to identify forward citations of included papers.

The Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) guidelines were followed to enhance transparency (Moher *et al*. 2010). The following data were extracted and tabulated: study name and year of publication; objectives; study population; data collection method; data analysis; and key findings, including any concepts, themes or metaphors that could be deemed barriers or facilitators to healthcare access (Pace *et al*. 2012). Directed content analysis was used to categorise findings as either health service barriers, refugee barriers or health service use facilitators.

Methodological quality assessment of all eligible studies was performed independently by two reviewers using the Mixed-Methods Appraisal Tool (MMAT) (Pace *et al*. 2012). Studies were assessed to be: low-average (25% of MMAT criteria met); average (50%); good (75%); or high quality (100%). Differences were resolved by discussion.

## Results

The search strategy resulted in 297 potentially relevant titles. After duplicates were removed, 132 records were screened and 75 full-text articles retrieved and assessed for inclusion. Of these, 12 original articles met the inclusion criteria (Fig. 1). No study was discarded as the result of quality appraisal outcome.

The key characteristics of the included studies are shown in Table 2. Six studies were judged to be high quality, four good, one average and one low quality. The studies covered a range of health areas: three studies involved mental health (Gifford *et al*. 2007; Yelland *et al*. 2014; Colucci *et al*. 2015) and two studies each looked at each of the following areas: general practice (Cheng *et al*. 2015*b*; Jiwrajka *et al*. 2017), primary health (Omeri *et al*. 2006; Clark *et al*. 2014) and pharmacy (Kay *et al*. 2016; Bellamy *et al*. 2017). The remaining studies focussed on

**Table 1. STARLITE approach applied to reporting of the literature search**

| | |
|---|---|
| S: Sampling strategy | *Comprehensive*: attempts to identify all relevant studies on the topic |
| T: Type of studies | Qualitative studies and mixed-method studies where qualitative data could be extracted |
| A: Approaches | Seven electronic databases; hand searching (reference lists and forward citations) |
| R: Range of years (start date–end date) | 2006–17 |
| L: Limits | English language, human |
| I: Inclusion and exclusions | Inclusion<br>• Refugee and/or asylum seeker population<br>• Related to health service use, access or service provision<br>• Australia is the country of resettlement<br>Exclusion<br>• Study did not identify barriers<br>• No empirical data<br>• Studies outside of Australia |
| T: Terms used | • Refugee*, refugee women, Asylum seekers* and health seeking behaviour*, service use, access to health services, health service utilisation, access to care, Australia, high income countries* |
| E: Electronic sources | Medline, Cinahl, Psycho-Info, ProQuest Central, ProQuest Social Science and Google Scholar |

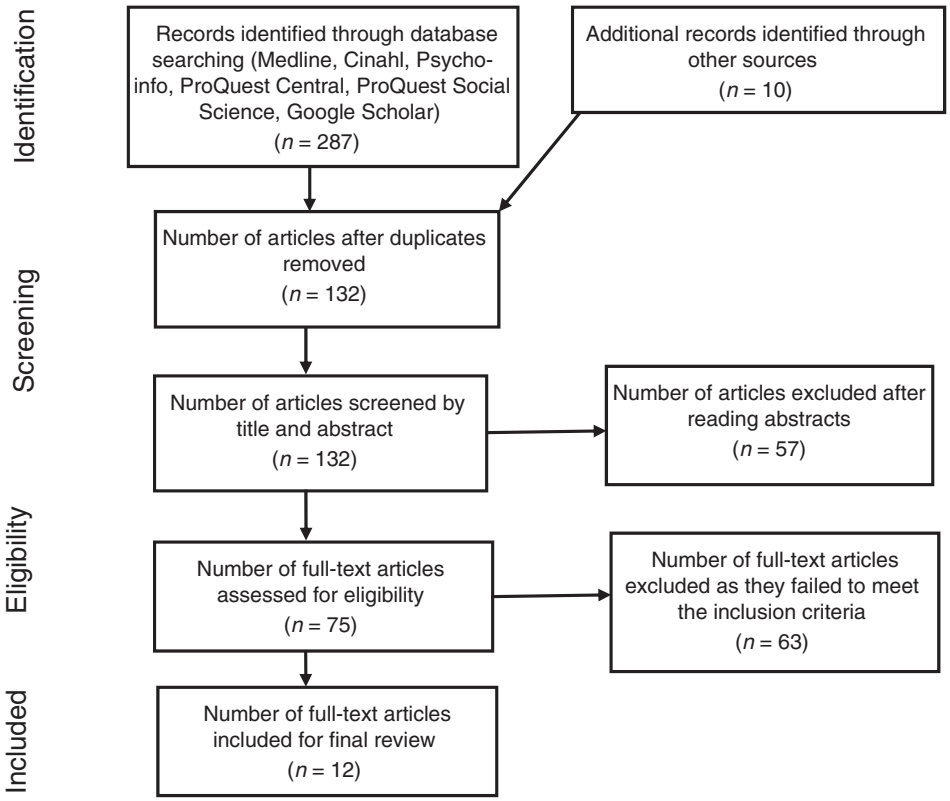


**Fig. 1.** PRISMA flow diagram of search result and studies selection.

maternal and child health (Riggs *et al*. 2012*a*), immunisation (Mahimbo *et al*. 2017) and rural health (Sypek *et al*. 2008).

Study participants were not always well described, particularly the type of health worker. More than 500 participants were involved across the 12 studies, including at least 246 health workers and at least 325 refugees.

The most common method of data collection was interviews (seven studies) and focus groups (six studies). One study supplemented interview data with field observations, and three studies collected data in multiple ways (Omeri *et al*. 2006; Cheng *et al*. 2015*b*; Colucci *et al*. 2015). One study, described as a case study, did not report how data were collected.

### *Key findings*

More barriers to health service use were identified than those things that facilitated access to health care for refugees after resettlement. Barriers identified by most studies related to gaps in knowledge and skills. Specifically, lack of cultural knowledge, poor cultural competency and poor communication skills were raised. Health service barriers were largely focussed on time constraints, but a range of service constraints and access issues were identified, including inconsistency in the use of interpreters, lack of professional experience with traumatised patients, lack of training in managing complex cases and lack of coordinated approaches to ensure continuity of care.

The issue of poor cultural understanding or cultural competency was raised in all included studies and was seen to limit the ability of healthcare professionals to offer culturally appropriate services (Omeri *et al*. 2006; Gifford *et al*. 2007; Sypek *et al*. 2008; Riggs *et al*. 2012*a*; Clark *et al*. 2014; Yelland *et al*. 2014; Cheng *et al*. 2015*b*; Colucci *et al*. 2015; Kay *et al*. 2016; Bellamy *et al*. 2017; Jiwrajka *et al*. 2017; Mahimbo *et al*. 2017), but several studies described cultural misunderstandings among both refugees and healthcare professionals (Gifford *et al*. 2007; Sypek *et al*. 2008; Riggs *et al*. 2012*a*; Yelland *et al*. 2014; Cheng *et al*. 2015*b*; Colucci *et al*. 2015; Kay *et al*. 2016; Bellamy *et al*. 2017; Jiwrajka *et al*. 2017).

Low or poor cultural competency raised several issues. One study directly linked poor understanding of refugees' backgrounds and cultural beliefs to reducing trust (Jiwrajka *et al*. 2017). Several studies included in this review discussed how health service utilisation by refugees was directly or indirectly associated with trust (Omeri *et al*. 2006; Gifford *et al*. 2007; Sypek *et al*. 2008; Clark *et al*. 2014; Jiwrajka *et al*. 2017). For example, a rural study involving interviews with a mix of refugees, healthcare professionals and volunteers found a belief among refugees that doctors were only for very sick people. This cultural misunderstanding had not been addressed and refugees had stopped seeking care (Sypek *et al*. 2008).

Refugees new to Australia have high expectations of doctors, including beliefs that doctors will be familiar with their experiences and cultural beliefs (Sypek *et al*. 2008; Bellamy *et al*. 2017; Mahimbo *et al*. 2017), but several mismatches in cultural expectations around healthcare were evident in preventative and mental healthcare (Omeri *et al*. 2006; Gifford *et al*. 2007;

**Table 2. Key characteristics of the included studies, including health access barriers and facilitators**
MMAT, Mixed-Methods Appraisal Tool

| Reference | Aim | Study population [Data collection method and data analysis] | Findings | | | Quality rating (MMAT)[A] |
|---|---|---|---|---|---|---|
| | | | Barriers – health services | Barriers – refugees | Facilitators | |
| Bellamy 2017 | To explore the barriers to accessing medicines and pharmacy services among refugees in Queensland, Australia, from the perspectives of resettled African refugees. | 16 refugees from different African countries<br>[Focus group discussion with thematic analysis] | • Gap between resettled refugees' expectations of health services and reality of the Australian health system<br>• Location of services not easy to access by public transport<br>• Healthcare professionals lack awareness of translating and interpreter services<br>• Minimal interactive communication<br>• Perceptions that physical health problems led to discrimination from healthcare professionals<br>• Lack of awareness of culture and refugee experiences | • Language barriers<br>• Poor access to translating and interpreter services<br>• Cultural beliefs affecting healthcare-seeking behaviour<br>• Poor understanding of differences in health systems in Australian and country of origin<br>• Preference for traditional medicine<br>• Negative perceptions of doctors<br>• Preference for healthcare professional of same gender | None reported | **** |
| Clark *et al*. 2014 | To identify the barriers to accessing primary healthcare services and explore medicine-related issues as experienced by refugee women in South Australia | 38 refugee women from six countries (Sudan, Burundi, Congo, Burma, Afghanistan, Bhutan) and healthcare providers and experts (number not reported)<br>[Focus groups with framework analysis] | • Interpreter services were used inconsistently or not at all<br>• Lack of information about local health services<br>• Support staff not aware of locally available services including those that initiate use of interpreters or bulk bill<br>• Long waiting times<br>• Service location and distance | • Not being able to speak or comprehend English<br>• Many refugee women had little or no education and not literate in own languages<br>• Very low previous exposure to urban centres<br>• Could not understand concept of western medicine and health beliefs | • Educate and support to GPs<br>• Remunerate and incentivise GP clinics<br>Health literacy education for refugees<br>• Register all GP clinics and pharmacies with translating agencies | *** |
| Cheng 2015*b* | To undertake in-depth investigation of factors influencing refugees' access to general practice services in urban general practice in Australia | Six health workers, five settlement workers and six Afghan refugees<br>Total participants 17<br>[Field observations and semi-structured interviews] | • Interpreters used infrequently<br>• Cultural response of not taking health issues seriously<br>• Long waiting times (average 45 min)<br>• Poor access to public transport for service<br>• High staff turnover | • Difficulty in making appointments over telephone due to language difficulties<br>• Written language not understood including appointment cards, forms or SMS reminder message<br>• Not being familiar with area and location<br>• Transport issues – especially for Afghan women | • Co-location of general practice, pathology, pharmacy and counselling services<br>• Coordinate appointment times with regard to transport needs | *** |

| | | | | | | |
|---|---|---|---|---|---|---|
| Colucci *et al.* 2015 | To explore perspectives of service providers on barriers and facilitators to engaging young people from refugee backgrounds with mental health services | 115 service providers from various agencies and five key informants<br>[Focus group discussion and key informant interviews with thematic analysis] | • No after-hours services.<br>• Service intake restrictions e.g. age<br>• Lack of activity-based programs<br>• Ineffective reminder systems<br>• Service providers overloaded<br>• High staff turnover<br>• Lack of cultural competency | • Differences in time and other concepts (including location and transport)<br>• Trust issue – fear of authority<br>• Different concepts of mental health illness and treatment<br>• Service details not known<br>• Focusing on bad past experience | • Simplified referral process<br>• Flexible appointment systems<br>• Drop-in and outreach services<br>• Key workers | **** |
| Gifford 2007 | To identify the psychosocial factors that assist refugee young people to make a good start in their new country; and to describe processes that support, enhance and facilitate settlement and wellbeing | 100 newly arrived refugee young people.<br>Total participants 100<br>[Longitudinal ethnography study, used mixed methods] | • Unable to establish trust<br>• Lack of understanding of refugee culture<br>• Lack of cultural competent services<br>• Service location and transport and distance not coordinated | • Bad past refugee experiences<br>• No vision of a future self among young people<br>• Language and low socio-economic status<br>• Feeling helpless or hopeless about future<br>• Lack of social interaction and connection | • Build positive self-identity and self-esteem<br>• Provide social support and social connections | *** |
| Jiwrajka *et al.* 2017 | To explore language differences as a barrier to health care and its near-fatal consequences, as well as communication breakdown in the context of the misalignment of health goals between the patient and the profession | 1 Rohingya refugee<br>[Case study. method of analysis not described] | • Doctors not adequately trained to use interpreters<br>• Lack of cultural competency among healthcare providers and services<br>• Discordance between patient and physician's goals of treatment<br>• Service location and transport and distance not coordinated<br>• Untrained workers | • Language difference is a barrier in accessing health care in Australia<br>• Low socioeconomic status and high chronic disease burden<br>• Uncertain about migration<br>• Low health literacy<br>• Traditional health beliefs | • Inclusion of cultural, religious, language and social issues in patient history taking | ** |
| Kay *et al.* 2016 | To explore barriers and facilitators to quality use of medicines in the primary healthcare setting | Nine primary healthcare providers (two GPs, three practice nurses, four pharmacists) and three refugee health leaders<br>Total participants 12<br>[Semi-structured interviews with thematic analysis] | • Lack of understanding regarding refugee issues<br>• Interpreters not used adequately<br>• Service cost<br>• Lack of inter service coordination and communication<br>• Poor transport links | • Communication and language barriers<br>• Limited health literacy<br>• Financial cost<br>• Types of physical health problems<br>• Lack of trust | • Better coordination between healthcare providers<br>• Improve healthcare provider training<br>• Improve engagement between pharmacists and refugees | **** |
| Mahimbo *et al.* 2017 | To explore challenges in the provision of immunisation services to newly arrived refugees among key stakeholders to improve vaccine coverage | 30 immunisation providers<br>[In-depth interviews] | • Variability in accessing program funding<br>• Lack of national policy for catch-up immunisation for refugees<br>• Unclear roles and responsibilities for catch-up immunisation<br>• Lack of central immunisation register for older children and adults<br>• Insufficient training among GPs<br>• Lack of cultural competence | None reported | • Guidance for GPs on refugee catch-up vaccinations | *** |

*(continued next page)*

**Table 2.** (*continued*)

| Reference | Aim | Study population [Data collection method and data analysis] | Findings<br>Barriers – health services | Barriers – refugees | Facilitators | Quality rating (MMAT)[A] |
|---|---|---|---|---|---|---|
| Omeri *et al*. 2006 | To explore and describe health and related resettlement issues and barriers faced by Afghan refugees in New South Wales | 61 Afghan community and health service providers<br>[Focus groups and key informant interviews] | • Lack of information about services<br>• Costs of travel<br>• Long waiting times for appointments<br>• Inaccessibility to services because of distance<br>• Lack of health-related information<br>• Lack of cultural competency | • Feelings of alienation<br>• Lack of familiarity with health services<br>• Cultural differences and stigma<br>• Changes to roles and gender issue<br>• Language barriers to accessing health services<br>• No recognition of qualifications | • Implement drop-in centre to address emotional health- and settlement-related issues | **** |
| Riggs 2012*a* | To explore experiences of using Maternal and Child Health (MCH) services from the perspectives of refugee families and service providers | 87 mothers from seven countries (Karen, Iraq, Assyria Chaldea, Lebanon, South Sudan and Bhutan) and 18 service providers<br>Total participants 105<br>[Focus group discussion and in-depth interview with thematic analysis] | • Transport difficulties<br>• Language challenges working with interpreters<br>• Cultural differences<br>• Time constraints<br>• Lack of community engagement | • Lack of awareness of available services<br>• Cultural differences<br>• Lack of trust | • Community engagement,<br>• Central telephone line for MCH service,<br>• Provision of reminders and access to translated information,<br>• Use of bilingual staff<br>• More home visits<br>• Co-located services | **** |
| Sypek *et al*. 2008 | To explore reported effect of regional resettlement of refugees on rural health services, to identify critical health infrastructure gaps for refugee resettlement | Five refugees, five GPs and practice managers and 12 volunteer support workers<br>Total participants 24<br>[Case studies, interview and situational description with thematic and descriptive analysis] | • Low healthcare practitioner numbers and high turnover of healthcare staff<br>• Lack of subsidised health services<br>• Lack of funding to specialist services<br>• Lack of coordination of early settlement<br>• Underutilisation of interpreting services<br>• Problem with transport | • Mismatch in expectations of health service delivery<br>• Communication difficulties due to language and culture<br>• Financial constraints<br>• Unfamiliarity with Australian healthcare system | • Altruism among volunteer networks | *** |
| Yelland *et al*. 2014 | To explore responsiveness of health services to the social and mental health of Afghan women and men with new babies | 30 Afghan refugees (16 women) and 34 health providers<br>Total participants 64<br>[Interviews and focus groups discussion with thematic analysis] | • Short appointment times<br>• No questions about refugee background<br>• No response to non-clinical needs<br>• Lack of access to interpreters when needed<br>• Lack of capacity to identify families with a refugee background and tailor services to needs | • Limited understanding of context of migration<br>• Dependency of Afghan women on husbands for appointments<br>• Poor access to interpreter services<br>• Different healthcare professionals at each antenatal visit<br>• Financial hardship | • Refugee status identification from the beginning of care<br>• Continuity of care | **** |

[A]Quality rating: * = low-average (25% MMAT criteria met); ** = average (50%); *** = good (75%); **** = high quality (100%).

Sypek *et al*. 2008; Colucci *et al*. 2015; Mahimbo *et al*. 2017). These mismatches were largely differences in understandings or beliefs about disease and healthcare and assumptions about cultural awareness.

Poor knowledge of refugee health and/or culture among healthcare professionals was raised in several studies as a negative influence on appropriate service provision (Riggs *et al*. 2012*a*; Clark *et al*. 2014; Yelland *et al*. 2014; Colucci *et al*. 2015; Kay *et al*. 2016; Jiwrajka *et al*. 2017). In some studies, refugees reported embarrassment, shame or fear of being judged by others, including the healthcare professionals providing their care. There was fear of diagnosis with infectious disease, which was associated with concerns about the implications for family relationships, employment and the effect on acceptance of residency applications (Clark *et al*. 2014; Bellamy *et al*. 2017; Jiwrajka *et al*. 2017). Refugees were reported to rarely raise sensitive health issues such as sexual abuse, family violence, alcohol or substance abuse, or mental health problems with their care providers (Sypek *et al*. 2008; Clark *et al*. 2014; Colucci *et al*. 2015). One study suggested refugees' concerns about raising sensitive issues could be overcome by ensuring continuity of care and the use of follow-up consultations (Clark *et al*. 2014) but there were also concerns expressed that lack of resources and lack of confidence may cause some healthcare professionals to avoid refugees as clients (Clark *et al*. 2014; Jiwrajka *et al*. 2017).

Communication difficulties between healthcare professionals and refugees were widely recognised and various; consistent reasons for this were reported (Omeri *et al*. 2006; Sypek *et al*. 2008; Riggs *et al*. 2012*a*; Clark *et al*. 2014; Yelland *et al*. 2014; Cheng *et al*. 2015*b*; Colucci *et al*. 2015; Kay *et al*. 2016; Bellamy *et al*. 2017; Jiwrajka *et al*. 2017; Mahimbo *et al*. 2017). Problems with language differences continue to exist despite the national Translating and Interpreting Service (TIS), which provides free access for GPs in Australia. Several studies pointed to inconsistent use of this service among healthcare professionals (Omeri *et al*. 2006; Gifford *et al*. 2007; Sypek *et al*. 2008; Riggs *et al*. 2012*a*; Clark *et al*. 2014; Yelland *et al*. 2014; Colucci *et al*. 2015; Kay *et al*. 2016; Jiwrajka *et al*. 2017). The main reasons given were lack of prior awareness that a refugee would be attending and consultation times too short to facilitate interpreter use (Riggs *et al*. 2012*a*; Clark *et al*. 2014; Jiwrajka *et al*. 2017).

Service constraints affecting health service use were often interrelated and included transport, location of services, hours of service, waiting times, appointment availability, unavailability or inadequate supply of interpreters, high staff turnover and failure to follow up or attend appointments (Omeri *et al*. 2006; Riggs *et al*. 2012*a*; Clark *et al*. 2014; Cheng *et al*. 2015*b*; Colucci *et al*. 2015; Kay *et al*. 2016; Bellamy *et al*. 2017; Jiwrajka *et al*. 2017; Mahimbo *et al*. 2017). Failure to attend was frequently associated with poor reminder and support services (Omeri *et al*. 2006; Sypek *et al*. 2008; Riggs *et al*. 2012*a*; Clark *et al*. 2014; Yelland *et al*. 2014; Colucci *et al*. 2015; Jiwrajka *et al*. 2017; Mahimbo *et al*. 2017). Such factors adversely affected continuity of care.

Time constraints were raised in the majority of the studies, and related to interpreter use and insufficient time to listen to refugee stories (Gifford *et al*. 2007; Sypek *et al*. 2008; Riggs *et al*. 2012*a*; Clark *et al*. 2014; Cheng *et al*. 2015*b*; Colucci *et al*. 2015; Bellamy *et al*. 2017; Jiwrajka *et al*. 2017).

Few facilitators to health service access or utilisation were reported and when they were, these were assumed to be beneficial, without any evaluation occurring. Several unevaluated strategies were recommended including: a simplified referral process, flexible appointment systems and drop-in services (Colucci *et al*. 2015); involvement of social supports and networks, the inclusion of cultural, religious and language in history taking (Jiwrajka *et al*. 2017); training for healthcare professionals (Kay *et al*. 2016); and community engagement programs (Riggs *et al*. 2012*a*).

## Discussion

This meta-synthesis provides an overview of contemporary barriers and facilitators to health service access for refugees after resettlement in Australia. Barriers were consistent across a range of different types of health services. A common theme was poor cultural understanding between refugees and healthcare professionals, which was seen to inhibit trust. Lack of trust also inhibits refugees reporting of sensitive, yet important issues. This is important as lack of trust appeared to play a significant role in hindering refugees' access to appropriate and timely health care.

A mismatch in expectations between refugee clients and care providers was common, adding to other challenges (Sypek *et al*. 2008; Morris *et al*. 2009; Riggs *et al*. 2012*b*; Clark *et al*. 2014; Cheng *et al*. 2015*b*; Kay *et al*. 2016; Bellamy *et al*. 2017). The high quality of health services available in Australia impresses refugees (Taylor and Lamaro Haintz 2018); however, it also creates high expectations, particularly with medical doctors. Such expectations can be unrealistic in the Australian context; for example, some refugees assume that doctors will know how to identify and treat all exotic or rare health conditions common in their home country (Tiong *et al*. 2006; Johnston *et al*. 2012). When expectations are not met, disillusionment can follow (Khan and Amatya 2017). Refugees need explanations when this occurs, and to know how the health system will provide care for them. Healthcare professionals need to explain the processes involved in healthcare: diagnosis, treatment and how health services work, including referrals and investigations. Care plans for refugees could involve more than treatment and address social and practical issues. This can be valuable for long-term care and could help develop trust and facilitate continuity of care. When trust is lost, and when refugees don't know how to seek further care, more health problems are created (Pavlish *et al*. 2010; Fleischman *et al*. 2015).

Communication difficulties remain a significant issue for health care access among refugees (Gifford *et al*. 2007; Sypek *et al*. 2008; Correa-Velez and Ryan 2012; Clark *et al*. 2014; Colucci *et al*. 2015; Jiwrajka *et al*. 2017). A couple of potential solutions were suggested. Greater involvement of bilingual co-workers or nurses was beneficial in mental healthcare (Raval 2006), and may have a role in other areas of healthcare. More consistent use of interpreters could be achieved by better flagging of individual patient needs in appointment systems, which enable interpreter service bookings to coincide with refugee appointments (Gifford *et al*. 2007; Sypek *et al*. 2008; Correa-Velez and Ryan 2012; Clark *et al*. 2014; Colucci *et al*. 2015; Jiwrajka *et al*. 2017).

Healthcare professionals' attitudes towards their patients can be adversely affected once they are aware of their health status (Pavlish *et al*. 2010; O'Mahony *et al*. 2012). Healthcare professionals in Australia need to recognise their own cultural expectations, particularly regarding Western constructs of healthcare. Lack of acknowledgement or respect for different health beliefs and practices can hinder trust building, which delays health seeking (Grove and Zwi 2006; Metusela *et al*. 2017). All Australian healthcare professionals should be trained in basic cultural understanding (Davidson *et al*. 2004; Grove and Zwi 2006; Sypek *et al*. 2008; Correa-Velez and Ryan 2012; O'Mahony *et al*. 2012; Clark *et al*. 2014; Truong *et al*. 2017).

Continuity of care and team approaches seem to be important to refugee health. The latter requires the involvement of community organisations and specific agencies (e.g. torture and trauma services). One strategy to this end has been the development of specialised health services that focus specifically on refugees (Davidson *et al*. 2004; Correa-Velez and Ryan 2012). Some studies emphasise the need for clear referral processes, flexible appointment systems and drop-in and outreach services (Sypek *et al*. 2008; Colucci *et al*. 2015). Future studies should evaluate the effectiveness of these approaches.

The review highlights several important implications for practice. Healthcare professionals working with refugees need more support and training. Health services need to better facilitate integration across systems; for example, general practice clinics and pharmacies should be registered with translating services. Patient records should include information relevant to supporting holistic care, such as cultural, language and social needs.

The review also offers several recommendations for policymakers. Consideration should be given to how health services are expected to operate, including the development of different care models, such as drop-in and outreach services and the involvement of key workers, flexible appointments and appropriate reminder systems. Remuneration that incentivises services that meet refugees' needs should be promoted, and the location of refugee services should take into account transport issues and access to other support, particularly pharmacies and counselling. This meta-synthesis has several limitations. We included contemporary studies in Australia to get a recent picture of current practice, but there were relatively few refugee-specific qualitative studies published in the chosen period and it is possible that the search strategy may have not captured all relevant articles. It is also likely that more data may be available in the 'grey' or unpublished literature. Our restriction to qualitative studies will have reduced the number of studies eligible for inclusion. Despite these issues, the included studies involved a relatively high number of participants, and common issues were evident across different areas of practice, which suggests that the barriers identified are widespread. Understanding the issues involved is a necessary step that precedes quantitative studies.

## Conclusion

This qualitative meta-synthesis literature review was prepared with the goal of recognising and reducing barriers to health service access for refugees who have resettled in Australia. Several implications for practice are evident that could improve healthcare experiences of refugees in Australia. This review shifts the focus from problems with refugees to shortcomings in health service delivery.

## Conflicts of interest

The authors declare no conflicts of interest.

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