Regional primary health care organisations and migrant and refugee health: the importance of prioritisation, funding, collaboration and engagement

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Abstract

Objective: This paper examines whether Australian regional primary health care organisations – in this case, Medicare Locals (MLs) and Primary Health Networks (PHNs) – have engaged with migrant and refugee health, and what factors encourage work in this area.

Methods: The study used mixed methods with surveys of ML (N=210) and PHN staff (N=66), interviews with ML (N=50) and PHN (N=55) staff, national consultations with migrant and refugee organisations (N=8 groups with 62 participants), and analysis of ML and PHN documents.

Results: Needs assessment documents identified migrant and refugee health issues in 46% of MLs and 74% of PHNs. However, 48% of MLs and 55% of PHNs did not report any activities on migrant health, and 78% and 62% did not report any activities for refugees, respectively. Key factors identified by participants as associated with whether ML and PHN focus on migrant and refugee health were the determination of local priority areas, policy context and funding, collaboration with migrant and refugee organisations and communities, and mechanisms for engagement.

Conclusions: Despite the importance of primary health care for migrants and refugees, there was relatively little attention paid to these population groups in MLs and PHNs, with a small number of notable exceptions.

Implications for public health: The paper concludes with a range of recommendations for improving regional primary health care organisation engagement with migrant and refugee health.

Key words: primary health care, migrant, refugee, asylum seeker, policy

Almost 30% of Australia's population were born overseas,[1] and over the past 10 years, Australia has accepted more than 170,000 refugees.[2] While health status may vary somewhat by migrant cohort (and in some contexts be affected by the 'healthy migrant effect'[3]), in general, it is recognised that a combination of pre-migration, migration and post-migration factors mean the health service needs of people from migrant and refugee backgrounds are more complex than for many other Australians.[4-6] In particular, people from refugee and asylum-seeking backgrounds (hereafter 'refugees') have worse health outcomes, especially in relation to mental health.[7,8]

Primary health care (PHC) plays an important role in addressing the health needs of migrants and refugees.[9-11] In the case of both these groups, there is a particular need for PHC approaches that are comprehensive, including an understanding of the social determinants of health (SDH), given the array of elements important to successful resettlement such as securing accommodation, enrolling in education and finding employment.[12,13] Drawing on Levesque,[14(p.5)] healthcare access refers to the "the opportunity to reach and obtain appropriate health care services in situations of perceived need for care". Accessibility results from individual, household and social and physical environment factors, and also features of health systems, organisations and providers. Key health system elements are the approachability, acceptability, availability, affordability and appropriateness of services.[14] In the case of new migrants and refugees, this relates to the extent to which services are well known, the cultural and social acceptability of care, the availability of appropriate services, the cost of services and whether health care is appropriate to meet their needs.

A range of barriers to PHC access have been identified for migrants and refugees including language barriers, cost, health and health system literacy and culturally inappropriate care, and in the case of refugees, the particular issue of trauma-related barriers.[10,2,15,16] In addition, health professionals report increased complexity in working with migrants and refugees, relating to a range of factors including language difficulties and multiple problems reflecting the impact of social determinants that require a multi-sector response, as well as difficulties for their clients in understanding and navigating different health service entitlements.[12,17,18] Factors associated with improved access to PHC include the availability of appropriate translation and interpreting services, specialist services for

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survivors of trauma and torture, advocacy services and partnership with migrant and refugee communities.[12,19,20]

In Australia, regional primary health care organisations were created and funded to assist with population health planning and PHC coordination across the country – 'regional' in this instance refers to bounded areas rather than non-urban location. These were initially devised as Divisions of General Practice. Then in 2011, 61 Medical Locals (ML) were funded by the Federal Government to improve PHC coordination and integration, address service gaps and improve service navigation for patients.[21] With a change of government, MLs were replaced in 2015 by 31 Primary Health Networks (PHNs) with a remit focusing more on commissioning services, rather than direct service provision.[22] As part of a broader project on population health planning in MLs and PHNs, this paper examines the extent to which migrant and refugee health needs were addressed within MLs and PHNs and the factors associated with a focus on migrant and refugee health. While the key findings related more generally to both groups, we acknowledge that the PHC needs of migrants and refugees vary and where relevant we highlight any differences found in relation to these groups.

Methods

As part of a four-year mixed methods multi-stage study of MLs and PHNs drawing on a critical theoretical approach,[23] the following qualitative and quantitative methods were used in this analysis:

- document review: publicly available needs assessments and annual reports from MLs (2012–2013, 2013–2014) and PHNs (2015–2016, 2016–2017)
- online survey with MLs (N=210, responses from 52/61 MLs) and PHNs (N=66 from 17/31 PHNs)
- telephone interviews with senior staff, executives and board and council members of MLs (n=50) and PHNs (n=55)
- eight focus groups with refugee/migrant community groups in each state/territory (N=62 participants).

These methods were integrated at the data collection and analysis stage,[24] and data from the ML analysis helped inform the research approach for the subsequent examination of PHNs. We describe the individual methods in further detail below.

Review of ML/PHN documents and webpages

We undertook analysis of ML report documents for 2012–2013 and 2013–2014, with needs assessment documents available for 59/61 MLs and annual reports for 60/61 MLs. PHN documents were also analysed, with needs assessments available for all 31 PHNs and at least one annual report from 2016 or 2017 for (29/31 PHNs – note also that three PHNs were run by one organisation and had a single report). These reports were coded in NVivo, identifying any activities relating to migrants and refugees. These activities were subsequently more finely coded according to a list of potential types of activities developed from our knowledge of PHC more generally and readings of the reports. Documents were coded for any formal consultation mechanisms involving these groups and for formal engagement mechanisms. We also examined ML and PHN webpages for board expertise.

Online survey

An online survey of senior staff, executives and board and council members was conducted with MLs and PHNs. The ML survey was developed and refined in a series of research team discussions and included closed and open-ended questions and was administered between September and November 2014. In relation to migrant/refugee health, participants were asked to rate the effectiveness of engagement with migrant health organisations on a scale from 0 (have not engaged) to 5 (very effective), and open-ended questions asked participants to identify the successes they had achieved in relation to migrant/refugee health, as well as the challenges. After MLs were replaced with PHNs, a second survey of PHNs' executives, board members, clinical councils, and community advisory councils was conducted (July to October 2016). The ML survey instrument was adapted for PHNs and included comparable items on effectiveness of collaborations and efforts and capacity in collaboration, as well as an additional question asking the extent to which funding processes facilitated work with migrants/refugees.

For both surveys, participants were recruited through an email to CEOs for distribution to relevant staff and board/clinical/community council members, with three follow-up emails at three-weekly intervals. We received 210 survey responses from 52 MLs (85% of MLs) and 66 responses from 17 PHNs (55% of PHNs).

Telephone interviews

Different approaches were employed to recruit interview participants in MLs and PHNs. In the ML survey, participants were offered the option of including their details for a follow-up interview and 106 people took this option. The final selection of interview participants was based on their seniority and involvement in population health planning, and to include both urban and rural MLs. Fifty-one people were invited, with one person declining due to a role change. Fifty semi-structured interviews were conducted between November 2014 and February 2015. PHN participants were purposively selected from six PHNs. These six PHNs were selected based on their geographical region (metro vs. rural, to cover issues relevant to both) from different states and territories, as well as their willingness to participate. Of a total of 82 people invited from the six PHNs, 55 people (67%) agreed to participate in an interview session, with interviews conducted between August and July 2016. The interviews canvassed a range of aspects of ML and PHNs (e.g. funding, collaboration, challenges), with specific questions about the extent to which migrant and refugee health had been addressed in the organisation and the facilitators and barriers to this work.

Focus groups

Focus group consultations with refugee/migrant community groups were held in each jurisdiction (eight focus groups, with 62 participants) from April to June 2015 (before the transition from MLs to PHNs). Participants were recruited through a list developed in each state and territory of relevant community and migrant and refugee health organisations. An invitation was sent to the CEOs of these organisations to seek permission and request one or two people from their organisation to attend the consultation session. The consultations were facilitated by two members of the research team, and discussion topics included health needs and population health planning priorities for migrants and refugees and any differences between these groups, as well as engagement with MLs around these issues, and issues with transitioning to PHNs.

Analysis

The survey data was analysed with SPSS Version 25, using simple descriptive statistics. Interviews and focus groups were audio-recorded, transcribed and de-identified for further analysis. These transcripts, as well as the survey open-ended answers and the documents, were analysed thematically[25] with the assistance of NVivo software (version 12). The initial coding frame included themes from the literature on PHC planning, population health, and key issues in relation to migrant and refugee health. This was iteratively built upon as key themes emerged from the data, and discussed in research team and reference group meetings. Eight ML and four PHN interviews were double coded by members of the team to ensure consistency of coding, and differences found resolved by discussion. Data were triangulated and negative case analysis undertaken.

We have included participant characteristics for verbatim quotes, where available and when not compromising anonymity.

The project was granted ethics approval by the Flinders University Social and Behavioural Ethics Committee.

Results

Our analysis of needs assessments documents from MLs and PHNs found that 27 (46%, two missing) MLs and 23 (74%) PHNs identified health issues for migrant and/or refugee health (they were often discussed interchangeably so we do not disaggregate here). However, in our analysis of annual reports, we found that 48% of MLs (29, 1 missing) and 55% of PHNs (16, 2 missing) did not report any activities in relation to migrant health, with these figures 78% (47, 1 missing) and 62% (18, 2 missing) for refugees (Table 1).

We found the following types of activities in relation to migrant and refugee health in the annual reports: 'clinical service provision' (ranging from screening programs through to full refugee primary care clinics); 'service facilitation' (ranging from cultural awareness training for GPs to funding interpreter services and transport services); 'health and health system education' (ranging from flyers on after-hours services in different languages through to refugee community champions to build health system knowledge); 'health promotion' (ranging from mental health awareness raising posters in a language other than English through to working with local government on inclusive communities); 'community health program' (ranging from provision of small grants to community health services for migrant/refugee health through to community health promotion programs for Culturally and Linguistically Diverse (CALD) women); 'community engagement/input' (ranging from consultation with culturally diverse groups through to an Afghan community project to identify and address priority issues); and 'policy advice to the states' (only one example found, advising on statewide refugee policies).

Table 1: Migrant and refugee focused activities.

	ML (N=60, 1 missing)		PHN (N=29, 2 missing)	
	Migrants* (incl. refugee)	Refugee# specific	Migrants* (incl. refugee)	Refugee# specific
Any activity	31, 52%	13, 22%	13, 45%	11, 38%
Clinical service provision	18	10	20	18
Service facilitation	30	14	10	8
Health and health service education	16	8	5	2
Health promotion	3	1	6	0
Community health program	1	0	1	1
Community engagement/input	7	1	4	1
Policy advice to states	2	2	0	0

Notes:
** Indicates any migrant or refugee activity (often these were discussed together).*
 # Indicates a subset that highlighted activities in relation to refugees specifically.

For those MLs and PHNs who did report activities, the main types were clinical service and service facilitation, especially for refugees (Table 1). MLs activities were also focused on health/health system education and PHNs were undertaking some health promotion but not with refugees. There were few activities by both MLs and PHNs relating to community health programs and community engagement. Interestingly, when we examined which MLs and PHNs were undertaking activities in migrant/refugee health we found that 12 MLs (20%) and one PHN (1%) of those reporting activities had not identified a need in their needs assessment documents, and 10 MLs (16%) and 11 PHNs (38%) who had identified a need had not undertaken any activities to date.

We examined the settlement data for PHNs (this was not available for MLs) to explore whether those areas with higher proportions of migrants and refugees reported more comprehensive activities.[26] We defined a sizable population of recent migrants as >10,000 recent migrants in the PHN's catchment area from 2016 Census data;[26] 16 out of 31 PHNs met this criteria. Of these 16, five were active in addressing migrant health. Ten had very minimal evidence of activity addressing migrant health (ample documents could not be collected to evaluate one PHN), even though recent migrants made up between 0.9% to 7.6% of their population.

We defined a sizable population of refugees as >1,000 permanent migrants under the Humanitarian Program 2012–2016 in the PHN's catchment area; 14 out of 31 PHNs met this criteria. Of these, seven were actively addressing refugee health, and six had no evidence of addressing refugee needs (one PHN could not be evaluated).

There were four PHNs that had programs addressing migrant and/or refugee health despite having smaller numbers of migrants and refugees in their area.

In the survey, only 16% of PHN respondents said that they had been 'successful' or 'very successful' in migrant and refugee health, with 72% reporting they had been 'neither successful or unsuccessful', and 12% reporting it had been 'unsuccessful' or 'very unsuccessful' (11 'don't know', 5 'missing', Table 2). This question was not asked in the survey of ML staff.

We identified a number of key factors that impacted on a focus on refugee/migrant health – the determination of local priority areas, policy context and funding, collaboration with migrant and refugee organisations and communities, and mechanisms for engagement.

Prioritisation

Our consultations with migrant and refugee organisations identified issues affecting health and wellbeing and access to health services including language barriers and poor access to interpreters; limited numbers of bilingual General Practitioners (GPs) and health workers; unaffordable cost and low

numbers of GPs bulk billing; and difficulties navigating the health system. Broader social health needs were also identified as important, including housing, social connections, education and employment, and – for refugees in particular – issues of safety:

> *Things that are crucial for refugees' health are safety. People heal well if they are feeling safe. All the components of safety; safe and secure shelter, safe and secure financial income, safe and secure education and training, and safe and secure mind, body and spirit really. No one could do any work to get better unless these issues are in place.* (migrant/refugee health service provider, metropolitan, female: focus group)

These social health needs were all seen as affecting both health and access to health services. However, despite these needs, in consultations with migrant and refugee organisations across the country participants felt that migrant and refugee health had not been a priority for MLs (these consultations occurred before the PHNs had been established).

In the ML interviews and survey open-ended responses, the majority acknowledged that migrant and refugee health had not been a priority, and PHN staff likewise noted the low priority given to migrant and refugee health. In each case the main reason given for this was that migrants and refugees made up a small proportion of their catchment population, particularly in rural areas – for example:

> *The [area] does not have a large migrant/refugee population and consequently, this has not been a priority area for investment given the limited funding and resources available for engagement.* (ML manager, rural: survey)

> *We are quite a new entity even now and we have a very small population of new migrants and refugees. It's hard to justify a large allocation of resources but we could have attempted to engage more and better understand their needs.* (ML manager, rural: survey)

> *In the larger PHN region, there's a few little pockets but it's not a large population base. It never featured highly in our needs.* (PHN manager, rural, male: interview)

Conversely, those MLs and PHNs that reported having larger migrant and refugee populations spoke of prioritising this group: "We have a very large and diverse refugee/asylum seeker population and the makeup of the Medicare Local's programs reflects that" (ML manager, metropolitan: survey). These MLs and PHNs undertook activities including GP capacity building, health literacy initiatives, running CALD specific health promotion programs and health expos and establishing refugee health clinics.

However, we do note our own findings above (for PHNs) that migrant and refugee population size was not necessarily always reflected in relevant reported activities.

A small number of participants noted that migrants and refugees should also be a priority because of their over-representation in other priority areas:

> *This [new migrants and refugees] is a population affected strongly by two of our priority areas: mental health and diabetes. Better consultation with this community may have enabled us to implement a meaningful and affordable initiative in collaboration with other agencies.* (ML senior executive: survey)

Policy context and funding

Factors related to policy context and funding that flowed from discussions about prioritisation were also highlighted as affecting work with migrants and refugees. In particular, the importance of specific funding for activities relating to migrants and refugees either through flexible funding or funding provided by state/territory government was highlighted as facilitating work in this area. Direct funding was seen as encouraging clinical services. On the flip side, it was noted that if migrant and refugee health was not a priority of state and/or federal governments these opportunities were limited, particularly if there was little flexibility in the way that funds could be expended:

> *Funding is limited and therefore limited opportunities sometimes without discretionary funding to engage appropriately.* (ML board member, metro: survey)

> *And the government I don't think, they're [migrants and refugees] not the flavour of the month… Therefore they will have less resources.* (PHN advisory group member, metro, female: interview)

Only a small minority of PHN survey participants (12%) felt that the funding agreement allowed PHNs to meet migrant and refugee health needs to a large or very large extent, 83% said it only did to a small or moderate extent and 5% said not at all (6 missing, this question was not included in the ML survey), see Table 2.

In interviews and consultations, participants also highlighted that funding reporting systems did not encourage this work, with one migrant organisation participant's quote reflecting this view: "Unless you're reporting on it then you don't have to do it. What gets measured becomes what you do" (migrant health stakeholder focus group, SA). In another example, a ML interview participant further stressed how these constraints also made social determinants of health approaches with migrants and refugees more difficult: "A lot of the challenging and social determinants type work is not easily amenable to showing neat outcomes in a short space of time" (ML board member, female: interview).

For those doing more work in the area, state funding was noted as helpful, as one PHN interviewee noted: "So we're actually funded by the [state] Department of Health who provide support for incoming migrants and refugees for primary health care, especially in their first 12 months of arriving" (PHN senior executive, female: interview). State-based migrant and/or refugee health frameworks or policies were seen to encourage such support.

Table 2: Survey quantitative findings for MLs and PHNs.

	ML N(%)	PHN N(%)
Extent of success in migrant and refugee health	Not included	8 (16%)=successful/very successful 36 (72%)=neither successful nor unsuccessful 6 (12%)=unsuccessful/very unsuccessful
Engagement with migrant organisations	117 (56%)=effective/very effective 44 (21%)=neutral 20 (10%)=somewhat or very ineffective 28 (13%)= not engaged at all	27 (43%)=effective/very effective 26 (41%)=neutral 6 (10%)=somewhat or very ineffective 4 (6%)=not engaged at all
Extent funding facilitated meeting migrant/refugee health needs	Not included	7 (12%)= to a large or very large extent 50 (83%)= to a small or moderate extent 3 (5%)= not at all

An additional funding issue raised was the tendering and commissioning processes. MLs could provide services themselves. For migrant and refugee organisations this meant a potential conflict of interest in terms of collaboration with an organisation that they may need to compete with for funding:

> *It's kind of like a paradox: you can't have a collaborative, equitable, good public health model with people co-operating and collaborating, and have competition: competition for funding, competition for knowledge … to have everything based on a business competition model just doesn't work.* (Migrant/refugee organisation: focus group)

PHNs differ from ML in that they were strongly encouraged to commission rather than provide services. However, reflecting our findings on PHN commissioning more generally there were significant concerns about this shift to a commissioning model for migrant and refugee health.[27] Participants highlighted a potential loss of expertise and community links in providing culturally appropriate services to migrant and refugee populations and interruptions to services if this process did not recognise the importance of community engagement and skills in migrant health and in particular refugee health. As one migrant/refugee organisation participant said: "If it's going to be a commissioning model then I think they need to think about how they commission services from the organisations that are already in the field and are already experts" (migrant / refugee organisation: focus group).

Collaboration with migrant and refugee organisations

Only 56% of ML and 43% of PHN survey respondents considered that engagement with migrant organisations had been effective or very effective (Table 2). Among the list of potential engagement 'partners' they were presented with (e.g. GPs, allied health providers, state government PHC, local government, Aboriginal organisations, private insurers), migrant organisations were one of the lowest-ranked in terms of effectiveness. Our analysis of documents identified very few examples of collaborative work by MLs in particular (Table 3). PHNs had more examples, particularly in relation to program-based collaborations around refugee health.

In our consultations with migrant and refugee organisations, there were examples of collaborative engagement; for example, in initial health screening and migrant and refugee health clinics that were operated in partnership with migrant and refugee organisations. However, overall there was a consistent view that, in general, engagement with them by MLs had been poor. In particular, these relationships were seen as one-sided: "unless you approach them [Medicare Locals] they weren't approaching you, which is sad". (migrant/ refugee organisation: focus group). Migrant and refugee organisations also criticised MLs for limiting their focus to initial consultation, rather than feedback and ongoing work: "Even when I was involved in their initial planning a bit, you don't necessarily get the feedback as to what was actually achieved from a plan or not and what is still lacking" (migrant/ refugee organisation: focus group). Another migrant/refugee organisation participant expanded:

> *They're responsive but you've got to work really hard, if you're not there and in their face, and you don't build relationships and networks it's not like it's natural to them to think yes, we've got to do something for this population group.* (Migrant/refugee organisation, female: focus group)

In an interview one ML participant also noted similar concerns: "There is some rhetoric around that [engaging with migrant and refugee organisations] and some initial engagements with refugee health organisation but it has become a 'tick the box' exercise rather than a long-term engagement" (ML board member, female: interview).

While both ML and PHN staff noted that time and resources were the biggest barrier to working more closely with migrant and refugee organisations and communities, they considered better consultation with migrant and refugee organisations as well as directly with communities as ways to improve their work in this area. Multiple participants in the ML survey noted this; for example: "[could have] sought out the voice of the refugee and migrant cohort especially on matters affecting them" (ML senior executive, rural); "a more comprehensive community engagement strategy would have assisted [work in this area]" (ML senior executive, rural); and "establish a forum especially for migrant and refugee community members" (ML senior executive, rural). Participants recognised that this needed to be more than 'rhetoric' and one spoke of the need for a two-way relationship: "Specific partnerships and collaborative activities with other organisations that work directly with new migrants/refugees. Having a clear purpose for engagement, that offers benefit to the people being engaged is also important" (ML program officer, metropolitan). PHN survey respondents likewise focused on closer ties to migrant and refugee organisations and communities as an area for improvement: "engage more directly with the communities" (PHN program manager, rural/metropolitan); and "closely communicate with the local migrant information centre or ethnic organisations" (PHN advisory group member, metropolitan).

For those who felt that they had stronger collaborations with migrant and refugee organisations and communities, previous work through the Division of General Practice, or MLs in the case of PHNs, were seen to have provided a basis for these stronger collaborations. These experiences underscore the importance of time in developing such collaborations.

Few of these collaborations were on social determinants of health despite these factors being seen by migrant and refugee organisations as very important. Our research found limited collaborative engagement on social determinants of

Table 3: Collaboration and consultation mechanisms.

	ML (N=60, 1 missing)		PHN (N=30, 1 missing)	
	Migrants* (incl. refugee)	Refugee# specific	Migrants* (incl. refugee)	Refugee# specific
Any mechanism	10, 17%	8, 13%	14, 47%	10, 33%
CALD/refugee reference groups	2	1	0	0
Part of a migrant/refugee committee or network	5	5	1	0
Program based collaboration	3	3	8	8
On board of migrant/refugee organisation	0	0	1	1
Migrant/refugee expertise on board/council	3	2	3	1
Migrant/refugee members on community council	N/A		1	1

Notes:

** Indicates any migrant or refugee activity (often these were discussed together).*

 # Indicates a subset that highlighted activities in relation to refugees specifically.

health in general and also specifically in relation to migrants and refugees – one migrant/refugee organisation participant concluded: "We actually do not yet see a kind of collaborative approach to address both the medical aspect of the health of migrants as well as conjunctively with the social determinants of the health of the people" (migrant/refugee organisation: focus group).

Mechanisms for engagement – individual champions and involvement in governance

In interviews with both ML and PHN staff and consultations with migrant and refugee organisations, the role of particular individuals who were 'champions' for migrant and refugee health was stressed as affecting the extent to which migrant and refugee health was a focus for the ML or PHN. An important way for this influence to flow through organisations was through having formal consultation mechanisms as these assisted in collaboration and prioritisation of work. Typical comments illustrating this were: "having this particular fellow on one of our advisory groups has really raised an awareness for us and given us opportunity for being able to work with these particular groups of people" (ML senior executive, rural, female: interview); and "I know that we do have a few different members of CALD background on our community advisory council. That is a particular voice in regard to CALD and the issues and refugee issues" (PHN program manager, metro, female: interview).

However, our document analysis found that 51/60 (one missing) and 16/30 PHNs (one missing) reported no formal engagement mechanisms concerning migrant and refugee health and there was little evidence of expertise on their boards of management (Table 3).

While we cannot determine the direction of causation, we did identify that those MLs and PHNs with migrants and refugees involved in formal engagement mechanisms were also those undertaking more work with them. Migrant/refugee organisations also noted that engagement could sometimes be individualised, rather than adopted by the organisation – as one participant remarked: "in reality, it seems to depend a lot on individuals within the organisation" (migrant/refugee organisation: focus group).

Case studies

We examined the MLs and PHNs to identify case studies that illustrated how the factors coalesced to affect the extent of migrant and refugee health activity.

A metropolitan ML in an area that received most of the state's refugee intake identified a range of migrant and refugee health priorities in their needs assessment). In response, it established a range of programs, including: i) education for GPs and their staff about refugee patient care, and cultural awareness and using mental health funding for refugees who have experienced trauma; and ii) a targeted migrant community health promotion program focusing on family connection, health, wellbeing, and employment. In terms of governance, the ML did not have migrant or refugee expertise evident on their board, but a board member did report in the survey that "our executive team has provided board updates on issues affecting minority groups". The ML collaborated with state health organisations and a university to work on system change through: i) establishing a refugee advisory group (for the local health system, including state health); and ii) seeking to co-locate refugee health nurses in primary care, creating partnerships between general practice and health and refugee support services. The ML noted the need to use flexible funding, and the small amount of their funding that was actually flexible for local needs.

A metropolitan PHN with a very high number of recent migrants and refugees consulted with refugee organisations as part of their needs assessments and subsequently identified a range of migrant and refugee health needs. The PHN named refugee and CALD communities as one of its priority areas. In terms of governance, there was no evidence of migrant or refugee expertise on their board, though a member of the community advisory council noted that the council "has a good range of cultural diversity as representatives". Another member noted: "I am from different cultural background and I am certain that my input has always been respected". The PHN also had a range of collaborations with migrant and refugee organisations in the region, which it noted were strong, high performing NGOs. The PHN provided: i) health education for migrants and refugees; ii) information in languages other than English; iii) support to CALD-specialist practices to offer after-hours care; and iv) support to CALD carers. The PHNs' documentation indicated multiple examples where state or non-government organisations were the lead organisations, rather than the PHN. PHNs saw this as appropriate, with one PHN senior executive noting the difficulty in allocating PHN funding to these areas, and that other organisations are already working in that space.

Discussion

The generally poorer health status of refugees in particular and PHC access barriers for migrants and refugees more generally would indicate the need for allocation of resources and effort on the basis of 'proportionate universalism' – where actions are universal but 'with a scale and intensity that is proportionate to the level of disadvantage.[28(p15)] However, our study indicates that MLs and PHNs, with a few notable exceptions, have paid limited attention to migrant and refugee health. Key factors associated with MLs and PHNs focusing on refugee and migrant health were the extent to which the issue was an identified priority within the organisation, state government policy context and nature of funding mechanisms, levels of collaboration with migrant and refugee organisations and communities, and mechanisms for engagement and local champions.

Funding mechanisms, contractual arrangements and reporting systems help shape what is possible in organisations. However, this study found that these institutional drivers[29,30] at the federal level did not support work with migrants and refugees. The analysis indicated that where state government priorities and funding models were supportive of migrant and refugee health (for example where there are explicit migrant or refugee health policies in states) work seemed to happen – highlighting the role of these institutional drivers in encouraging on-the-ground work. The analysis indicated the need for dedicated resources for migrant and refugee health. Alongside this, however, is the need for flexible funding models so regional primary health care organisations can set their own priorities that stem from their own needs assessment processes, and then fund activities flowing from these processes.

There is an interaction between prioritisation and funding. Thus, funding decisions frame

the determination of priorities and these priorities influence subsequent funding. In many cases migrants and refugees were not considered a local priority by MLs or PHNs, largely relating to smaller population numbers relative to other population groups in their catchments, particularly in light of the funding constraints. This highlights how funding models shape prioritisation and how more flexible funding mechanisms, alongside dedicated funding streams, may provide regional primary health care organisations more scope to respond to multiple local priorities.

Collaboration with migrant and refugee organisations and communities in priority setting and service planning is crucial for a responsive PHC system. However, for both MLs and PHNs this was clearly an area for improvement. Strategies to encourage the meaningful involvement of migrant and refugee community organisations and members in health planning and implementation are needed. One way this can be done in regional primary health care organisations is through migrant and refugee health representation and input in governance, mindful of some of the differences between migrant and refugee groups. Governance structures have a crucial role to play in developing partnerships and collaboration and promoting community health,[31,32] but there were multiple gaps in current governance structures. Promoting representation on the PHN community councils could assist in facilitating the voices of both migrants and refugees. Likewise, PHN involvement in other migrant and refugee organisations would represent a reciprocal exchange. In addition, direct community engagement with migrant and refugee communities would facilitate additional perspectives of migrants/refugees. Relatedly, the importance of considering the particular needs of refugees is important. For example, features of the refugee experience such as torture and trauma can have particular impacts on PHC access and subsequent health outcomes[9,12,16,19,20,33-36] and necessitates refugee-specific initiatives, rather than more general migrant programs.

Likewise, addressing the social determinants is a crucial element of a comprehensive PHC response for migrants and refugees.[11,13,37] However, current KPIs and funding and reporting mechanisms for PHNs do not support this, reflecting more biomedical models of health and a neoliberal focus on efficiency and cost-effectiveness.[38] Work on the social determinants of health is complex and requires significant cross-sectoral collaboration, sustained funding and longer-term reporting frames.

While the transition from MLs to PHNs was unforeseen, the study used several modes of data collection with two forms of regional primary health care organisations, which provided multiple perspectives on migrant and refugee PHC in Australia. However, this spread of data points and small variations in methods/questions did affect comparability in some instances. In addition, some PHN data was collected early in their development, the consultations with migrant and refugee organisations occurred before PHNs were established (but after MLs were told they would end), and PHN staff interviewed were employed in a smaller number of PHNs. MLs themselves were also relatively early in their development. The survey sampling was filtered through the CEO, and the lower response rate for PHNs, while not surprising given they were early in their establishment, did mean less coverage of PHN staff views. In the document analysis, we were aware that not all activities may be systematically reported and that there were likely inconsistencies in reporting. For example, the differences between reported migrant/refugee needs and activities in MLs and PHNs may relate to reporting discrepancies rather than inconsistences in planning. The combined analysis of migrant and refugee groups (other than in the document analysis) may obscure specific findings in relation to each of these broader populations, as well as sub-groups within them.

Conclusion

Equity in migrant and refugee PHC health access and health outcomes cannot be realised unless a 'proportionate'[39,40] priority is given to migrant and refugee health, in PHC policy, planning, performance measures and funding models. A key rationale for the existence of regional primary health care organisations is that they would be able to identify gaps in PHC service provision and then fill those gaps. Our data suggests that in relation to migrant and refugee health this has not always happened. Regional primary health care organisations require long-term investment and organisational stability to build and maintain collaborations with migrant and refugee organisations and communities. Attention to the social determinants of health is particularly crucial for migrants and refugees and requires a focus on comprehensive approaches to PHC that take account of this.

Implications for public health

Addressing the health needs of migrants and refugees in regional primary health care organisations requires a focus on comprehensive PHC including action on the social determinants of health; policy support including state and national policy frameworks; greater and more stable funding including state funding, both dedicated and flexible funding and expertise retained in commissioning processes; workforce capacity for engaging in migrant and refugee health; and two-way mechanisms for community participation, collaboration and partnership with migrant and refugee communities and organisations.

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Supporting Information

Additional supporting information may be found in the online version of this article:

Supplementary Appendix 1: Data collection tools.