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**Suggested citation**

Owen A, Grootemaat P, Samsa P, Fildes D and Eagar K (2009) ***A Review of the Literature and Practice on Models of Care for Refugee Health***. Centre for Health Service Development, University of Wollongong



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## 1 Overview of the literature

Since the NSW Health issued *Strategic Directions in Refugee Health Care in NSW* ten years ago, it has provided a framework and direction for service and strategy development in refugee health in NSW. In consideration of the significant changes in national government policies, major changes in the countries of origin of refugees and significant refugee health service developments in the last decade, NSW Health has resolved to develop a new plan for refugee health to guide future service development.

The first stage in the new planning process was a review of implementation of each of the strategies and recommendations of the Strategic Directions document based on interviewing the major service providers and input by the NSW Refugee Health Plan Steering Committee. *The Review of the NSW Health Strategic Directions in Refugee Health 1999 – 2009 - A Decade of Change* (Final Draft) provides a platform for the development of the new refugee health plan for NSW.

Another plank in the planning process is this review of the literature. It focuses on new evidence that has been accumulated in the decade since Strategic Directions was written. As is reported in more detail in the following sections, there is new evidence on the changing health status of refugees. Evidence is also beginning to accumulate from recent studies on pre-departure medical screening for visa applicants and the 'fit-to-fly' examination. However, there is no new evidence based on controlled studies about the relative merits of universal screening/assessment or other case finding strategies, and in particular on the issues of most interest to the new Plan – comparative studies of different models.

Once refugees' health needs are described, the key question for the new plan is how best to respond to them. A review of models of care across Australia and internationally informs the answers to the questions of how best to respond (i.e. the set of objectives, strategies and suitable measures) that are embodied in the new plan.

The current approaches to refugee health internationally and nationally are described in Sections 2.1 and 2.3 and evidence from different approaches in NSW is reviewed in Section 2.4. The implications for planning the approach to Refugee Health in NSW are briefly reviewed at the end of each section and carried forward to inform the evidence base for the new Plan.

### 1.1 *What is known about the health status of refugees?*

Refugees are said to “*experience a threefold challenge to their health and well-being: ...the treatment of psychiatric disorders precipitated by the refugee experience; ... the treatment and prophylaxis of infectious and parasitic diseases endemic to their countries of origin; ... and the prevention of chronic diseases endemic to host countries.*” (Palinkas et al. 2003, p.20)

However, this analysis is too limited as it fails to include the social, emotional, community, cultural, language and practical problems that are part of the refugee experience, as well as issues such as health literacy that limit access to mainstream health services. It also fails to recognise that health impacts vary by country of origin, while people are in transit/exile and after resettlement.

A key challenge is mental health, in particular where there is post-traumatic stress or some other vulnerability that has resulted from the refugee experience. New models in responding to the mental health needs of refugees emphasise an ecological approach as distinct from clinic-based services, which “*are of limited value in addressing the constellation of displacement-related stressors that confront refugees on a daily basis, and that represent a significant threat to their psychological well-being.*” (Miller and Rasco 2004, p.3)

The intervention domains of concern within the ecological model are closely related to the displacement-related stressors, such as responding to social isolation, the loss of social networks and social support, unemployment and poverty, the loss of valued social roles, and the skills needed to negotiate the local environment (Miller and Rasco 2004).

There is evidence on the value of more ecological approaches in mental health from a number of academic and advocacy groups concerned with the plight of refugees that will not be described in any detail here. These groups exist in NSW as well as in other States and access to the work in the wider network can be achieved through the Refugee Council of Australia - the national umbrella body for organisations working with refugees and asylum seekers, is involved in new research, policy development, information and representation on refugee issues (<http://www.refugeecouncil.org.au/>). A similar organisation with more resources of this type is operating in the UK (<http://www.refugeecouncil.org.uk/>).

There is also a large and growing amount of evidence on the effectiveness of interventions. The NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) is a key national resource. It helps refugees recover from their experiences and build a new life in Australia. It has authored several key reports and it holds an extensive set of resources and publications including research papers, training kits, current evidence and reports (<http://www.startts.org.au/Default.aspx>). There are similar services in other states. One example is STARRS (Supporting Survivors of Torture and Trauma), the Adelaide-based specialist torture and trauma counselling service. [http://www.sttars.org.au/servlet/Web?s=521203&p=Pub\\_AboutUs](http://www.sttars.org.au/servlet/Web?s=521203&p=Pub_AboutUs)).

In the mental health area in NSW, and with a similar level of detail in its information base, the Transcultural Mental Health Centre (TMHC) is a state-wide service that promotes access to mental health services for people of CALD background. TMHC uses 'a whole-of-lifespan approach', involving work with children, adolescents, families, adults and older people (<http://203.32.142.106/clearinghouse/>).

Extensive work on post-traumatic stress has also been undertaken at the Australian Centre for Post-traumatic Mental Health at the University of Melbourne. It undertakes trauma related research, policy advice, service development and education to help organisations and health professionals who work with people affected by traumatic events (<http://www.acpmh.unimelb.edu.au/>).

There is a growing body of evidence on the social dimensions of the needs of refugees and on how to respond to those needs. One example is the work of the La Trobe Refugee Research Centre (part of the School of Social Sciences). The focus is on public awareness, the social determinants of wellbeing of people who are refugees and the contexts that either hinder or promote social inclusion and promote optimal resettlement (<http://www.latrobe.edu.au/rhrc/>).

The Refugee Resource Centre at the University of NSW has also been carrying out research into refugee flows and forced migration and resettlement issues. It conducts research, education and advocacy programs, partnering with community based refugee organisations (<http://www.crr.unsw.edu.au/>).

Detention health is an area where good evidence on health needs only recently exists. In 2006-2007, the Department of Immigration and Citizenship (DIAC) engaged the CHSD (Eagar et al. 2007) to undertake a study on the health of people held in Australian detention centres between 1 July 2005 and 30 June 2006. The conclusions were published in the online version of the Medical Journal of Australia (Green and Eagar 2009) along with an accompanying editorial (Phillips 2009) that pointed out:

*"This is the largest Australian study to date of the health of people who have been in detention, and the first to follow up a cohort over an entire year. Studying the health of*

*such people in the past in Australia has been challenging; 5 previous studies, although valuable, were necessarily small scale.”*

This was not a typical Australian primary care population and had significant issues, especially the group in detention for more than 2 years. Detainees have more social, digestive, psychological, neurological, eye problems, injuries and risk factors (especially self harm) and, reflecting their younger age, less cardiovascular, endocrine & respiratory problems than a typical primary care population. The more time in detention, the more health problems detainees develop, especially mental health and social problems, but also neurological (headache), musculoskeletal (back pain and injuries), ear (otitis) and skin (lacerations). Both the time in, and reasons for, detention were found to be significantly related to the rate of new mental health problems detainees develop. The relationship between these variables and incidence rates of physical health problems was more complex. (Green and Eagar 2009)

Another domain of relevance to the Australian context is the treatment and prophylaxis of infectious and parasitic diseases. In this domain there is a collection of articles, an editorial and a letter on refugee health in an issue of the Medical Journal of Australia in December 2006 that provided a useful summary of recent (i.e. 2004-2006) refugee health status concerns.

The editorial accompanying the articles (Smith 2006) made a series of observations based on the associated articles. The evidence on physical health covered:

- Health issues in newly arrived African refugees attending general practice clinics in Melbourne. Key issues included the high rate of inadequate immunity to vaccine-preventable diseases which emphasised the need for adult diphtheria-tetanus vaccines, testing for malaria in refugees who come from areas where the disease is common, and increasing the rate of TB testing by making these tests more affordable to immigrant groups. (Tiong et al. 2006)
- Data/evidence from a review of infectious disease screening of refugees by the Migrant Health Unit, Western Australia in 2003 and 2004 that identified that there was a high prevalence of infectious diseases within certain groups of refugees. This supported the need for comprehensive post-arrival medical assessments and appropriate follow-up health care for refugees and humanitarian entrants with high rates of disease (Martin and Mak 2006)
- Data/evidence from an outpatient setting on the treatment of malaria in recently arrived African migrants indicated that outpatient treatment of carefully selected recently arrived adult African refugees with asymptomatic or minimally symptomatic malaria potentially is an efficacious and safe strategy (Chih et al. 2006)
- Data/evidence on malaria in refugee children diagnosed despite reported pre-departure anti-malarial treatment which indicated the continuing need for comprehensive and timely onshore assessment (Cherian et al. 2006).

The 2006 MJA editorial makes the comment that the research evidence base now indicates a high prevalence of various conditions among recent refugee arrivals, with the caveat that some of the data were collected before the introduction (in mid 2005), of the pre-departure medical screen (PDMS), administered in the few days before departure.

There are the necessary public health and prevention concerns with regard to AIDS and Hepatitis infections in the wider community and this requires considerable attention to screening at various points in the refugee experience – pre-departure, on arrival and in the community (for more discussion on this, see Section 1.2 below on screening issues).

However, this is not the case for all groups. Eagar et al. (2007) found that the rate of infectious disease among those in immigration detention centres was particularly low. Low

prevalence of tuberculosis has also been reported in two other studies. One investigated tuberculosis in foreign fishermen between September 2005 and December 2006. Of the 1,471 fishermen assessed, 20 required treatment (Gray et al 2007). Another older report investigated tuberculosis prevalence amongst detainees at two immigration detention centres that did not contain any foreign fishermen (King et al. 2001). Over an 18-month period from January 2000, 7,000 people were examined and only ten were treated for tuberculosis.

Although little has been published about the chronic conditions of refugees in Australia living in the community, there is some evidence in the international literature. One study on complex and chronic conditions was published by Kinzie et al. (2008). This was a US study on the prevalence of hypertension and diabetes in 459 Vietnamese, Cambodian, Somali, and Bosnian refugee mental health patients. The prevalence of hypertension was 42% and of diabetes was 15.5%. This is significantly higher than the US norms, especially in the groups younger than 65 years. Diabetes and hypertension were higher in the high-trauma versus low-trauma groups (Kinzie et al. 2008 p.108). These results are likely to be generalisable to Australian conditions.

Finally, as noted above, there is a growing body of evidence on the social, emotional, community and practical problems that refugees experience. While the health system alone cannot effectively meet these needs, health services have important advocacy and referral roles that require refugee health services to be delivered in partnership with both government and non-government providers.

### **1.1.1 The health needs of refugee children**

Cooke et al. (2004) from the Royal Children's Hospital, Melbourne report that many children from refugee backgrounds have special health care needs resulting from various health conditions, malnutrition and exposure to difficult living conditions. They also indicated that the difficulties in accessing health care for recently arrived paediatric refugees in Australia means that a more complete and accurate picture is hard to put together.

The paper by Cooke et al. (2004) reviewed routinely collected data for all 199 East African children attending a hospital Immigrant Health Clinic for the first time over a 16 month period. Although 63% of parents reported medical consultations since arrival, 77% of this group reported outstanding, unaddressed health problems. This suggests that there are difficulties for this group in both diagnosis and follow up. The availability of interpreters and information on health services were the main factors hindering access to care.

Similar points were made in NSW, based on a study to describe the common health conditions in newly arrived refugee children resettled in Sydney and seen at The Children's Hospital Westmead. This paper estimated that only one in five refugees access specialised refugee health services (Sheikh-Mohammed et al. 2006) and barriers to access include the language divide, cultural factors and financial problems.

In a more recent study based at The Children's Hospital Westmead (Sheikh et al. 2009), 239 newly arrived children attending a specialist paediatric refugee clinic were prospectively screened for common diseases between May 2005 and December 2006. The authors reported that of those tested, 16% had schistosomiasis, 5% had malaria and 4% were hepatitis B carriers. Mantoux tests for tuberculosis found 24% of 216 children tested were positive at  $\geq 10$ mm induration and 33% tested positive at  $\geq 15$ mm induration, including four children with active disease.

The findings in Sheikh et al. (2009) emphasise the importance of screening refugee children for common treatable conditions, even if they are asymptomatic. The importance of routinely screening for nutritional deficiencies was highlighted, as vitamin D deficiency was the most common diagnosis and anaemia was present in 15%. Disease prevalence was higher in

children from Africa than Asia or the Middle East, and most of the children were asymptomatic.

### 1.1.2 Health needs over time

While much of the literature focuses on initial screening, the health needs of refugees are much broader. There is increasing recognition in the mainstream health literature on the need for effective diagnosis and treatment of chronic diseases such as diabetes and heart disease. It logically follows from the goals of connecting refugees to primary care as well as to specialist refugee and mainstream services, that the burden of navigating a complex health system will be greater for refugee groups who have complex health problems.

Ongoing primary and secondary care services are a key component of the health services that refugees require. At the universal level, these include health promotion, prevention and primary care. Some people also require ongoing access to specialist refugee health services as well as to mainstream specialist medical services. The implication is that, as well as delivering health services to refugees, refugee health services have important roles as both advocates for refugees and as key resources that help refugees navigate their way through the health system.

*“Ongoing data collection is key to maintaining a responsive, targeted service for a continually changing population.”* (Cooke et al. 2004 Abstract)

## 1.2 Screening issues

Since mid 2005, what is now the Department of Immigration and Citizenship (DIAC) has been rolling out an additional medical check known as a pre-departure medical screen (PDMS) in the few days before departure. This medical check was introduced in response to representation by Refugee Health Services citing significant numbers of cases of communicable diseases being identified among new arrivals. Conducted mainly by medical staff of the International Organization for Migration (IOM), it is largely a fitness-to-fly check, although it does include screening for malaria, measles–mumps–rubella vaccination, and empirical treatment for intestinal parasites.

Although DIAC is expanding the geographical coverage for the PDMS, all current humanitarian entrants including those who have been proposed (Visa 202 holders) are subject to some level of screening. This may include a major screen by a medical practitioner or a basic screen by nursing staff. Additionally, the Australian Government requires those migrating under its Humanitarian Program to undertake certain health checks before being issued with a visa. The effects of PDMS have been positive. *“This may have lowered the rate of malaria and intestinal parasite burdens”*, however Smith (2006 p 587) also noted that *“recent experience in New South Wales has been that cases of malaria continue to be detected despite antigen testing overseas.”*

Other issues relevant to screening were raised in the MJA articles in 2006:

*“The detection rate for HIV among this previously screened population reported here by Martin and Mak (page 607) is low (0.12%), but is not zero. Further consideration of whether to repeat routine HIV screening after arrival is warranted. Hepatitis B tests are only conducted in a minority of entrants, (see Reference 2 in Smith 2006) yet this disease has important personal and public health implications.”*

*“Additionally, conditions such as anaemia, schistosomiasis and vitamin D deficiency flagged in the articles are, appropriately, not screened for overseas, yet warrant early detection and treatment.”*

*“At the same time, the risk to the public from various conditions must not be exaggerated, as this is potentially detrimental to attitudes about already marginalised*

*people, as shown by Leask et al (page 591). The fact that refugees have considerable health care needs is well documented, and these needs vary with region of origin and other factors.”* (Smith 2006 including references 3 and 4)

The Australasian Society for Infectious Diseases guidelines on refugee screening outline the best evidence on what to screen for in newly arrived refugees. These guidelines recommend that all refugees be offered a comprehensive health assessment within one month of arrival in Australia.

*“This should include TB, blood-borne viruses, schistosomiasis, helminth infections and STIs, other infections indicated by examination, catch-up immunisations. Further physiological, dental, nutritional, reproductive and developmental health issues should be addressed.”* (Australasian Society for Infectious Diseases 2009)

The advent of new GP screening items offering a one-off payment such as those under the Medicare Enhanced Primary Care items (714 and 716) has changed the mix of resources potentially available in the community. However, these new opportunities also raise new issues such as training and meeting accreditation criteria (Benson and Smith 2007).

GP screening services may be complementing more specialised assessments, but how the two systems work (or can work) together in practice is not clear. Raman et al. (2009) cited Medicare statistics that showed that the screening items had a limited impact with only 694 consultations over the first two years being provided for children aged 0-14 years in NSW.

The paper by Raman et al. (2009) documented the health needs of refugee children (under 14) who accessed three comprehensive refugee health services in New South Wales in 2005 and compared them to the number of refugee children settling in NSW in the same year. Only around one in five (331) was seen in a refugee specific clinic. The authors concluded that a *“small proportion of refugee children arriving in NSW have access to comprehensive screening and assessment, in spite of significant health needs. There is variation in screening practices, and follow up is poor.”* (Raman et al. p. 466)

The picture for the universality and the comprehensiveness of screening appears mixed at best when viewed from both the perspective of the specialist clinics for children and by examining what little is known about screening in the community in primary care. And this is the case for understandable reasons.

*“Consultation and screening of refugee families is time consuming and complex, nearly always requires interpreters, cultural awareness and sensitivity, and lengthy explanation to parents about the results of screening tests and about treatment prescribed. This is logistically difficult to achieve in busy general practices.”* (Raman et al. 2009, p. 469)

## 2 Models of refugee health service provision

This Section summarises the international and Australian literature, the current models of refugee health in States and Territories other than NSW and the existing models within NSW. Best practice depends on the context where it has to work, so this review does not include an exhaustive list of models described by how they are implemented in different countries. The approach taken is to highlight relevant issues across different countries, jurisdictions and within NSW.

The key concerns for health service design and planning to support practical models of care for refugees were described in chapter in a text book on refugee health covering 'from crisis to settlement' (Allotey P 2003). The main issues identified were those arising from the apparent dichotomy between specialisation and mainstreaming to meet special needs.

*“Service delivery that accommodates special needs is therefore necessary for obtaining service outcomes. A primary factor in deciding which service models to adopt is the respective ability of the different service models to incorporate those special needs.”* (Finney Lamb and Cunningham 2003, p.126)

Models of refugee health service provision will always include initial screening for a range of health and social needs, with the focus being both the health of the person and the protection of the community where settlement is occurring. The refugee settlement context is the main determinant of the model of provision, with important principles being equality of access to the same level and quality of primary care services that are available to the local population, and specialist services being adequately resourced to screen the number of arrivals in their defined geographic area and assist in the decisions about how their needs can be met. Most specialist models have as their goal the full integration of the refugee into the normal levels of mainstream health and social services.

### 2.1 Evidence from international literature

There is much international literature available on the needs of refugees. It covers the full range of needs – physical health, mental health, and extensive literature to assist health service providers in meeting these needs. However, literature looking at models of care of refugees is much more difficult to access and assess. Information that has been collected previously has generally been descriptive or has *“limited or untested validity or reliability.”* (Hollifield 2002)

In the various countries that accept refugees, there are a large number of jurisdictions that have responsibility for providing health care to refugees. This responsibility is often shared between differing layers of government including federal/national governments, state and local as well as a range of non-profit organisations. Every country, state and region has different models. As Finney Lamb and Cunningham (2003 p.124) write:

*“The adoption of a particular health service model for special needs groups is influenced by external factors such as existing health service infrastructures, and health and social policies”*

It follows that it is not useful to describe in detail the whole range of service provision models as this would necessitate coverage of the range of systems to put the detail into context. Accordingly, the discussion of models here is limited to using examples of literature where relevant principles and frameworks are described and suitable generalisations can be reliably made.

### 2.1.1 General principles and frameworks

Le Feuvre (2001) nominates two principles that should underlie the provision of services to refugees. The first is that refugees should have access to all of the same primary care services that are available to the local population, and the nature and quality of these services should be the same. The second principle is that if any specialist service is provided, it should have as its goal the full integration of the refugee into the normal levels of mainstream general practice (pp. 131-132). Le Feuvre (2001 pp. 132-134) also describes four possible approaches that can be adopted depending on the broader context of health service provision:

- A separate primary care service for refugees
- A stand-alone assessment service and resource centre
- Resourcing existing practices
- Nothing.

Watters (2001 pp 1714-15) advocates for a more holistic approach that includes integrating health and social services and advocacy across systems:

- Greater involvement of settled minority ethnic groups in service provision
- Working across traditional health and social service boundaries to meet the expressed needs of clients
- Combining advocacy services to ensure that refugees gain the maximum benefits from existing health and social care services.

Feldman (2006) conducted a literature review of primary health care for refugee services and developed a framework for services. He notes that the framework can be used for education and training, planning and commissioning, and to provide criteria for comparison and evaluation. This framework consists of:

- Gateway services to facilitate entry into primary care
- Core primary health care services such as GPs and health centres
- Ancillary services such as language and information services, specialist mental health and services for survivors of torture, and targeted health promotion and training of health workers.

### 2.1.2 Screening principles

Current practices in screening vary widely throughout the world and even within countries. The issue of 'what needs to be screened for' is paramount. The threefold need categories of Palinkas et al. (2003) is a helpful starting point but screening needs to be considered more broadly than just these three dimensions. Another issue to consider along with practical and logical principles is that, in a context of relative resource scarcity, there is little point in screening for conditions that are not significant, cannot be reliably detected or have no effective interventions.

There is a strong body of evidence supporting general health screening as well as screening for mental health problems. Barnes (2001 p.147) argues that mental health screening should be considered as part of a general health screening program and Vergera (2003 p.72) starts from the practical position that "*ideally the domestic health assessment should complement the mandatory overseas health assessment.*"

Stauffer (2002 p 881) lists the following criteria for a screening program that include the issues of the screening context, reliable detection and effective interventions:

- The condition sought should be an important health problem.
- There should be an accepted treatment for patients with recognised disease.
- Facilities to diagnose and treat should be available to the patient.
- There should be a recognised latent or asymptomatic disease stage.
- There should be a suitable test or examination (acceptable sensitivity, specificity, reliability, and positive and negative predictive value).
- The test should be acceptable to the population.
- The natural history of the disease, including development of latent to clinical disease, should be adequately understood.
- There should be an agreed-upon strategy of whom and how to treat.
- The diagnosis and treatment should be cost effective.
- There should be documented benefit from detection and treatment.

The Australasian Society for Infectious Diseases (2009, p.7) recommends that all refugees should be offered a comprehensive health assessment, ideally within one month of arrival in Australia. This should include:

- Screening for, and treatment of, tuberculosis, malaria, blood-borne viral infections, schistosomiasis, helminth infection and sexually transmitted infections;
- Testing for, and treatment of, other infections (eg *Helicobacter pylori*) as indicated by clinical assessment;
- Assessment of immunisation status and catch-up immunisations where appropriate.

The assessment can be undertaken by a general practitioner or within a multidisciplinary refugee health clinic. An article by Phillips and Benson (2007) outlines key considerations for general practitioners in developing an effective catch up immunisation program for refugees, including getting the right vaccines at the right time, and ensuring completion of immunisation courses. An appropriate interpreter should be used when required. The initial assessment should take place over at least two visits, the first for initial assessment and investigation, and the second for review of results and treatment/referral. Psychological, dental, nutritional, reproductive and developmental health issues should also be addressed at the post-arrival health assessment.

Screening programs therefore need to be part of a flexible response within a specific context and scaled to take account of the available mix of screening and treatment and support services. Decisions on the best ways to allocate resources between screening and treatment will also include considerations of more local levels of evidence about the risks and levels of need being managed and the trade-offs between public and personal health concerns. For example, there is still doubt on the value of compulsory screening for tuberculosis and HIV. Coker (2004 p 298) argues that the compulsory screening for these conditions is not based on adequate evidence and has practical and ethical problems.

The other critical factor of relevance is the background of the refugee. The evidence is that health status varies based on factors such as country of origin, age, sex and educational status and these factors need to be taken into account in deciding what to screen for. The general principle is that, while all refugees should have access to screening services, not all refugees need the same type or level of health screening. Health screening needs to be universally available but be sufficiently flexible to identify key public and personal health

issues in the most efficient manner. In this context, issues of both sensitivity and specificity need to be taken into account.

### 2.1.3 International examples of refugee health models

This section provides selective examples of refugee health models in other countries. It does not aim to be comprehensive but rather to illustrate a range of approaches adopted in other countries.

#### **Boston**

The Boston Center for Refugee Health and Human Rights (BCRHHR) is located at the Boston Medical Center, USA. It has what it describes as an innovative model of out-patient care. It provides comprehensive medical, mental health, and dental care - coordinated with legal and social services - to over 300 individuals from 67 countries each year. Interpreter services are available for over 30 languages. The Centre operates as an interdisciplinary collaboration between Boston Medical Center (Departments of Psychiatry, Medicine, Family Medicine, Pediatrics, Social Work, and Interpreter Services), Boston University (Schools of Medicine, Public Health, Dentistry, and Law), Global Lawyers and Physicians (a non-government organisation) and the National Center for Post-Traumatic Stress Disorder (<http://www.bcrhhr.org/>).

#### **Minnesota**

As part of the Refugee Health Program in Minnesota health assessments for newly arrived refugees are coordinated by the Minnesota Department of Health. Examinations take place within the first 90 days of settlement and are carried out by a mixture of public health clinics and private providers. These providers collaborate with local Volag caseworkers to assist new refugees in accessing relevant services. Volags are Voluntary Resettlement Agencies (usually religious organisations) whose goal is the successful resettlement of refugees in the United States. They use funding from the State Department's Bureau of Population, Refugees, and Migration to carry out this task. As part of this model newly arrived refugees are screened for Tuberculosis, Hepatitis B, Intestinal Parasites and Lead Poisoning (Minnesota Department of Health 2009)

#### **California**

The US Government Office of Refugee Resettlement funds and coordinates post arrival health assessments and time limited medical services for refugees. The Californian Health Refugee Program coordinates three programs funded by this Office:

- Refugee Health Assessment Program – provides comprehensive health assessments, focusing on screening and prevention of communicable diseases and early identification and diagnosis of chronic diseases
- Refugee Preventative Health program – aims to improve the treatment of chronic health conditions amongst refugees
- Refugee Medical Assistance Program – provides time- limited (up to 8 months) benefits from Californian Government health services.

These services are generally provided by the various county health services (<http://www.cdph.ca.gov/programs/Pages/RHPPProgramDescription.aspx>)

#### **Denmark**

Models within Denmark vary considerably between different groups of migrants. Some groups are systematically introduced to the Danish health system while others are not. Danish policy does not ensure equal access to health care for all groups (Annual EUPHA meeting 2006).

## Netherlands

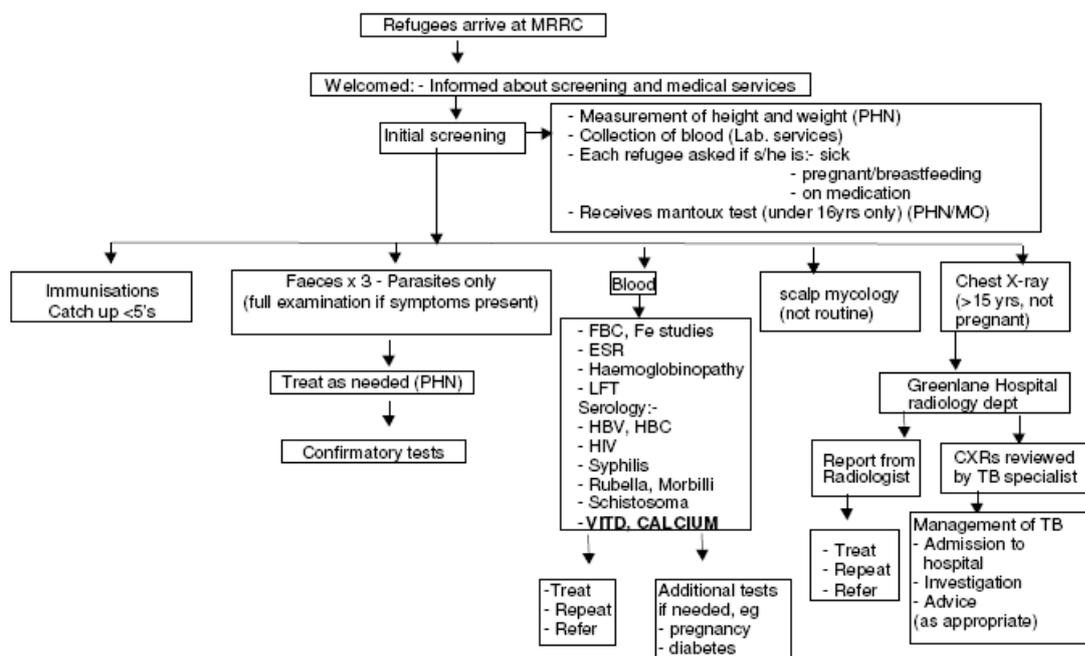
Preventative and curative services are largely integrated into mainstream services. Community Health Services are responsible for preventative health services and referral to primary care. There is an emphasis on using mainstream providers with close cooperation and coordination between all partners (Annual EUPHA meeting 2006).

## New Zealand

**Refugee services are concentrated in Auckland. The Auckland Regional Public Health Service Refugee Health Clinic at Mangere Refugee Reception is the National Refugee Health Screening Centre in New Zealand. It works with a strict screening protocol (see Figure 1).**

The Auckland Refugees as Survivors Centre (ARAS) provides a counselling service for the treatment and rehabilitation of survivors of torture and trauma. A Refugee Community Health Worker Team provides assistance to families from refugee backgrounds in the Auckland region and two community health services provide mental health assessment, diagnosis and treatment for clients from refugee backgrounds in Auckland. Refugees in other parts of New Zealand receive mainstream services ([http://www.refugeehealth.govt.nz/Refugee\\_Health\\_Service.htm](http://www.refugeehealth.govt.nz/Refugee_Health_Service.htm))

**Figure 1 New Zealand screening protocol**



## 2.2 Models of care for children

Zwi et al. (2007) reported on the findings of a Working Party of the Royal Australasian College of Physicians on the health needs of refugee children. It provides a set of consensus principles for how health services need to be enhanced in order to address the complex health needs of refugee children, young people and their families. These principles are relevant to the new plan:

1. Develop services that consistently affirm the dignity of refugees.
2. Develop a whole-of-government approach to best address the health and well-being of refugees settling in Australia and New Zealand.

3. Provide publicly funded health care to all refugees, with a mixture of targeted and mainstream services.
4. Provide high quality, accessible, culturally respectful and affordable health care for refugee families.
5. Offer comprehensive health assessments post arrival (addressing physical and psychosocial needs) and appropriate follow-up care for every refugee who arrives in Australia or New Zealand.
6. Develop services with appropriately trained, multidisciplinary team members, multicultural health workers, refugee workers and readily available professional interpreters.
7. Abolish the differential access to health services based on visa category.
8. Abolish current Australian legislation that allows children to be housed in detention centres.
9. Ensure that previous health records are made available and provide personal health records for refugee children, to allow for improved communication of their health needs.

In a refinement on the College position, a manuscript titled '*Elements of good practice for health service delivery for newly arrived refugee children*', (Woodland et al. 2009) highlights ten generic elements of relevance to the new plan associated with improved access, equity and quality of care in service delivery for newly arrived refugee children. The authors based their findings on current national and international literature and existing service models in the Australian paediatric refugee health care area. The ten elements are identified as:

- routine comprehensive health screening
- coordination of initial and ongoing health care
- culturally and linguistically appropriate service provision
- accessible and affordable services and treatments
- integration of physical, developmental and psychological health care
- intersectoral collaboration
- consumer participation
- data collection and evaluation to inform evidence based practice
- capacity building and sustainability
- advocacy.

The authors conclude that the ideal service models vary by jurisdiction, but the principles embodied in these elements provide a framework for refining current service models and for future service development. The rationale for the refinement of models is essentially threefold. The first is that refugee children are a highly vulnerable group within the community with specific health needs related to their background and experiences. The second is that refugee families facing multiple barriers in accessing appropriate care within the mainstream health system and the third is that there are significant complexities associated with the delivery of comprehensive, effective health care to refugee populations in Australia.

### ***2.3 Models in States and Territories other than NSW***

There are significant differences between the States and Territories in the numbers of refugees who have settled and the models of provision that have been adopted.

### 2.3.1 Victoria

In the past ten years more than 38,000 refugees have settled in Victoria under Australia's Humanitarian Program (Refugee Health Research Centre, 2006). The Immigration Update 2007-2008 reports that there were 1,546 refugees settled in Victoria in that period and that total humanitarian entrants was 3,216 (Australian Government Department of Immigration and Citizenship, 2008). Rural settlement initiatives in Victoria have seen diverse settlement of refugees within Victoria, including in metropolitan, rural and regional areas.

The Victorian refugee health model is based on general practitioners in community health centres and private practice, supported by refugee health nurses (Smith, 2006). Victoria incorporates an array of integrated and refugee-specific services and programs that have evolved from a strong tradition of local multidisciplinary primary health care, in particular with the employment of GPs in Community Health Centres. In addition Victoria has built a strong regional focus in a number of hospitals and clinics through its Regional Humanitarian Settlement Pilot sites, as well as State-wide services run through metropolitan hospitals.

To assist new Humanitarian Program entrants to settle, the Australian Government funds various services provided by non-government organisations under the Integrated Humanitarian Settlement Strategy. One of these services is Early Health Assessment and Intervention, which primarily provides a torture and trauma assessment with referral to other health care services as required. Assistance is available for the first 12 months after arrival. The Victorian Foundation for Survivors of Torture (VFST) is the provider of the Early Health Assessment and Intervention program in Victoria. (VFST, 2004)

The Victorian Department of Health (previously the Victorian Department of Human Services) and its funded agencies provide a range of key services for refugees and asylum seekers (VDHS, 2008). In addition a number of state wide, regional and local initiatives have been implemented, including specialist services and the improvement in flexibility and accessibility of existing services (VDHS, 2008). The Victorian Department of Human Services (VDHS) (2008) outlines a number of initiatives, programs and services in the Refugee Health and Wellbeing Action Plan 2008-2010.

In 1987 the Victorian Foundation for Survivors of Torture (Foundation House) was established to provide torture and trauma counselling and health promotion assistance to newly arrived refugees. The Refugee Special Needs Dental program was established in 1997. The Refugee Health Nurse Program was established in 2005 and further major expansion occurred in 2006. This program provides refugee health nurses in metropolitan, regional and rural areas of Victoria. Further expansion of the program in 2008-09 aimed to provide more refugee health nurses for rural and regional health services (VDHS, 2008).

Specialist refugee health services have been largely established in metropolitan locations, with some co-located with large mainstream health facilities. In 2001 an Immigrant Health Clinic at the Royal Children's Hospital commenced with a multifaceted clinic providing assessment, consultation and research and education. A Refugee Health Service was also integrated with the Victorian Infectious Diseases Service at the Royal Melbourne Hospital, providing specialist infectious diseases advice and inpatient and outpatient services, as well as research and education. In 2003 a Multicultural Health and Support Service was established to work state-wide with CALD and refugee communities affected by issues related to HIV, hepatitis C and sexually transmissible infections.

Regional refugee health services have evolved in response to the establishment of Regional Humanitarian Settlement Pilot sites. The first pilot site was established in Shepparton in 2005. A Refugee Child Health Clinic was also established in Shepparton. Ballarat was established as Victoria's second Regional Humanitarian Settlement Pilot site in 2007. Barwon Health responded by establishing a GP referral service as part of its existing Infectious Diseases Clinic in Geelong.

In 2007 a refugee health clinic was established at Dandenong Hospital (Southern Health) through a partnership between the hospital, local GPs and the refugee health nurse at Greater Dandenong Community Health Centre. In 2008 the asylum seeker clinic in Dandenong was consolidated as part of the Dandenong Refugee Health Service at Dandenong Hospital.

Refugee health services in Victoria have evolved to serve the needs of both metropolitan and rural and regional refugee populations. The rural and regional model of refugee health care is characterised by the establishment of refugee health clinics within community health services. These clinics are supported by state wide programs such as the Refugee Health Nurse program, the Refugee Special Needs Dental Program and infectious disease services. Metropolitan services are characterised by the provision of specialist services located within mainstream services that also provide referral services to primary care practitioners as well as access to state-wide programs.

### 2.3.2 Queensland

Over the past ten years there have been increasing numbers of Humanitarian entrants into Queensland, with their origins different to previous years and often having poorer health status (Queensland Refugee Health Service Plan, 2008). Humanitarian entrants into Queensland, including refugees, is approximately 1,600 entrants annually and they will be settled in the metropolitan and regional areas of Brisbane, Logan/Gold Coast, Toowoomba, Cairns and Townsville (Queensland Refugee Health Service Plan, 2008).

The Queensland refugee health model is primarily based on the provision of refugee health clinics in central and regional areas and increased capacity in refugee health nurses who work with local GPs and other practice staff. The Queensland Refugee Health Service was approved and established in 2008. The aim of the service is to provide refugees, special humanitarian entrants and asylum seekers with a standard initial health assessment, short term health management, support for complex cases and referral to continuing care, GPs in particular. A 'hub and spoke' model forms the basis of the service, with a central hub in Brisbane supporting local services across the state. (Queensland Refugee Health Service webpage accessed 4<sup>th</sup> Nov 2009 at:

[http://www.health.qld.gov.au/multicultural/health\\_workers/refugee\\_hlth.asp](http://www.health.qld.gov.au/multicultural/health_workers/refugee_hlth.asp)).

The Queensland Integrated Refugee Community Health Clinic (QIRCH) in Brisbane provides an initial clinical nurse and GP health assessment and short-term medical treatment for complex health needs. QIRCH will also manage the transfer of patient care to a local GP for ongoing health care and management. The Logan Refugee Health project operates 1-3 days per week and provides initial health screening, commences catch up of the immunisation schedule and referral to other services and health professionals. (QIRCH webpage accessed 3<sup>rd</sup> Nov 2009 at: <http://www.mater.org.au/Home/Services?QIRCH-Clinic.aspx>)

Torture and trauma support is provided through the Queensland Program of Assistance to Survivors of Torture and Trauma. Settlement services operate in Brisbane, Toowoomba, Logan and the Gold Coast, Cairns and Townsville. Asylum seekers in Queensland who are ineligible for Medicare are not charged for health care by Queensland Health Services. The Transcultural Mental Health Centre will also help refugee and asylum seekers gain free assessment and treatment for adults in hospital or community based services. (Queensland Refugee Health Service webpage accessed 4<sup>th</sup> Nov 2009 at: [http://www.health.qld.gov.au/multicultural/health\\_workers/refugee\\_hlth.asp](http://www.health.qld.gov.au/multicultural/health_workers/refugee_hlth.asp))

### 2.3.3 South Australia

For the years 2007-2008 there were approximately 975 humanitarian entrants into South Australia of which 567 were refugees settling permanently in the state (Australian Government Department of Immigration and Citizenship, 2008).

Refugee health services in South Australia follow a mainly biomedical model that provides initial screening and treatment of infections and other health problems in the initial twelve months and then assists refugee patients to gain access to continuing care through mainstream health services and primary care practitioners. There has been criticism of this approach in that GPs are largely under-resourced in the provision of effective initial care for refugees. Johnson et al. (2008) argue that a better model involves the provision of initial care for the complex health needs and settlement challenges of refugees through the existing specialist health service in Adelaide.

The Migrant Health Service (TMHS) in Adelaide provides a complete health check once Humanitarian entrants arrive in South Australia. TMHS also provides women's health clinics, immunisation assistance, education and referral services and counselling services for current and past experiences. The Survivors of Torture and Trauma Assistance and Rehabilitation (STTARS) is also available to help refugees whose experiences include torture and trauma (STTARS website accessed 6<sup>th</sup> Nov 2009 at: <http://www.sttars.org.au/>). The South Australian Health Network is a group of health professional who have an interest in providing health services to refugees and other humanitarian entrants.

### **2.3.4 Western Australia**

The 2007-2008 Immigration Update (Australian Government Department of Immigration and Citizenship, 2008) recorded the permanent settlement of 1,010 refugees in that state for that period. Western Australia has a largely biomedical model of health care for refugees and asylum seekers based on centralised services for initial and complex care after which patients are referred to local GPs for health care management. The main focus is in detecting and treating communicable diseases such as tuberculosis, malaria, sexually transmitted diseases and parasitic diseases (Health Department of WA, 2000).

The Migrant Health Unit in Perth provides a comprehensive health assessment to all refugees settling in Western Australia, treatment and management for communicable diseases, review and catch-up of immunisation status, liaison and referral services to primary and community health care services and advocacy services (WA Department of Health Migrant Health Unit webpage accessed 6<sup>th</sup> Nov 2009 at: [http://www.health.wa.gov.au/services/detail.cfm?Unit\\_ID=886](http://www.health.wa.gov.au/services/detail.cfm?Unit_ID=886)). Western Australia has a Refugee Health Network that provides only limited services. These include assistance in finding a health provider and answering general inquiries.

### **2.3.5 Northern Territory**

Approximately 160 refugees were settled in Darwin in 2008-2009 (General Practice Network Northern Territory (GPNNT) website accessed 2<sup>nd</sup> Nov 2009 at: <http://www.gpnnt.org.au/site/index.cfm?display=49427>). The Northern Territory model of care is similar to the biomedical model used in South Australia in which a specialist service provides initial and complex care while GPs provide other and ongoing care in a primary care setting.

The Refugee Health Service in the Northern Territory began in May 2009 (GPNNT website). An initial Refugee Health Assessment is provided as well as follow-up care through the service for 12 months after arrival. The Refugee Health Service provides primary care through the Northlakes Medical Centre and the Vanderlin Drive Surgery. The Melaleuca Refugee Centre provides services for the survivors of torture and trauma as well as resettlement services. The Northern Territory Centre for Disease Control and Community Health also has input into the program.

### **2.3.6 Tasmania**

Approximately 400 to 500 refugees arrive in Tasmania every year (DHST website accessed 2<sup>nd</sup> Nov 2009 at: [http://www.dhhs.tas.gov.au/about\\_the\\_department/structure/groups/chief\\_health\\_officer/population\\_health/units/population\\_and\\_health\\_priorities/multicultural\\_health/refugee\\_health](http://www.dhhs.tas.gov.au/about_the_department/structure/groups/chief_health_officer/population_health/units/population_and_health_priorities/multicultural_health/refugee_health)).

The Tasmanian model of care for refugees is similar to the Western Australian model in which centralised services are based in a public hospital and focus mainly on infectious diseases and screening (Smith, 2006).

Tasmania's Bi-cultural Community Health Program provides support and training for new arrivals across the state. The Refugee and Humanitarian Arrival Clinic (RAHAC) is based at the Royal Hobart Hospital. RAHAC provides a free comprehensive health assessment to assist GP's in addressing the initial health needs of refugees. The clinic also takes referrals from GPs and relevant health workers. There is also an RAHAC outreach clinic at Launceston General Hospital that provides the same services and supports for Northern Tasmania. A Refugee Migrant Liaison Officer also works out of the Royal Hobart Hospital.

### **2.3.7 ACT**

The ACT recorded a total of 251 Humanitarian entrants of which 83 were classified as refugees in the period 2007-2008 (Australian Government Department of Immigration and Citizenship, 2008).

Companion House Refugee Health Service provides medical services and is attached to Companion House Torture and Trauma Service. Companion House is staffed by four part time doctors, an administrator and a full time practice nurse. The service provides targeted specialist care in the first twelve months of a refugee's arrival after which patients are referred to primary care.

However, a recent submission to the ACT Legislative Assembly (Companion House, 2009) noted that it was increasingly difficult in the past two years to transfer patients out to community GPs due to the lack of GPs in the local area. The submission pointed out that the Primary Health corporate model was more suited to acute care episodes rather than the chronic and complex care needs experienced by refugees. It went on to say that the service often found itself working in parallel to traditional services instead of as a transitional service.

### **2.3.8 Conclusions from models in other States and Territories**

In an editorial in the Medical Journal of Australia, Smith (2006) has described how there are varying levels of assessment and health services provided for refugees and humanitarian arrivals in the different states. Victoria has made significant efforts in providing comprehensive health services for refugees that incorporates a wider array of health professionals and services. Queensland has also worked to develop a regionalised approach to care with an increasing focus on the broader aspects of refugee health. Counselling and other services for psychological problems related to torture and trauma of refugees are mainly provided in the non-government sector.

Victoria is one state in which the refugee health service employs a comprehensive approach to health that focuses on physical, psychological, psychosocial needs, including oral health, nutrition, under-managed chronic conditions and issues related to violence. A number of other states have also begun to incorporate a more comprehensive approach to refugee health. It is also evident that some states have not yet moved past a model of care that focuses solely on the detection and treatment of infectious diseases.

The health-related sections from three evaluations of regional humanitarian settlement projects (in Shepparton, Mount Gambier and Ballarat) have been distilled into a set of lessons. They provide insights into the training and information needs in local communities, screening and needs assessment issues and the demands on the local systems that are making responses to those needs (Piper 2009).

## 2.4 NSW models and experiences

Over the past five years NSW has received 32% (20,494) of total Australian humanitarian entrants where their place of settlement is known. These newly arrived refugees and asylum seekers are highly diverse in respect of their ethnicity, gender, age, class, religion and socio-economic status.

Of the 6,500 refugees settled in NSW over the 2 year period between 2006 and 2008, half were born in either Iraq (38%) Sudan (9.3%) or Afghanistan (8%) and 45% of these refugees were under the age of 19 (NSW Department of Health 2008).

Approximately 80% of refugees initially settle in the Sydney Metropolitan area. The majority of these settle in Western Sydney with the most common local government areas of settlement being Fairfield (20.7%), Liverpool (11.4%), Blacktown (11%) and Auburn (8.9%) (NSW Department of Health 2008). Significant numbers of refugees also initially settle in rural and regional areas of NSW. Over the last 5 years the major settlement locations have been the Hunter, Illawarra, Murrumbidgee, Mid-North Coast and Northern Rivers Area.

Most Areas in NSW have models of care that include specialist clinical services with an Area wide set of roles such as area diabetes or community nutrition services, sexual health and sexual assault and violence related services. There are also more specialised services or Area programs for priority population groups including aboriginal health, women's health, multicultural health, youth health and locality based community development services in disadvantaged communities.

IHSS is a program funded by the Department of Immigration and Citizenship (DIAC) that aims to assist in the settlement process for refugees. In NSW, Humanitarian entrants receive specialised services provided on contract through ACL and Anglicare. These services provide settlement support including case co-ordination, airport reception, provision of settlement information, help in finding accommodation, help in arranging income support and enrolling in Medicare, promote access to English classes and to short-term torture and trauma counselling services.

As a part of the service IHSS case managers are required to link newly-arrived refugees with a GP or a medical centre with 7 days. Ongoing support is provided by IHSS for up to twelve months after a refugee arrives in Australia (NSW Department of Health 2009). More information about settlement issues comes from the reports produced by review processes (see Piper 2009) and information about IHSS can be found at: [http://www.immi.gov.au/living-in-australia/settle-in-australia/find-help/refugee\\_humanitarian/ihss.htm](http://www.immi.gov.au/living-in-australia/settle-in-australia/find-help/refugee_humanitarian/ihss.htm)

GPs can bill Medicare under Item Numbers 714 or 716 for a refugee assessment. However, the take up rate is reported to be low.

NSW Health does not directly fund refugee services, although departmental policy and guidelines identify refugees as a target population. A summary of the state-based services and models of care available for refugees in NSW are summarised in Table 1. This Table highlights a variety of models for refugee medical assessment in NSW. A single point of referral for refugees is provided for in Newcastle, Wollongong, Wagga Wagga and Coffs Harbour. According to key stakeholder consultations, the Greater West of Sydney has a range of models of primary and specialist refugee health care, with about 20% of the refugee population attending public health clinics.

Encompassing a state-wide approach, the NSW Refugee Health Service (RHS) is funded through Sydney South West Area Health Service. Its state-wide role relates to policy, planning, education, information, advice provision and the development of resources and tools. The service collaborates with Area Health Services, state-wide multicultural health

services and other agencies to improve access to health care for refugees and to foster more appropriate care (Sydney South West AHS 2009a).

The RHS also provides clinical and health promotion activities focussing primarily on the greater west of Sydney (<http://www.sswahs.nsw.gov.au/sswahs/refugee/>). The Service employs salaried GPs and three FTE Refugee Health nurses and 20% of all new arrivals in Sydney are seen in these clinics. GP training is also a key function of the Refugee Health Service, but the GPs seeing refugees may not be those who are trained.

Established in 1988, STARTTS is a NSW State-wide service providing a range of services for refugees who have been exposed to torture and trauma (NSW Department of Health, 2008). The services offered include counselling, group therapy, group activities and outings, camps for children and young people, English classes and physiotherapy. More information about STARTTS can be found at: <http://www.startts.org.au/>

STARTTS has developed specialised outreach services in similar regional Areas as described in Table 1. These include:

- Coffs Harbour – 5 days per week. Outreach services are provided in Lismore and Armidale.
- Wollongong – 3 days per week. Outreach services are provided in Wagga Wagga on a fortnightly basis.
- Newcastle. Outreach services are provided in Maitland and Singleton and the Central Coast, when required (NSW Department of Health 2009).

The Transcultural Mental Health Service (TMHC) is a State-wide service based in Western Sydney. It promotes access to mental health services for people of CALD backgrounds and publishes the results of studies and conferences. It has produced a series of monographs on the vulnerabilities and resettlement challenges facing refugees (Barnes 2003).

In view of the high proportion of refugee children arriving in NSW, a number of specialist paediatric services have been established with the support of the Refugee Health Service. Specialist refugee paediatric clinics and programs have been developed by the Children's Hospital, Westmead, The Sydney Children's Hospital, Randwick, Liverpool Hospital, and the John Hunter Hospital, Newcastle. These services aim to detect personal and public health problems at an early stage, improve health, development and learning, and to reduce the need for secondary or tertiary healthcare at a later time (NSW Department of Health 2009).

Paediatric medical assessments and care for refugee children is also available in regional and rural centres in NSW, wherever paediatricians are located. The level of health screening and interventions may be variable and dependent on availability of local resources (NSW Department of Health 2009).

The workshop accompanying the presentation of the findings from the present literature review, held in November 2009, provided the opportunity to describe the various models in current use in NSW and briefly examine their strengths and weaknesses (Sydney South West Area Health Service 2009b).

Table 1 summarises the models of care in NSW, drawing on material from the *Final Draft - Review of the NSW Health Strategic Directions in Refugee Health 1999 – 2009 - A Decade of Change* (NSW Department of Health 2009). All rural and regional services attempt to see 100% of newly arrived refugees/SHP arrivals, with different models operating in different places (see Table 1). There are obvious similarities and differences between the models in place for refugee health in different Areas, but overall, because of the responsibilities of Area Health Services in NSW, they share a range of common features and operational and governance characteristics.

### 2.4.1 Special context of Greater Western Sydney

Western and South Western Sydney may present a special case for consideration in the new plan. This region receives 60-65 new refugees per week on average, with numbers and country of origin at any point in time largely dependent on the 'push' factors in the re-settlement context.

The Areas that attract significant numbers of refugees and new settlers (Sydney South West and Sydney West) are both predominantly metropolitan Area Health Services (with smaller semi-rural communities on the periphery) with populations of over 1.2 million people that are experiencing strong population growth. They serve diverse communities with older established populations in the centre and inner ring western suburbs and in the rural areas and major urban growth corridors with high birth rates and a younger age profile.

Both Areas include LGAs with large multicultural populations, high levels of socioeconomic disadvantage and high health need related to low income, higher unemployment, lower levels of educational attainment, high child protection notification rates and high reported rates of violence.

Refugees are settled directly into the community so there may be large distances between major areas of settlement e.g. Liverpool, Auburn, Fairfield etc, and difficult transport challenges especially for newly arrived refugees if they are expected to travel to a clinic.

The NSW Refugee Service (RHS) is funded through Sydney South West Area Health Service, but is a state-wide approach. Its role relates to policy, planning, education, information, advice provision and the development of resources and tools. The service collaborates with Area Health Services, state-wide multicultural health services and other agencies to improve access to health care for refugees and to foster more appropriate care.

### 2.4.2 Rural NSW

A recent study by Sypek et al (2008) explored the impact of regional resettlement of refugees on rural health services in an attempt to identify critical health infrastructure required for successful refugee resettlement. The study took place in four de-identified rural communities in NSW, each of which were classified as Areas of Medical Workforce Shortage.

The study highlighted that the difficulties experienced in rural Australia in securing equitable access to health services are amplified for refugees, particularly in primary health care. Sypek et al developed a list of, what they argue are, 'critical' health infrastructure for refugee health in the early resettlement period.

With regards to primary care, this list included access to general practice with staff willing to provide refugee health care and some surge capacity, subsidised dental services and access to trauma counselling services. The importance of care coordinator for first six months to one year of refugee resettlement was also highlighted.



**Table 1** *Summary of Refugee Health models used in NSW*

Area	Location	Population	Refugees seen per year	Model type	Description from draft review	Staffing	Coverage
Sydney Metropolitan Area -The Refugee Health Service - RHS	RHS office at Liverpool and administered by Sydney South West Area Health Service.	Metropolitan	600-700 clients per year	A range of models of primary and specialist refugee health care. Health promotion is a key service.	The RHS provides short-term health care and referral to health services through one (weekly) clinic in Liverpool and 2 (weekly) clinics located in Blacktown and Auburn Community Health Centres. Refugee nurses follow up clients to ensure referral services are accessed and effective treatment is followed.	3 FTE Refugee Health Nurses together with salaried GPs. NSW Health does not directly fund refugee health services, although departmental policies and guidelines recognise refugees as a target population.  Non-humanitarian refugees are given the option of accessing GPs by the local DIAC funded settlement service (IHSS) - refugees must be linked with a GP within 7 days of arrival.	20% - 25% of new arrivals are seen in the clinics while others are seen by GPs on referral from IHSS.
Sydney Metropolitan Area- HARK Clinic Westmead Childrens' Hospital	Westmead Children's Hospital	Refugee children		Hospital Clinic	The HARK clinic provides early detection and intervention for health issues such as poor vision, hearing difficulties, under-immunisation etc		
Sydney Metropolitan Area – Liverpool Paediatric Clinic	Liverpool Hospital	Refugee children in SSWAHS		Hospital Clinic	The SSWAHS Department of Community Paediatrics in collaboration with NSW RHS and the Liverpool Chest Clinic for refugee children and young people from SSWAHS	1 paediatrician part time	
Sydney Metropolitan Area- FLYHT Youth Health Clinic	Fairfield	Refugee youth	Recently established	Community health clinic	A specialised Youth Health Clinic developed in partnership with youth health service (FLYHT), community paediatrics, RHS and STARTTS.		

Area	Location	Population	Refugees seen per year	Model type	Description from draft review	Staffing	Coverage
Hunter/New England Health	Newcastle Community Health centre	Regional	Not reported	Provides a family-centred, on-arrival refugee health screening clinic.	Families are referred by the local IHSS provider and offered a free comprehensive medical assessment, investigations, follow-up treatment, immunisations, oral health education, hearing and optometry screening and referral. Children are assessed by a Paediatrician from JH Children's Hosp, while a GP and an adult infectious diseases specialist provide the medical assessments of adult refugees.	The service employs one part time paediatrician (0.4), 2 X 0.6 FTE registered nurses, who provide services at the clinic and who work with GPs to ensure follow-up and linkage to appropriate health care. The service also supports GPs through education and training, screening and management guidelines and referral advice.	The service provides almost 100% coverage of refugees who present.
Hunter/New England Health	New England area	Regional /rural	Not reported	Refugee Health Nurse working with General Practitioners	The RHN travels between town centres promoting health care access for newly arrived refugees. The service provides support to GPs through education and training, screening and management guidelines and referral advice.	0.6 FTE registered nurse.	The service provides almost 100% coverage of refugees.
SES/Illawarra Refugee Health Program	Wollongong area	Regional	123 newly arrived refugees between March 2007 and February 2008.	Provides routine comprehensive health assessment on arrival.	Refugee families are visited at home by the multicultural health worker who provides them with information about the health system and are linked to 3 trained and supported local GPs by the IHSS settlement service caseworker. The refugee health nurse facilitates communication between GP and hospital services and supports GPs in coordinating care of complex cases. This is supported by quarterly health clinics provided by SCH (outreach service).	All referrals go to 2 trained and supported private practice GPs, with support from 2 X 0.6 RH Nurses. Back up provided by specialist clinics at the Wollongong Hospital.  In 2007, Sydney Children's Hospital implemented the General Practitioner-Hospital collaborative care model in collaboration with the Wollongong Hospital, the SESIH Multicultural Health Service and the local Division of General Practice. The model places a network of refugee-friendly GPs in private practice at the centre of care for newly arrived refugees.	The service provides almost 100% coverage of refugees.

Area	Location	Population	Refugees seen per year	Model type	Description from draft review	Staffing	Coverage
North Coast Area Health Service (Coffs Harbour Refugee Health Clinic)	Coffs Harbour Health Campus	Regional/rural	Approx 240 refugees between 2006 and 2008.	Provides a weekly clinic.	The clinic provides a comprehensive health assessment to newly arrived refugees and health care to other refugees that access the clinic for other medical problems. The IHSS provides transport to the clinic for initial assessment and prescriptions are filled by the CNC who delivers medications to the patients' home free of charge to the patient. Refugees are referred to a GP in the community for ongoing care.	7 general practitioners (rotating roster), a CNC, a registered nurse (0.2) and an administrative officer. The clinic is funded by Medicare through refugee health assessment and care plan item numbers. The CNC is a public health nurse paid for by the Area Health Service.	Anglicare referral ensures 100% coverage of Visa 200 arrivals.
Greater Southern Area Health Service	Multicultural Council Wagga Wagga (MCWW)	Regional/rural	In 2006 between 150 and 200 refugees settled in Wagga Wagga.	As required.	MCWW provides initial orientation, information and referrals linking newly arrived refugees with housing, employment agencies and centreline. St Vincent de Paul provides social, societal and basic life skill support and education as well as support at medical and other appointments liaising with MCWW (Duncan et al, 2009).	One part-time GP performing initial assessment and intervention.	Regional centres and outlying towns

## 2.5 A typology of service provision models

Table 2 presents a typology of the various models of service provision that are currently in place. This typology is not meant to be comprehensive as many variations of these broad models existing in practice.

In reality, a refugee may move through several of these models over time. For example, a person may initially be seen in a specialist clinic and followed up by a RHN before being transferred to the primary care of a GP at a later time. Equally, a refugee may receive concurrent care from providers operating in different service models. For example, children seen in a specialist paediatric clinic may also be accessing other services concurrently.

**Table 2** *Typology of service provision models*

Model	Characteristics	Examples/comments
GP primary care	Refugee linked to a GP on arrival who undertakes initial health screen or comprehensive assessment and refers to other services as required	This is the standard GP-led primary care model. It is implicit in the DIAC IHSS approach. MBS items exist for screening etc.
Community health primary care	Refugee linked to a multidisciplinary publicly funded community health centre on arrival. Staff at the CHC undertake initial health screen or comprehensive assessment and refers to other services as required	Some Victorian services, including centres with salaried doctors.
Specialist community clinic or centre	Refugee linked to a specialist centre on arrival that undertakes initial health screen and delivers initial services. Over time, links refugee into GP and other primary care services as required but may continue to provide some specialist services (eg, torture and trauma).	SSWAHS RHS, Companion House ACT.
Refugee Health Nurse	Refugee linked to a RHN on arrival who undertakes initial health screen, links refugee into GP and other services as required and acts as ongoing case manager until the refugee is ready for referral to mainstream services.	The RHN may be employed by a specialist clinic/service or by a CHC
Hospital specialist clinic	Referral service for designated target group/s	Paediatric clinics at Westmead Children's, Sydney Children's Liverpool and John Hunter. Other examples include women's health clinics, dental clinics and infectious diseases clinics.
Mixed	Any combination of the above	

Several dimensions distinguish the various service models. One is the first point of contact and whether this first point of contact is a primary care or specialist service. Another is the nature of the provider who takes on the initial and ongoing care coordination roles. Whether the service aims to be universal or targeted also differs, as does the degree to which training and research is embedded into the service model. The level of collaboration with other refugee providers is a further dimension and another is the philosophy underlying the service. Some services are grounded in a social justice model, some in a public health model and some in a personal health model.

### **3 Discussion – implications for NSW of the findings from the literature**

In locations with significant ongoing refugee settlement, a mix of models is likely to be needed. Publicly funded clinics offer a number of advantages, including centralised knowledge and strong links with key refugee agencies. Specialised health care services targeting refugees also provide important education and support to GPs and other health care staff. Important additional screening resources are potentially available through Medicare-funded GP assessments but there are concerns about how the accreditation and training issues are to be resolved.

As with any health care provision to special-needs groups, particularly where there are relatively low numbers of people overall but potentially high levels of need, there are debates about the requirements for mainstream versus specialised services. Multicultural health services, ethnic health workers, interpreter services, refugee health services, refugee nurses and torture and trauma services fall into the specialist service category.

Whatever the model for providing health assessments, newly arrived refugees need help to overcome the barriers they face in accessing health care. Increased availability of DIAC-funded case workers and of volunteers will help refugees negotiate our complex health care systems. Community education about available health care services is also important. Mainstream health care services must be capable of providing sensitive, culturally appropriate care to these vulnerable groups (Smith 2006, p.587).

Interventions that aim to improve the health of refugees are arguably a sub-set of models that work in a multicultural context. Regardless of the model, the initial need is for screening for existing health conditions and communicable diseases and specialised follow-up of particular health and mental health problems.

However, effective refugee health services are not limited to services in the initial period after arrival. Ongoing services that are effectively targeted at the health promotion/prevention end of the health resource spectrum are required, particularly given that the principle that refugees should have access to mainstream services, including primary care. Equally, some people will require ongoing access to specialist refugee health services as well as to mainstream specialist medical services. Mainstream interventions are expected to be delivered collaboratively involving the refugee's cultural community wherever possible and with the health sector.

Effective interventions for all special needs groups are usually specialised in their approach and service delivery models are also aimed at modifying existing health services, both generalist and specialist, so that they reflect the needs of consumers. Cultural competencies are promoted to ensure that special needs are identified as an important component in education and professional development for community health and hospital staff (Owen et al. 2008).

#### ***3.1 The balance between primary and specialist services***

There has been an increasing trend towards the establishment of specialist teams within the health system in recent years and a strategic issue for refugee health is the best local mix of service types and a balance between primary and specialist services.

While there is common view in the literature that there needs to be a strong generalist primary care base, many of the examples of best practice come from small specialist teams that have established their own data collection and evaluation systems. They can point to the good outcomes that they are achieving and the need to expand such programs. Examples in NSW include the Refugee Health Service, STARTTS, the TMHC and specialist clinics for children.

However, the establishment of more specialist teams will not be feasible in the context of the whole of NSW. For rural communities, a strong generalist primary care service can deliver a range of services locally without the need for consumers to travel long distances to access specialist services. From an efficiency perspective, a generalist primary care model is more cost effective in cases where it can be demonstrated that health outcomes are similar. This implies the need for training and effective linkages to specialist services as required.

The international literature highlights a wide range of primary care services that target refugee health. For example, in London new types of primary care services have been developed in areas where large numbers of refugees can be found. These services are coordinated by specialist health visitors. These health visitors are public health nurses who predominantly work with refugee families with children under the age of five. They provide a service to all refugee families in their own homes and in community clinics. However there has been little systematic analysis and evaluation of the effectiveness of such and as a result there is little evidence to guide primary care services in the development of new models (Feldman 2006).

One possible exception to the paucity of evaluation evidence can be found in Victoria. The Victorian Refugee Health Nurse Program (RHNP) employs community health nurses with expertise in working with culturally and linguistically diverse and marginalised communities. These nurses support the provisions of a coordinated model for refugee health care with complementary and multiple entry points. They are based in community health services with high refugee populations and have a focus on the early health assessment of newly arrived refugees, assisting and referring people to other primary and specialist health services. They also work with local general practitioners and community health services to help them better respond to the health and wellbeing needs of refugees (Victorian Refugee Health Network 2008).

An independent evaluation of the Greater Dandenong Community Health Service Refugee Health Nurse Program was recently undertaken. It found that the strength of the program was strongly influenced by nursing practice changing from traditional clinical practice, which is often task, individual and disease treatment orientated, to creative, non-traditional nursing practices involving an 'active outreach' model of nursing care to provide services within and outside of the clinic or hospital setting (Victorian Government Department of Human Services 2008).

Finney Lamb and Cunningham (2003) described an inherent tension between specialised service funding models and the ability of broader integrated mainstream services to adequately meet the health needs of refugees and other groups with special needs. They point to the need for capacity building in mainstream services to allow better integrated and more grassroots, community-based health care to be delivered in the future. Cooperative approaches are required in which advocacy groups, volunteers, asylum seekers and refugees work with mainstream health services to assess and build the capacity of mainstream services.

The implications for developing a Refugee Health Plan were summarised by Finney Lamb and Cunningham (2003, pp128-129) under two main issues – the ability to determine the infrastructure support needed to meet special needs and the feasibility of re-orienting the mainstream services to provide the necessary support.

*“Once the infrastructure requirements for supporting the special needs of a refugee clientele group have been identified, health service planners should identify which health service models best accommodate these needs. Since the health service literature for refugee populations in resettlement countries is primarily descriptive, there is little information to guide these decisions. However, lessons can be drawn from other marginalised groups with similar special needs”.* (Finney Lamb and Cunningham 2003, p. 129)

### 3.2 *Best practice – screening/initial health assessment protocols*

Getting the right balance between specialist and primary generalist care relies on good assessment as well as a good referral system. There is evidence that pre-departure screening is necessary but not sufficient – it is most useful for infectious and parasitic diseases, but of little help in more chronic or less easily detected conditions.

*“It is apparent that the screening conducted overseas, no doubt under difficult circumstances, remains suboptimal.”* (Smith 2006 p. 587)

Assuming a universal assessment is the aim on arrival and re-settlement, there are a limited number of options for the first point of contact – GP, Refugee Health Nurse or specialist one-stop clinic. The levels of specialist care will vary locally - e.g. the Refugee Family Health Clinic at a hospital/CHC, support offered at women’s health clinics, paediatric clinics, infectious diseases, respiratory clinics and so on, will depend on local availability and hospital role delineation.

There is a need for flexibility as countries/circumstances of refugees can change and expectations of care differ (e.g. NSW expects to receive Iraqis as 80% of intake, plus increasing numbers in refugee intake). Further, the importance of an early link to a primary care provider needs to be recognised and organised within the context of local resources and expertise that gives access to the ‘right’ mix of mainstream primary, secondary and tertiary services.

### 3.3 *The roles of health professionals*

In the editorial introducing two papers on the role that GPs play in providing health care services to refugees, Smith (2006) argued that while there is an ongoing requirement for comprehensive health assessments for refugees, and a need to do more than screen for infectious diseases. There are recognised limitations to GPs being able to perform comprehensive assessments. These limitations include time constraints, the challenges of using an interpreter over the phone, and the need for specialised knowledge of the health needs of refugees.

In commenting on the South Australian experience, Johnson et al. (2008, p.5) go further in describing the limitations of GP-based models and conclude that GPs are *“under-resourced, at both an individual GP level as well as a structural level, to provide effective initial care for refugees”*.

Who coordinates care is a key issue as coordination of care may be critical for complex cases (i.e. GP, clinic or Refugee Health Nurse). In particular, those with more ‘social’ types of un-met need (such as for housing and social support as well as community care) will need collaboration with a number of providers of refugee support that are outside the health system.

The evidence on how best to coordinate the mix of professionals and others to meet refugee needs in the community is not helpful apart from the conclusion that, ultimately, all coordination is local (Leutz 2005).

However, there is sufficient in the literature to question the assumption that care coordination is automatically best undertaken by the GP, with some literature now making a distinction between case management and care coordination. This literature includes papers reporting on the Australian Coordinated Care Trials, in which the patient’s GP was the ‘case manager’ working in partnership with salaried ‘care coordinators’ (see, for example, Perkins et al 2001). Similar models, while not so formalised, existing in refugee health services, in which Refugee Health Nurses take on the role of care coordinator in partnership with a medical case manager. More generally, there are anecdotal reports of practice nurses taking on the same role in general practice.

### 3.4 *Continuity and measurement issues*

In a paper prepared for the Canadian Health Services Research Foundation, the Canadian Institute for Health Information, and the Advisory Committee on Health Services of the Federal/Provincial/Territorial Deputy Ministers of Health, Reid et al. (2002) reviewed the concept of continuity and came up with three useful categories – forming a typology of ‘continuity’ that is arguably more useful than ‘integration’ and could be used to inform the new plan.

The authors point out that the patient and health system levels of continuity are where more work needs to be done:

*“Continuity of care means different things to different types of caregivers, but all recognize three types: continuity of information, of personal relationships and of clinical management. The type of continuity should be agreed to, before discussions or planning begin.*

- **Informational** continuity means that information on prior events is used to give care that is appropriate to the patient's current circumstance.
- **Relational** continuity recognizes the importance of knowledge of the patient as a person; an ongoing relationship between patients and providers is the undergirding that connects care over time and bridges discontinuous events.
- **Management** continuity ensures that care received from different providers is connected in a coherent way. Management continuity is usually focused on specific, often chronic, health problems.

*Multiple measures are needed to capture all aspects of continuity; no single measure is able to reflect the whole concept. Some measures are more useful in some contexts than others.*

*More emphasis is needed on the development and application of direct measures of continuity from the patient's perspective and to measure continuity across organizational boundaries.”*  
(Reid et al. 2002, p. i)

The typology was also published in a more accessible form in the British Medical Journal (Haggerty et al. 2003). It has some potential as a framework for examining the system-level impacts of the new plan because of its relevance for understanding local and State-wide capacity building efforts.

Canadian research that is related to the work on continuity has relevance for the new plan in the area of the measurement of the impact of the plan itself over the longer term. This work has investigated knowledge translation as part of research impact measurement, as well as building on previous work on performance measurement frameworks in health care (Adair et al. 2003 and 2006).

## 4 Conclusions from the literature

The literature consistently identifies key service delivery principles and these provide a framework for refining current service models and for future service development. However the literature is less clear about what is 'best practice' in relation to service delivery models. The 'best' mix of primary and specialist services and the required levels of community support and service provision will vary by location. While common principles can be adopted across the state, the model of service delivery that will work best in Western Sydney will not necessarily work in rural NSW (and vice versa). Further, the 'best' mix of services for an individual refugee will vary based on factors such as, but not limited to, time since arrival in Australia, country of origin, age and health status.

In the past ten years there has been a growing body of relevant literature including guidelines for screening for infectious diseases after arrival and further elucidation of the issues faced by refugees on resettlement, plus principles devised to inform service delivery models for children. There is also growing emphasis on the importance of an ecological approach as distinct from clinic-based doctor-led services, and on the ongoing need to work in partnership with communities.

The literature is consistent in identifying that there is an initial need for assessment of existing health conditions and screening for communicable diseases with specialised follow-up of particular health and mental health problems. However, the literature is also consistent in making the point that effective refugee health services are not limited to service provision just in the newly arrived period.

Ongoing services that are effectively targeted at the health promotion/prevention end of the health resource spectrum are required, particularly given the principle that refugees should have access to mainstream services, including primary care. Equally, some people will require ongoing access to specialist refugee health services as well as to mainstream specialist medical services. Mainstream interventions are expected to be delivered collaboratively involving the refugee's cultural community wherever possible and with the health sector.

There is work on performance measurement frameworks in health care, in particular concepts related to the different domains of continuity, that have potential relevance to refugee health planning by informing the measurement of the system-level impacts of the new plan and for understanding local and State-wide capacity building issues.

## 5 Contemporary national developments

The new Refugee Health Plan will be implemented at a time when significant national reform initiatives are being discussed and some changes are being made to Medicare. As a result of a number of national reviews and agreements it is expected that the expected reforms will have some potential for developing the primary health care and community health sector.

### 5.1 *National Health and Hospitals Reform Commission*

The Commission (NHHRC) provided advice to the Commonwealth in 2009 on performance benchmarks and practical reforms to the Australian health system to be implemented in both the short and long term.

The interim report flagged an option that the Commonwealth would be accountable for primary care ('all other aspects of care in the community, primary medical care and community health care', NHHRC 2008, page 4), prevention, aged care and indigenous health, however the Commission noted the lack of a coherent plan for how it would all fit together.

*"Importantly, we are signalling our view about the desirable direction of the Commonwealth taking a more active role in ensuring adequacy of the full range of primary health care services. This would involve moving beyond general practice to allied health, district nursing, community mental health services and community health services, for example. We believe that there needs to be significant investment in primary health care infrastructure, an objective that the Commonwealth Government has partially set out to address through the establishment of GP Super Clinics. State governments have also responded to this challenge through major programs such as GP Plus in South Australia, HealthOne in New South Wales and Primary Care Partnerships in Victoria. But there is no integrated plan for the development, resourcing and networking of state-based primary health services, general practice and other private or non-government primary health services."* (NHHRC 2008 page 22).

The final report delivered in June 2009 (NHHRC 2009) made no advances on this position, alluding to the backing of the World Health Organization's Commission on Social Determinants of Health (Commission on Social Determinants of Health 2008) in a call for governments to take action. The COAG meeting of December 2009 essentially delayed practical action in favour of further consultation.

The delay in the larger reform process was followed by the announcement of 15 measures to simplify the benefits schedule, remove red tape and encourage preventative care expected to be in place by 1 May 2010. These changes to Medicare will support longer GP consultations with higher rebates and simplify the process for care planning and review (Roxon 2009).

### 5.2 *National Primary Health Care Strategy*

In June 2008, the Minister for Health and Ageing announced that a National Primary Health Care Strategy will be developed. A review of the Medicare Benefits Schedule enhanced primary care items was also undertaken alongside development of the Strategy with a focus on reducing red tape for doctors, simplifying the Medicare schedule, and giving more support to prevention.

A discussion paper (*Towards a National Primary Health Care Strategy: A Discussion Paper from the Australian Government*) was released on 30 October 2008 (Commonwealth of Australia 2008). The final report proposed key elements that 'could underpin a future Australian primary health care system' but did not include specific proposals where could changes be made.

The challenge for the Refugee Health Plan in this area is to anticipate the national developments in a way that is also consistent the State Health Plan (NSW Department of Health (2007a).

### **5.3 National Prevention Taskforce**

In April 2008, the Minister for Health and Ageing announced the establishment of a new National Preventative Health Taskforce. In announcing the Taskforce, the Minister also announced that the Commonwealth was committed to ensuring that preventative health measures become a key part of health funding agreements between the Commonwealth and state and territory governments.

The Taskforce provided evidence-based advice to governments and health providers on preventative health programs and strategies, focusing on the burden of chronic disease currently caused by obesity, tobacco and alcohol (National Preventative Health Taskforce (2009)).

The Taskforce report contributed to the framework for the Preventative Health Partnerships under the Australian Health Care Agreements and the Minister launched the National Preventative Health Strategy on 1 September 2009. The Strategy recommends a range of interventions aimed at reducing the chronic disease burden associated with three lifestyle risk factors – obesity, tobacco and alcohol.

The National Partnership Agreement on Preventive Health was established to address the rising prevalence of lifestyle related chronic diseases in Australia through a range of activities including the national roll out of funding for interventions in pre-schools, schools, workplaces and communities to support behavioural changes in the social contexts of everyday lives, and focusing on poor nutrition, physical inactivity, smoking and excessive alcohol consumption (including binge drinking);

### **5.4 Implications for the Plan**

This summary highlights how the Plan will be implemented against a very fluid environment at the national level. The key aspects of the AHCA are in place but agreements at the level of COAG have been held over to mid 2010. The net result is that recommendations in the Plan will need to be considered in the context of subsequent recommendations and commitments made at a national level.

Developments in NSW in this area have implications for the NSW Refugee Health Plan. NSW Health has been actively reviewing policy and practice through a process that included the Review of Community Health (Eagar et al. 2008a, 2008b). That Review recommended a strategy to supersede the existing policy framework (NSW Department of Health 2006) and the primary and community care implementation framework (NSW Department of Health 2007b).

## 6 Next steps

Several key issues emerge that require consultation with stakeholders in the development of the next plan:

1. Service delivery principles that should be adopted across NSW to guide future service development in refugee health care:
  - General principles – such as, for example, access, equity, dignity and social justice need to be affirmed for inclusion in the next plan
  - Screening – universal or targeted?
  - Primary care – what services need to be available on a universal basis?
  - Specialist care – what services need to be available?
  - The balance between screening, prevention, primary care and specialist care – is the ‘right balance’ between these the same across NSW?
  - Principles for transitioning refugees to mainstream care
2. How best to translate the above principles into one or more models of care that are appropriate:
  - In different geographic locations in NSW
  - For different age groups (children, adults)
  - For newly arrived refugees and those who have been in Australia longer
  - For both physical and psychosocial health
3. Partnerships. Who does NSW need to partner with to achieve optimal outcomes for refugees? What needs to happen to strengthen required partnerships?
4. Capacity building. What does NSW need to do to build the required workforce capacity and the evidence-base?

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