

**Addressing the gaps: The health and wellbeing of people from a  
refugee background settling in Queensland.**

**A discussion paper**

**May 2011**

**By**

**Refugees and Primary Health (RaPH) project**

**Mater UQ Centre for Primary Health Care Innovation**

**Funded by Connecting Health in Communities (CHIC) Chronic Disease Initiative**

## EXECUTIVE SUMMARY

It well recognised that the physical and mental health and wellbeing of refugees depend on their access not only to health services. The establishment of optimal health and well being for refugee communities demands attention to social and economic issues in their lives. It also needs to consider such issues as building the capacity of refugee communities to

- articulate, plan and comment on health related policy
- develop and implement innovative responses to the health and well being needs of their own communities
- provide opportunities for social connection, resourcing and community mobilisation

The conclusion of the Refugees and Primary Health project (RaPH) in consultation with a number of concurrent initiatives looking at health issues for refugee communities, highlight the notable absence of a policy to guide the development of an effective coordinated health response that respects the multiple layers of the issue. While significant progress has been achieved in recent years in developing clinical service responses to refugee health issues through the Refugee Health Queensland, and through other community initiatives such as the Ethnic Communities Council of Queensland Chronic Disease project, the imperatives to build health public policy, create supportive environments and strengthen community action have been somewhat neglected.

This paper is intended to inform stakeholders and sector participants about current issues for refugees accessing primary care in Queensland and to raise questions for further discussion. The aim of producing a paper such as this is to create broader informed community discussion and momentum for building a refugee health and wellbeing policy for Queensland. The paper invites its audiences to consider whether

- the health system is sufficiently well equipped to understand and respond to health and well being needs of refugee communities well into the settlement phase.
- a comprehensive care model addressing health and well being can be located within four systems - the health system, the patient, the delivery systems and the community.
- the Comprehensive Primary Health Care model adequately articulate the principles required to guide the development of a health and well being framework for refugee communities.
- building health care policy with primary attention to partnership will adequately facilitate the development of an integrated approach to refugee health and wellbeing.

It is hoped that this paper can be adopted by RHeaNA (Qld) or other refugee health and well being network as a tool for informed discussion and as a means to collect information and viewpoints to input to policy. This would enable the voice of refugee communities to be heard.

## INTRODUCTION

This discussion results from a two year project funded by Queensland Health through the Southside Partnership Council as part of the Connecting Health in Communities (CHIC) initiative Chronic Disease funding.

The paper is intended to inform stakeholders and sector participants about current issues for refugees accessing primary care in Queensland and to raise questions for further discussion. Questions are posed at the end of each section. The aim of producing a paper such as this is to create broader informed community discussion and momentum for building a refugee health and wellbeing policy for Queensland.

### **Scope of the discussion paper**

Queensland has a number of dedicated programs and services which target the health needs of refugees settling across the state. The level of coordination and planning has become an issue of concern for many practitioners and managers across government and community care services. The refugee communities have also articulated confusion and concerns about accessing multiple services and programs especially during the early settlement phase when they are already experiencing numerous difficulties in accessing support. (*REF: qualitative study*)

The development of an integrated model of service delivery addressing the primary health and well being needs for vulnerable populations is severely compromised due to the short term and uncoordinated nature of a many initiatives. There is an apparent lack of leadership and policy in the Queensland context to assist in the planning and integration of a holistic health and well being approach to refugees beyond initial settlement phase. In the absence of a policy which coordinates development of service and community support, initiatives will continue to be short term and uncoordinated. This is also reflected at the national level and momentum exists for continuing advocacy for a national refugee health policy.<sup>1</sup>

In 2008 a significant injection of resources (\$1.08 million) into refugee health in Queensland led to the establishment of the first state-wide response by Queensland Health to the identified on arrival health needs of refugees settling in the five key areas (Brisbane South/North, Logan/Gold Coast, Toowoomba, Cairns and Townsville). This discussion paper acknowledges the Queensland Refugee Health Service plan (April 2008) and addresses its comments to facilitate the development of a policy framework which takes account of the long term health and well being needs of refugee populations.

The discussion paper is the culmination of a 2 year project, RaPH (Refugees and Primary Health) funded by CHIC (Connecting Health in Communities) Chronic Disease initiative. RaPH used a partnership (*appendix list of partners*) approach to develop a model for better integration and coordination of existing services available to meet the health needs of refugees settling in Brisbane South. Through this collaborative process, a key issue

identified was the lack of an overarching framework to facilitate an integrated approach to refugee health and wellbeing. The purpose of the discussion paper is:

- To initiate dialogue among government, non government and community on developing a Queensland primary care framework for refugee health and wellbeing
- To document the findings from the RaPH project and propose a framework for health and wellbeing grounded in principles of partnership and community empowerment
- To support and guide the engagement of refugee communities in health and community services
- To articulate some shared principles, language and priorities
- To assist in planning for change and sustainability and to facilitate flexibility and responsiveness to changing demographics
- To build on current good programs and practice incorporate existing knowledge of service integration and chronic disease management

The discussion paper has been prepared using the available knowledge and evidence in the area of refugee health, chronic disease management and the broader determinants of health. It draws on State and National policy documents and strategies as well as the direct experiences of refugee communities and service providers.

## **BACKGROUND**

### **The refugee program in Queensland**

Queensland received 1021 humanitarian entrants (visa subclass (200) refugee, (202) global special humanitarian and (204) woman at risk) 2010/2011. <sup>2</sup> The majority of new arrivals tend to settle in Brisbane (65%) and smaller percentages settle in Logan/Gold Coast (17%), Toowoomba (11%), Cairns (4%) and Townsville (3%) (Queensland Refugee Health Service Plan 2008, p19). The Humanitarian entrants are split between African (30%), Middle East (24%), Asia (46%). Queensland has a population of approximately 4.4 million (Dec 2009 ABS) and has the highest interstate migration 13,500 (2009) and a net overseas migration 53,300 (2009). The refugee humanitarian program consists of a relatively small percentage of overall population growth for Queensland however it is a highly significant population which has steadily increased over the past decade.

It is well documented that humanitarian entrants on arrival experience differences in health status compared to Australian born and skilled migrants as a result of: trauma and torture, prolonged displacement and social and economic disadvantage. The experience of refugees in the first 12 to 18 months of settlement strongly influences how successful long term settlement will be.<sup>3</sup> Given the inherent health inequalities of this population group it is imperative that a coordinated long term approach is adopted underpinned by principles of health and wellbeing.

Table 1 outlines key developments to support refugees in Queensland.

**Table 1. Key developments in building for support for people from refugee background in Queensland 1991-present.**

Year	Key Development
1991	Brisbane Women's Health Centre consulted with a group of Latin-American women who had concerns about their unmet needs as refugees survivors of torture and trauma.
1992	Establishment of the Brisbane Refugee Torture and Trauma Research and Support Project initiated by the Brisbane Women's Health Centre. Research and support project undertaken with a four language groups – Spanish, Farsi, Vietnamese and Khmer and funded by the Consumer Health Forum of Australia.
1994	PASTT (Program of Assistance to Survivors of Torture and Trauma) established by the Federal Government. The Brisbane Refugee Torture and Trauma Research and Support Group was asked to establish a new community based service for survivors of torture and trauma in Queensland.
1995	QPASTT (Queensland Program of Assistance to Survivors of Torture and Trauma) was established with PASTT funding
1995	Queensland Health (QH) matched the PASTT funding
1995	QH convened an intersectoral working group to develop and implement a health service delivery model for newly arrived refugees.
1997	Two year funding from Department of Health and Family Services (Fed) for the Brisbane Inner South Refugee Health Program to develop, implement and evaluate a model of coordinated health care for newly arrived refugees in Brisbane.
1998	Department of Immigration funded the Early Intervention Program of QPASTT as part of the Integrated Humanitarian Settlement Service (IHSS)
2000	QPASTT facilitated a network of over 30 organisations to address the gaps in refugee health.
2001	QPASTT secured small grant from QH and in partnership with Mater Health Services, QH, GPs, refugee communities and other key stakeholders established QIRCH (Queensland Integrated Refugee Community Health) Clinic
2002	St Vincent's and Holy Spirit provide funding to allow QIRCH to open full time
2004?	Logan Community Health establishes a refugee health clinic
2006	Refugee Health workshop to develop a budget proposal for a refugee health service Aust Government introduced a new Medicare item number (item 714) for comprehensive health assessments for humanitarian entrants within 12 months of arrival
2007	Steering Committee appointed and QH allocated \$1.08 M for the establishment of Refugee Health Queensland
2007	QPASTT transfers auspice of QIRCH Clinic to Mater Health Services.
2008/09	QH allocated \$1.2 recurrent funding for the Queensland Refugee Health Service and developed a four year service plan

## The Queensland Policy context

Key Queensland Government documents which have been identified in relation to refugee health and wellbeing include:

- Queensland Health Strategic Plan for Multicultural Health 2007 – 2012
- Queensland Strategy for Chronic Disease 2005 – 2015
- Queensland Strategy for Chronic Disease 2005 – 2015 – Framework for self management 2008 - 2015
- The Queensland Compact Towards a fairer Queensland Nov 2008
- Position Statement Primary Health and Community Care in Queensland 2002 – 2007
- Queensland Refugee Health Service Plan April 2008
- Queensland Government Multicultural Policy 2004 – Making a world of difference policy
- Queensland Government African strategy (draft)
- Queensland Health Position Statement on Multicultural Health 2000
- Queensland Health Language Services Policy 2000

A summary of the contents of relevant national and state based documents are listed in Appendix 1.

## **HEALTH ISSUES OF CONCERN FOR REFUGEE COMMUNITIES**

The community has noted that in recent years there has been a growing interest in and commitment to addressing the health needs of people from refugee backgrounds settling in Queensland.<sup>4</sup> The particular initiatives of the Queensland government in this regard are listed elsewhere. This commitment is laudable and has and will continue to make an invaluable contribution to the ongoing health and well being of individual families and communities settling in Queensland.

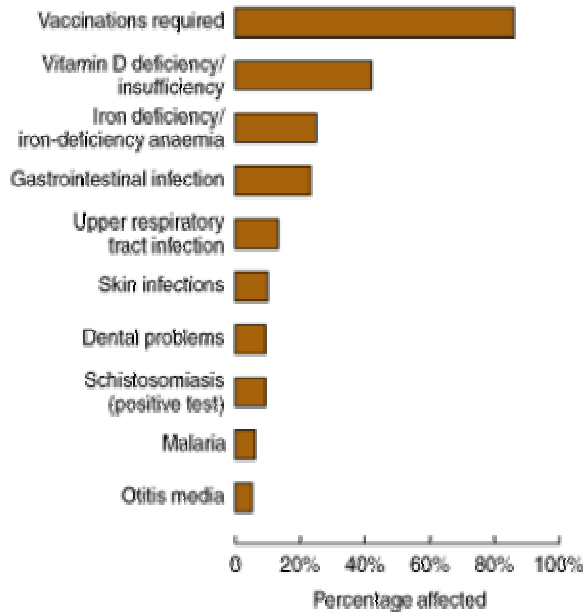
The greatest focus of service and policy initiatives to date has been on the early settlement period immediately following arrival. Current research into the health status of people from refugee backgrounds arriving in Brisbane has identified a number of clinical issues across the communities of newly arrived refugee and humanitarian entrants including<sup>5</sup>

- Nutritional deficiencies ( iron, folate, Vitamin A, Vitamin D)
- Intestinal Parasitic disease
- Infectious disease (tuberculosis, hepatitis)
- Immunisation

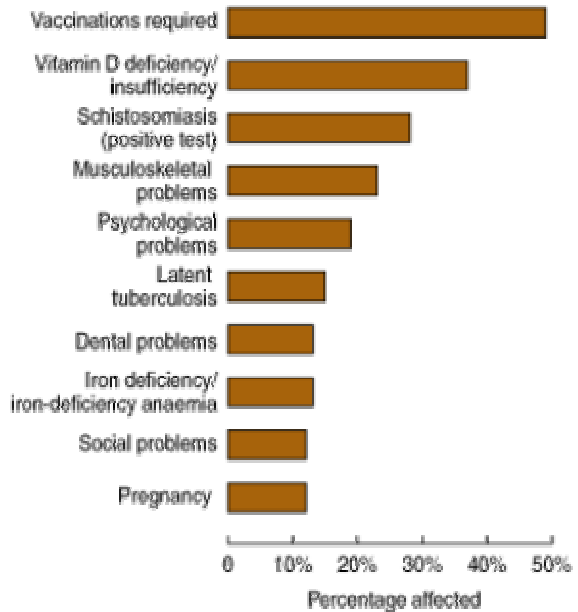
This is confirmed by a Victorian study. Table 2 identifies the 10 most common problems identified by general practitioners in newly arrived African refugee patients in Melbourne in 2005.<sup>6</sup>

**Table 2 . The 10 most common problems identified by general practitioners in newly arrived African refugee patients in Melbourne, 2005**

**A: Refugees aged less than 15 years**



**B: Refugees aged 15 years and older**



While it is important to establish the immediate health issues for recently arrived refugees on arrival, it is equally important to address the legacy of these health issues. The Victorian paper “*Towards a health strategy for refugees and asylum seekers in Victoria*” describes some of the ongoing health concerns for people from refugee backgrounds and the key issues associated with responding to those needs.<sup>7</sup> Key amongst those issues are the mental health impacts of associated with exposure to trauma, socio economic impacts of poverty and alienation, and the ongoing health risks in terms of chronic disease that endure from prolonged stress and deprivation and disrupted health care.

It is well documented that humanitarian entrants on arrival experience differences in health status compared to Australian born and skilled migrants as a result of: trauma and torture, prolonged displacement and social and economic disadvantage. The experience of refugees in the first 12 to 18 months of settlement strongly influences how successful long term settlement will be (Vic Strategy Refugee Health and Wellbeing). Given the inherent health inequalities of this population group it is imperative that a coordinated long term approach is adopted underpinned by principles of health and wellbeing. It is clear that new arrivals need assistance in accessing health care on arrival. However the impact past trauma and torture experiences and significant life events might trigger a need for additional assistance to access health services at a later point. The health impacts of the refugee experience span physical, psychological and social domains and endure well into the settlement phase. How well equipped is the system to understand respond to those needs well into the settlement phase?

**Question: How well equipped is the system to understand and respond to health and well being needs of refugee communities well into the settlement phase?**

## **SECTOR ISSUES OF CONCERN**

Queensland has a number of specialist and mainstream agencies providing services of vital importance to the health and wellbeing of refugees and asylum seekers. These services together with the refugee communities are generally regarded as the “sector”.

The sector is a key stakeholder in discussions about the needs and plans for development of health services for refugee communities. The sector has both acknowledged the extensive gains in service development and also the ongoing gaps and weaknesses. It has also highlighted the fact that there is also no guiding mechanism to ensure that service development and planning is coordinated, services are integrated, and development is sustained and responsive to emerging issues. There is a need in for an enabling structure to facilitate connection, collaboration and coordination.

Evidence suggests that people from non-English speaking backgrounds are over-represented among those using hospital out-patient services for general medical care <sup>8 9</sup>; Research conducted by the Ethnic Communities Council Queensland further indicates that people from CALD backgrounds (including people from refugee backgrounds) are disproportionately represented in avoidable admissions and inappropriate use of hospital services.<sup>10</sup> Improved engagement with the primary care system has the potential to address these problems. <sup>11</sup> What is needed at this point is a framework to guide the development of engagement strategies with refugee and immigrant communities.

A forum hosted by the RaPH project in October 2009 articulated key elements of a framework to guide effective development of refugee health and well being initiatives. Informed by the Wagner Model for management of chronic disease, and the Expanded Chronic Care Model <sup>12</sup> the forum used a systemic approach. Primary strategies to each of four key systems were highlighted.

1. Health system - Maintaining the commitment to and development of the early intervention approach
2. Patient system- Enhancing self management through development of health promotion and prevention strategies at individual and community level
3. Delivery system - Developing the partnership approach to health care, building the capacities of partnerships, and developing an appropriately skilled workforce
4. Community system - Strengthening community action through recognition of the community as partner not simply consumer.



## **Health system**

An early intervention approach is particularly important for people from refugee backgrounds. Good physical and mental health are vital resources for settlement, and neglecting this phase will lead to long term costs both to the individuals social emotional and physical health and to the health system costs in financial terms. The early intervention approach needs to encompass settlement and as well as health provision. The early phase is an opportunity to build trust in services. Trust is seen to be a potent enabler and conversely mistrust is potent barrier to engagement – a factor common for refugees who may be survivors of human rights abuse. Psychological sequelae such as internalised mistrust may serve as a barrier to forming social connections<sup>13</sup>. Studies indicate that both protective and risk factors in the early settlement environment are as important in influencing health and settlement outcomes as are those occurring prior to arrival <sup>14</sup> First impressions are formative and a good first experience of engaging with the primary health system will inform ongoing expectations. The implications for patient engagement are obvious with obvious likely impact of factors such as willingness and capacity to self management, confidence and compliance.

## **Patient system**

The early settlement period provides a window of opportunity to introduce people to treatment and illness prevention services and assist them to establish a positive relationship with the health care system.

Low level of health literacy is linked with poor health outcomes, higher levels of chronic disease and higher hospital admissions. <sup>15</sup> Recent arrivals to Australia often have poor literacy in their first language, and poorer literacy in English. Moreover recent research has indicated that new arrivals place most trust in information including health information from family members and friends. <sup>16</sup> The quality of health information reaching new arrivals is therefore dependent on the level of health literacy of their reference community. To introduce effective self management strategies, attention needs to be directed to developing the health literacy of the community.

## **Delivery system**

There is no doubt considerable good will on the part of service providers and funders to build a service environment that meets the needs of the refugee population. However, the absence of an overarching framework has led to many initiatives to be implemented as short term one off initiatives with little enduring impact. Partnerships that have been built around settlement and service delivery for new arrivals to Australia do not endure to meet the long term requirements of settler populations. As a result linkages between services are fragmented.

It was a well accepted concept that health service delivery must be constructed on effective and efficient partnerships. Partnerships are cost effective, they enable resource sharing and minimise duplication, and

ultimately build better community health outcomes.<sup>17</sup> Partnerships however need to be resourced as entities in themselves in order to be sustained, inclusive, responsive and innovative.

Formalised partnerships are a legitimate vehicle able to give input to policy making. Partnerships properly constituted can ensure all levels of health service delivery are involved - clinicians, service users, general community, specialists and management. There is a requirement to bring everyone at the table to create the authorised environment. Resourced partnerships can do this.

Increasing diversity means that services have to provide ongoing workforce development programs to ensure that staff are able and confident to work effectively with new client groups. The sector has identified the urgency for the health workforce to be trained resourced and reflective of the diversity of the population. This is especially relevant given the emerging evidence that CALD communities present with higher levels of chronic disease.<sup>18</sup> The number and small size of some new arrival groups requires different approaches to the use of interpreters and bilingual staff than is possible in dealing with relatively large, homogenous groups.

Ensuring diversity is a priority for the health workforce at all levels – including clinicians and community support workers. The new Certificate.... In ..... developed by the ECCQ is an example of building the ..... In this way the workforce can become an effective bridge between the “us’ and “them” mentality that divides the professional mainstream service provider and the culturally diverse consumer community. The workforce is thus able to assist two way communication. A culturally competent workforce is able to understand the culturally significant needs and views of the service users and recommend appropriate service responses. It is also able to interpret the operation of the health system as it is currently configured to diverse consumers and consumer groups.

An effective diverse workforce is able to increase likelihood of receiving service user feedback and giving this input to service planning and design. It is also able to promote consumer choice and engagement and improve health outcomes.

### **Community system**

Empowered communities enable health service consumers to contribute to decisions around service delivery, service evaluation and service planning. The concept of community empowerment goes beyond information sharing and the production of resources. It drives at the need to engage people as equal partners in service delivery. It results in communities with the capacity to assist their new members to make lifestyle changes and sustain them in that healthy end. It ensures that consumers are meaningfully involved and supported and allows for health management from the bottom up. It builds prevention against chronic disease.

A framework to guide the development of health service for refugees in Queensland needs to include resources for building the leadership capacity of refugee communities to facilitate the capacity of that leadership to

represent their community and to facilitate community engagement.

**Question: The sector has identified 4 systems (the health system, the patient, the delivery systems and the community) that are required to contribute to a comprehensive care model addressing health and well being of refugee communities. Do these four systems adequately describe all stakeholders?**

## ARTICULATION OF A MODEL

### Key principles

This paper argues for the development of a coherent health and well being framework to guide the development of responses in Queensland. This framework needs to enable and embrace multisectoral collaboration and to be guided by the philosophy of comprehensive primary health care namely

the interconnecting principles of equity, access, empowerment, community self-determination and intersectoral collaboration....[encompassing] ...an understanding of the social, economic, cultural and political determinants of health. <sup>19</sup>

The primary care approach is a fundamental cornerstone in any endeavour to build health public policy for refugees and asylum seekers. It acknowledges the social political and historical context of the refugee experience and the difficulties faced by refugee communities healing from past experiences in a new environment where socio economic and cultural issues interplay with issues of grief and loss to impact on the health and well being of individuals and communities. A clinical medical model approach to health issues for refugee communities will limit effectiveness as indicated in the table below. <sup>20</sup>

	<b>Comprehensive Primary Health Care</b>	<b>Medical Model</b>
<b>View of health</b>	Positive wellbeing	Absence of disease
<b>Locus of control over health</b>	Communities and individuals	Medical practitioners
<b>Major focus</b>	Health through equity and community empowerment	Disease eradication through medical interventions
<b>Health care providers</b>	Multidisciplinary teams	Doctors
<b>Strategies for health</b>	Multi-sectoral collaboration	Medical interventions

As such this paper argues for the further development of a refugee health and well being policy framework which

- Acknowledges the priority to support community empowerment
- Recognises the need for responses to be developed on a partnership basis
- Provides for and resources planning to facilitate flexibility and responsiveness to changing demographics
- Builds on current good programs and practice
- Enables collaboration between all levels of government to cover responsibility for health housing, income security, family well being, and education.

**Question: Does the Comprehensive Primary Health Care model adequately articulate the principles required to guide the development of a health and well being framework for refugee communities?**

### **Other relevant models**

A number of important innovative models have been trialled in the health delivery system and have much to offer the development of a framework for the health and well being of people from refugee background settling in Queensland. In particular the RaPH project has drawn on the work of two innovations namely

i) – the Primary Care Amplification Model<sup>21</sup>. This model includes building a “beacon” practice which focuses on providing clinical services which support and enhance the capacity of local general practice, particularly in the management of complex patients. The “beacon” model has a strong governance structure supportive of research and innovation and is resourced to match functions. An adaptation of the Primary Care Amplification model could be designed for Refugee Health Queensland to provide beacon practice support to general practices managing referrals and care of refugee patients.

ii) – the Expanded Chronic Care Model<sup>22</sup>. This model builds on the Wagner Chronic Care Model and its focus on clinically oriented systems to include recognition of the social determinants of health, and build in enhanced community participation as a key strategy in the provision of care. The Expanded Chronic Care model facilitates “individual and community empowerment so that all people, both ill and well, are able to achieve a greater sense of control over the many complex factors that affect their health.” (Barr et al)

The health and well being framework for the health and well being of people from refugee background settling in Queensland needs to include the essential elements of these models and articulate important additional elements to ensure the framework addresses not only health issues but the social determinants of health and has a broad sectoral and community reach.

### **The Partnership approach**

The experience of the RaPH project indicates that policy development is required to guide the development of a framework that addresses the health and well being needs of refugee communities. The development of partnerships is a necessary precondition for the implementation of this framework. Strategies are required to enable the community to take the lead in addressing its needs and enabling those needs to be addressed within the health system, patient system, delivery system and the community.

To recap, strategies to address the following systemic issues include but are not restricted to

1. Health system – Continue the commitment to excellence in the provision of early intervention clinical services in the immediate arrival and post arrival phase. Development the capacity of clinical service provision for people from refugee backgrounds well into the settlement phase. The partnership approach enables effective linkages to be built between early intervention services, ongoing systems of care, feedback to policy to enable innovation responses to new and emerging issues as settlement patterns change.

2. Patient system- Enhance self management through development of health promotion and prevention strategies at individual and community level. Building health literacy at a community level is an identified high priority. The partnership approach ensures the primary source of health information, namely the community, is effectively honoured and acknowledged and resourced in health promotion and prevention strategies.
3. Delivery system – Build the capacity of services through workforce strategies enabling multiple entry points to enhance coordination, flexibility and evidence base. The partnership approach is sustained through building the capacities of partnerships including ensuring sustainability of partnerships through resourcing.
4. Community system – Build the leadership capacity of refugee communities to facilitate the capacity of that leadership to represent their community, and to facilitate community engagement.

Each of these systems are essential elements of refugee health and well being framework and progress towards building those systems needs to be guided by a clearly articulated health and well being policy framework and coordinated and directed through an effective “Refugee Health and Well Being Partnership”.

## **RATIONALE FOR A REFUGEE HEALTH AND WELLBEING PARTNERSHIP**

It has been established that health and wellbeing of people from refugee backgrounds does not depend simply on their access to health services. The establishment of optimal health and well being for refugee communities demands attention to social and economic issues in their lives. It also needs to consider such issues as building the capacity of refugee communities to

- articulate, plan and comment on health related policy
- develop and implement innovative responses to the health and well being needs of their own communities
- provide opportunities for social connection, resourcing and community mobilisation

The recommendation of this paper is for the development of the Refugee Health and Wellbeing Partnership to be inclusive of all stakeholders (health services, policy makers, and community representatives) and hosted and managed outside of a direct health service provider. Such a partnership would be able to bring health and community services together to plan and work collaboratively to address the needs of refugees and asylum seekers.

This is also timely as the Government is considering the role of Medicare Locals and is seeking input from community stakeholders on local issues. A Refugee Health and Wellbeing Partnership would be well positioned to advocate and support policy initiatives and engage in strategic planning with potential Medicare Locals. Furthermore at a national level a Queensland Refugee Health and Wellbeing Partnership would be able to provide input to national initiatives.

**Question: The framework's key strategy is the development of a Refugee Health and Wellbeing Partnership. Can the framework adequately facilitate the development of an integrated approach to refugee health and wellbeing through this strategy?**

## **CONCLUSION**

The paper is intended to inform stakeholders and sector participants about current issues for refugees accessing primary care in Queensland and to raise questions for further discussion. The aim of producing a paper such as this is to create broader informed community discussion and momentum for building a refugee health and wellbeing policy for Queensland.

It is important that the developmental focus of refugee health and well being policy be nurtured and directed strategically. The recommendation of RaPH and its partners is for the designation of a mechanism to do this. An example of an effective mechanism for policy development is RHEANA (Refugee Health Network of Australia – Queensland chapter). There may be other options for Queensland. This mechanism needs to be inclusive of all stakeholders (health services, policy makers, and community representatives) and hosted and managed outside of a direct health service provider.

It is hoped that this paper can be adopted by RHeaNA or other refugee health and well being network as a tool for informed discussion and as a means to collect information and viewpoints to input to policy. This would enable the voice of refugee communities to be heard.



## APPENDIX 1

### SELECT SUMMARY OF RELEVANT POLICY DOCUMENTS

#### Commonwealth Government

Name of Document	Date of publication	Summary of key issues relevant to RaPH
<b>National primary health care strategy</b>		
<i>Department of Health and Aging</i>  <i>Towards a National Primary Health Care Strategy: A Discussion Paper from the Australian Government</i>	2008	Asks for input around the following objectives <ul style="list-style-type: none"> <li>• Accessibility of services</li> <li>• Patient centred services</li> <li>• Focus on prevention</li> <li>• Well integrated coordinated</li> <li>• High quality care</li> <li>• Management of health information</li> <li>• Flexibility to meet community needs</li> <li>• Working environments to retain workforce</li> <li>• Training and education of workforce</li> <li>• Cost effective</li> </ul>
<i>Department of Health and Aging</i>  <i>Building a 21<sup>st</sup> Century Primary Health Care System: A Draft of Australia's First National Primary Health Care Strategy</i>	2009	Sets out the case for reform <ul style="list-style-type: none"> <li>• Changing nature of the health system</li> <li>• Demand pressures</li> <li>• Variable access (especially cultural issues)</li> <li>• Poor integration</li> <li>• Safety and quality</li> <li>• Workforce shortages and inflexibility</li> </ul> <p>The future needs to address</p> <ul style="list-style-type: none"> <li>• Regional integration</li> <li>• Information and technology</li> <li>• Skilled workforce</li> <li>• Infrastructure</li> <li>• Financing and system performance</li> </ul> <p>Four priority directions for change</p> <ul style="list-style-type: none"> <li>• Improving access and reducing inequity</li> <li>• Better management of chronic conditions</li> <li>• Increasing the focus on prevention</li> <li>• Improving quality safety performance and accountability</li> </ul>

#### Queensland Government

Name of Document	Date of publication	Summary of key issues relevant to RaPH
<b>Queensland Health policy statements</b>		
<i>Queensland Health Multicultural Policy Statement</i>	March 2000	Sets out principles of Access, Equity, Communication, Responsiveness, Effectiveness, Efficiency and Accountability to be embedded in <ul style="list-style-type: none"> <li>• QH Corporate plan</li> <li>• Health Outcome Plans</li> </ul>

		<ul style="list-style-type: none"> <li>• Organizational Improvement Plan</li> <li>• Service agreements with health service Districts</li> <li>• Public Health Service Area Outcome Plans</li> <li>• Agreements with ngo's.</li> </ul>
<b>Queensland Health Strategic Plans</b>		
<i>Queensland Health Equity and Diversity Plan 2007 – 2010</i>	June 2007	Sets out Queensland Health EEO Operational Plan
<i>Queensland Health Strategic Plan for Multicultural Health 2007/2012</i>	June 2007	<p>Strategic Directions for Queensland Health</p> <ul style="list-style-type: none"> <li>• Strengthening multiculturalism in the public sector – to have inclusive service planning and delivery (e.g. Websites, Multicultural Clinical Resource, QH Translation Guide, QH Staff training on diversity, Commitment to specific groups of disadvantage – African communities and Pacific islander communities, Commitment to Logan Refugee Health Clinic and QLD Refugee Health Clinic)</li> <li>• Productive diversity – to have a diverse workforce that represents the general population ( e.g. Internal QH recruitment strategies)</li> <li>• Supporting communities – to invest in and build the capacity of multicultural communities so that they can become healthier communities (e.g. Build capacity of multicultural ngo's, develop strategies to work for multicultural communities)</li> <li>• Community relations and anti racism (Involve community reps to advise on implementation of strategic plan, use of multicultural web site, research)</li> </ul>
<p><i>Queensland Health Strategic Plan for Multicultural Health 2007/2012</i></p> <p><i>Detailed Report on Implementation of the 2007-08 Actions</i></p>	July 2008	<p>Achievements of the <i>Queensland Health Strategic Plan 2007-2012</i> to date include</p> <ul style="list-style-type: none"> <li>• All health districts have established a Interpreter Service coordinator role</li> <li>• Data collection improved</li> <li>• Queensland Health Multicultural Steering Committee met on a quarterly basis</li> <li>• Development of multicultural resources</li> <li>• Pilot cultural diversity for training</li> <li>• Multicultural support officers</li> </ul>
<p><i>Queensland Health Strategic Plan for Multicultural Health 2007/2012</i></p> <p><i>2008-09 Implementation Plan</i></p>	June 2008	<p>Achievements of the <i>Queensland Health Strategic Plan 2007-2012</i> to date include</p> <ul style="list-style-type: none"> <li>• Queensland Health Interpreter Service</li> <li>• Service Plan for the Queensland Refugee Health Service</li> <li>• Development of resources for staff including the website and the Multicultural Clinical Support Resource</li> <li>• <i>Safe Services : Diverse Communities</i> training package</li> <li>• Development of an Evaluation Plan of the <i>Queensland Health Strategic Plan for Multicultural Health 2007/2012</i></li> <li>• 11 Multicultural Mental health Coordinators</li> <li>• Creation of the <i>Queensland Health Equity and Diversity Plan 2007 – 2010</i></li> </ul>
<i>Queensland Health Strategic Plan for Multicultural Health</i>	2009	Achievements of the <i>Queensland Health Strategic Plan 2007-2012</i> to date include

<p>2007/2012</p> <p>2009-10 Implementation Plan</p>		<ul style="list-style-type: none"> <li>• Queensland Health Interpreter Service – ISIS</li> <li>• Special Needs Populations - Refugee Health Queensland operational with 6 service locations, Pacific Islander health needs project</li> <li>• Culturally Competent staff - Cross cultural learning and development strategy, Multicultural clinical support officer roles piloted at RBH and Gold Coast, QTMHC 13 Multicultural mental health coordinators</li> <li>• Workforce strategies - Recognition of Multicultural Community Health Worker role, Darling Downs West Moreton multicultural workforce projects.</li> <li>• Resource development and translation</li> <li>• Improved data</li> <li>• Leadership and partnership - Involvement of communities in health planning at State and District levels, enhance CHIC health worker project at ECCQ</li> <li>• Community engagement - ECCQ position, 12 Coordinators for Chronic Disease to link with ECCQ, fact sheets for communities</li> </ul>
<p>Queensland Health Advancing Health Action</p>	<p>August 2008</p>	<p>Sets 5 key areas as challenges</p> <ul style="list-style-type: none"> <li>• Expanding services to meet population growth</li> <li>• Stemming the tide of preventable disease – targeting obesity, drinking, smoking, sun exposure</li> <li>• Mothers and babies</li> <li>• Mental health</li> <li>• Rural and indigenous</li> </ul>
<p>Queensland Health Strategic Plan 2007 – 2012 Version 2</p>	<p>?January 2009</p>	<p>Reviews the 2007-2012 Strategic plan and sets the following priorities</p> <ul style="list-style-type: none"> <li>• Making Queenslanders healthier</li> <li>• Meeting needs safely and sustainably</li> <li>• Reducing inequities (focus on indigenous health, rural and remote, access to mental health)</li> <li>• Developing staff and enhancing organizational performance</li> </ul>
<p><b>Queensland Health Chronic Disease Strategy documents</b></p>		
<p>Queensland Health Chronic Disease Strategy 2005-2015</p>	<p>December 2005</p>	<p>Strategy has identified a number of key areas</p> <ul style="list-style-type: none"> <li>• <b>System enablers</b> - Positive policy environment and community capacity, Health system organization, Self management, Information systems and decision support, Delivery system design: workforce</li> <li>• <b>Primary prevention and reducing risk factors</b> - Raise community awareness and promote consistent messages, encourage behaviour change that promotes health and well being, increase workforce capacity, create healthy environments, focus on early years of life children and young people</li> <li>• <b>Secondary prevention</b> - early detection and early management of disease markers</li> <li>• <b>Management and tertiary prevention</b> - Management and the acute-primary health care interface, palliative care, rehabilitation</li> </ul>

<p><i>Queensland Health Chronic Disease Strategy 2005-2015</i></p> <p><i>Framework for self management 2008-2015</i></p>	<p>2008?</p>	<p>Target populations</p> <ul style="list-style-type: none"> <li>• ATSI</li> <li>• CALD</li> <li>• People in low socioeconomic circumstances</li> <li>• People from rural and remote</li> <li>• Children and young people</li> <li>• Older Queenslanders</li> </ul> <p>The framework is based on the core principles</p> <ul style="list-style-type: none"> <li>• Person centred approach</li> <li>• Promoting health and well being</li> <li>• A capacity building approach</li> </ul> <p>And the following enabling principles</p> <ul style="list-style-type: none"> <li>• A quality improvement orientation</li> <li>• A focus on equity and access</li> <li>• Integration and coordination through partnerships</li> <li>• A sustainable and supportive system</li> </ul>
<p><i>Chronic Diseases in Queensland</i> Legislative Assembly of Queensland Social Development Committee</p>	<p>January 2010</p>	<p>Recommendations include</p> <ul style="list-style-type: none"> <li>• Targeting entire populations using a range of strategies</li> <li>• Concentrate on modifiable risk behaviours – alcohol, tobacco, obesity, mental health</li> <li>• Promote action across all levels of government, private and ngo sector as well as general community</li> <li>• Move efforts beyond the health systems to include transport, housing, welfare and education</li> <li>• Focus on at-risk groups (ATSI, CALD, socio-economically disadvantaged, rural and remote)</li> </ul>
<p><b>Refugee Health Queensland Service Documents</b></p>		
<p><i>Queensland Refugee Health Service : Service Plan</i></p>	<p>April 2008</p>	<p>Purpose of service</p> <ul style="list-style-type: none"> <li>• Health assessments /screening/vaccination</li> <li>• Coordination complex cases</li> <li>• Supported referral</li> <li>• Describes the Hub and Spoke model</li> </ul>
<p><a href="http://www.health.qld.gov.au/multicultural/health">www.health.qld.gov.au/multicultural/health</a> <i>Queensland Refugee Health Service</i></p>	<p>July 2008</p>	<p>Describes the Hub and Spoke model Hub – has a small state-wide team to do planning, coordination, education, monitoring as well as conduct Brisbane South Clinic Service spokes are</p> <ul style="list-style-type: none"> <li>• South Brisbane</li> <li>• North Brisbane</li> <li>• Logan</li> <li>• Toowoomba</li> <li>• Cairns</li> <li>• Townsville</li> </ul>
<p><b>Queensland Compact for working with community</b></p>		
<p><i>The Queensland Compact : Towards a fairer Queensland</i></p>	<p>November 2008</p>	<p>Guides the relationship between the Queensland Government and the Non-profit Community Services Sector. Commitments are</p> <ul style="list-style-type: none"> <li>• Build strong working relationships</li> <li>• Improve engagement in planning and policy</li> </ul>

		<ul style="list-style-type: none"> <li>• Improve the sector's capacity and sustainability</li> <li>• Continue to improve service quality and innovation</li> </ul>
<p><i>The Queensland Compact : Towards a fairer Queensland</i></p> <p><i>Compact Governance Committee Action Plan</i></p> <p><i>November 2008 – November 2010</i></p>	March 2009	<ul style="list-style-type: none"> <li>• <b>Improve engagement in planning and policy</b> - data from CHIC to ensure commitment to needs based planning, commitment to engagement with sector</li> <li>• <b>Improve the sector's capacity and sustainability</b> - Identifying workforce issues, developing a statewide framework for indigenous primary health care - increasing Indigenous participation in design and delivery of primary health services</li> <li>• <b>Continue to improve service quality and innovation</b> - Two intersectoral forums to be held each year to share innovation</li> </ul>

### Victorian documents

Name of Document	Date of publication	Summary of key issues relevant to RaPH
<b>Developing a state wide refugee health and well being policy</b>		
<p><i>Towards a health strategy for refugees and asylum seekers in Victoria</i></p> <p><i>Prepared for Department of Human Services by the Victorian Foundation for Survivor of Torture</i></p>	July 2004	<p>Recognises that the physical and mental health and well being of refugees depends not only on access to health services.</p> <p>Recommendations include meeting the need for</p> <ul style="list-style-type: none"> <li>• Early health assessment and treatment for recent arrivals</li> <li>• Programs for children and families</li> <li>• Enhanced access to mental health services</li> <li>• Assistance for asylum seekers</li> <li>• Capacity building for universal mainstream specialist health and community services to meet the needs of refugees</li> </ul> <p>Health services can contribute to well being through</p> <ul style="list-style-type: none"> <li>• Linking to services</li> <li>• Supporting community capacity</li> <li>• Providing sites for social connection</li> </ul> <p>Outlines health concerns (Chronic Disease) and associated key issues for individual's health and systems access.</p> <p>Sets out the rationale for a coherent framework for a Victorian Refugee Health Strategy.</p>
<p><i>Refugee Health and Well Being Action Plan 2005-2008</i></p> <p><i>Victorian Department of Human Services</i></p>	2005	<p>Purpose of Action Plan is to</p> <ul style="list-style-type: none"> <li>• Assist DHS and other stakeholders to better respond to health and well being needs of refugees</li> <li>• Support refugee communities to positively engage with Victoria's health and community service system</li> </ul> <p>The strategic priorities</p> <ul style="list-style-type: none"> <li>• <b>Accessible service – multiple entry points, focus on early health assessment, access to specialists -</b></li> </ul>

		<p>Refugee health nurse initiative, Refugee Dental Services program, Immigrant /refugee health clinics, School nurses, Refugee mental health clinic - VFST</p> <ul style="list-style-type: none"> <li>• <b>Build capacity of services – enhance coordination, promote flexibility, build data</b> - Mental health services, Research and data, GP's in community health centres</li> <li>• <b>Build individual and community capacity – provide a range of services including practical support, advocacy, information, links to housing and community services</b> - Targeted support for children and young people, family and reproductive rights education, safety net for people of refugee background, disability services, housing and homelessness services</li> </ul>
<p><i>Refugee Health and Well Being Action Plan 2008-2010: Current and future initiatives</i></p> <p><i>Victorian Department of Human Services</i></p>	<p>November 2008</p>	<p>Provides demographic profile</p> <p>Outlines impacts of refugee experience</p> <p>Sets out the case for culturally appropriate service provision</p> <p>The strategic priorities</p> <ul style="list-style-type: none"> <li>• <b>Accessible service – multiple entry points, focus on early health assessment, access to specialists</b> - Early comprehensive assessment, access to oral health, managing complex conditions, health and well being of asylum seekers, better use of language services, provide housing and homelessness support, access to specialist mental health support, responding to alcohol and drug use, responding to disability, family violence and sexual assault support, support for children and families, supporting young people</li> <li>• <b>Build capacity of services – enhance coordination, promote flexibility, build data</b> - Rural and regional settlement planning, build capacity of departmental staff</li> <li>• <b>Build individual and community capacity – provide a range of services including practical support, advocacy, information, links to housing and community services</b> - Address vitamin d deficiency, catch up immunisation, access to pharmaceuticals, sexual and reproductive health programs, social support for frail aged, health literacy</li> </ul>
<p><i>Access to Specialist services by refugees in Victoria</i></p> <p><i>A report prepared for the Department of Human Services by the Victorian Refugee Health Network (Victorian Foundation for the Survivors of Torture – Foundation House)</i></p>	<p>July 2009</p>	<p><b>Purpose of the report:</b></p> <ul style="list-style-type: none"> <li>• To explore existing care pathways for refugees requiring specialist health services</li> <li>• To provide service delivery model options to inform departmental and service provider planning decisions</li> </ul> <p><b>Key findings:</b></p> <ul style="list-style-type: none"> <li>• Significant variance in service response, capacity and frameworks across Vic</li> <li>• Critical nature of the partnerships between specialists and primary care providers requiring robust referral and communication protocols</li> <li>• Need for innovative service models eg family centred practices and strategies for building capacity in the wider health system to respond to refugee health needs</li> </ul>

		<p><b>Service Model options/features:</b></p> <ul style="list-style-type: none"> <li>• Refugee health service models are integrated within the broader health system</li> <li>• Accessible to key settlement areas</li> <li>• Services are affordable or free of charge</li> <li>• Adequate admin support to coordinate service delivery</li> <li>• Qualified interpreters</li> <li>• Primary care involvement including GPs and refugee health nurses essential</li> <li>• Clear pathways between specialist and primary care services</li> <li>• Clearly documented communication protocols between providers to facilitate streamlined transition through the care continuum</li> <li>• Case coordination for more complex health issues</li> <li>• Consistency of screening/assessment processes</li> <li>• Simultaneous care adults/children (family centred)</li> <li>• Clear pathways facilitated transition to culturally “competent” mainstream services eg maternity, mental health</li> </ul> <p>Two service models identified:</p> <ul style="list-style-type: none"> <li>• Visiting specialist to local community health services</li> <li>• Collaborative Care Model</li> </ul> <p><b>Some recommendations:</b></p> <ul style="list-style-type: none"> <li>• Consolidate and expand the role of a state-wide specialist refugee health service to include: fellows program, professional development, secondary consult support to GPs and specialists, research, provision of expert advice to govt and development of clinical guidelines to be used as the basis for local protocol development</li> <li>• Working with universities and professional bodies to include refugee and immigrant health including working with interpreters in the curricula</li> <li>• Workforce planning for specialist services in rural areas (as per settlement pattern)</li> <li>• Development of clear and efficient referral pathways and clinical guidelines between settlement services, primary care and specialist services</li> </ul>
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## APPENDIX 2

### RAPH project partners

Access Inc  
Brisbane South Division of General Practice  
Ethnic Communities Council of Queensland (ECCQ)  
Griffith University  
GPPartners  
Mater Mothers Refugee Maternity Service  
Multicultural Development Association Inc (MDA)  
Multilink  
Queensland African Communities Council (QACC)  
Queensland Health (QH)  
Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT)  
Refugee Health Queensland (RHQ)  
Refugee Health Research Centre, La Trobe University  
Refugee Primary Health Care Centre Discipline of General Practice, University of Queensland  
Southeast Primary Health Care Network  
South East Alliance of General Practice (SEA-GP)  
Transcultural Mental Health Queensland (TCMH)



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