

Joint Submission to Queensland Health

Identification of Queensland priorities under the
National Primary Health Care Strategic Framework
to inform the development of the state-wide GP and
primary health care plan

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Prepared by:

Multicultural Development Association

In collaboration with:

Refugee Health Network of Australia – QLD Branch

RHeaNA

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Queensland Program of Assistance to Survivors
of Torture & Trauma (QPASTT)



QPASTT

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Introduction

The Multicultural Development Association (MDA) has prepared this submission in collaboration with the Queensland Branch of Refugee Health Network Australia (RHeaNA) and the Queensland Program of Assistance of Survivors of Torture and Trauma (QPASTT).

We welcome the opportunity to contribute to the development of the National Primary Health Care Framework for Australia. This submission outlines our concerns in relation to equitable access to primary health care services. While our particular focus is on newly arrived migrants and refugees, many of the needs and challenges raised in this response are shared across culturally and linguistically diverse (CALD) communities in Queensland¹.

We commend the intergovernmental work to develop a more integrated and responsive model of primary health care for high risk groups. We look forward to ongoing engagement in the development and implementation of this Framework.

Key Recommendations

We support the National Vision for Primary Healthcare in Australia.

A strong, responsive and sustainable primary health care system that improves health care for all Australians, especially those who currently experience inequitable health outcomes, by keeping people healthy, preventing illness and reducing their need for hospital services.

The four strategic outcomes from the National Primary Health Care Strategy that have been highlighted for greater focus are also reflective of what we see as important gaps in CALD and refugee health care.

- 1 Build a consumer-focused integrated primary health care system;
- 2 Improve access and reduce inequity;
- 3 Increase the focus on prevention, screening and early intervention; and
- 4 Improve quality, safety, performance and accountability

While we endorse the Government's broad vision and core objectives for progressing with the National Framework, we recommend that careful consideration is given to the needs of CALD and refugee populations within these objectives.

Our recommendation is that the National Primary Health Care Framework focus on the following five key areas to improve access to primary health care services for our clients.

1. Universal primary health care necessitates access to low and no cost community based health care for migrants and refugees. This includes access to ambulatory specialists, allied health care and access to treatments that are not mainstream.

¹ In 2011, 20% of the population in Queensland were born overseas and almost 10% speak a language other than English at home, Census 2011: Diversity in Queensland

2. Access to funded interpreter services need to be available for all healthcare professionals to facilitate the delivery of quality primary health care. This includes mental health, oral health and other allied health professionals.
3. Best practice models of primary care need to demonstrate cultural responsiveness so that they can be adapted to address the specific needs of all communities, including CALD and refugee populations.
4. Development of a national refugee health care plan will facilitate the implementation of cost effective refugee health services. While there are well known complexities, there are also commonalities in many areas, including health, education and workforce knowledge and skills.
5. Systematic collection of data to identify people of refugee and CALD background so that their health care needs can be documented. Specifically a minimum dataset of country of birth and first language spoken would be required.

Background

Queensland's Cultural Diversity

In 2011, 20% of the population in Queensland were born overseas and almost 10% speak a language other than English at home.²

Primary health care data from Queensland Health³ highlights some of the disparity in primary health between people of mainly English speaking background (MESB) and people of non-English speaking backgrounds (NESB). People from Oceania countries of birth had higher rates of hospitalisation (8 out of 11 categories) and North Africa regions also recorded higher rates of hospitalisation (5 out of 11). The categories of hospitalisation that recorded the greatest differences were vaccine preventable hospitalisations, diabetes, heart failure and chronic preventable hospitalisations.

Multicultural Development Association

In 2011- 2012, MDA welcomed a total of 2,438 clients and the Brisbane Multicultural Centre hosted social inclusion activities for a further 1,500 people.

The new arrivals support team worked with 1,298 people of 77 different cultural identities over 2011-2012. MDA Case Managers had almost 17,000 interactions with their clients over this financial year.

² Census 2011: Diversity in Queensland

³ www.health.qld.gov.au/multicultural/health_workers/health-data-summary.pdf

The top 10 main cultural groups assisted in the past financial year include⁴:

Ethnicity	Total Number	% of total clients
Hazara	215	12%
Kurdish	157	9%
Persian/Farsi	116	7%
Arabic	97	6%
Tamil	82	5%
Congo	79	5%
African (NFD)	77	4%
Iranian	68	4%
Tutsi	60	3%
Rohingya (Burma)	53	3%

To deliver settlement services, MDA works in partnership with a range of refugee health services including local refugee health clinics (part time nurses), Mater Hospital Centre for Primary Healthcare Innovation, QPASTT, Transcultural Mental Health QLD and Harmony Place.

Our Service Experience

Through our direct service experience we are aware of the following needs and inequities across the current health care system.

- Many General Practices refuse to see refugee or CALD patients due to: the length of time of sessions; need to use interpreters; and the frequency of missed appointments.
- Low level of ability among health practitioners to offer a culturally responsive service, including use of interpreters (despite TIS hotline), which often results in disengagement.
- Clients tell us they would like health services to be professional, timely and underpinned by the principals of equity, dignity and hope.
- Clients are seeking knowledge of the Australian health care system and health literacy.
- Limited direct engagement with cultural communities by health care providers.
- Limited capacity of GPs and other services to refer to mental health services (ATAPs Programs typically do not fund interpreters, do not use culturally sensitive

⁴ Multicultural Development Association Annual Report 2011-2012

modes of intervention and rely on clients to initiate access).

- Health professionals lack an understanding of the refugee experience and subsequent physical and psychology impacts.
- Health services models aren't flexible in responding to irregular and high periods of service demand.
- Health Professionals are seeking a coordinating system of care and do not know who to contact for support and professional training.
- Discrimination experienced by clients in accessing health services.

Primary Health Care Needs

Refugee and Migrant Experience of Health Care

Each refugee arrives in Australia with multiple and sometime complex health needs. Some require immediate medical care while others suffer chronic pain, infectious diseases and nutritional deficiencies that need to be addressed as soon as possible after arrival. Many have mental health issues, particularly after spending long periods of time in detention. Some have undiagnosed chronic illnesses such as diabetes and ischaemic heart disease. It is well recognised that refugees and asylum seekers arrive with a comparatively poorer state of well being than other migrants⁵. However, many of these conditions are treatable and when these health issues are addressed early in the settlement period, people manage the acculturative process better. Receiving support soon after arrival reduces the cost of health interventions, helps to ensure preventive health issues such as immunisation are addressed and can reduce the frequency (and cost) of recurrent presentations for emergency care.

Newly arrived migrants and refugees require assistance in the early settlement period to ensure that they are provided with functional health literacy and educated about how to navigate the local health system. Currently there are many barriers to receiving quality health care. These include: pre-existing health issues including mental health; language barriers; low levels of health literacy; cultural differences, limited understanding of Australian health service systems, low socio-economic factors as well as experiences of war, conflict and persecution. Currently, there is limited support available to enable migrants and refugees to access the appropriate health services soon after arrival. We know that our clients are not accessing the on arrival medical assessments, treatments and ongoing care required. This comes at a significant economic and social cost to our society.

⁵ Lehn A (1997) Recent Immigrant's Health and Their Utilisation of Medical Service. Results from Longitudinal Survey of Immigrants to Australia, Department of Immigration and Multicultural Affairs Update March Quarter, 32-38

Without a systematic way to collect relevant data about people from refugee and CALD communities, it is not possible to adequately document their health needs. These communities remain invisible in the health system⁶. Few primary care databases collect information such as country of birth or first language spoken. While these health needs remain inadequately documented, it will not be possible for the health system to be proactive within the primary health care system and the health care needs are more likely to escalate without early intervention and require secondary (hospital) care more frequently.

Impacts of Recent Changes in Queensland Health

The recent decentralisation of Queensland Health into 17 Health and Hospital Service Districts has impacted on the delivery of health services to newly arrived refugees. The centralised functions of a number of critical services including; Refugee Health Queensland and the Queensland Tuberculosis Control Centre offered coordinated referral pathways, support for both specialist practitioners and general practitioners. These services facilitated access to affordable treatments and enabled linkages to ongoing community care to address the many health issues without the need to attend hospital services. Refugee Health Queensland provided general practitioners with clear guidelines for the management of many conditions that reduced the need for referrals to hospital clinics e.g. for infectious diseases (such as strongyloides, and schistosomiasis). There is significant concern among health practitioners and community services about the health care system's ability to identify, control and treat some of these health issues without these integrated pathways in place.

The work of the Multicultural Unit of Queensland Health in providing an overarching policy framework to improve multicultural health was commendable. The recent development of the *Queensland Health Guidelines for Multicultural Policy Implementation* to assist Hospital and Health Services to implement actions to achieve 10 annual performance indicators under the *Queensland Multicultural Action Plan 2011-14* is an important first step. However, this policy framework by itself will not generate the impetus for operational change to improve the integration of primary health care services. Without such integration, the intended outcomes are unlikely to be achieved. It is essential that a framework for partnership with Medicare Locals and other Federal Government funded programs are included in this vision. Recent media announcements indicate that this Unit is no longer funded by Queensland Health.

It is essential that health care delivery is provided in a culturally sensitive manner and leadership is needed to achieve this result. It is important to note that these issues are not currently addressed in primary health policy documents and this oversight needs to be addressed urgently.

⁶ Claire E. Brolan, Robert S. Ware, Nicholas G. Lennox, Miriam Taylor Gomez, Margaret Kay, and Peter S. Hill, Invisible populations: parallels between the health of people with intellectual disability and people of a refugee background *Australian Journal of Primary Health*, 2011, 17, 210–213

Cost of Health Services – Access and Equity

Equity is a core value of Australia's healthcare system. Our organisations share concerns that the current model of activity based funding in Queensland Local Health and Hospital Districts allows Districts to choose the services offered. This may result in a reduction of services available to our clients if they are not seen as cost effective or of high priority due to the lack of data and the relatively small numbers compared with the general population.

On arrival clients are managing multiple health needs that require an integrated response. Following an initial medical assessment and immunisation this can include pathology, radiology, specialist referrals to oral health, child health, maternity, infectious diseases, gastroenterology, endocrinology and pharmacology. This requires coordination, affordable vaccines and pharmaceuticals, specialists in ethno-specific conditions, supportive transitions between services and effective links to ongoing care.

We are concerned that without a strong understanding of the cultural or refugee backgrounds of patients and their health care journey, current services, including specialists in areas of refugee and ethno-specific health, will be lost and gaps in services will increase.

Access to Interpreters

Private health providers do not have a requirement or incentives to use interpreters. Often family members are inappropriately used to interpret what are complex, technical and sometimes culturally taboo topics. Many health professionals who do have access to fee free interpreting service (via QLD Health or TIS hotline) do not see the benefit in training and see organising interpreters as a costly hassle. MDA and QPASTT services see every day how clients struggle to manage: a lack of information and understanding; an inability to follow up with appointments and treatments; and sometimes misdiagnosis. Clients have the right to access services with appropriate language support that will ensure full understanding. Ultimately there is a benefit to the health system if culturally appropriate care is provided through better concordance with treatment.

Currently dental care, physiotherapy, dietetic advice, diabetes education and mental health care (to name a few) are simply not available to our clients because fee free interpreting services are not able to be accessed for these health professionals.

Access to interpreters is an essential part of providing equitable access to health services.

Best Practice Models of Primary Care

Models of best practice exist in the community. For example, Queensland Health enabled the development and piloting of the Primary Care Amplification Model at Inala Primary Care (IPC). This 'beacon' practice has successfully built upon existing infrastructure in the

community to target a particular health need. Models such as this can be adapted to enhance culturally responsive health service delivery⁷.

Chronic disease management is important for all Australians including CALD and refugee populations. Interventions for diabetes and other chronic diseases need to be available and delivered in a manner that is appropriate to their cultural needs e.g. advice on diet needs should consider the religious and cultural needs of the individual patient. Local initiatives such as IPC have been replicated overseas to improve the responsiveness to these high risk groups⁸.

A National Plan for Refugee Health

The five objectives outlined in the Framework could effectively support the development of an integrated, national refugee primary health care plan. Many aspects of this work could be achieved within existing resources by targeted on arrival refugee health needs in operational planning, integrated service development models, workforce development and training.

While there are well known complexities, there are also commonalities in many areas, including health, education and workforce knowledge and skills. It is recognised that some states (Victoria, New South Wales and Tasmania) already have well-developed refugee health plans that could guide the development of a national approach.

Data Collection and Monitoring

It is challenging to monitor primary health care needs and service responses without adequate data. The multicultural sector does not have reliable data to inform and improve services and programs for CALD and refugee communities.

The new contractual requirements for Local Health and Hospital Services to report on the whole of government performance indicators under *Queensland Multicultural Action Plan 2011-14* is an important first step. However, it does not require services to collect any data in regards to culture or language which is essential in delivering culturally responsive services. Country of birth or first language spoken would form the basis of a minimum data set to inform service delivery.

Medicare Locals have recently completed their community needs analysis. In different regions CALD and/or refugee populations have been identified as vulnerable groups. We commend the Medicare Locals on initiating plans to engage with cultural communities in their region.

⁷ Margaret Kay, Claire Jackson and Caroline Nicholson, Refugee health: a new model for delivering primary health care, Australian Journal of Primary Health, 2010, 16, 98–103

⁸ WJ Heerman, MJ Wills, 2001, Adapting Models of Chronic Care to Provide Effective Diabetes Care for Refugees, Vol 29, No. 3 pp90-95

Conclusion

An integrated system of primary health care inclusive of Local Health and Hospital Services, Medicare Locals, community service organisations and cultural communities will improve the health outcomes for CALD and refugee populations. A national approach will provide leadership and coordinate the expertise and resources needed to educate primary care providers and improve the systems of support. A prevention and early intervention approach will result in significant social and economic benefits to our newest residents and our whole community.

Multicultural Development Association

MDA is an independent, non-government, settlement organisation committed to achieving the best settlement outcomes for our clients and to working actively to promote multiculturalism.

Through our presence in metropolitan and regional Queensland, we work in partnership with our clients, other service providers, government agencies and the private sector to achieve quality service delivery through advocacy, client service delivery, community development and multicultural sector development.

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The Refugee Health Network of Australia (RHeaNA) - Queensland

Refugee Health Network of Australia (RHeaNA) is an organisation that includes health professionals from multiple disciplines who work in primary and specialist health care sectors as well as key stakeholders each of whom have expertise in the area of refugee health.

Our expertise includes the delivery of clinical care, the coordination of refugee health services and research in refugee health. The focus of this national network is to enhance the quality and accessibility of health care for refugees. Effective delivery of refugee health care involves a locally responsive and flexible health service.

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The Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT)

QPASTT provides flexible and cultural sensitive services to promote the health and wellbeing of people who have been tortured or who have suffered refugee related trauma prior to migrating to Australia. QPASTT aims to provide services which address the range of physical, psychological and social needs that survivors of torture and trauma have. Our services are free and confidential.

QPASTT is a not-for-profit, community organisation working across Queensland. QPASTT is a state wide organisation. The main office is located in the suburb of Woolloongabba in Brisbane and the organisation does outreach work in Gold Coast, Logan and Weipa and has offices in Toowoomba, Townsville, Rockhampton, Cairns. Or maybe

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