Refugees in Australia: changing faces, changing needs

Mitchell M Smith

A national strategy for meeting the particular health needs of refugees would provide a more comprehensive approach

The profile of refugees being resettled in Australia depends on global geopolitical conflicts, representations from the United Nations High Commissioner for Refugees to the Australian Government, and Australia's response. Recent years have seen an enormous shift within Australia's annual refugee intake, with 70% originating from countries in sub-Saharan Africa.[1]

The Australian Government requires those migrating under its Humanitarian Program to undertake certain health checks before being issued with a visa.[2] Additionally, since mid 2005, the Department of Immigration and Multicultural Affairs (DIMA) has been rolling out an additional medical check known as a predeparture medical screen (PDMS) in the few days before departure (Kathy King, Director, Special Health Projects, DIMA, personal communication). This medical check was introduced in response to 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 DIMA is expanding the geographical coverage for the PDMS, not all current humanitarian entrants are subject to this screening.

In this issue of the Journal, a collection of articles and a letter on refugee health indicate a high prevalence of various conditions among recent refugee arrivals (Chih et al, *page 598*; Tiong et al, *page 602*; Martin and Mak, *page 607*; Cherian et al, *page 611*). Some of the data were collected before the introduction of the PDMS, which may have lowered the rate of malaria and intestinal parasite burdens. However, recent experience in New South Wales has been that cases of malaria continue to be detected despite antigen testing overseas. 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,[2] yet this disease has important personal and public health implications.

It is apparent that the screening conducted overseas, no doubt under difficult circumstances, remains suboptimal. 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.[3,4] Health care professionals in Australia may be unfamiliar with some conditions, and diagnosis might be delayed if these conditions are not detected in their asymptomatic stages through adequate screening. The principles of prevention and early intervention, our existing knowledge about refugee health care needs, and the additional evidence from the articles in this issue of the Journal justify a call for nationally coordinated, comprehensive health assessments to be offered to all newly arrived refugees.

This need for comprehensive health assessments was highlighted in a recent report on refugee children.[5] However, entire families in this setting have the same requirements, and a family-centred approach is needed. Health assessments must not only focus on infectious diseases, but should take into account the refugee trauma experiences of families and individuals, and assess physical, psychological and psychosocial needs. Sufficient attention needs to be given to oral health, nutrition, undermanaged chronic conditions, and the impacts of violence.

Currently, each state and territory has a different model and varying coverage for postarrival checks, as shown by some of the reports in this issue. Some jurisdictions have centralised clinics in public hospital venues, focusing mainly on infectious disease screening (eg, Tasmania, Western Australia). NSW, with an annual intake of 4000 refugees who are dispersed widely across the state, has a state-funded Refugee Health Service with some clinical role but which also supports mainstream health services to assist refugees. Victoria has a different model again, with a focus on general practitioners in community health centres and private practice, supported by refugee health nurses.

Sheikh-Mohammed et al (*page 594*) and Tiong et al (*page 602*) highlight the important role that GPs play in providing health care services to refugees. However, there are limitations to GPs being able to perform comprehensive assessments, including time constraints, the challenges of using an interpreter over the phone, and the need for specialised knowledge. The release in May this year of a new Medicare item number for refugee health assessments goes some way towards supporting GPs who take on this role.[6] Unfortunately, the opportunity to link the release of this item number to targeted GP education was missed at the national level. Indeed, a system of "accredited practices" could even be envisaged, with key GPs linked into, and supported by, clinicians and public health staff experienced in refugee health.

As with health care provision to other special-needs groups, there are debates about the need for mainstream versus specialised services.[7] 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.

Whatever the model for providing health assessments, newly arrived refugees need help to overcome the barriers they face in accessing health care.[8] Increased availability of DIMA-funded case workers and of volunteers will help refugees negotiate our complex health care systems.[9] 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.

At the national level, there are a number of initiatives underway in refugee health in addition to the new Medicare item number. In response to issues similar to those raised in the articles in this issue, the Department of Health and Ageing has, over the past year, convened a working group on refugee health, with representatives from all states and territories. This group has made recommendations to the Australian Health Ministers' Advisory Council, some of which aim to address issues raised by Tiong et al (*page 602*). These include the cost of certain medications, such as praziquantel for schistosomiasis, and the limited availability of some vaccines for catch-up schedules.

Refugee health is a varied field crossing multiple disciplines and presenting complex issues. The development of a national refugee health strategy would promote greater direction, coordination and standardisation nationally. One aspect should be data collation and monitoring of disease detection prevalence across jurisdictions. National guidelines relevant to refugee health, some of which are already being developed, are required. Finally, although clinicians and others working with refugees do network informally, more formalised networks between these health professionals will aid communication and collaboration across borders.

Author details

Mitchell M Smith, MB BS, MPH, FAFPHM, Director
NSW Refugee Health Service, Sydney, NSW.
Correspondence: mitchell.smith@sswahs.nsw.gov.au

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