

# The Refugee Health Network of Australia: towards national collaboration on health care for refugees

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*Until now, services have been poorly coordinated and individual practitioners unsupported*

Each year Australia accepts around 14 000 refugees who have been forced to flee their homelands as a result of war and other traumatic events. The majority of these new arrivals have been assessed and granted permanent humanitarian visas offshore. Only a minority arrive by boat or aeroplane to seek asylum here.<sup>1</sup> Among resettlement countries, Australia makes a significant contribution to the international effort, and our refugee settlement support services are laudable. However, we struggle at times to provide accessible and responsive health care services for refugees.

Like other migrants destined for Australia, offshore refugees undergo a health assessment overseas to detect conditions of public health importance. Nevertheless, many refugees carry considerable health burdens that are not the focus of this medical assessment. They have had limited access to health care, and many suffer nutritional deficiency, are not immune to vaccine-preventable conditions and may suffer chronic illnesses such as hepatitis B.<sup>2-4</sup> As a result of torture and other forms of trauma, many are psychologically vulnerable.

Achieving good health care for refugees in Australia presents a number of challenges, both for the refugees who seek care and for the health care practitioners who seek to provide effective services. Our refugee population is too dispersed to have a single health assessment service such as New Zealand's Mangere Refugee Reception Centre. Some states have specific services for short-term health assessment, while elsewhere, health care for newly arrived refugees is devolved to mainstream general practice, community health centres, or small non-government organisations.<sup>5</sup> This patchwork of disconnected services is further strained by the trend for refugees to settle in outer metropolitan, regional and rural townships across Australia, where health services are already stressed.<sup>6</sup>

Lack of coordination and the isolation of those caring for refugees can lead to a number of problems. First, health care providers may be unaware of how best to manage unfamiliar disease profiles.<sup>7</sup> Refugee health is a field that changes rapidly. About 5 years ago, 70% of newly arrived refugees were from

Africa.<sup>8</sup> In the financial year 2009–10, refugees from Burma or Iraq made up more than one-quarter of the humanitarian intake, and 15% were from Bhutan or Afghanistan.<sup>1</sup> Doctors might need to focus on schistosomiasis and prevention of rickets in one cohort, then malaria and micronutrient deficiencies in another. Policies and practices for screening refugees for tuberculosis differ between states.

Second, doctors may be unaware of specific provisions for and needs of refugees. For the 4 years that a specific refugee health assessment item (Item 714) existed on the Medicare Benefits Schedule (MBS), fewer than half of newly arrived refugees benefited from it (data retrieved as a Medicare Australia item report). Preventable deaths can occur when hospital referral mechanisms are not understood or interpreters not used.<sup>9</sup>

Third, emerging issues in refugee health care are rarely met with timely public policy solutions. Although populations known to be at high risk of vitamin D deficiency have formed a substantial part of the humanitarian intake for at least a decade, access to high-dose vitamin D treatment remains problematic. Schistosomiasis is highly prevalent in many African countries, but the standard treatment (praziquantel) was not subsidised under the Pharmaceutical Benefits Scheme (PBS) until more than 5 years after the first intakes of refugees from these countries. Since 2005, when changes to the funding of vaccinations were introduced, catch-up immunisation for refugees has become increasingly difficult, and long-term funding of free catch-up vaccines remains precarious in many states. Psychiatric services for asylum seekers and refugees remain underresourced.

These problems reflect, in part, inadequate networks of communication between health care providers, and between health care providers and policymakers. The recently formed Refugee Health Network of Australia (RHeNA) is helping to overcome these barriers. RHeNA is a national collaboration of over 140 refugee health service providers (general practitioners, nurses, specialists, public health practitioners, academics and policymakers) across all states and territories. Its key purposes are summarised in the Box.

RHeNA supplements discipline-specific groups, such as the Royal Australian College of General Practitioners' newly formed Special Interest Group in Refugee Health, and draws on state-level networks in Victoria and South Australia. Since its formation, the Network has collaborated in providing rapid feedback to the Australian Government Detention Health Advisory Group on health issues among asylum seekers exiting immigration detention centres. Through pooling data from refugee health services, the Network is uncovering an emerging problem of vitamin B<sub>12</sub> deficiency among Bhutanese and Afghan refugees.<sup>10</sup> RHeNA has provided input at a national level on primary health care reforms, humanitarian settlement services, MBS item numbers, national hepatitis B policy, and the need for certain pharmaceuticals to be listed on the PBS.

## Refugee Health Network of Australia: key purposes

- To inform and support quality holistic health care for refugees in Australia.
- To provide advice to policymakers at Commonwealth and state and territory level on current and emerging issues in refugee health in Australia.
- To provide a forum for exchange of information between providers of refugee health care and other relevant stakeholders across Australia.
- To develop a research agenda and disseminate research findings. ◆

RHeaNA has engaged in a direct program of outreach to GPs and nurses about emerging health issues in each state, most recently in supporting GPs involved in providing quality health care to asylum seekers since the new policy of transferring asylum seekers from immigration detention centres to community detention took effect. In the new primary care landscape, where integrated care is an important focus, RHeaNA provides a much-needed forum for collaboration and communication between practitioners, policy-makers and researchers, to support more effective health care for this vulnerable population.

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