Critical health infrastructure for refugee resettlement in rural Australia: Case study of four rural towns

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Abstract

**Objective:** To explore the reported impact of regional resettlement of refugees on rural health services, and identify critical health infrastructure for refugee resettlement.

**Design:** Comparative case study, using interviews and situational analysis.

**Setting:** Four rural communities in New South Wales, which had been the focus of regional resettlement of refugees since 1999.

**Participants:** Refugees, general practitioners, practice managers and volunteer support workers in each town (n = 24).

**Results:** The capacity of health care workers to provide comprehensive care is threatened by low numbers of practitioners, and high levels of turnover of health care staff, which results in attrition of specialised knowledge among health care workers treating refugees. Critical health infrastructure includes general practices with interest and surge capacity, subsidised dental services, mental health support services; clinical support services for rural practitioners; care coordination in the early settlement period; and a supported volunteer network. The need for intensive medical support is greatest in the early resettlement period for ‘catch-up’ primary health care.

**Conclusion:** The difficulties experienced by rural Australia in securing equitable access to health services are amplified for refugees. While there are economic arguments about resettlement of refugees in regional Australia, the fragility of health services in regional Australia should also be factored into considerations about which towns are best suited to regional resettlement.

**KEY WORDS:** access, community service, health service access, rural service planning, resilience.

Introduction

Each year Australia resettles around 13 000 refugees, one-third of these in New South Wales (NSW). Newly arrived migrants tend to settle in metropolitan centres, near family and other supports. Federal government policy has increasingly focused on settling newly arrived refugees in regional areas. Regional Australia has advantages as a settlement location, particularly in relation to housing affordability and employment opportunities, but might be perceived negatively by refugees if their access to education or health services is compromised.

Refugees are a heterogeneous population, whose health needs reflect access to primary health care services in their countries of origin and asylum, intercountry differences in patterns of infectious diseases and micronutrient deficiencies, and exposure to torture and trauma. Although the rates of hospital admissions for refugees appear to be equal to or slightly lower than those for the general Australian population, the primary health care needs of refugees in the early resettlement period are significant. A number of small-scale observational studies have indicated that a comprehensive primary health care program for refugees must address dental disease, chronic pain-related conditions, infectious diseases, micronutrient deficiencies and lack of protection against vaccine-preventable diseases. Reproductive health care has been identified as a priority for refugee health care, but few Australian studies have explored access to these services by refugee women.

Australia has a publicly funded universal health care scheme (Medicare) for all citizens and permanent residents, which provides access to free treatment in public hospitals, and free or subsidised treatment by GPs, specialists and optometrists. Humanitarian entrants and holders of temporary protection visas may access the publicly funded universal health care scheme. Asylum seekers generally do not have access to Medicare. In Victoria and the Australian Capital Territory, asylum seekers may access free health care in public hospitals.
In December 2006, the Tamworth City Council declined a request by the Department of Immigration and Citizenship to be a resettlement location for five refugee families. At issue was not racism, the mayor argued, but the adequacy of resources to support resettlement, including public health screening services. The decision attracted a great deal of local and national media discussion, and was subsequently reversed. The Tamworth debate highlighted a gap in research into the health services needed to provide sustainable and appropriate health care for refugees in regional Australia. This paper aims to identify critical health service infrastructure to support regional resettlement for refugees, using case studies of four regional towns that have been sites of refugee resettlement.

Methods

Study sites

The four towns in this study were selected because of their differing experiences with refugee resettlement, and were all located within the footprint of one area health service. All towns were classified as Areas of Medical Workforce Shortage. Inhabitants of this region reported the highest level of difficulty accessing health care across NSW, with 24% of men and 25% of women stating that they could not access health care when they needed it, compared with 15.6% for the general NSW population.

Town A was the site of large-scale resettlement of refugees on a planned short-term basis between 1999 and 2001. A small number of refugees submitted successful claims for permanent visas, and remained in Australia. Town B has been the site of planned resettlement of refugees on permanent visas for many years. Town C was the site of short-term resettlement of refugees on temporary protection visas, with refugees being recruited to address critical shortages in the town’s workforce. Town D was the site of recent planned resettlement of refugees on permanent visas, commencing in 2004.

The four settlement towns hosted refugees whose countries of origin included countries from East and West Africa, Europe and the Middle East. Refugees in Towns B and D were provided with settlement support through the Integrated Humanitarian Settlement Strategy. This scheme provides intensive settlement support to recently arrived refugees with specific visas. Among other things, the Integrated Humanitarian Settlement Strategy provides on-arrival reception and assistance, accommodation referral and support services, and short-term torture and trauma counselling. Because they held temporary humanitarian visas and temporary protection visas, respectively, refugees in Towns A and C had access to short-term torture and trauma counselling, but were not provided with other settlement support. All refugees in all towns had access to Medicare.

Key health service and social indicators for each town are presented in Table 1.

Data collection

Key informants in each town (refugees, workers in general practice, volunteer support workers) were identified by members of the NSW Regional Refugee Service Providers Network (Table 2). Workers in general practice included GPs, counsellors and practice managers. Interviews were conducted in person, addressing the informant’s experiences with health care delivery for refugees, obstacles and enhancers to good service provision. Interviews lasted between 25 and 40 min, and were tape-recorded. Refugee informants were fluent in English.

Data were analysed for emergent themes, using the constant comparator method. This study was approved by the Australian National University Human Research Ethics Committee.

Results

The experiences of volunteers, refugees and health workers varied in the four settlement towns (Box 1).
Although the four settlement towns had varying types and levels of hospital services, the differences described by all interviewees related to accessing primary health care.

### Availability of appropriate primary health care services

Two towns had GPs who had become skilled in refugee health, and undertook almost all of the initial health assessments of refugees. Refugees in Town C had an initial health assessment performed in Australian Immigration Detention Centres; it was a source of frustration for health care providers that refugees were not given copies of these health assessments. Access to GPs who would not require a co-payment for their services was a barrier to health service access in several towns. This was less problematic in the one town where all refugees were employed, and could afford health care when needed. In other towns, informal advocacy was conducted by volunteers to encourage general practices to charge refugees only the Medicare rebate, which effectively means that refugees do not have a point-of-service fee. A GP and practice manager whose practice did not charge refugees a co-payment reflected that the financial burden was a major concern for practice management, as refugees required prolonged consultations and coordination of care by the practice nurse and manager.

There was a significant unmet need for dental care, with the public provision of dental care in all towns being regarded as insufficient. One volunteer reported paying over $1000 for private dental care for one refugee, while another refugee was told he would have to travel to Sydney for treatment, a trip he could not afford. Similarly, assessment and treatment services for refugees whose hearing had been damaged either by chronic ear infections or by close exposure to artillery were often unavailable in the towns.

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**TABLE 1: Health service and social indicators for four towns in rural New South Wales (NSW)**

<table>
<thead>
<tr>
<th>Health service indicators</th>
<th>Town A</th>
<th>Town B</th>
<th>Town C</th>
<th>Town D</th>
<th>NSW</th>
</tr>
</thead>
<tbody>
<tr>
<td>RRMA</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Number of GPs/number of practices</td>
<td>37/11</td>
<td>43/11</td>
<td>9/2</td>
<td>30/7</td>
<td></td>
</tr>
<tr>
<td>GP: population ratio†</td>
<td>N/A</td>
<td>1:1742</td>
<td>1:1700</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Number of hospital beds</td>
<td>155</td>
<td>255</td>
<td>35</td>
<td>151</td>
<td></td>
</tr>
<tr>
<td>Social indicators</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Index of relative social disadvantage‡</td>
<td>984</td>
<td>985</td>
<td>978</td>
<td>953</td>
<td>1000</td>
</tr>
<tr>
<td>Index of education and occupation§</td>
<td>975</td>
<td>985</td>
<td>935</td>
<td>952</td>
<td>1010</td>
</tr>
<tr>
<td>Unemployment rate¶</td>
<td>8.3%</td>
<td>7.2%</td>
<td>7%</td>
<td>7.5%</td>
<td>6%</td>
</tr>
<tr>
<td>Percentage born overseas¶</td>
<td>8.5%</td>
<td>6.2%</td>
<td>5.8%</td>
<td>8.8%</td>
<td>16.1%</td>
</tr>
</tbody>
</table>

†FTE GP: population ratios, provided by relevant divisions of general practice; ‡IRSD combines variables relating to education, occupation, non-English-speaking background, indigenous origin and the economic resources of households;§EDUOCC combines variables relating to occupational classification, unemployment, early school leaving and lack of educational qualifications;¶Derived from Australian Bureau of Statistics. EDUOCC, index of education and occupation; FTE, full-time equivalent; IRSD, index of relative and social disadvantage; N/A, not available; RRMA, rural and remote area classification.

**TABLE 2: Summary of study interviewees**

<table>
<thead>
<tr>
<th>Town A</th>
<th>Town B</th>
<th>Town C</th>
<th>Town D</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practice</td>
<td>1 doctor with long-term experience in refugee health care</td>
<td>1 GP with long-term experience in refugee health care</td>
<td>1 general practice administrator†</td>
</tr>
<tr>
<td>Patients from refugee background</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Volunteer support workers</td>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

†GPs who had provided refugee health care were no longer living in Town C.
Lack of access to appropriate mental health services was highlighted repeatedly by interviewees. In one town, trauma counselling was provided on a voluntary basis by a skilled counsellor. In another town, outreach was provided by the state torture and trauma support service every 3 months, with volunteers providing mental health support for refugees. In a town where refugees did have funded counselling included in their settlement provision, the sole counsellor reported that the extent of the mental health needs of her clients was overwhelming for one person.

Language accessibility

Most respondent GPs were adept at using the telephone interpreter service, but some expressed doubt about whether colleagues were as familiar with the service. One respondent working in health service administration recommended that refugees arrange their own interpreters, stating that he understood that there was a need to book a week in advance; in fact, interpreters were readily available in the language of refugees in that community through the Doctors Priority Line, and the service is only fee-free if booked through the surgery.

The telephone interpreter line, though useful, was not without difficulties, even for GPs who knew how to access it.

I’ve found the people on the other end wonderful, but it is a bit of hassle from within a general practice perspective getting on to them. You can’t just ring up and immediately get on to somebody. You have to ring up . . . and quote your registration number and they won’t let you on unless you’ve registered beforehand, and it’s quite a problem. (GP)

Some refugee respondents were also uncertain about using interpreters, citing concerns about privacy and being misrepresented.

In several towns language-concordant GPs provided health care for refugees. There is a risk with this strategy of ascribing all refugee health care to the language-concordant GP, and overwhelming him or her. In addition, there can be confusion about the language with needs interpreting. One respondent, for example, referred Dari-speaking refugees to a doctor who spoke English and Arabic.

Mismatch in expectations of health service delivery

Both refugee and GP respondents described instances of misunderstanding about conceptions of appropriate delivery of care, with each indicating that he or she doubted the validity of the other’s position. One refugee said that the Western treatment of ringworm with an ointment was ineffective, as the problem should be treated ‘from within’. ‘In Australia they only give drugs to very sick people’, said another refugee, describing how he could not obtain medications for a headache that had persisted for 5 weeks. For GPs, some refugee clients seemed overly focused on medication, a position...
characterised by one GP as ‘demanding antibiotics for a cut foot’.

Discussion

Our study identifies the critical health infrastructure to support successful refugee resettlement in regional Australia, summarised in Box 2. The challenges are related to primary health care, not hospital care, a finding that is supported by recent studies that found that refugees were not higher users of hospital services. After the initial settlement period, interviewees felt that the health needs of refugees were not greater than those of the general community, with the exception of needs for services for psychological illness and distress.

The strength of our study is its case study approach in four rural towns in NSW. Our study has some limitations. Interviews with respondents from refugee backgrounds were conducted in English, so refugees who might have been more marginalised because of language difficulties were excluded. A respondent bias might have operated, as refugees were invited to participate by people they knew, and might have been reluctant to criticise. All refugee respondents tempered any negative comments with positive statements about their experiences. We were unable to talk to doctors in Town C, as all those who provided health care at the time of the resettlement of refugees had left.

None of the respondents reported that screening for and treatment of diseases of public health concern posed a challenge. The GPs felt that they were supported by local public health services, and were able to carry out the necessary screening by themselves. Much of the published research on refugees, particularly those from Africa, has focused on diseases of public health importance. Health service approaches that focus on initial screening of refugees for diseases of public health importance do not address the need for intensive, comprehensive health care by primary health care services in the early months of resettlement.

Refugees often have complex mental health care needs, which might overwhelm the mental health services of rural towns. A solution might lie in expanding the funding of specialist refugee counselling services in the capital cities to better support intensive outreach service and training.

In three towns the turnover of health service staff had resulted in loss of capacity in refugee health care. Two ways to enhance the capacity of rural GPs to manage complex and sometimes rare health conditions in refugees are through participation in networks of service providers, or support from specialised refugee health services. Our study was conducted before the introduction of the Refugee Health Check to the Medicare Benefits Schedule. The Refugee Health Check is a comprehensive health assessment for refugees to be performed by GPs in the first year of a refugee’s resettlement. We are unable to comment on whether this has led to a reduction in the financial burden to practices that provide a lot of refugee health care.

A key contributor to the success of rural resettlement of refugees is the vibrant volunteer support network provided by rural Australians. There is no formal system of training and supporting volunteers. Volunteers are at high risk of burnout, particularly if they are taking on the role of de facto counsellor to highly traumatised patients. In one town, the pool of volunteers is mostly drawn from church groups, and is shrinking as their members age or become exhausted. These volunteers might be sustained by provision of funded case coordinators for refugees in the first year of resettlement in regional Australia, modelled on the Victorian model of nurse coordinators in community health centres.

The Doctors Priority Line of Telephone Interpreter Service (1300 131450), which provides free accredited interpreters for any Medicare-funded service, is internationally unique. However, it continues to be underused in rural Australia. It is concerning that even practices that were geared to refugee health care misunderstood how the service worked, or found it complex. Asking refugees or volunteers to arrange their own interpreters is a practice that cost-shifts from the Commonwealth to the patient, as refugees are asked to pay for a service that would be free to a doctor. There is an urgent need for the telephone interpreter service to review how it promotes its service to rural Australia and to actively address misunderstandings about the service.

Our study found a deep commitment to good health care and social justice by both volunteers and health workers, which was noted and appreciated by refugees.
However, there are questions about the sustainability of service provision if it relies too much on the altruism of rural residents. The Department of Immigration and Citizenship should acknowledge that for the first year of settlement, refugees are likely to have heightened needs for health care, and choose settlement locations that have the required health infrastructure. State health services should be aware that dental needs for refugees are significant in the first 6 months of settlement, and consider a voucher system to provide this. Finally, volunteers who support newly resettled refugees should be able to access specific mental health primary prevention programs to prevent burnout.

Acknowledgements

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References