Towards health for all in regional Australia: critical health infrastructure for refugee resettlement

Scott Sypek, Greg Clugston, Christine Phillips

Each year Australia resettles nearly 14000 refugees. Federal government policy has increasingly focused on settling newly arrived refugees in regional and outer metropolitan areas. Although housing is more affordable in regional Australia, refugees and volunteers have raised concerns about access to health care.

They are not alone in this concern. 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. The mayor argued that the issue was the adequacy of resources to support resettlement, including public health screening services. Although the decision was subsequently reversed, it highlighted a gap in knowledge about the health services needed to provide quality health care for refugees in regional Australia.

Rural Australia has fragile health infrastructure which can be a barrier to ‘mainstream’ and diverse communities accessing health services. This lack of health resources combined with a dispersed population, low number of health professionals, high staff turnover and lack of specialised training adversely affects health services in rural areas. This is especially the case for refugees who often have additional health needs or difficulty navigating Australia’s health system.

Refugees are a heterogeneous population, whose health needs reflect the quality of health care services in their countries of origin, patterns of infectious diseases and micronutrient deficiencies, and exposure to torture and trauma. We aimed 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.

Four towns with diverse experiences

The four towns in this study had differing experiences with refugee resettlement. Town A had large-scale short-term resettlement of refugees between 1999 and 2001, and some remained at the time of this study. Town B has been the site of planned resettlement of refugees on permanent visas for many years. The major challenges in relation to accessing health services were being able to afford GP services and finding a GP who spoke the same language or who would use an interpreter.

In Town C, refugees on temporary protection visas were recruited to address critical shortages in the town’s workforce. Because all refugees had employment, they could afford to pay for services that were not bulk-billed, although language difficulties remained a challenge.

Town D is the site of recent planned resettlement of refugees on permanent visas. Inhabitants of the region where these towns were located reported the highest level of difficulty accessing healthcare across NSW.

All refugees in all towns had access to Medicare. Interviews were conducted with key informants in each town (seven refugees, seven workers in general practice and ten volunteer support workers). The interviews addressed the informant’s experiences with health care delivery for refugees, obstacles they faced and enhancers to good service provision.
Critical health infrastructure for refugee resettlement in regional Australia

The challenges in providing good refugee health care are related to primary health services and are needed most in the early resettlement period, with the exception of mental health services. Informants reported that it was easier to access public health screening than general primary health care in all towns. Critical health infrastructure consists of: accessible general practice; dental care; psychology services; and support for volunteers assisting with in refugee settlement.

Rural areas in Australia need adequate and accessible general practice services for the complex health issues involved in caring for many refugees. Two towns had GPs that had developed refugee health care as an expertise and conducted most of the initial assessments. Low levels of bulk billing in general practice was a barrier to health service access in several towns. On the other hand, staff in a general practice which bulk billed refugees and had developed a specific expertise, found that the care coordination and length of consultations imposed a financial burden on the practice.

This study found that the public provision of dental care in all towns was insufficient. This has lead to the occasional practice of volunteers paying for private dental care for refugees, or refugees being referred to major cities over 100 km away.

Lack of access to appropriate mental health services was highlighted repeatedly, with a diversity of “stop-gap” models operating in the towns. 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 three months, with volunteers providing mental health support for refugees. In a third town, the sole counsellor reported that the extent of the mental health needs of refugee clients was overwhelming for one person.

The vibrant volunteer support network provided by rural Australians is key to the successful resettlement of refugees. Conversely, 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 six months of resettlement.

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, such as the Refugee Health Network of Australia, or support from specialised refugee health services.

Volunteers and health workers have a deep commitment to good health care and social justice, which was appreciated by refugees. However, there are questions about the sustainability of service provision if it relies on the altruism of rural residents. Careful selection of towns for resettlement which have the appropriate health infrastructure, and enhancing care and coordination in the first six months after resettlement, is likely to provide more sustainable health care for refugees.

For more information contact Associate Professor Christine Phillips, Australian National University College of Medicine, Biology and Environment on christine.phillips@anu.edu.au