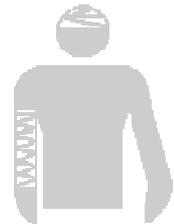
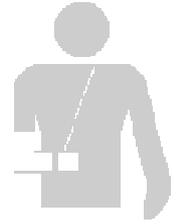




ethnic  
communities'  
council of  
victoria

# REFUGEES IN REGIONAL VICTORIA

Implications for Regional  
Health Care Services



[www.eccv.org.au](http://www.eccv.org.au)

Research Paper 2011



Ethnic Communities' Council of Victoria (ECCV) Inc. was established in 1974 as a voluntary community based organisation.

Over 35 years later, ECCV is a non-partisan, broadly based, statewide, peak advocacy body representing ethnic and multicultural communities in Victoria.

ECCV's role includes supporting, consulting, liaising with and providing information to Victoria's ethnic communities.

ECCV delivers policy projects for key partners in areas like multicultural policy, aged care programs and skilled migration strategies.

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## Acronyms

<b>AMEP</b>	Adult Migrant English Program
<b>AMES</b>	Adult Migrant English Service
<b>BRMC</b>	Ballarat Regional Multicultural Council
<b>BSL</b>	Brotherhood of St. Laurence
<b>CALD</b>	Culturally and Linguistically Diverse
<b>CVWPM</b>	Commonwealth Victoria Working Party on Migration
<b>DHS</b>	Department of Human Services
<b>DIAC</b>	Department of Immigration and Citizenship
<b>GP</b>	General Practitioner
<b>IHSS</b>	Integrated Humanitarian Settlement Services
<b>MBS</b>	Medicare Benefits Scheme
<b>MRC</b>	Migrant Resource Centre
<b>NGO</b>	Non-Government Organisation
<b>NSW</b>	New South Wales
<b>PBS</b>	Pharmaceutical Benefits Scheme
<b>RAP</b>	Refugee Action Program
<b>RBP</b>	Refugee Brokerage Program
<b>RHN</b>	Refugee Health Nurse
<b>SGP</b>	Settlement Grants Program
<b>TB</b>	Tuberculosis
<b>TIS</b>	Translating and Interpreting Service
<b>TPV</b>	Temporary Protection Visa
<b>UNHCR</b>	United Nations High Commissioner for Refugees
<b>VMC</b>	Victorian Multicultural Commission
<b>WHO</b>	World Health Organisation

## Methodology

As well as extensive analysis conducted on the two *Pilot Program Evaluation Reports* for Ballarat and Shepparton, relevant literature was examined using numerous primary and secondary sources. Several interviews were also conducted for this policy research paper, especially from those presently working in the health care sector of regional areas throughout Victoria, to determine whether or not the Government should continue to pursue direct regional settlement of humanitarian entrants.

## Foreword

With more than two thirds of Australians reported to live in major cities, it is unfortunate that too often rural and regional issues are treated as something of an addendum or afterthought, if they are given any serious consideration at all. As this timely report indicates a number of spiraling concerns in rural and regional communities, especially in the area of healthcare, represent very real dilemmas in urgent need of address.

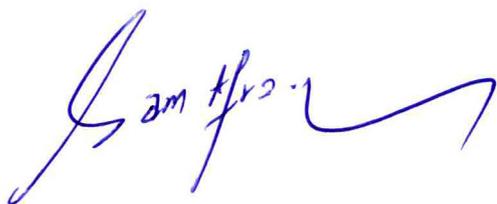
ECCV has made a point of collaborating with our partner Regional Ethnic Communities Councils (RECCs) in recent years to raise awareness of these issues and seek viable solutions. Based on these efforts, no area of concern continues to be more pressing than the difficulties faced by refugees and humanitarian entrants. It remains a highly specialised area that has been afforded only sporadic study to date and one only need read the stories cited in this report to get a sense of shortfalls in service delivery and confusion among clients over who to refer to regarding what ailment or injury.

Some blame may fall at the disparate responsibilities appointed to local, state and federal levels of government, but structures and systems are only part of the problem. Attitudes amongst all stakeholders need to change.

As such, ECCV intern Sally Karmouche is to be congratulated for bringing together relevant data from pre-existing literature and presenting a host of new insights based on candid personal interviews with clients and key stakeholders. Special thanks too must go to all the individuals and organisations who offered the benefit of their experience and suggestions for improvements. The result is a paper that only underlines the urgent need for a more cohesive and coherent approach to healthcare delivery.

The good news is that none of these challenges identified is insurmountable if all parties show appropriate commitment and goodwill. Victoria has already proven itself to be a co-operative and compassionate population through their successful absorption of generations of refugees and humanitarian entrants. It is hoped that the recommendations cited in this paper will help further that reputation.

It gives me great pleasure to commend this report to you.



Sam Afra JP  
Chairperson  
Ethnic Communities' Council of Victoria

## Executive Summary

“A simple equation is sometimes presented,  
that regional areas need population and workers and that refugees need jobs  
and therefore the refugees should go to regional areas.  
Our research suggests the equation is not necessarily so simple”.

(BSL balancing priorities, p. v)

Resettling into a foreign environment can be a long, difficult, and stressful exercise under the best of circumstances. When the parties involved are refugees and humanitarian entrants from far across the globe and their destination is relatively new to the hosting process, the challenges are even more pronounced. The nature of these challenges has become more apparent as the Australian Government furthers its efforts to encourage migrants and refugees to settle in regional areas.

A number of policies and programs were instituted to assist in this aim. Foremost among them was the Regional Humanitarian Settlement Pilots where all three levels of Government collaborated to identify regional locations where they could settle unlinked, newly arrived refugees. The Federal Government also introduced two new categories to the Medicare Benefits Schedule (MBS), namely MBS item numbers 714 and 716, to provide initial health assessments for refugees and other humanitarian entrants within the first 12 months of arrival<sup>1</sup>.

This report examines how effective these and other initiatives have been in improving the capacity of health care services in regional areas. It focuses on two pilot programs instituted in the regional centres of Ballarat and Shepparton with each representing a comparative study of the implications of direct refugee settlement upon regional health services.

The report finds that despite considerable shortages, the health systems in both locations handled the demands associated with direct settlement remarkably well. It also concludes, unsurprisingly, that government funding and support is vital for settlement success. However, of even greater importance is the intensive planning, co-ordination, flexibility and dedication of the individual health care providers themselves.

Based on these findings, it is clear that an overall emphasis on increasing health literacy levels of refugees is essential to the continued success of the policy of regional refugee settlement. Public policy makers, ethnic community organisations, and health care professionals in regional areas all have a role to play.

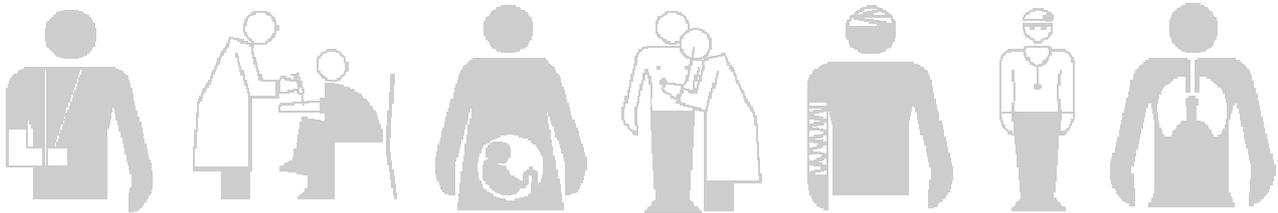
To ensure the health care needs of the refugees are suitably met, a number of recommendations are made. These include :

- that the social model of health should be considered before the direct settlement of humanitarian entrants into regional areas.
- that any future direct settlement schemes build upon the lessons of past experiences and be implemented only if the focus is on the long-term.
- that more accurate planning and research to ensure that the Settlement Grants Program (SGP) better reflects the time commitments involved in delivering services for humanitarian entrants.
- that General Practitioners (GPs) be able to use the Medical Benefit Scheme (MBS) item numbers 714 and 716 up to five times per-humanitarian entrant.

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<sup>1</sup> Victorian Refugee Health Network, *Access to specialist services by refugees in Victoria*, Report prepared for the DHS, July 2009, p. 25.

- that research be conducted into making interpreter services mandatory with the MBS item numbers 714 and 716.
- that funding and support for Refugee Health Nurses better reflect their contribution in a more comprehensive way.
- that interpreter services be made available (free of charge) to all specialist health care services.
- that an education campaign be undertaken with medical specialists in regional areas on the importance of using the interpreter services.
- that Health Service Providers in regional areas promote the development of health literacy.



## Key Terms of Reference

<b>Refugee</b>	A person who is outside the country of his nationality owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, and is unable to or, owing to such fear, is unwilling to avail himself/herself of the protection of that country, or to return there, for fear of persecution <sup>2</sup> .
<b>Humanitarian Entrant</b>	A person who has been granted Australian citizenship because of their status as a refugee either offshore or onshore <sup>3</sup> . Each year the Commonwealth Government of Australia accepts around 13,000 refugees through its <i>Humanitarian</i> program <sup>4</sup> .
<b>Unlinked Refugees</b>	Refugees who have been identified for resettlement in Australia under the Refugee and Special Humanitarian Program, who have not been proposed by someone already in Australia and who have no pre-existing family or strong social links already residing in Australia <sup>5</sup> .
<b>Rural</b>	Non-metropolitan areas that do not have significant metropolitan centres that have populations less than 50,000 <sup>6</sup> .
<b>Regional</b>	Non-metropolitan areas that do not have significant metropolitan centres that have populations less than 100,000 people.
<b>Health</b>	The World Health Organisation (WHO) defined 'health' as: a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity <sup>7</sup> .
<b>Health Literacy</b>	The degree to which individuals have the capacity to obtain, process, and understand basic health information and service needs, to make appropriate health decisions <sup>8</sup> .

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<sup>2</sup> United Nations High Commissioner for Refugees (UNHCR), "Definitions & Obligations", <http://www.unhcr.org.au/basicdef.shtml> (accessed 15 September 2010).

<sup>3</sup> Australian Government, DIAC, "Immigration and Refugees" <http://www.immi.gov.au/visas/humanitarian/> (accessed 10 November 2010).

<sup>4</sup> Ibid.

<sup>5</sup> Margaret Piper and Associates, *Regional Humanitarian Settlement Pilot: Mount Gambier*, Report of an evaluation for the DIAC, November 2008, p. 5.

<sup>6</sup> I. W. Gray et al, *Immigrant Settlement in Country Areas*, Bureau of Immigration Research, Australian Government Publishing Service, Canberra, 1991. p. 1.

<sup>7</sup> Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

<sup>8</sup> The US Department of Health and Human Services, *Healthy People 2010: Understanding and Improving Health*, available <http://www.healthypeople.gov/Document/pdf/uih/2010uih.pdf> (accessed 11 Oct 2010), November 2000.

## I. Background

In 2003, an Australian Government report recommended that, where appropriate, ‘unlinked’ refugees should be directed to parts of regional Australia<sup>9</sup>. As a consequence, \$12.4 million was committed in the 2004-05 budget to further increase humanitarian settlement in regional areas<sup>10</sup>; the aim being to double the number of refugees settling in regional areas by 2005-06<sup>11</sup>. By 2007, around 10% of newly arriving humanitarian entrants settled directly in regional Victoria<sup>12</sup>.

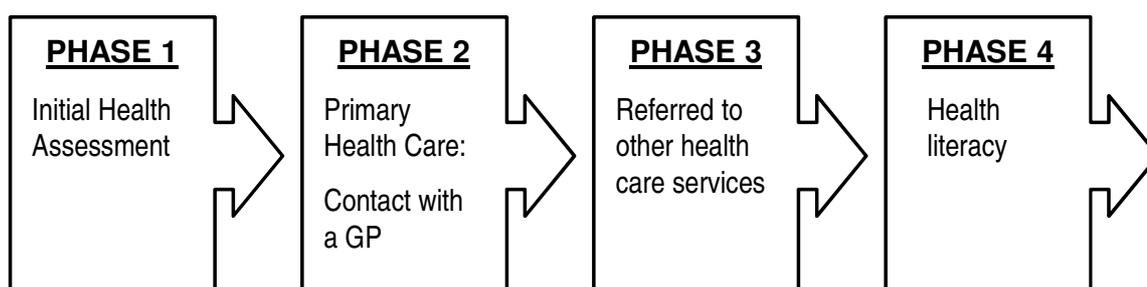
Common reasons cited for this drive into regional centres include :

- increasing concentration of immigrants in Melbourne and Sydney
- increasing involvement by State and Local Governments in attracting immigrants
- concerns about brain drain overseas, the size of the population in regional Australia, and a growing interest in sharing the perceived benefits of immigration
- an increasing emphasis on the size and quality of the labour force as a prerequisite for economic development<sup>13</sup>.

### 1.1 Four Phases of Healthcare

Discussions about the healthcare of refugees and humanitarian entrants invariably centre on the Four Phases of Health Care (see **Fig.1.**) which traverse from the initial pre-arrival health assessment through to the final stage of the individual pursuing their own understanding of the Australian health care system – in effect becoming autonomous in their health literacy.

**Fig.1. Four Phases of Health Care**



<sup>9</sup> Australian Government, Department of Immigration and Citizenship (DIAC), *Review of Settlement Services for Migrants and Humanitarian entrants*, <http://www.immi.gov.au/living-in-australia/delivering-assistance/government-programs/settlement-policy/review-settlement-services.htm> (accessed 4th Oct 2010), May 2003, p. 9.

<sup>10</sup> Australian Government, DIAC, *Australia's humanitarian program: research note no.9, 2005-2006*, <http://www.apf.gov.au/LIBRARY/pubs/RN/2005-06/06r09.pdf> (accessed 4<sup>th</sup> October 2010), 2005.

<sup>11</sup> Janet Taylor and Dayane Stanovic, *Refugees and regional settlement: Balancing priorities*, May 2005, p. 1.

<sup>12</sup> Victorian Refugee Health Network, *Access to specialist services by refugees in Victoria*, Report prepared for the DHS, July 2009, p. 12.

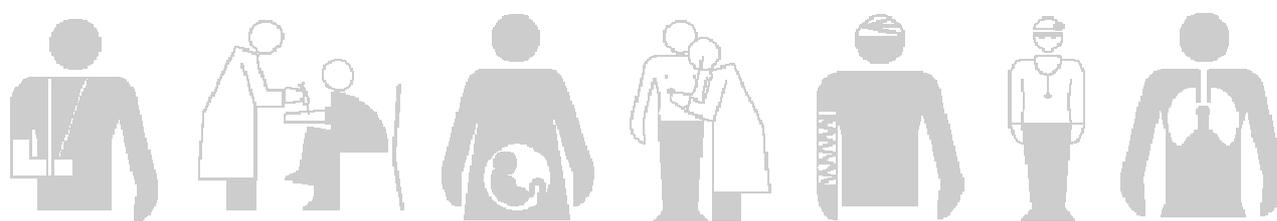
<sup>13</sup> CVWPM, *Final Report*, Department of Premier and Cabinet, Victoria, 2004, p. 37.

## 1.2 Phase 1 – Health Assessment before arrival

Prior to arrival in Australia, refugees like all other migrants, must undergo a health assessment<sup>14</sup>. These assessments are conducted by off-shore medical professionals approved by the Australian Government<sup>15</sup>. The main health issues they check for are :

- Tuberculosis (TB)
- Hepatitis
- HIV / AIDS

If active TB is found, Australian migration law does not allow a visa to be granted until the person has undergone treatment and has been declared free of the disease<sup>16</sup>. If Hepatitis or HIV / AIDS is detected then entry is assessed on the cost of the condition to the Australian community of health care and community services<sup>17</sup>. If they pass these assessments, they generally move onto Phase 2.



## 1.3 Phase 2 – Issues once settled in Regional Victoria

Once settled in regional Victoria, the individual refugee or settlement assistance worker tends to ensure they have access to primary health care. Primary health care incorporates personal care with health promotion, prevention of illness and community development<sup>18</sup>. General Practitioners (GPs) are at the forefront of primary health care delivery.

## 1.4 Phase 3 – Other Health Care Services

Whilst GPs are often the initial point of contact for people from a refugee background living in regional areas, the GPs will often have to refer them to other health care services. These include medical specialist services, dental services, mental health services, and pharmacies.

<sup>14</sup> Albert Tiong, *Health needs of newly arrived African refugees from a primary health care perspective*, January 2006, p. 9.

<sup>15</sup> Australian Government, DIAC, "Fact Sheet 22 – The Health Requirement", available: <http://www.immi.gov.au/media/fact-sheets/22health.htm> (accessed 7 October 2010).

<sup>16</sup> Ibid.

<sup>17</sup> Ibid.

<sup>18</sup> Primary Health Care Research and Information Service (PHC RIS) website: [http://www.phcris.org.au/infobytes/about\\_phc.php](http://www.phcris.org.au/infobytes/about_phc.php) (accessed 7 October 2010).

## 1.5 Phase 4 – Health Literacy

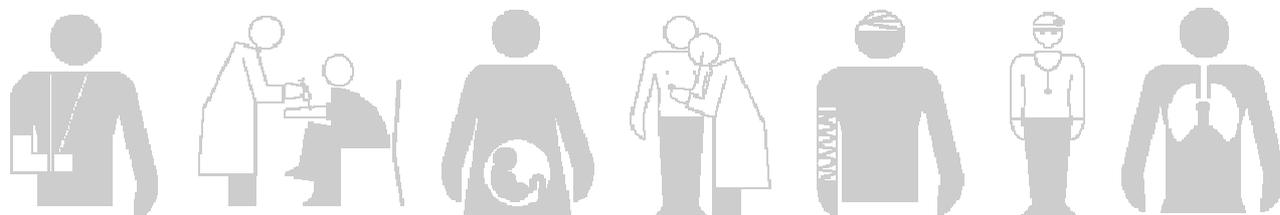
Health literacy refers to the degree to which individuals have the capacity to obtain, process, and understand basic health information and service needs, to make appropriate health decisions<sup>19</sup>. The majority of (if not all) refugees are from developing countries where health care systems are very different to Australia's. These differences in health care services have numerous implications for refugees accessing health care in Victoria.

“Understanding the system and how it works makes a big difference”

— Leigh Rhode  
Director, Community and Integrated Care, Goulburn Valley Health  
Chair of Health sub-committee for Congolese Community Pilot

In each of these four phases health care issues (mental and physical) arise for people from a *refugee background*. However, as the pilot programs in Ballarat and Shepparton reiterate, direct refugee resettlement in regional areas represents a convergence of two overarching issues :

- General shortfalls and service gaps in the health care provision available in rural and regional centres
- Unique needs of refugees and humanitarian entrants associated with resettlement.



<sup>19</sup> The U.S Department of Health and Human Services, *Healthy People 2010: Understanding and Improving Health*, available <http://www.healthypeople.gov/Document/pdf/uih/2010uih.pdf> (accessed 11 October 2010), November 2000.

## 2. Government services

### 2.1 Federal Government

The main Federal programs and policies are :

- the Integrated Humanitarian Settlement Strategy (IHSS)
- the Settlement Grants Program (SGP)
- the Adult Migrant English Program (AMEP)
- Translating and Interpreting Service (TIS) and
- the new refugee-specific Medicare Benefits Schedule (MBS) item numbers.

#### 2.1.1 *Integrated Humanitarian Settlement Strategy*

The Integrated Humanitarian Settlement Strategy (IHSS) is available to newly-arrived humanitarian entrants. It provides them with initial, intensive settlement support for around six months after arrival.

<b><u>IHSS SERVICES</u></b>	
➤ <b>Case coordination, Information and Referrals</b>	includes a co-ordination plan based on an initial needs assessment, information about and referral to other service providers and mainstream agencies.
➤ <b>On arrival reception and assistance</b>	includes meeting entrants on arrival, taking them to suitable accommodation, providing initial orientation and meeting any emergency needs for medical attention or clothing and footwear.
➤ <b>Accommodation Services</b>	helps entrants to find appropriate and affordable accommodation and provide them with basic household goods to start establishing their own household in Australia.
➤ <b>Short term torture and trauma counseling services</b>	provides an assessment of needs, a case plan, referral for torture and trauma counselling and raises awareness among other health care providers of health issues arising from torture and trauma experiences <sup>1</sup> .

The IHSS is funded on a unit cost basis and, in many instances (especially in regional areas) the numbers of arrivals are not sufficient to fund a full-time worker<sup>20</sup>. Yet, experts insist newly arrived refugees require a level of assistance during the first few weeks that can only really be delivered by a full-time worker<sup>21</sup>.

<sup>20</sup> Ibid., p. 30.

<sup>21</sup> Margaret Piper and Associates, *Regional Humanitarian Settlement Pilot: Mount Gambier*, Report of an evaluation for the DIAC, November 2008, p. 43.

### 2.1.2 *Settlement Grants Program*

The Settlement Grants Program (SGP) was introduced in 2005 with the aim of funding services, which help clients to become self-reliant and participate equitably in Australian society as soon as possible following arrival<sup>22</sup>. The SGP is a discretionary, application-based grants program with decisions being awarded by the Minister for Immigration and Citizenship. Organisations that receive grants are offered the grants for periods of one, two or three years. They are not ongoing in order to incorporate variables over time<sup>23</sup>.

### 2.1.3 *Adult Migrant English Program*

The Adult Migrant English Program (AMEP) provides up to 510 hours of free English language tuition for eligible migrants and humanitarian entrants who do not have functional English<sup>24</sup>. AMEP classes are delivered at approximately 250 locations across Australia. If migrants choose to be part of the AMEP, they are required to register within three months of arrival or visa grant if onshore, and they must commence class within 12 months<sup>25</sup>.

### 2.1.4 *Translating and Interpreting Service*

The Department of Immigration and Citizenship (DIAC) provides the Translating and Interpreting Service (TIS) nationally for people who do not speak English and for those English speakers who need to communicate with them<sup>26</sup>. TIS has 24-hour, seven day-a-week access to over 1750 contracted interpreters across Australia, speaking more than 170 languages and dialects<sup>27</sup>. Free access to TIS is provided for those non-English speakers communicating with approved groups and individuals, such as pharmacies and private medical practitioners providing Medicare rebateable services (there is a doctors' priority phone number)<sup>28</sup>.

### 2.1.5 *Medicare Benefits Schedule item numbers: 714 and 716*

In 2006 the Federal Government introduced two new Medicare Benefits Schedule (MBS) item numbers (714 and 716), which provide initial health assessments for refugees and other humanitarian entrants within the first 12 months of arrival<sup>29</sup>. The health assessment includes medical history, a physical examination and investigation, development of a management plan and additional referrals to specialists for follow-up assessment and management as required<sup>30</sup>. The item numbers recognise the unique and often-complex health concerns for refugees and consequently allow for longer consultations and enhanced care planning by GPs.

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<sup>22</sup> Australian Government, DIAC, "About the SGP", <http://www.immi.gov.au/living-in-australia/delivering-assistance/settlement-grants/what-sgp-about.htm> (accessed 17 September 2010).

<sup>23</sup> Ibid.

<sup>24</sup> Australian Government, DIAC, "AMEP", <http://www.immi.gov.au/living-in-australia/help-with-english/amep/facts-figures/amep-overview.htm> (accessed 17 September 2010).

<sup>25</sup> Ibid.

<sup>26</sup> Australian Government, DIAC, "TIS National", [http://www.immi.gov.au/living-in-australia/help-with-english/help\\_with\\_translating/](http://www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/) (accessed 18 September 2010).

<sup>27</sup> Ibid.

<sup>28</sup> Ibid.

<sup>29</sup> Victorian Refugee Health Network, *Access to specialist services by refugees in Victoria*, Report prepared for the DHS, July 2009, p. 25.

<sup>30</sup> Ibid.

## 2.2 Victorian Government

The two major Victorian Government programs and policies that assist refugees living in regional areas are :

- the Refugee Action Program (RAP) and
- the Refugee Health Nurse Program (RHN).

### 2.2.1 *Refugee Action Program*

The Refugee Action Program (RAP) evolved from the Refugee Brokerage Program (RBP), which operated from 2005-06 to 2008-09. The Victorian Multicultural Commission (VMC) contracts partner organisations around Victoria to deliver the RAP. These organisations then directly engage with and support local refugee communities to determine the best means for responding to community-identified needs and concerns<sup>31</sup>. RAP aims to gradually build the capacity of vulnerable communities from a refugee background to the point of sustainability. Once they have reached this point, they are transitioned out of the program and other, more vulnerable communities are engaged<sup>32</sup>.

### 2.2.2 *Refugee Health Nurse Program*

The Refugee Health Nurse Program (RHN) was established in 2005 to provide a co-ordinated approach to refugee health through the recruitment of community health nurses with expertise in working with culturally and linguistically diverse (CALD) and marginalised communities<sup>33</sup>. The nurses are based in community health services with high refugee populations (including regional areas). For a full list of where the program operated in 2008-09 see **Appendix Two**.



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<sup>31</sup> Victorian Multicultural Commission, "Refugee Action Program"

<http://www.multicultural.vic.gov.au/images/stories/pdf/refugee%20action%20program%20summary%20document.pdf> (accessed 20 September 2010).

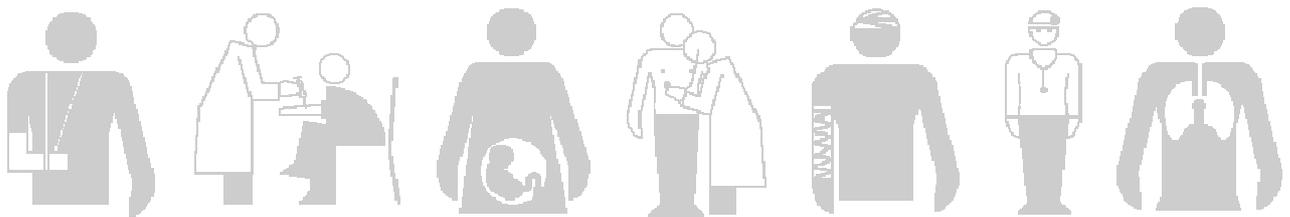
<sup>32</sup> Ibid.

<sup>33</sup> Victorian Government, Primary Health Branch, "Guidelines for the Refugee Health Nurse Program",

<http://www.health.vic.gov.au/communityhealth/downloads/rhnp.pdf> (accessed 20 September 2010), October 2008.

**OFFICIAL ROLE OF REFUGEE HEALTH NURSE**

- Undertake early health and social needs assessments of refugee clients.
- Facilitate and coordinate mainstream and specialist referrals to health and community service providers.
- Work closely with local settlement services to respond quickly to the needs of newly arriving people.
- Promote social connection and integration through referrals to established social support and orientation programs.
- Enable individuals, families and refugee communities to improve their health and wellbeing.
- Provide information and support regarding clients' rights, entitlements and obligations under the Victorian health care system.
- Work with health promotion programs that identify refugees as a population group to provide health promotion interventions specific to refugees.
- Actively engage local refugee community leaders in community consultation to inform the local RHNP service response.
- Collect refugee health data for reporting, service planning and evaluation.
- Support the Community Health Service to develop culturally responsive and high quality refugee health and wellbeing assessment and service provision.
- Actively participate in professional development and networking opportunities.



### 3. Regional Resettlement Pilot Programs

When the two pilot programs were first mooted, it was understood that each jurisdiction and population needed to be considered according to its own unique capacities, challenges and opportunities. The individuals, health care providers, community services and refugees countries of origin were different in each area.

So while Shepparton and Ballarat both faced many of the health care issues identified over the four phases of health care provision for refugees living in regional areas, their migration history placed them in different circumstances to deal with the issues. As Leigh Rhode, Director of Community and Integrated Care at Goulburn Valley Health, noted “Shepparton is not a blank canvas” whereas Karen Werner, Ballarat Refugee Health Nurse admitted that refugees were “new to Ballarat”<sup>34</sup>.

#### 3.1 Pilot sites

##### *Shepparton*

Located approximately 176kms north of Melbourne, Shepparton was identified as a potential settlement site shortly after the Australian Government decided to focus on humanitarian settlement in regional areas in 2003-2004. Discussions were held with local stakeholders, local government representatives as well as with employer groups in the Shepparton region<sup>35</sup>. Shepparton expressed strong support for a small-scale pilot program involving the settlement of ten unlinked refugee families<sup>36</sup>. They established a steering committee to work with DIAC to prepare for the refugees. By late 2005, ten families from the Democratic Republic of Congo started moving into Shepparton.

##### *Ballarat*

Approximately 113kms west of Melbourne, Ballarat was seen to be suitable for humanitarian settlement as it had well-developed infrastructure, had a desire for migrants, and could offer affordable housing<sup>37</sup>. Discussions began with local stakeholders in 2006 and by May 2007, the first two families, comprising of twelve people arrived from Togo<sup>38</sup>. All twelve families (57 people) were settled in Ballarat in 2007<sup>39</sup>.

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<sup>34</sup> Interview with Leigh Rhode, Director Community and Integrated Care Goulburn Valley Health, and Chair of Health sub-committee for Congolese Community Pilot, Monday 20<sup>th</sup> September 2010.

<sup>35</sup> Margaret Piper and Associates, *Shepparton Regional Humanitarian Settlement Pilot: Summary report on an evaluation undertaken by Margaret Piper and Associates for DIAC*, March, 2007. p. 4.

<sup>36</sup> Ibid.

<sup>37</sup> Ibid., p. 22

<sup>38</sup> Ibid., p. 28.

<sup>39</sup> Ibid.

While Ballarat's population (92,000) is larger than Shepparton's (59,000)<sup>40</sup>, both centres continue to experience a net-loss of young people (15-29 year olds) to Melbourne for education and employment<sup>41</sup>. Like most of regional Victoria, local planners in both areas have acknowledged migration is essential for further development and growth<sup>42</sup>.

### 3.2 Migration history

#### *Shepparton*

The Goulburn region, with Shepparton at its centre, has a long history of migration. This has been influenced by a well developed agricultural and irrigation industry, income derived through farm employment, a mix of ethnicity and religious beliefs and a background of skilled migration<sup>43</sup>. Early waves of Italian and Greek migrants were followed by Albanians, Turks and migrants from many other parts of the world, resulting in 30-40 different nationalities currently living in Shepparton<sup>44</sup>. Many of these migrants have settled in Shepparton for the long-term.

For example, some have taken over the farms in Shepparton they once worked at, using knowledge from their country of origin to diversify the produce (eg. changed from growing fruit to tea)<sup>45</sup>. Since the mid-1990's there has been a substantial increase in the arrival of humanitarian refugees. These include, Iraqis, Albanians from Kosovo, Afghanis, and Sudanese, all of whom internally migrated to Shepparton from larger cities (indirect migration)<sup>46</sup>.

In 2004-05 Shepparton experienced its first direct migration of unlinked refugees arriving directly from refugee camps. The settlement of Congolese refugees into Shepparton marked the first time in Australia that refugees had been directly settled in a regional area without them first settling in major cities<sup>47</sup>.

#### *Ballarat*

During the 1850s gold rush, migrants flocked from across the globe into Ballarat, including over 10,000 Chinese people<sup>48</sup>. Despite its multicultural origins, Ballarat is now regarded as a city with little cultural diversity<sup>49</sup>. Until recently, over 90% of Ballarat's population was Australian-born, with British migrants making up the majority of the other 10%<sup>50</sup>.

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<sup>40</sup> City of Ballarat: <http://forecast.id.com.au/Default.aspx?id=210&gid=10&pg=30051> Greater Shepparton City Council: Shepparton: <http://www.greatershepparton.com.au/ourregion/profile/stats/> (accessed 20 October 2010)

<sup>41</sup> Spatial Analysis & Research, Department of Planning and Community Development, Victoria, "Info Sheet 2: Ageing trends in Victoria", [http://www.dpcd.vic.gov.au/\\_data/assets/pdf\\_file/0005/30749/DPCD\\_2-Ageing\\_trends.pdf](http://www.dpcd.vic.gov.au/_data/assets/pdf_file/0005/30749/DPCD_2-Ageing_trends.pdf) (accessed 21 October 2010), 2006.

<sup>42</sup> Margaret Piper and Associates, *Regional Humanitarian Settlement Pilot: Ballarat*, Evaluation report for the Department of Immigration and Citizenship (DIAC), January 2009, p. 20.

<sup>43</sup> Apollo Nsubuga-Kyobe and Chris Hazelman, "Diversity Management Strategies: Community Driven Employment Initiatives: Congolese Experience in Shepparton", in *Migration Action*, Vol XXX, No. 2, 2007, p. 25.

<sup>44</sup> *Ibid.*, p. 27.

<sup>45</sup> Interview with Chris Hazelton, Manager Ethnic Council of Shepparton and District Inc., Monday 20<sup>th</sup> September 2010.

<sup>46</sup> Apollo Nsubuga-Kyobe and Chris Hazelman, "Diversity Management Strategies: Community Driven Employment Initiatives: Congolese Experience in Shepparton", 2007, p. 25.

<sup>47</sup> *Ibid.*

<sup>48</sup> Chinese-Australian Historical Images in Australia: <http://www.chia.chinesemuseum.com.au/biogs/CH00018b.htm> (accessed 14 October 2010) 2005.

<sup>49</sup> Margaret Piper and Associates, *Regional Humanitarian Settlement Pilot: Ballarat*, Evaluation report for the Department of Immigration and Citizenship (DIAC), January 2009, p. 19.

<sup>50</sup> *Ibid.*

There have been some small groups of migrants settling in Ballarat including people from Iran, India and various African nations. Recently, former refugees from Sudan began to move into the region, relocating from Melbourne partly because of cheaper rental accommodation and education opportunities in Ballarat, and to avoid community tensions<sup>51</sup>.

Recognising that the combination of low diversity and an ageing population, together with an exodus of young people is not good for the future prospects of any region, Ballarat, like Shepparton, agreed to directly settle unlinked humanitarian refugees<sup>52</sup>. The twelve families from the small West African nation of Togo arrived in Ballarat in mid-2007.

### 3.3 Refugee intake

In terms of refugee populations, Ballarat and Shepparton have two of the highest in regional Victoria.

**Fig.3. Refugee Settlement in top 10 Regional Local Government Areas (LGA),  
Victoria 2005-08**

Rural LGA	Total No.
Greater Shepparton	360
Greater Geelong	157
Mildura	98
La Trobe	87
Ballarat	84
Swan Hill	78
Mount Alexander	38
Warrnambool	27
Colac-Otway	24
Moira	23
Other	49
<b>Total Rural</b>	<b>1,025</b>

Source: Victorian Department of Human Services (DHS), *Refugee health and wellbeing action plan 2008-2010: Current and Future initiatives*, November, 2008 p. 17

<sup>51</sup> Ibid., p. 22

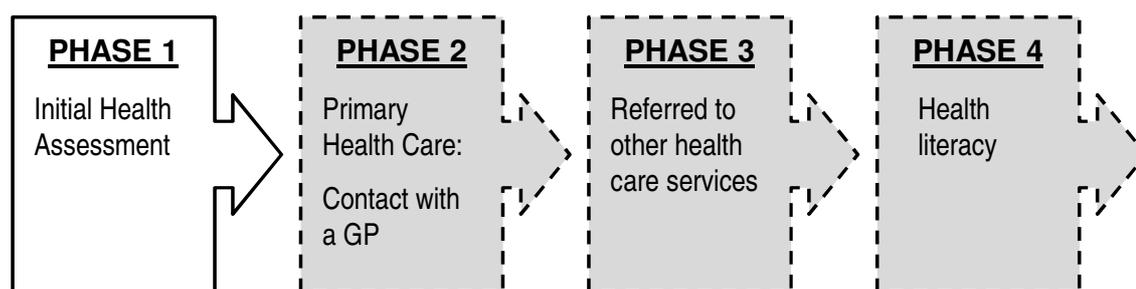
<sup>52</sup> Ibid., p. 20

## 4. Identified Health Care Issues

Despite Ballarat and Shepparton having different histories and levels of migration, the direct settlement of humanitarian entrants challenged both health care systems in similar ways. They both had to deal with issues that arose in the four phases of health care provision that newly-arriving humanitarian entrants usually proceed through.

- **PHASE 1**                      miscommunication issues from the initial health assessment and the local health care providers.
- **PHASE 2 and 3**              shortage of GPs in regional areas, and the absence of some specialist services
- **PHASE 4**                      with entrants misunderstanding or being uninformed about Australia's health care system

### 4.1 PHASE 1 – Prior Health Assessments



In Ballarat and Shepparton health care subcommittees were established to co-ordinate and manage the health care needs of the entrants. Both subcommittees have been commended on their commitment and focus to the health care needs of the entrants<sup>53</sup>. Despite this, both committees encountered issues outside their control in the early phases of providing health care for the entrants.

Details from the initial health assessment, conducted prior to the entrant's arrival in Australia, were often unknown. The lack of advance information about the health status of the entrants or what health information they were given on arrival hindered the health committee's efforts to inform local providers<sup>54</sup>. Only three out of the first five Congolese families in Shepparton had any health records (including vaccination status) and none had a full history<sup>55</sup>.

In Ballarat, only some of the Togolese had results from the initial offshore health screening, none had any complete health records<sup>56</sup>.

<sup>53</sup> Margaret Piper and Associates, *Regional Humanitarian Settlement Pilot: Ballarat*, January 2009, p. 35 and Margaret Piper and Associates, *Shepparton Regional Humanitarian Settlement Pilot*: March, 2007, p. 19.

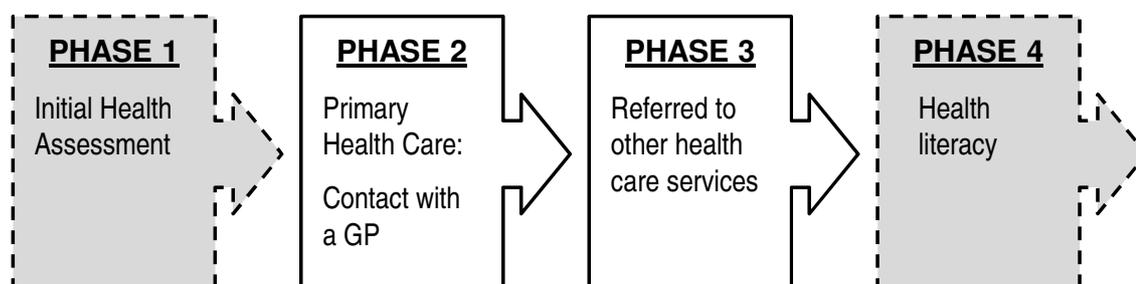
<sup>54</sup> Margaret Piper and Associates, *Shepparton Regional Humanitarian Settlement Pilot: Summary report on an evaluation undertaken by Margaret Piper and Associates for DIAC*, March, 2007, p. 18.

<sup>55</sup> Ibid.

<sup>56</sup> Interview with Karen Werner, Refugee Health Nurse, Ballarat, Thursday 16<sup>th</sup> September 2010.

Furthermore, some entrants were arriving with active health problems that health providers had expected would have been identified in the pre-departure health screening<sup>57</sup>. Some entrants required follow-up for malaria and TB, despite expectations that this would not be the case (and thus no management plans had been developed)<sup>58</sup>.

## 4.2 Phase 2 and 3 – GPs and other Health Services



Issues also arose with access to and capacity of GPs and other health care services. In the Shepparton region the ratio of GPs to people is about 1:1,010, while in Ballarat it is 1:1,600<sup>59</sup>. Furthermore, only some of these GPs bulk-bill and even fewer have the capacity to take on new patients<sup>60</sup>. For the refugee health nurse in Ballarat, finding GPs for the Togolese was “extremely difficult”<sup>61</sup>. She attributes this to the “foreignness of it all”, the unfamiliarity of potential problems and time constraints of refugee patients<sup>62</sup>.

Likewise, in Ballarat, after the first initial consult with a dentist, the RHN found it very difficult to find a dentist who would take Togolese patients on. She described a complex voucher system where the Togolese people were required to renew vouchers at certain dentists, but hardly any local dentists accepted the vouchers anymore, which resulted in confusion and disappointment. The RHN admitted it was “lucky they had me” to place pressure on local dentists to see the Togolese people<sup>63</sup>.

In Victoria, people from a refugee background who have been assessed as having TB, are required to attend on-going appointments at a certified clinic in Melbourne. This presented a problem for the entrants in both Shepparton and Ballarat who were required to travel to the Melbourne clinic to be assessed, often more than once<sup>64</sup>. The RHN in Ballarat took one of the Togolese entrants to the Melbourne clinic, which is two hours from Ballarat, only to wait at the clinic for a further hour or so then to be told in five minutes that the X-ray was fine and that they could go home<sup>65</sup>.

<sup>57</sup> Margaret Piper and Associates, *Shepparton Regional Humanitarian Settlement Pilot*, March 2007, p. 18.

<sup>58</sup> Ibid. and Interview with Karen Werner, Refugee Health Nurse, Ballarat, Thursday 16 September 2010.

<sup>59</sup> Goulburn Valley Division of General Practice, <http://www.phcris.org.au/divisions/profiles/detail.php?div=327> (accessed 14 October 2010).

<sup>60</sup> Interview with Leigh Rhode, Director Community and Integrated Care Goulburn Valley Health, & Chair of Health sub-committee for Congolese community Pilot, Monday 20<sup>th</sup> September 2010.

<sup>61</sup> Interview with Karen Werner, Refugee Health Nurse, Ballarat, Thursday 16 September 2010.

<sup>62</sup> Ibid.

<sup>63</sup> Ibid.

<sup>64</sup> Margaret Piper and Associates, *Regional Humanitarian Settlement Pilot: Ballarat*, Evaluation report for the Department of Immigration and Citizenship (DIAC), January 2009, p. 18.

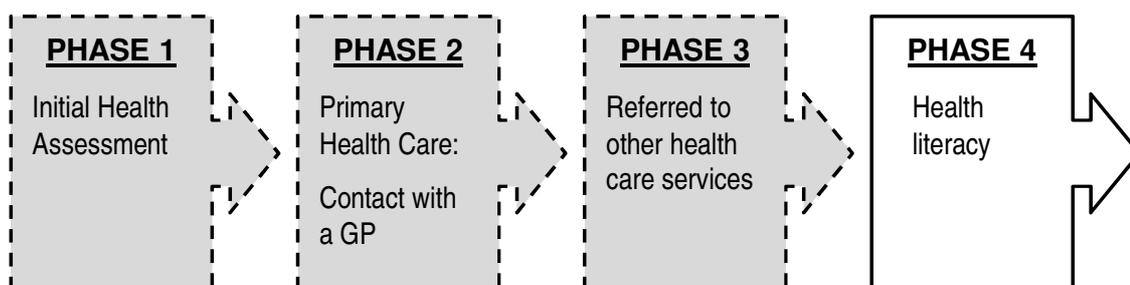
<sup>65</sup> Interview with Karen Werner, Refugee Health Nurse, Ballarat, Thursday 16 September 2010.

Similarly, she had an experience with another one of her clients, a refugee living in Nhill<sup>66</sup> who was required to have six-monthly checks at the Melbourne clinic, yet he lives five hours away<sup>67</sup>.

Mental health is another major health issue for newly arriving refugees. Most of the Togolese in Ballarat had experienced considerable levels of trauma and loss in the past, exacerbated by long periods in refugee camps and separation from members of their extended families<sup>68</sup>. Three Ballarat counsellors were identified to provide their services to the Togolese community. Foundation House provided professional supervision and informal support to the counsellors. The entrants were automatically referred to counsellors after they had been in the country for 3-4 months.

Some direct referrals were also made. The counsellors report finding this work demanding, in part because of the high levels of trauma experienced by their clients and the challenges they confront in finding the best way to support them<sup>69</sup>. Like their colleagues elsewhere, the counsellors have found it hard to explain their function to their clients who are unfamiliar with counselling and consider it to be for ‘mad people’<sup>70</sup>. This misunderstanding is reminiscent of a phase 4 issue.

### 4.3 Phase 4 Issues – Understanding the Australian Health Care System



Issues around understanding the Australian health care system (health literacy) also arose. The number of health requirements for new entrants was particularly daunting. They were often forced to go through “grueling schedules” of appointments (GPs, TB tests, hospitals, dentists etc)<sup>71</sup>. In Shepparton, even simple things, such as taking GP referrals to specialist appointments, were foreign and misunderstood (see Box 3)<sup>72</sup>.

Additionally, some entrants didn’t understand the regime for taking medication that was prescribed, or who was responsible for ensuring that medication was taken (the doctor, pharmacist, RHN etc). They also were unaware of how to manage a healthy diet in the Australian context, many of them being exposed to soft drinks and fast food for the first time<sup>73</sup>.

<sup>66</sup> Nhill is a small town of some 2000 people on the Western Highway, 40 km west of Dimboola and 374 km north-west of Melbourne (halfway to Adelaide).

<sup>67</sup> Interview with Karen Werner, Refugee Health Nurse, Ballarat, Thursday 16 September 2010.

<sup>68</sup> Margaret Piper and Associates, *Regional Humanitarian Settlement Pilot: Ballarat* January 2009, p. 39.

<sup>69</sup> Ibid.

<sup>70</sup> Ibid.

<sup>71</sup> Margaret Piper and Associates, *Regional Humanitarian Settlement Pilot: Ballarat*, 2009, p. 18.

<sup>72</sup> Ibid.

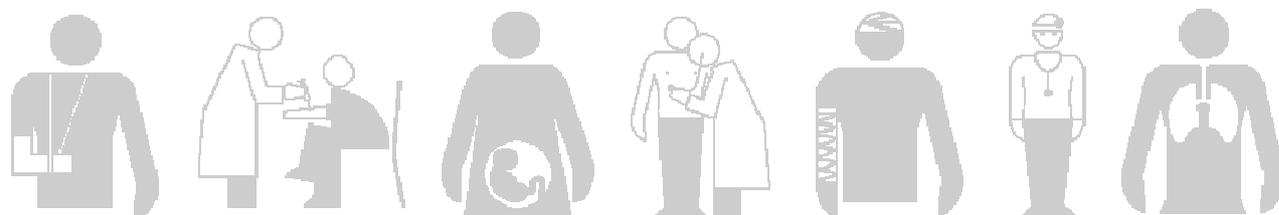
<sup>73</sup> Ibid.

When it came to mental health services, some entrants expected counsellors to be able to “solve all their problems immediately”, and became disillusioned when they realised the sessions were “just about talking”<sup>74</sup>. Additionally, it was found during consultations with some of the entrants in Ballarat, that they were using traditional medicines but had not thought it important to disclose this to the RHN or their doctor<sup>75</sup>.

### **EXAMPLES OF HEALTH LITERACY**

- In one of Victoria’s regional hospitals a Samoan lady was diagnosed with diabetes. She had to have several blood tests. She was confused and upset at why the nurses had to prick her to get her blood. Why did they have to inflict pain in that way ? Something as common as a blood test was misinterpreted by the lady, who had obviously never had the concept of a blood test explained to her, or had misunderstood information provided<sup>1</sup>.
- A Congolese patient presented themselves to the emergency department of one of Victoria’s regional hospitals, but became despondent and visibly upset when they had to wait for a prolonged period of time to see a doctor. It was later revealed that the patient believed they had been made to wait because they were “Congolese”, not because there was a shortage of medical staff at the hospital<sup>1</sup>.
- Several people from refugee backgrounds were arriving at hospitals in regional areas looking for Panadol. No one had explained to them that Panadol was available over the counter at supermarkets and pharmacies and that they didn’t need to see a doctor to obtain it.

The goal should always be for frontline service providers to have sufficient funding and personnel to deliver the highest quality outcomes. Not only does assisting humanitarian entrants with their health literacy levels allow them to better understand the Australian health care system and ensure a rapid resolution of any health problems they may have, it is vital for the entrant’s sense of belonging.



<sup>74</sup>Margaret Piper and Associates, *Regional Humanitarian Settlement Pilot: Ballarat*, January 2009, p. 39

<sup>75</sup> *Ibid.*, p. 37.

## 5. Issues of Sustainability

While the Pilot programs in Shepparton and Ballarat demonstrate that regional areas can often cope with the health issues of humanitarian entrants, the larger question is whether they provide the ongoing care necessary for the entrants after the initial settlement services have departed.

Mental health issues, for example, can be long term, persistent, and complex. According to Leigh Rhodes, Shepparton is “only now coming to terms with the mental health issues” of people from a refugee background<sup>76</sup>, and that is just one of many ongoing health care issues that persist past the time when the initial settlement services depart.

The use of interpreters in regional areas too continues to present as a “big issue” especially for GPs<sup>77</sup>. According to Margaret Piper, the use of interpreters by GPs remains a thorny issue in regional areas with many GPs considering interpreters an unnecessary intrusion and a waste of valuable time<sup>78</sup>.

Likewise, when people from a refugee background first arrive in regional areas they have the assistance of either (or all) health subcommittees, RHN and the IHSS workers and are generally seen as a priority by health services<sup>79</sup>. If they present themselves to a doctor, dentist, counsellor etc. for the first time, in most cases they are seen almost immediately<sup>80</sup>. However, once funding runs out for these services or interest in meeting with the subcommittee diminishes, they soon find themselves having to become independent.

Moreover, these settlement services are available only to refugees if they settle in regional areas in their first 12 months. If they migrate internally from other parts of Victoria, then they have to settle in regional areas and access health services using their own initiative.

In both Shepparton and Ballarat the IHSS provider and the RHN played integral roles in co-ordinating and facilitating health care services for the entrants.

### *Integrated Humanitarian Settlement Strategy*

The Integrated Humanitarian Settlement Strategy (IHSS) provider for delivering services in Victoria is Adult Migrant English Service (AMES). For regional areas, AMES prefers to identify a local agency that they can subcontract to deliver services<sup>81</sup>. AMES had neither worked with organisations in Ballarat nor Shepparton. This was partly because most humanitarian entrants had come to the areas through secondary migration, receiving IHSS services elsewhere.

<sup>76</sup> Interview with Leigh Rhode, Director Community and Integrated Care Goulburn Valley Health, and Chair of Health sub-committee for Congolese community Pilot, Monday 20<sup>th</sup> September 2010.

<sup>77</sup> Interview with Sue Casey, Manager Health Sector Development, Foundation House, Thursday 2 September 2010.

<sup>78</sup> Margaret Piper and Associates, *Regional Humanitarian Settlement Pilot: Mount Gambier*, Report of an evaluation for the DIAC, November 2008, p. 39.

<sup>79</sup> Interview with Karen Werner, Refugee Health Nurse, Ballarat, Thursday 16 September 2010.

<sup>80</sup> Ibid.

<sup>81</sup> Margaret Piper and Associates, *Regional Humanitarian Settlement Pilot: Ballarat*, January 2009, p. 23.

In Shepparton it was also partly due to unfortunate timing. AMES only took over IHSS services just as the Shepparton pilot was about to roll out<sup>82</sup>. AMES subcontracted services to Goulburn Ovens TAFE (GOTAFE) in Shepparton, and to the Ballarat Regional Multicultural Council (BRMC) in Ballarat. In both cases AMES joined the committee discussions only after the pilot projects were confirmed. Again, in Shepparton this was because of the timing of AMES's takeover. Both evaluation reports strongly encourage AMES to be involved earlier to avoid confusion, uncertainty and miscommunication issues<sup>83</sup>.

This was the case in Ballarat where an IHSS worker could only be employed on a part-time basis<sup>84</sup>. Consequently, the IHSS worker found themselves working considerable amounts of overtime. The stress levels associated with this were high, and resulted in three different workers attempting to fulfill the role<sup>85</sup>.

Humanitarian entrants are only eligible for IHSS services for the initial 6-12 months of their settlement. In Shepparton, many of the Congolese entrants found exiting the IHSS difficult. They claimed they had received sufficient help for six months, and then received "nothing"<sup>86</sup>. In Ballarat, through SGP services, the Togolese families were linked with new services. Again, funding was insufficient to meet apparent needs<sup>87</sup>.

Despite these factors, IHSS workers in both areas had integral roles in facilitating health care services for the entrants in the regional areas. Timely referrals were made to appropriate agencies, including Centrelink, health services, English language providers and schools<sup>88</sup>.

### *Refugee Health Nurse*

The Refugee Health Nurse (RHN) program has also been influential in Shepparton and Ballarat. Ballarat especially has benefited from this Government initiative.

The evaluation report suggests that the RHN in Ballarat was in fact the reason "things worked so smoothly" in regards to health care in Ballarat<sup>89</sup>. The RHN undertook roles such as identifying suitable GPs for the Togolese, introducing GPs to new MBS item numbers, ensuring children received immunisations, supporting health care professionals so they did not feel they needed to cope alone, and ensuring medicines were obtained and properly stored<sup>90</sup>.

There are many instances where the RHN's used their own initiative to introduce simple strategies such as a family diary for each family to record appointments, and setting each family up with a clearly labeled first aid container<sup>91</sup>. The RHN in Ballarat also took on the responsibility of ensuring that entrants who arrived with a health undertaking received necessary checks, a role usually left up to the IHSS worker<sup>92</sup>.

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<sup>82</sup> Margaret Piper and Associates, *Shepparton Regional Humanitarian Settlement Pilot: Summary report on an evaluation undertaken by Margaret Piper and Associates for DIAC*, March 2007, p. 13.

<sup>83</sup> Margaret Piper and Associates, *Regional Humanitarian Settlement Pilot: Ballarat*, January 2009, p. 25.

<sup>84</sup> Ibid.

<sup>85</sup> Ibid.

<sup>86</sup> Margaret Piper and Associates, *Shepparton Regional Humanitarian Settlement Pilot*: March, 2007, p. 23.

<sup>87</sup> Margaret Piper and Associates, *Regional Humanitarian Settlement Pilot: Ballarat*, January 2009, p. 32.

<sup>88</sup> Ibid.

<sup>89</sup> Ibid., p. 36.

<sup>90</sup> Ibid.

<sup>91</sup> Ibid.

<sup>92</sup> Ibid., p. 37

The RHN in Shepparton was also fundamental to successful health care provision. They oversaw entrants' linkages to and progression through various health providers as well as thinking of entrants holistically and linking them up with community groups and helpful organisations such as the Country Women's Association<sup>93</sup>.

During the Shepparton and Ballarat pilot programs, for example, the health workers ensured DIAC was aware of the miscommunication channels between the initial health assessment results and what GPs received in settlement areas.

For issues in **Phase 2** and **3**, the health subcommittees, the RHN and IHSS workers in both Ballarat and Shepparton came up with numerous solutions. The existing health care services in both Ballarat and Shepparton have been able to adapt and expand to meet refugee-specific health care needs (see **Appendix 3**).

For example, in Shepparton, they located a locally accredited practitioner who could undertake the necessary tests for TB, thus saving the entrants a trip to Melbourne<sup>94</sup>. They also ensured that, wherever possible, each entrant was only seen by one GP thereby enabling continuity and the establishment of trust<sup>95</sup>. They also developed flow charts for GPs for referral procedures and information exchange, in particular regarding cases of malaria and TB<sup>96</sup>.

The RHN in Ballarat is currently going through the process of applying for a locally accredited practitioner to examine TB patients<sup>97</sup>. Additionally, after the Togolese in Ballarat had been settled for some time, it became evident that there were high levels of vitamin D deficiency amongst the group. The RHN consequently conducted education campaigns for GPs through emails making them aware of the vitamin D issues. An Immigrant Health Clinic has been set up in Ballarat, which delivers once a month treatment facilities for vitamin D deficient migrants. The clinic now has fourteen regular patients<sup>98</sup>.

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**Phase 4** issues have been progressively dealt with as well. For example, in Shepparton, the committee introduced a back-up system for the transfer of paperwork (from GP to specialists) to ensure that appointments would go ahead even if the entrant forgot original documents<sup>99</sup>. They developed forms in the entrants' dialects, using photographic styles to inform entrants when their medication should be taken<sup>100</sup>. Additionally, they organised two days of instruction for entrants about nutrition, healthy eating, hygiene and dental care. The entrants also received basic first aid training and were provided with a simple first aid kit<sup>101</sup>.

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<sup>93</sup> Margaret Piper and Associates, *Shepparton Regional Humanitarian Settlement Pilot*: March, 2007, p. 19.

<sup>94</sup> Margaret Piper and Associates, *Shepparton Regional Humanitarian Settlement Pilot*: March, 2007, p. 19.

<sup>95</sup> Ibid.

<sup>96</sup> Ibid.

<sup>97</sup> Interview with Karen Werner, Refugee Health Nurse, Ballarat, Thursday 16 September 2010.

<sup>98</sup> Ibid.

<sup>99</sup> Ibid.

<sup>100</sup> Ibid

<sup>101</sup> Ibid.

In Ballarat they have also realised the need to make people from a refugee background 'independent'<sup>102</sup>. In order to achieve this, the RHN and the IHSS worker taught the Togolese group how to do everyday activities such as catching a bus, and what to do when they entered a doctor's office<sup>103</sup>.

#### **THE NEED FOR A LONGER VIEW**

- A number of key stakeholders in Ballarat had the impression that the purpose of the project was to make Ballarat into a national hub for all Togolese settlement, and that many more Togolese would follow the arrival of the initial ten families<sup>1</sup>.
- They soon discovered, however, that this was not the case.
- Only a very small number of Togolese refugees were targeted for resettlement in Australia and there was no guarantee that many, if any, more unlinked cases would be sent to Ballarat<sup>1</sup>.
- Rather, other Togolese were sent to other Australian cities, namely Perth, fostering a sense of uncertainty, disenchantment and isolation.

### **5.1 Challenges and Champions**

Whilst Government funding for programs like the IHSS and RHN are important, the success of the programs are largely dependent on individual efforts and commitment levels. Both Ballarat and Shepparton identified and made use of "health champions", that is, health professionals who are respected in the local community<sup>104</sup>. These people help reassure the entrants who were afraid of health risks and generally champion the refugees in the health sector<sup>105</sup>.

The employment of skilled workers who can operate with a high level of independence and flexibility and who can empathise with, and provide support to the entrants was paramount to the success of the Ballarat and Shepparton Pilots<sup>106</sup>.

Volunteers were also fundamental to the Pilot's success. In Shepparton, there is general agreement that the pilot project could not have been delivered without the assistance of volunteers<sup>107</sup>. Volunteers range from church groups, community groups, Non-Government Organisations (NGOs) and individual families. Yet, the Government funding for these programs doesn't necessarily reflect their contribution.

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<sup>102</sup> Ibid.

<sup>103</sup> Ibid.

<sup>104</sup> Ibid.

<sup>105</sup> Ibid.

<sup>106</sup> Margaret Piper and Associates, *Regional Humanitarian Settlement Pilot: Mount Gambier*, November 2008, p. 44.

<sup>107</sup> Margaret Piper and Associates, *Shepparton Regional Humanitarian Settlement Pilot*: March, 2007, p. 26.

The RHN and IHSS programs are for the short-term, and often only provide funding for part-time work. This doesn't necessarily reflect some of the longer-term issues for humanitarian entrants, such as mental health issues. ECCV is particularly concerned that the health care expectations of people relocating from metropolitan areas may be unrealistic, and thus confusion, disappointment and frustration can develop.

Moreover, direct health care issues (such as seeing a GP and immunisation etc.) are only part of the concern facing humanitarian entrants arriving in Australia. No matter how well regional areas can cope with the health care needs of people from a refugee background, if other factors such as employment and accommodation aren't taken care of, the overall wellbeing of the entrants will suffer.

## **5.2 The Social Model of Health**

The Social Model of Health recognises the effect of social, economic, cultural and political factors and conditions on health and wellbeing and is based on the understanding that in order for health gains to occur, these other factors must be addressed accordingly. It advocates for an *inter-sectorial approach* to collaboration which argues that social and environmental determinants of health cannot be addressed by the health sector alone. Rather, there needs to be a co-ordinated approach among different government departments (for example, department of employment, education, social welfare and transport) and the private sector (such as service providers)<sup>108</sup>.

Examples of the social model of health were evident in both Shepparton and Ballarat. For example, in Ballarat, employment issues caused some negative impacts on the entrants' overall health and wellbeing. Despite some of the Togolese males having experience in trades and professions, they found employment very difficult to secure. The fact that their qualifications were not recognised in Australia was very frustrating to some of the entrants<sup>109</sup>. Going back to University to receive recognised qualifications was seen as embarrassing for some, and hampered their ability to provide for their families<sup>110</sup>. This led to feelings of hopelessness and despair, which consequently impacted on their mental health.

Given the importance of other aspects of life on entrants' health, all measures should be taken to ensure the regional settlement location chosen for direct settlement has relevant support services in areas such as employment, education and accommodation. When planning for the arrival of humanitarian entrants, the health subcommittee should ensure it works collaboratively with other subcommittees (such as housing and education) to ensure an inter-sectorial approach to health care. This recognises that other aspects of the entrants' lives will impact their ability to overcome some of their health issues. It supports a holistic approach to health care, where entrants receive both direct services (such as seeing GPs) as well as indirect health services (such as attending community events), which collectively develop their longer-term sense of health and wellbeing.

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<sup>108</sup> Victorian Curriculum and Assessment Authority, VCE Health and Human Development Unit 3, "Social Model of Health", <http://www.vcaa.vic.edu.au/vce/studies/healthnhuman/VCEHealthHDUnit3.doc> (accessed 20 October 2010).

<sup>109</sup> Ibid., p. 42.

<sup>110</sup> Ibid.

## Observations and Recommendations

“Their health hasn’t been looked after. They’ve come with chronic conditions, but they’ve got bigger things to worry about”.

(Medical observer, p. 15)

The evaluation reports for the Ballarat and Shepparton Pilot programs outline important lessons learnt during the projects such as :

- the need to train health care staff about the backgrounds of refugees and management of conditions that might present, as well as the necessity to remain flexible to challenges that may arise<sup>111</sup>.
- the need to be flexible and to think laterally and creatively about issues that present<sup>112</sup>.

Additionally, the Shepparton health subcommittee developed a ‘Capacity Checklist’ for regional areas considering direct refugee settlement which includes a comprehensive list of requirements for successful health care service in regional areas. Learning from these settlement experiences as well as other experiences from unlinked refugee settlement allows regional areas to learn from previous mistakes and challenges. For example, particular consideration should be given to strengthening the following government policies.

### *Integrated Humanitarian Settlement Strategy*

With funding for the Integrated Humanitarian Settlement Strategy (IHSS) allocated on a unit cost basis, often the numbers of humanitarian entrants settling in regional areas are only sufficient to fund a part-time settlement worker. Yet ECCV maintains that part-time assistance is insufficient to the needs of humanitarian entrants in the first 6-12 months of arrival. People from a refugee background arrive in Australia with numerous health issues. Not only are there immediate health concerns, but also ongoing ones like mental health.

Moreover, as the social model of health demonstrated, health and wellbeing depends on many other aspects of a person’s life other than just seeing GPs and other health services. The IHSS worker has to co-ordinate many areas of regional community services to ensure entrants receive a holistic approach to health care. This is a demanding, time-consuming process that requires commitment, flexibility and innovation.

### **Recommendation :**

- **that funding for the IHSS be sufficient to cover the costs of at least one full-time settlement worker.**

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<sup>111</sup> Ibid.

<sup>112</sup> Ibid., p. 37.

*Settlement Grants Program*

According to the Federal Government, when humanitarian entrants exit IHSS, they are referred to general settlement services provided through migrant resource centres, migrant service agencies and organisations funded under the Settlement Grants Program (SGP)<sup>113</sup>. Like the IHSS, funding of SGP doesn't always reflect the time commitments involved in delivering services for humanitarian entrants. In Ballarat, for example, SGP funding only allowed one part-time worker<sup>114</sup>. This was considered "unworkable" by the BRMC, the organisation that received the SGP grant<sup>115</sup>. They claimed that in reality, the SGP worker was on duty at least five days per week to meet the needs of the Togolese families<sup>116</sup>.

**Recommendation :**

- **that more accurate planning and research to ensure that SGP better reflects the time commitments involved in delivering services for humanitarian entrants.**

*Medicare Benefits Schedule item numbers: 714 and 716*

Because the new refugee-specific Medicare Benefits Schedule (MBS) item numbers 714 and 716 only provide initial health assessments, some GPs claim they don't acknowledge the on-going nature of many problems. In other words, they provide for a longer consultation time for the first visit, but not for subsequent visits.

For a longer-term solution, ECCV believes it would be beneficial if GPs could use the item numbers up to five times per humanitarian entrant. This would acknowledge the time-consuming nature of many initial health care problems of people from a refugee background and encourage GPs to take on humanitarian entrant patients, knowing that they will be compensated for the longer consultation times.

**Recommendation :**

- **that consideration be given to allowing GPs to use the MBS item numbers 714 and 716 up to five times per humanitarian entrant.**

*Refugee Health Nurse (RHN)*

With Refugee Health Nurses (RHN) bringing knowledge and reassurance into health care systems that have often never dealt with refugee-specific health issues before, ECCV argues that funding and support for RHNs should better reflect their contribution in a more comprehensive way.

<sup>113</sup> Australian Government, DIAC, "IHSS" <http://www.immi.gov.au/living-in-australia/delivering-assistance/government-programs/settlement-programs/ihss.htm#> (accessed 10 October 2010).

<sup>114</sup> Margaret Piper and Associates, *Regional Humanitarian Settlement Pilot: Ballarat*, January 2009, p. 33.

<sup>115</sup> Ibid.

<sup>116</sup> Ibid.

**Recommendation :**

- **that funding and support for Refugee Health Nurses better reflect their contribution in a more comprehensive way.**

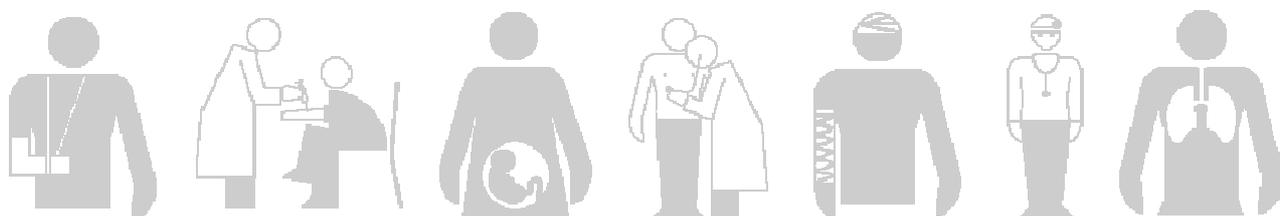
*Interpreting Services*

With many, if not most, humanitarian entrants utilising the MBS item numbers 714 and 716 not having English as their first language, even more education on the importance of interpreters for health care services needs to occur.

ECCV suggests research be conducted into making interpreter services mandatory with those item numbers. Interpreter services also need to be made available (free of charge) to all specialist health care services. Once this occurs, an education campaign needs to take place with medical specialists in regional areas, on the importance of using the interpreter services.

**Recommendations :**

- **that research be conducted into making interpreter services mandatory with the MBS item numbers 714 and 716.**
- **that interpreter services be made available (free of charge) to all specialist health care services.**
- **that an education campaign be undertaken with medical specialists in regional areas on the importance of using the interpreter services.**



## Conclusion

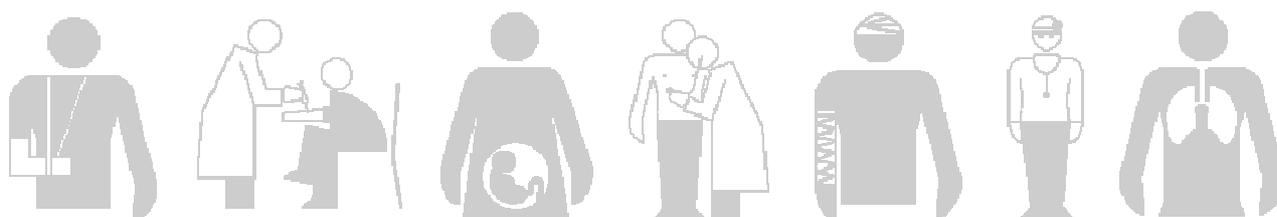
Of all the insights gleaned from the Ballarat and Shepparton pilot programs into the proposed roll-out of the Federal and Victorian Governments' direct settlement of refugees into regional areas, perhaps the most pertinent concerns the limitations of the policy life-cycle and pilot system itself.

With the considerable resources, time, effort, and money required to develop the readiness and capacity of local health care providers to deal with refugee-specific health issues, it is in no one's best interests to continue pursuing direct settlement in locations where there is no focus on long-term settlement and development.

Intensive investment in health care providers may always seem justified in locations such as Shepparton where migrants are continually arriving and departing, but there is a risk that all the effort expended during the pilot program in locations such as Ballarat, where there is not a continual flow of these arrivals, will have been wasted if finances, resources and personnel are withdrawn at the pilot's completion.

The clearest indicator of the benefits of a long-term approach can be found in the development of health literacy levels of the entrants. The longer refugees have access to specialised healthcare, the greater their understanding of the local health care system, and their ability to become autonomous and self-determining of their own healthcare needs, such as knowing what to do at a doctor's appointment, how counselling works, and what the MBS and PBS covers.

Many humanitarian entrants arrive in Australia having endured circumstances unimaginable to most Australians. The findings from the Ballarat and Shepparton programs provide a clear warning about the risks of inflated expectations, confusion and frustration when a sporadic and piecemeal approach is taken to funding and resourcing regional healthcare providers. It is clear that regional direct settlement for humanitarian entrants needs to have a long-term focus if the capacity of local healthcare service providers is to be improved and feelings of isolation and loneliness among humanitarian entrants are to be avoided.



## Appendices

### Appendix 1 :

VicHealth's *Refugee Resettlement in Regional and Rural Victoria: Impacts and Policy Issues 2008*.

#### **12 Propositions for regional settlement of refugees :**

- Regional Refugee Settlement has the potential to provide “win-win” benefits for refugees and host communities if care is taken in the planning and is integrated and well resourced
- Refugee Settlement has to be based on a holistic approach
- Future challenges lie in the implications of various settlement pathways (direct or secondary settlement)
- Needs to be a commitment to long-term sustainability
- Effective processes for consulting and engaging with refugee communities are essential
- A supportive host community is essential
- Support services for refugees need to be adequately resourced and integrated
- Support needed for local level planning and co-ordination
- Consideration should be given to developing links between skilled migrants and resettled refugees
- Long term funding essential
- Whole of government approach necessary
- Establish and support processes for monitoring the impacts of refugee settlement in regional areas.

**Appendix 2:**

**List of where the Refugee Health Nurse Program Ran, as of 2008-09 :**

**Metropolitan local government areas :**

- Greater Dandenong ( Greater Dandenong Community Health Service, Southern Health)
- Brimbank (ISIS Primary Care)
- Maribyrnong (Western Region Health Centre)
- Moonee Valley/Melbourne (Doutta Galla Community Health Service)
- Hume (Dianella Community Health)
- Darebin (Darebin Community Health)
- Maroondah (Eastern Access Community Health)
- Wyndham (ISIS Primary Care)

**Rural local government areas :**

- Ballarat (Ballarat Community Health Centre)
- Colac-Otway (Hesse Rural Health Service)
- Shepparton (Goulburn Valley Community Health Service)
- Warrnambool (South West Health Care)
- Latrobe Valley (Latrobe Community Health Service)
- Mount Alexander (Castlemaine and District Community Health Service)
- Greater Geelong – Corio (Barwon Health)
- Bass Coast (Bass Coast Community Health Service)

(Victorian Refugee Health Network, *Access to specialist services by refugees in Victoria*, Report prepared for the DHS, July 2009, p. 26)

Appendix 3:

Refugee-specific health needs and services in Ballarat and Shepparton

Site	Ballarat	Shepparton
<b>Bulk-billing GP(s) in Community Health</b>	Ballarat Health Service (attached to the hospital) and Ballarat Community Health Centre Limited capacity through some private bulk-billing clinics	GV Division of GPs working to re-establish new GP clinic at CHS for refugees  Melbourne University School of Rural Health planning to open Refugee Health Assessment clinic
<b>Refugee Health Nurse Program in Community Health</b>	0.5 EFT	0.5 EFT
<b>High dose Vitamin D</b>	Some Availability	Not Available
<b>Community Health Counselling</b>	Ballarat Community Health Centre provides generalist counselling services	Generalist counselling services also available
<b>Specialist Mental Health Service</b>	Area mental health service based in Ballarat Health Service and Ballarat Community Health Centre	Goulburn Valley Community Health provides a range of services: inpatient and community mental health for aged, adults, adolescents and children
<b>Foundation House Short Term Torture and Trauma counselling</b>	Ballarat Community Health Service	Goulburn Valley Community Health Service
<b>TB physician</b>	No system currently in place for TB	Goulburn Valley Health Local Physician sees refugee patients through private rooms-bulk billed
<b>Paediatric</b>	Ballarat Health provides a full range of paediatric services. No specific refugee responses	A local paediatrician provides bulk-billed appointments for refugees in private clinic and is a VMO at Goulburn Valley Health
<b>Women's health</b>	Ballarat Health provides a full range of antenatal care services	Goulburn Valley Health provides an antenatal clinic involving block booking with interpreters in main language groups
<b>Infectious Diseases Physician/ Capacity</b>	Some expertise within Ballarat Health Service, however no ID specialist	Some expertise within Goulburn Valley Health to undertake ID screening and treatment

(Victorian Refugee Health Network, *Access to specialist services by refugees in Victoria*, Report prepared for the DHS, July 2009, p. 32)



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