Victorian Refugee Health Network's submission to the Coordinator General for Migrant Services in response to the Discussion Paper: 'Next steps to improve Australia's settlement and integration of refugees'

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About the Victorian Refugee Health Network

The Victorian Refugee Health Network (VRHN) was established in June 2007 with the aim to ensure that all Victorians of refugee background, including those seeking asylum, have timely access to appropriate services and other resources required to build and maintain health and wellbeing. The network does this by facilitating greater coordination and collaboration amongst health and community services to provide more accessible and appropriate health services for people of refugee backgrounds. The network harnesses the expertise from the health sector and the community to identify and respond to systemic issues and provide credible, trusted advice towards policy and service development.

The Network reports regularly to the Department of Health in Victoria providing advice on the most significant issues that are impacting refugee and asylum seeker health and wellbeing at the current time. More information about the Network may be found on our website: www.refugeehealthnetwork.org.au

Background

The Australian Humanitarian Settlement Program (HSP) is, by world standards, a large and generous program of resettlement. The intent of this program is to provide 'initial settlement support to people who have recently arrived in Australia on refugee or humanitarian visas and to some eligible people onshore. The objective of the HSP is to build people's skills and knowledge for social and economic well-being through a tailored, needs-based, case management approach."[1] A review of settlement and integration services was put forward to the Department in the report entitled 'Investing in Refugees, Investing in Australia (the Shergold Review)'. The three key areas requiring improvements noted in the Discussion paper were employment, English language learning and making social connections. VRHN note that throughout the 'Shergold Review' there is also recognition that good health is vital for newly arrived refugees to participate in these three key areas of settlement.

[1] Delivery of the Humanitarian Settlement Program (2019) https://www.anao.gov.au/work/performance-audit/delivery-the-humanitarian-settlement-program

Introduction

VRHN commends the work of the Department and Coordinator General for Migrant Services in their commitment to improving settlement outcomes and we welcome the opportunity to provide feedback in response to the Discussion Paper: 'Next steps to improve Australia's settlement and integration of refugees'. Good health is a crucial component of settlement, whereby safeguarding and achieving good health provides the means for improving other settlement outcomes including employment, education, and social engagement. The "Settling Better" report[2], produced by the Centre for Policy Development in 2017, highlighted that addressing improved health outcomes for refugee groups was a key pillar in creating better settlement outcomes, particularly in improving this groups social and economic participation. VRHN propose that improvement in the following areas would ensure greater coordination between settlement and health services and improve health outcomes for clients. A National Framework for Refugee Health and Wellbeing will be suggested and explored in this paper offering a structure for a culturally safe and responsive health care system in Australia and a centralised source that guides good health outcomes for HSP clients. The subsequent recommendations are based on current gaps in systems and service delivery models that impact on health access, literacy, and outcomes for HSP clients.

1. National Refugee Health and Wellbeing Framework
    a. *Improving health data collection and proxy indicators for refugee communities*
    b. *Improving culturally safe and responsive general health care practices*
    c. *Ensuring culturally and linguistically appropriate public health messaging*
    d. *Ensuring safety and emergency procedures are accessible for all community members*
    e. *Coordination and investment in specialised health services*
    f. *Build cultural competency standards related to mental health & wellbeing*
2. Improvement in data collection and linkages
3. Improvements to immediate Medicare access and Medicare Benefits Schedule (MBS) Items
4. Quality controlled Key Performance Indicators related to Health Outcomes in HSP
5. Better connection between State and Federal domains focusing on health

[2] Settling Better Report (2017) Centre for Policy Development & The Boston Consulting Group https://cpd.org.au/wp-content/uploads/2017/02/Settling-Better-Report-20-February-2017.compressed.pdf

1. National Refugee Health and Wellbeing Framework

A Refugee Health and Wellbeing Framework shows a commitment to improving the health and wellbeing of refugees and offer a structure for coordinated care and specialised practice standards. The Shergold Review recommended the development of a national results-driven framework to improve outcomes relating to the wellbeing of clients in settlement programs[3]. VRHN proposes that the implementation of a national framework for refugee health and wellbeing that encompasses "results-driven accountability principles" would provide consistent mechanisms for improvements in settlement, employment, and integration outcomes.

Refugee Health and Wellbeing frameworks currently exist and operate at a State-level promoting a shared vision for improved health outcomes as well as the investment in specialised refugee health services. A National Refugee Health and Wellbeing Framework would help guide and oversee gaps identified in: service accessibility and appropriateness[4], continuity of care, relevant health data, develop national resources that support good practice in refugee health and improve policy at a national level relating to health and settlement outcomes for people from refugee backgrounds. It would also provide guidance for those States and Territories that don't have a refugee health and wellbeing framework.

This overarching framework, with result-driven objectives, will support improvements in refugee health outcomes by:

a) Improving health data collection and proxy indicators for refugee communities

A national framework for Refugee Health and Wellbeing will be strongly dependent on establishing improvements on aggregated data for refugee communities (further explored in section 2). Data is crucial to capture the lived experience and inequities currently present for this cohort and help inform service planning and delivery. For example, recent ABS Statistics reveal the significant health disparities that exists for people who were born overseas, particularly those who were born in the Middle East and North Africa, compared to those born in Australia[5]. According to these statistics, people who were born overseas are three times more likely to die from COVID-19 than those born in Australia. Further to this, those who were born in a country in the Middle east and North Africa are ten times more likely to die from the virus. Whilst this data indicates the correlation between a person in Australia who was born overseas and their level of risk of mortality specifically related to the COVID-19 virus, these figures also reflect a wider understanding of disparities in health-care access and subsequent health outcomes for people from culturally and linguistically diverse backgrounds in Australia. This data conveys crucial information to the sector and highlights that culturally competent heath care practices such as specialised refugee health services in each state are key in combatting these disparities in health outcomes. A National framework that provides minimum data set principles and data linkage will support a better understanding of health service access, and service improvements for people who enter Australia through the Refugee and Humanitarian Program.

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[3] Investing In Refugees, Investing in Australia (2019) 'The findings of a Review into Integration, Employment and Settlement Outcomes for Refugees and Humanitarian Entrants in Australia' By Shergold P., Benson K.& Piper M. pg.48

[4] Australian Health Performance Framework https://meteor.aihw.gov.au/content/721590

[5] 'Death due to COVID-19: Country of birth' https://www.abs.gov.au/articles/covid-19-mortality-australia#death-due-to-covid-19-country-of-birth

b) Improving cultural competency in general health care practices

General practitioners and other health providers require support to overcome a number of challenges they experience when working with people from refugee backgrounds, such as uncertainly of clinical knowledge, using interpreters, cross cultural negotiation and health system barriers.[6] Many GPs are unaware that there is no centralised onshore screening process for newly arrived refugee and humanitarian entrants. In the absence of this knowledge base, clients have been missing out on comprehensive clinical investigations early in settlement, leading to prolonged ill health and potential higher risk to the community and potential higher cost interventions in the future.

Establishing a national health framework which invests in evidenced information and resources can have a positive impact on 'patient care' through the means of upskilling the mainstream health services. A number of resources have been developed and updated as once off projects such as the *Australian Refugee Health Practice Guide*[7] and the *Recommendations for comprehensive post-arrival health assessment for people from refugee-like backgrounds.*[8] A National Framework that guides resource development and information dissemination would help ensure resources are updated frequently and that a consistent 'best practice' standard for general practitioners and primary care is regularly reviewed and updated.[9]

c) Ensuring culturally and linguistically appropriate public health messaging

For many clients from refugee backgrounds, there has been little to no prior exposure to public health messaging that promotes preventative health care and builds health literacy knowledge. Language barriers also prevent this exposure to public health messages that community members utilise to build health literacy knowledge. This may include understanding behaviours that may increase risks to health (smoking) as well as protective behaviours for better health outcome (physical activity etc.).

A National Framework would ensure communication strategies consider diverse community needs and that public health messaging are made more accessible. Culturally and linguistically appropriate strategies for public health will help enhance health literacy and health care for diverse communities. More recently, this has been pertinent in messaging around infectious diseases to mitigate risks for the public safety for all Australians in the broader health protection effort towards preventing transmission.

d) Ensuring safety and emergency procedures are accessible for all community members

Looking at broader health safety messaging related to climate emergencies, it is imperative that the Commonwealth also strongly consider mechanisms that would aid messaging to culturally and linguistically diverse community members. Over the last few years, Australia has seen an increasing amount of climate emergencies requiring swift and informed response from community members to help ensure their safety including events such as

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[6] Wittick, T., Walker, K., Furler, J.,& Lau, P. (2018) 'An online resource supporting refugee healthcare in Australian general practice: an exploratory study', *Australian Journal of General Practice*. 47(11) 802-806.
[7] Australian Refugee Health Practice Guide http://refugeehealthguide.org.au/
[8] https://www.asid.net.au/documents/item/1225
[9] Wittick, T., Walker, K., Furler, J.,& Lau, P. (2018) 'An online resource supporting refugee healthcare in Australian general practice: an exploratory study', *Australian Journal of General Practice*. 47(11) 802-806. (p.806).

bushfires, flooding, asthma related storms and other unprecedented weather events. As newly arrived refugees resettle into new environments, remaining informed and having access to linguistically diverse health and safety messaging is crucial to save lives. Whilst these procedures are also under the jurisdiction and responsibility of State Government, a national framework would oversee and guide inclusionary practice that would help ensure CALD communities are aware and can effectively respond to emergencies.

e) Coordination and investment in specialised health services

While the benefits of 'mainstreaming' health provision to people from refugee backgrounds is recognised, health professionals also recognise the specific physical and mental health needs of people from refugee backgrounds as a result of their experiences pre, during and post migration. Refugee Health Services have specialised knowledge and provide a culturally safe service that inform, prioritise, and integrate physical and mental health strategies.

Specialised refugee health services have been proven to increase refugee access to primary health services, improve the response of health services to refugees' needs and enable refugee individuals, families, and communities to improve their physical and mental health and wellbeing. A National Framework for Refugee Health and Wellbeing would create an overarching system that will contribute to improved outcomes, through the provision of specialised services for refugees, a structure for coordinated care and formal links between HSP and specialist refugee health services.

f) Build cultural competency standards related to mental health & wellbeing

Refugee background communities face a range of obstacles when seeking and engaging with mental health services. Building the capacity of the Australian mental health sector to respond to the needs of people from refugee backgrounds is a significant piece of work. Noting the Bilateral agreement that has recently been signed between the Commonwealth and Victorian Government as part of the new National Mental Health and Suicide Prevention Agreement, a strong emphasis should be made around cultural competency standards within these national frameworks. The system response requires a complementarity of lived and culturally experienced workers in conjunction with nuanced, expert, and skilled health professionals that are targeted to the needs of refugee groups in regions across Australia. This National framework could build on existing culturally competency standards such as those developed by 'Migrant and Refugee Partnerships' and endorsed by several medical colleges including the Royal Australian and New Zealand College of Psychiatrists[10]. The framework was developed over two years and provide guidelines for clinicians on culturally responsive health care for people with migrant and refugee backgrounds.

Recommendation 1 Development of a National Refugee Health and Wellbeing Framework.

Recommendation 2 To improve coordination efforts between the Commonwealth Department of Health and State-based resources through the objectives of the National Refugee Health and Wellbeing Framework.

[10] Competency Standards Framework (2019) https://culturaldiversityhealth.org.au/competency-standards-framework/

2. Improvement in data collection and linkages

Measuring health outcomes and health service access for people from refugee backgrounds has not generally been possible, as most administrative health datasets do not identify people who have arrived in Australia through the Refugee and Humanitarian Program. If this cohort were able to be identified within these datasets, the de-identified and aggregated data could be utilised to better understand service access and health outcomes. VRHN understand that the Coordinator General is leading the development of the 'Refugee and Humanitarian Entrant Data Plan 2021-2023'[11] which is a welcome initiative for the sector to improve the current data points as well as develop new data sources.

There continues to be a shortage of health data regarding refugees which impacts on the visibility of priority issues of concern within refugee populations and ability to inform service models to address these needs. For example, the performance of health care and the health system in Australia is currently measured through the Australian Health Performance Framework (AHPF) which is a tool informed by several selected dimensions including determinants of health, the health system, health status, and health system context[12]. Through these indicators, this tool has the capability to provide rich information at the National and State and Territory levels on the health care needs and service accessibility for various population groups, however there is a significant gap in data that capture the experience and/or record of refugee background communities (e.g., languages spoken, country of origin, date of arrival in Australia etc.). Improvements in the collection and integration of refugee data into national performance measures related to health could be utilised to understand and improve service access and health outcomes. Without aggregated data pertaining to these dimensions of health care and the health system for refugee background communities, it is not possible to measure these vital outcome measures for health, and how the Australian health care system is performing and responding to the needs of this population group.

- Data Flow

Further to the identification of people who arrived through the Refugee and Humanitarian Program in datasets, service usage patterns and measurement of integration indicators (including health) would be strengthened through linkage of the immigration database with health and other databases. When data is captured by Commonwealth agencies this is not often shared to all relevant parties which means vital sources of information that can help with follow up client care, settlement placement decisions, service planning and coordination of services is missed[13]. This can lead to loss of continuity of care with significant risks to the individual and can also contribute to unnecessary repetition of health screening and vaccinations. The transfer of data that is available to the Commonwealth, such as the offshore and onshore health information, would greatly assist primary health care and specialised health providers prepare and respond to the needs of newly arrived clients in a timely manner. This flow of health data is also essential between States and Territories as people move interstate and health information can get lost without a process of linkages of data.

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[11]'Improved data on refugees and humanitarian entrants' https://immi.homeaffairs.gov.au/settling-in-australia/coordinator-general-for-migrant-services/improved-data-on-refugees-and-humanitarian-entrants
[12] Australian Health Performance Framework https://meteor.aihw.gov.au/content/721590
[13] Investing In Refugees, Investing in Australia (2019) 'The findings of a Review into Integration, Employment and Settlement Outcomes for Refugees and Humanitarian Entrants in Australia' By Shergold P., Benson K.& Piper M.

Refugee Health Services currently rely on the HSP provider to share health information by the health alerts which *may* have been captured and arisen on the HAP system. Offshore health information is not always provided in a timely manner and/or information is often outdated e.g., offshore health information available has been reported to be 12 months old. Health workers are, at times, only notified of the need for complex healthcare on or after arrival. This places new entrants at risk and puts strain on state health systems. Entry into NDIS is based on diagnosis, and new refugee arrivals with disability may not have a formal diagnosis. Without comprehensive and timely offshore and onshore health screening processes there is a lack of prior warning and preparation regarding individuals who have arrived with significant health conditions that require immediate linkages with specialists to assess and facilitate the process of an NDIS referral. Ensuring access to complex tertiary care requires as much notice as possible to ensure continuity of treatment after arrival and adequate handover to the treatment facility. Improvements to this offshore process in addition to the flow of this data would allow for interim measures to be arranged including access to essential assistive devices such as wheelchairs pending a NDIS outcome.

It is also important that offshore health information is reviewed by refugee health specialist as not all significant medical issues are given a health alert by the HSP system. This would also provide more formalised relationships between HSP providers and the health sector. Additionally, with an increased government commitment towards regional settlement a coordinated, integrated approach is essential to ensure that health providers in regional communities are prepared, upskilled, and appropriately resourced to deliver health care to new arrivals.

Recommendation 3 To ensure Refugee Health Services have timely and direct access to offshore medical reports and flagged health alerts as well as health information from interstate.

Recommendation 4 Offshore health information to be reviewed by specialist Refugee Health Services as not all significant medical issues are given a health alert by the HSP system.

Recommendation 5 The Australian Government, through Council of Australian Governments, lead a process of data linkage to understand access to health services and health outcomes for people who enter Australia through the Refugee and Humanitarian Program. This may be led by the Department of Social Services, Department of Health, and/or Department of Home Affairs, in consultation with the Australian Bureau of Statistics.

3. Improvements to immediate Medicare access and Medicare Benefits Schedule (MBS) Items

- Medicare Access

The links between health, settlement, and integration of people from refugee backgrounds are well established, with health acting as both an enabler and indicator of integration.[14] One of the immediate deliverables of HSP is for the client to be registered with Medicare within three days of arrival[15]. HSP clients are automatically qualified for Medicare services being part of the program however, even after Settlement Services have assisted the client with this essential registration, there are consistent accounts of extensive delays obtaining a Medicare number. With many new arrivals experiencing immediate and chronic health conditions, clients require immediate health care access as well as access to Pharmaceutical Benefits Scheme (PBS) prescription items. Addressing this delay in service access is crucial so that all clients can access immediate health care to ensure good health and outcomes for the client.

Another more recent issue related to Medicare access, concerns the Ukrainian cohort who are placed on the 449-visa subclass under which they do not have Medicare access. Without the bar being lifted at Ministerial intervention, which transpired for the Afghan arrivals on a 449 visa, the sector is concerned of the administrative burden that this places on the public health system as well as the pressure on the client to cover any medical costs whilst they await their transition to a 786-visa subclass. As of 6th June 2022, only 455 Ukrainian arrivals have been transferred to the 786-visa subclass (which has Medicare access) out of over two thousand applications awaiting this visa pathway. Whilst this provides a specific example that has occurred for the Ukrainian arrivals, VRHN recommend that Medicare access should be available for all future emergency cohorts arriving on the 449 visas.

- Medicare Benefits Schedule (MBS)

Previously there was an MBS item that specifically provided the billable means for General Practitioners to conduct a '*Health assessment for refugees and other humanitarian entrants'* (Items 714 and 716)[16]. Explanatory notes regarding this assessment provides detailed points of references and expected practice standards for general medical services set out according to the Medicare Benefits Schedule Book.[17] These specific MBS items recognised that differing practice standards for health assessments are required for this cohort consistent with good clinical practice. To conduct a comprehensive assessment according to these explanatory notes MBS item 714 also encouraged General Practitioners to compensate for extra time to deliver quality care.

These items have since been removed and this assessment now fall under MBS item numbers 701, 703, 705 and 707 for general health assessments. At this stage it is unclear

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[14] Alison & Ager, Alastair. (2010). Refugee Integration: Emerging Trends and Remaining Agendas. Journal of Refugee Studies. 23. 589-607. 10.1093/jrs/feq046.
[15] Delivery of the Humanitarian Settlement Program (2019) https://www.anao.gov.au/work/performance-audit/delivery-the-humanitarian-settlement-program
[16] Australian Government Department of Health and Ageing (2006) http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/B55546F33798EF39CA257CD00081F202/$File/2006-11-MBS.pdf Pg.50-53
[17] Australian Government Department of Health and Ageing (2006) http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/B55546F33798EF39CA257CD00081F202/$File/2006-11-MBS.pdf Pg.50-53

how many people have these assessments on arrival, as the MBS billing item number is the same item as these other assessment types. Responding to the health needs of recently arrived refugee patients is resource-intensive in terms of the time, knowledge, experience and financial expectations of many GPs. They are required to use appropriate cultural as well as medical diagnostic skills to guide treatment. They also need to be able to respond effectively to language, cultural or psychosocial complexity. Multiple lengthy consultations are often needed to see patients with more complex health issues. Given the limited English language skills of many Refugee and Humanitarian arrivals, there is a high need to use interpreters for consultations. While access to the Translating and Interpreting Service (TIS) is free for GPs, the service is greatly under-utilised, and a key factor influencing this is the time (therefore cost) of using an interpreter. MBS acknowledgement of the additional time required for using an interpreter within the consultation would help to address this.

Without these MBS items there is no visibility on how many individuals and families arriving under the HSP has completed an on-arrival refugee health assessment raising concern on the delay in identifying health issues which may lead to complications and thus high costs for individuals and the health system. It also highlights that there is inadequate accountability for who is required to conduct these assessments. Reinstating specific MBS items for refugees and other humanitarian entrants would provide further measures to ensure a specialised and comprehensive approach is taken when conducting these health assessments within their first year of arrival. It would also make data available that tracks health assessments of Refugees and Humanitarian entrants to ensure coverage given the significant implications both for public health and individual health and well-being if on-arrival health assessments are not undertaken.

Recommendation 6 The Minister to permanently lift the bar for all people under the 449-visa subclass and grant immediate access to Medicare.

Recommendation 7 Improved processes that will ensure the immediate provision of Medicare numbers to clients.

Recommendation 8 The Australian Government Department of Health to reintroduce a unique MBS item number for Health assessment for refugees and other humanitarian entrants to track the completion rate and to identify people from refugee backgrounds within the broader MBS data set.

Recommendation 9 Allowing more than one Health Assessment item to be claimed for an individual patient to allow the time and flexibility for comprehensive assessment and follow-up.

4. Quality controlled Key Performance Indicators related to Health Outcomes in HSP

A person's health literacy level, their ability to access and to establish ongoing health care support are key indicators of integration that lead to good health outcomes. Currently, one of the Settlement Service Charges (SSC) that settlement services complete as part of service provision relating to health and a Key Performance Indicator (KPI) is 'to support a client to manage health appointments'[18]. The 'application' level for this outcome relates to whether a client can locate and make use of appropriate health services which is an important part of settlement service provision. However, there are no further KPI's regarding ongoing health care and outcomes for the client even if there are physical and mental health needs apparent. There are varying levels of health and service literacy among refugee background communities that impact on help seeking behaviours and subsequent health outcomes.[19] It is imperative there is investment into building the health literacy of new arrivals that would develop self-efficacy and skills in health investigation, health service navigation and understanding of preventative interventions according to a western medical model. Quality controlled KPI's related to health provide an opportunity to link clients with comprehensive health care as early as possible in their resettlement journey, enhance health literacy and avoid escalation to acute care.

For better health care outcomes for refugees in the HSP, more quality control in KPI's related to Health should be considered including whether:

A) every client in HSP has had a refugee health assessment that has *commenced* within 28 days of entry into the program.
B) the health care service has conducted a comprehensive refugee health assessment according to specialised practice guidelines[20][21]
C) settlement services have connected every client with a State-based specialised Refugee Health service e.g., Refugee Health Program (RHP) in Victoria, the NSW Refugee Health Service (RHS) etc. This would facilitate the follow up and/or outcome of the refugee health assessment.
D) The completion and/or referral to activities that support and enhance health literacy level for the client to be self-reliant.

To actualise these KPI's, greater investment in HSP is required to better equip settlement services to coordinate preventive health measures. Current models are restricted in their capacity to execute these additional KPI's without more investment in the program and actions related to health outcomes.

Recommendation 10 The inclusion of quality health indicator metrics in the current HSP.

Recommendation 11 Building the health literacy of new arrivals to develop self-efficacy and skills in health investigation, health service navigation and understanding of preventative interventions according to a western medical model.

[18] Delivery of the Humanitarian Settlement Program (2019) https://www.anao.gov.au/work/performance-audit/delivery-the-humanitarian-settlement-program
[19] Improving health literacy in refugee populations (2016) https://www.mja.com.au/system/files/issues/204_01/10.5694mja15.01112.pdf
[20] Refugee Health Assessment: Template 2018 https://refugeehealthnetwork.org.au/wp-content/uploads/FINAL_2018_Sept21_On-Arrival-Refugee-Health-Assessment.pdf
[21] Australian Refugee Health Practice Guide (2018) https://refugeehealthguide.org.au/

5. Better connection between State and Federal domains focusing on health

Health is a key indicator of integration but also 'serve[s] as potential means to support the achievement of integration'.[22] There is a documented gap in health knowledge and capacity of settlement services and general practitioners to plan for and respond to pre-arrival and on-arrival health care needs[23]. Settlement Case Managers do not necessarily have health/medical expertise although they are contractually required to attend to and plan for the management of the HSP arrivals immediate health needs. There also continues to be significant challenges in identifying GP practices that have an interest in, and capacity for, refugee primary healthcare provision. Obstacles to engaging and maintaining GPs in both private practice and community health include concerns about time constraints and the financial viability of service provision given language difficulties and the often complex medical and psycho-social health needs of refugee patients. Many GPs feel they lack the training, skills, and knowledge to be able to address their more complex and less common health concerns, despite the range of resources and training opportunities that have been developed. State funded, specialised health services have been key in combatting service access issues, providing comprehensive and specialised health care that address the disparities in health outcomes that exist for this group including in primary care, infectious disease, paediatrics and mental health[24]. Noting the existing pressures and resource challenges on State funded programs and this gap in 'mainstream' service provision, federal funding of specialised doctors in particular in primary care, infectious disease, paediatrics and psychiatry would complement the work of already established, State funded, specialised services.

An important component of achieving a skilled, sustainable, and extensive workforce in refugee health are Commonwealth supported training programs across medical, nursing and allied health disciplines. These programs conducted through relevant accredited training organisations (for example medical colleges) and embedded within refugee health programs will build capacity and expertise within the health system and reduce pressures upon current programs and hospitals.

According to the recent evaluation of the Refugee Health Program (RHP) in Victoria there has been a 70%[25] increase in RHP clients between 2013-14 and 2019-20. Commonwealth investment in specialist primary care for refugees would expand the capacity of already established specialist refugee health services to respond to this increased demand. These doctors would build the capacity of refugee health programs to respond to the health needs of new arrivals by conducting comprehensive refugee health assessments and making on-the-spot medically informed decisions regarding refugees on-arrival health care pathway. Further to recommendation 7, building the specialist primary care force that targets on arrival health needs would ensure a comprehensive assessment is conducted before clients are transferred to universal primary and specialist health care.

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[22] Ager, A., & Strang, A. (2008). 'Understanding Integration: A Conceptual Framework', *Journal of Refugee Studies* 21(2), pp. 166-191. Retrieved from https://academic.oup.com/jrs/article/21/2/166/1621262.
[23] Chaves NJ, Paxton GA, Biggs BA, Thambiran A, Gardiner J, Williams J, Smith MM, Davis JS. (2007) The Australasian Society for Infectious Diseases and Refugee Health Network of Australia recommendations for health assessment for people from refugee-like backgrounds: an abridged outline. Med J Aust. :310-315.
[24] McBride J., Block A. & Russo A, (2017) 'An integrated healthcare service for asylum seekers and refugees in the South-Eastern Region of Melbourne: Monash Health Refugee Health and Wellbeing' Australian Journal of Primary Health Practice & Innovation http://dx.doi.org/10.1071/PY16092
[25] 'Number of People Accessing the RHP' Evaluation of the Victorian Refugee Health Program, December 2021 pg. 139

To support the economic and social participation of refugees, national objectives for good health outcomes are vital. These objectives (refer to Recommendation 1) would provide more formalised means for the State (Department of Health) and Federal governments (Department of Home Affairs) to work collaboratively to support key areas of settlement. Culturally competent heath care practices, such as those implemented by State funded refugee health services, help ensure refugees are accessing primary and specialist care as early as possible, thus mitigating health risks, and potentially avoiding escalation to acute care. Without adequate means for service navigation people turn to hospitals to receive treatment which are already under significant pressure and provide additional risks for exposure to other infections e.g., COVID-19.

Commonwealth investment in refugee primary healthcare provision that is linked with State-funded programs provide preventative measures for the wellbeing of clients and would also reduce costs to the Federal Government where healthcare is being accessed in a tertiary setting. By facilitating appropriate and more immediate linkages with specialised health care services at early stages of resettlement, clients are more equipped to socially and economically participate.

Recommendation 12 Upskilling GPs in the delivery of best practice standards for refugee health assessments and ongoing health care. This would fall under the premise of the National Framework. This would also be complementary to implementing recommendation 7 on this report.

Recommendation 13 Commonwealth funding doctors to join already established specialist refugee health programs in each state. This would include specialists in primary care, infectious disease, paediatrics and psychiatry. It would also include more broadly Commonwealth supported training programs for medical, nursing and allied health clinicians to develop skills and expertise in refugee health.

Summary of recommendations:

Recommendation 1 Development of a National Refugee Health and Wellbeing Framework.

Recommendation 2 To improve coordination efforts between the Commonwealth Department of Health and State-based resources through the objectives of the National Refugee Health and Wellbeing Framework.

Recommendation 3 To ensure Refugee Health Services have timely and direct access to offshore medical reports and flagged health alerts as well as health information from interstate.

Recommendation 4 Offshore health information to be reviewed by specialist Refugee Health Services as not all significant medical issues are given a health alert by the HSP system.

Recommendation 5 The Australian Government, through Council of Australian Governments, lead a process of data linkage to understand access to health services and health outcomes for people who enter Australia through the Refugee and Humanitarian Program. This may be led by the Department of Social Services, Department of Health, and/or Department of Home Affairs, in consultation with the Australian Bureau of Statistics.

Recommendation 6 Department of Home Affairs to permanently lift the bar for all people under the 449-visa subclass and grant immediate access to Medicare.

Recommendation 7 Improved processes that will ensure the immediate provision of Medicare numbers to clients.

Recommendation 8 The Australian Government Department of Health to reintroduce a unique MBS item number for Health assessment for refugees and other humanitarian entrants to track the completion rate and to identify people from refugee backgrounds within the broader MBS data set.

Recommendation 9 Allowing more than one Health Assessment item to be claimed for an individual patient to allow the time and flexibility for comprehensive assessment and follow-up.

Recommendation 10 The inclusion of quality health indicator metrics in the current HSP.

Recommendation 11 Building the health literacy of new arrivals that would develop self-efficacy and skills in health investigation, health service navigation and understanding preventative interventions from a western medical model.

Recommendation 12 Upskilling GPs in the delivery of best practice standards for refugee health assessments and ongoing health care. This would fall under the remit of the National Refugee Health and Wellbeing Framework. This would also be complementary to implementing recommendation 7 on this report.

Recommendation 13 Commonwealth funding doctors to join already established specialist refugee health programs in each state. This would include specialists in primary care, infectious disease, paediatrics and psychiatry. It would also include more broadly Commonwealth supported training programs for medical, nursing and allied health clinicians to develop skills and expertise in refugee health.