Multicultural Framework Review

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About the Victorian Refugee Health Network

The Victorian Refugee Health Network (The Network) 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

Table of Contents

Table of Contents **2**
Glossary **3**
Recommendations **4**
Introduction **6**
Commonwealth level Policy **8**
I. National Refugee Health and Wellbeing Framework 8
II. Department of Home Affairs' review into settlement services 13
Immigration Medical Examination (IME) Offshore health assessment and the HAPlite system 13
Onshore health assessment 14
Communication between Department of Home Affairs and the National Disability Insurance Agency (NDIA) 16
Health indicators in settlement services 17
III. Accessing effective health care for people from refugee backgrounds 19
General Practitioner health care access and conduct 21
Accreditation points for cultural competency for General Practitioners 21
IV. The use of interpreters in health care settings 23
Interpreter Access Issues for People of Refugee Backgrounds 23
Interpreting Services for Allied Health Services 24
Opportunities for further inter-governmental collaboration **26**
I. Better connection between State and Federal domains focusing on health 26
Data Flow between State and Federal Governments 27
Case Study Example: PRIME: Program for Refugee Immunisation, Monitoring and Education 28
Inclusion strategies to promote a multicultural workforce **29**
I. Improve the skills and qualifications recognition system of prior overseas studies and workforce experience. 29
Investment in a bilingual and bicultural Workforce 30
The impact temporary visa status has on health **32**
I. The impact of temporary visa status 32
Conclusion **33**

Glossary

BVE	Bridging Visa E
CALD	Culturally And Linguistically Diverse
FIS	Free Interpreting Services for allied health professionals[1]
HAP	Health Assessment Portal[2]
HAPlite[3]	is a subset of the HAP system, that can be accessed by registered health providers
HSP	Humanitarian Settlement Program
IME	Immigration Medical Examination
LGA	Local Government Area
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
RHP	Refugee Health (Nurses) Program
TIS National	Translating and Interpreting Service

[1] Pilot Project delivered by the Department of Home Affairs' Translating and Interpreting Service (TIS National) on behalf of the Australian Government
[2] To record the Immigration Medical Examination and manage health undertakings
[3] Offshore health assessment and the HAPlite system https://www.rch.org.au/immigranthealth/clinical/HAPlite/

Recommendations

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

Recommendation 2: The Australian Government Department of Health to provide funds to maintain evidence-based resources in refugee health to support practitioners.

Recommendation 3: Australian health care services are adapted for cultural and linguistic diversity by ensuring they are aware of and utilise existing services and frameworks such as TIS National and Cultural Competency Standards Framework for Clinicians[4].

Recommendation 4: Review of Australia's offshore health assessment processes to include data collection methods that are inclusive of gender diversity, accurate reporting of disability and associated needs, and up-to-date health information that is accurately captured prior to their arrival in Australia.

Recommendation 5: The Australian Government Department of Social Services to work with refugee health providers and settlement services to design services and indicators that support new arrivals to access appropriate health services and to troubleshoot access barriers that may arise.

Recommendation 6: "Develop health passports for refugees and migrants, particularly those in vulnerable circumstances (women, children, migrants whose journeys are forced/irregular), to improve continuity of care from origin to destination"[5] as recommended by the WHO Report.

Recommendation 7: A formalised partnership between NDIS and the Department of Home Affairs is established so that newly arrived refugees with a disability (with or without diagnosis) are linked in with NDIS service support as soon as they arrive. A rapid assessment and diagnosis on arrival will help ensure there is timely and appropriate health interventions into NDIS as soon as possible.

Recommendation 8: 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 the Australian medical model.

Recommendation 9: The inclusion of quality health indicator metrics in the current Humanitarian Settlement Program.

Recommendation 10: 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 and implementing accreditation points for cultural competency.

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[4] [4] Competency Standards Framework (2019) https://culturaldiversityhealth.org.au/competency-standards-framework/

[5] Promoting the health of refugees and migrants: experiences from around the world. Geneva: World Health Organisation; 2023. Licence: CC BY-NC-SA 3.0 IGO (Page 76)

Recommendation 11: That women are supported and incentivised to work as interpreters to adequately resource the industry.

Recommendation 12: That TIS National expand their eligibility criteria to become a practicing interpreter. To be employed by TIS you must be an Australian resident or citizen meaning people on temporary visas who speak languages that are in high demand are not able to fill this gap in the industry.

Recommendation 13: The continuation and expansion of Free Interpreting Services (FIS) so that all allied health services and psychological services have access to free interpreting services including dental services.

Recommendation 14: That Language service providers are providing support options to interpreters for debriefing and referral into mental health services to support with reports of burnt out and experience of vicarious trauma.

Recommendation 15: Improve coordination efforts between the Commonwealth Department of Health and State domains focusing on health.

Recommendation 16: The Network recommends that the Australian government improve the skills and qualifications recognition system so that health professionals who arrive through the Refugee and Humanitarian Program have better opportunities to economically participate in and build a multicultural Australian workforce. In particular, the Australia's Subsidy for Overseas Trained Professionals (ASDOT) should be restored to help fund people with overseas qualifications through the costly recognition process[6].

Recommendation 17: Both State-based and National health services should be employing bicultural workers and recruit for diversity to build an inclusive and multicultural workforce.

[6] Settlement Services International (SSI) 2023, Billion Dollar Benefit: A roadmap for unleashing the economic potential of refugees and migrants. Page 11

Introduction

The Network commends the Department of Home Affairs in their commitment to build a cohesive, multicultural society and we welcome the opportunity to provide feedback on the Multicultural Framework review.

Over 950,000 refugee and humanitarian entrants have arrived in Australia since the end of the second World War[7]. People who arrive in Australia through the Refugee and Humanitarian Program want to work and bring a host of skills that contribute to Australian society, culture, and economy[8].

Good health enables participation in a new society, and a person's ability to access health care is an indicator of integration. People from refugee backgrounds, including those seeking asylum, have complex health and social welfare needs, which are well documented[9]. There are current gaps in health service systems and service delivery models in Australia that impact on health access, literacy, and health outcomes for people from culturally and linguistically diverse backgrounds, particularly those from refugee backgrounds. Access to culturally appropriate and safe health care is central to the Networks core values advocating for health equity and health justice for all Australians.

The Network understands that the Multicultural Access and Equity Policy[10] that was released in 2018, provides guidance on multicultural access and equity commitments for governmental department and agencies to meet the needs of all Australians. This submission outlines there are a number of concerns and challenges that Australians from refugee backgrounds face when trying to access and receive appropriate health care and support services. As outlined in this policy document, "Australian Government departments and agencies are responsible for applying these commitments to their work".[11] The performance of the departments and agencies on implementing this policy was last reviewed in 2015 and is due for an update. The Network believe that objective assessment processes are important to ensure Australian departments and agencies are upholding their commitment to servicing the needs of all Australians.

In this report, the Network provides a number of recommendations related to health care access, service provision and workforce development to help improve health outcomes for people of refugee backgrounds and reduce barriers to inclusion in Australian society.

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[7] 'Post-WW2 refugee arrivals to pass 950,000 in 2023' https://www.refugeecouncil.org.au/950000-refugee-arrivals/
[8] Tyrrell, L., Duell-Piening, P., Morris, M., & Casey, S. (2016). *Talking about health and experiences of using health services with people from refugee* backgrounds. Retrieved from the Victorian Refugee Health Network website: http://refugeehealthnetwork.org.au/wp-content/uploads/Report_2016_September_Victorian-Refugee-Health-Network_Talking-About-Health_FINAL-WEB.pdf,p.32.
[9] Brandenberger, J., Tylleskär, T., Sontag, K. et al. A systematic literature review of reported challenges in health care delivery to migrants and refugees in high-income countries - the 3C model. BMC Public Health 19, 755 (2019). https://doi.org/10.1186/s12889-019-7049-x
[10] Multicultural affairs (2018) Access and Equity. https://www.homeaffairs.gov.au/about-us/our-portfolios/multicultural-affairs/about-multicultural-affairs/access-and-equity#:~:text=The%20Multicultural%20Access%20and%20Equity,their%20cultural%20and%20linguistic%20backgrounds.
[11] Ibid.

In line with the terms of reference outlined for this submission, the Network will provide feedback on the following areas:

1. Improvements in Commonwealth level policy areas to help improve health outcomes for Australians from refugee backgrounds,
2. Opportunities for further inter-governmental collaboration,
3. Inclusion strategies to promote a multicultural workforce, and
4. The impact temporary visa status has on health.

A National Framework for Refugee Health and Wellbeing will be suggested in this report, offering a national structure to oversee a culturally safe and responsive health care system in Australia. Safeguarding and achieving good health is a key pillar of integration and ensures all Australians in our multicultural society have equitable and safe access to the health care system.

Commonwealth level Policy

I. National Refugee Health and Wellbeing Framework

A Refugee Health and Wellbeing Framework shows a commitment to improving the health and wellbeing of refugees and offers a structure for coordinated care and specialised practice standards. 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)'. Throughout the 'Shergold Review'[12] the development of a national results-driven framework was recommended to improve outcomes relating to the wellbeing of people from refugee backgrounds arriving in Australia.

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[13], 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 refugee health and wellbeing framework that provides guidance on 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.

This national framework will strongly depend on improvements on aggregated data for refugee communities. 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 revealed 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[14]. 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

[12] 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
[13] Australian Health Performance Framework https://meteor.aihw.gov.au/content/721590
[14] '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

subsequent health outcomes for people from culturally and linguistically diverse backgrounds in Australia.

The Australian Institute of Health and Welfare (AIHW) have recently released a report on the health of culturally and linguistically diverse populations in Australia[15]. Cultural and linguistic diversity (CALD) can be defined by a number of aspects including a person's country of birth, ethnicity, any language spoken other than English, where their parents were born and religious affiliation.[16] The 'CALD' community is not a homogeneous group and have vast differences in relation to their health care needs, patterns of disease, previous experience of health care access, and risk factors. It is highlighted in the report that "further analysis is required to explore how the combination of migration pathway, length of time spent in Australia, other sociocultural and economic factors affect health status and outcomes."[17] Measuring health outcomes and health service access patterns for people from refugee backgrounds is currently limited, 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 may be utilised to understand service access and health outcomes. It is important that there is a national set of standards that guide the health system to effectively capture data that is representative of the diversity of the population that Australia holds. This will help ensure there is more comprehensive investigation into the health needs of all Australians and help inform evidence-based policy and service planning.

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

b) Improving cultural competency in general health care practices

There are reported challenges that 'mainstream' health service providers face when working with people from refugee backgrounds, such as uncertainty of clinical knowledge, using interpreters, cross cultural negotiation and health system barriers.[18] 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 health interventions.

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

[15] Australian Institute of Health and Welfare (2022) Reporting on the health of culturally and linguistically diverse populations in Australia: An exploratory paper, catalogue number PHE 308, AIHW, Australian Government.
[16] Ibid.
[17] Ibid.
[18] 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.

once off projects such as the *Australian Refugee Health Practice Guide*[19] and the *Recommendations for comprehensive post-arrival health assessment for people from refugee-like backgrounds.*[20] 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.[21] It also ensures there are consistent practice standards across States and Territories, noting the frequency of interstate resettlement requiring continuity of care.

Recommendation 2: *The Australian Government Department of Health to provide funds to maintain evidence-based resources in refugee health to support practitioners.*

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 oversee communication strategies to ensure they 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. This has been previously exemplified when addressing the disparities in health outcomes for Australians who were born overseas who posed a greater risk of Covid morbidity.[22] Employing bicultural workers and community engagement activities were critical in reducing inequalities in healthcare communication.

[19] Australian Refugee Health Practice Guide http://refugeehealthguide.org.au/
[20] https://www.asid.net.au/documents/item/1225
[21] 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).
[22] '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

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 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. The Network was recently funded by Department of Family, Fairness and Housing (DFFH) to develop and deliver a suite of targeted communications and engagement initiatives to multicultural and multifaith communities impacted by the floods in Victoria. The Network found that the employment of bicultural workers and engagement with the community face-to-face was effective in the timely and efficient delivery of public health messaging. Whilst these procedures and programs 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 of 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 such as the Refugee Health Program in Victoria, 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 oversee the continuation of specialised refugee health services that creates safe passage to specialist and primary care providers.

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

Refugee background communities face a range of obstacles when seeking and engaging with mental health services[23]. 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

[23] Victorian Refugee Health Network & Foundation House (2023) Understanding key issues in accessing mental health services for refugee background communities in Victoria Diverse Communities Mental Health and Wellbeing Project, Survey Report

Victorian Government as part of the new National Mental Health and Suicide Prevention Agreement, a strong emphasis should be made around cultural competency and accessibility 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 is particularly crucial for services that operate in rural, regional, and remote areas where there is limited service options available.

Recommendation 3: *Australian health care services are adapted for cultural and linguistic diversity by ensuring they are aware of and utilise existing services and frameworks such as TIS National and Cultural Competency Standards Framework for Clinicians.*

This national framework could build on existing cultural 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[24]. The framework was developed over two years and provide guidelines for clinicians on culturally responsive health care for people with migrant and refugee backgrounds.

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

II. Department of Home Affairs' review into settlement services

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."[25] Throughout the 'Shergold Review' as previously mentioned, there is recognition that good health is vital for newly arrived refugees to participate in key areas of settlement including employment, making social connections, and engaging in English language learning.

Throughout the settlement journey, there are a number of opportunities where systems could be improved to ensure the health of newly arrived refugees are supported through this program which will be explained below.

Immigration Medical Examination (IME) Offshore health assessment and the HAPlite system

Before clients arrive in Australia, clients complete an IME offshore health assessment and settlement services in Victoria are subsequently informed by the Refugee Health Program whether there is a health alert on the HAPlite system[26]. An alert may indicate whether an individual has any mobility issues or diagnosed health conditions identified in this offshore health assessment. [27]

There are a number of areas of concerns relating to offshore health assessment that will be explored further below including:

- 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.
- These health assessments reportedly do not include a specific section on disability, causing inconsistencies in capturing health information and assessing for disability in this process.
- The HAPlite report that services refer to when providing health care support to people who have arrived through HSP includes data on gender that only represents Male/Female dichotomies and no record of gender diversity.

Settlement services and 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 a strain on health service systems. Entry into National Disability Insurance Scheme (NDIS) is based on diagnosis, and new refugee arrivals with disability may not have a formal diagnosis or have any documented evidence available prior to arrival. Without comprehensive and timely offshore and onshore health screening processes there are substantial delays in accessing urgent support for individuals who have arrived with significant health conditions, including

[25] Delivery of the Humanitarian Settlement Program (2019) https://www.anao.gov.au/work/performance-audit/delivery-the-humanitarian-settlement-program
[26] See Glossary
[27]

disability treatment and support needs. Often these individuals and families require immediate linkages with specialists to assess and facilitate the process of a NDIS referral or state-based disability services. 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.

The lack of gender diversity in data recorded in the HAPlite System is having throughput impact on appropriate service provision in Australia. There are reports that people who have recently arrived are being misgendered by services based on the referral information received from Department records. Given refugee claims can be related to facing persecution based on sexuality, gender identity or expression it is essential that services receive the right information, and this is captured accurately in Departmental systems. Improvements in the Department of Home Affairs data collection methods is critical to ensure they are inclusive of the LGBTIQ+ community and that health services are receiving correct information on client records to provide appropriate and trauma-informed care.

Recommendation 4: *Review of Australia's offshore health assessment processes to include data collection methods that are inclusive of gender diversity, accurate reporting of disability and associated needs, and up-to-date health information that is accurately captured prior to their arrival in Australia.*

Onshore health assessment

Currently there is no mandated process or measure on how many individuals and families arriving under the Humanitarian Settlement Program (HSP) have completed an on-arrival refugee health assessment. Previously there was a Medicare Benefits Schedule (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)[28]. These specific MBS items recognised that differing practice standards for health assessments are required for this cohort consistent with good clinical practice. These MBS 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 how many people have these assessments on arrival, as the MBS billing item number is the same item as these other assessment types. Due to this, there is no visibility on how many individuals and families arriving under HSP have completed an on-arrival refugee health assessment. This raises concerns of the delay identifying and responding to the health concerns and disability support needs of newly arrived refugees.

[28] 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

One of the immediate deliverables of HSP is for the client to be registered with Medicare within three days of arrival[29]. HSP clients are automatically qualified for Medicare services being part of the program however, there are often extensive delays obtaining their 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.

Recommendation 5: *The Australian Government Department of Social Services to work with refugee health providers and settlement services to design services and indicators that support new arrivals to access appropriate health services and to troubleshoot access barriers that may arise.*

In a recent report released by the World Health Organisation that highlights policy considerations to improve refugee and migrant health, notes a number of recommendations that should be considered in the Multicultural Framework Review including to:

- "ensure that all health care services are adapted for cultural and linguistic diversity so that refugees and migrants have access to culturally appropriate, quality health services;"
- "develop health passports for refugees and migrants, particularly those in vulnerable circumstances (women, children, migrants whose journeys are forced/irregular), to improve continuity of care from origin to destination"[30]

Recommendation 6: *"Develop health passports for refugees and migrants, particularly those in vulnerable circumstances (women, children, migrants whose journeys are forced/irregular), to improve continuity of care from origin to destination" as recommended by the WHO Report.*

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

[30] Promoting the health of refugees and migrants: experiences from around the world. Geneva: World Health Organisation; 2023. Licence: CC BY-NC-SA 3.0 IGO (Page 76)

Communication between Department of Home Affairs and the National Disability Insurance Agency (NDIA)

On arrival into Australia, negotiating a new and unfamiliar health system can be a complex undertaking for people from refugee backgrounds, particularly for those with multiple health needs requiring numerous investigations and follow-up appointments. This can often be compounded by cultural and language differences between new arrivals and healthcare providers. Many new arrivals will be unfamiliar with illness prevention approaches and may be unaccustomed to the culture that characterises relationships between healthcare users and providers in Australian (e.g., the emphasis on choice and informed consent).[31] Without immediate linkages to onshore health screening processes, there are substantial delays in accessing urgent support through the NDIS for individuals who have arrived with significant health conditions, including disability treatment and support needs.

The NDIS aims to increase choice and control for participants. However, the consumer-driven approach of the NDIS is reinforcing existing inequities driven by social determinants of health, such as English proficiency, health and health system literacy, education, household structure, household income and residential location[32]. At all stages of the NDIS access and engagement, people who are:

i) familiar with liaising with professionals and meetings,
ii) able to navigate internet-based information and resources,
iii) understand the health system and
iv) can advocate for themselves or their child, are at a considerable advantage[33].

People of refugee backgrounds, especially those who are newly arrived, are often disadvantaged by this consumer-driven approach. The ongoing low rates of NDIS participation from people of CALD backgrounds is evidence of this. Accessing the NDIS is based on finding funded mainstream services for information, assessment, advocacy, and other supports to enter the scheme. These interfaces must be more assertive, informed, and coordinated in responding to and supporting people from diverse backgrounds. The Network recommends that a formalised partnership between NDIA and the Department of Home Affairs is established so that newly arrived refugees with a disability (with or without diagnosis) are linked in with NDIS service support as soon as they arrive. A rapid

Recommendation 7: *A formalised partnership between NDIS and the Department of Home Affairs is established so that newly arrived refugees with a disability (with or without diagnosis) are linked in with NDIS service support as soon as they arrive. A rapid assessment and diagnosis on arrival will help ensure there is timely and appropriate health interventions into NDIS as soon as possible.*

[31] Victorian Foundation for Survivors of Torture (2012). Promoting refugee health: a guide for doctors, nurses and other health care providers caring for people from refugee backgrounds. Retrieved from http://refugeehealthnetwork.org.au/wp-content/uploads/PRHonline-editionJuly2012.pdf
[32] 30 Warr, D, Dickinson, H, Olney, S, et. al. 2017, Choice, Control and the NDIS, Melbourne, University of Melbourne.
[33] Ibid.

assessment and diagnosis on arrival will help ensure there is timely and appropriate health interventions into NDIS as soon as possible.

Health indicators in settlement services

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'[34]. 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 limited 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.[35] 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.

Recommendation 8: *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 the Australian medical model.*

For better health care outcomes for refugees in the HSP, more quality control in KPIs 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[36][37]
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.

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

Settlement services play an important role in supporting access to health services and coordinating follow up care. 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 9: *The inclusion of quality health indicator metrics in the current Humanitarian Settlement Program.*

III. Accessing effective health care for people from refugee backgrounds[38]

Barriers to accessing effective health care for people from refugee backgrounds are well documented in the literature.[39][40][41] In the Network's consultation with communities from refugee backgrounds and service providers,[42,43,44] the following barriers and enablers were highlighted when accessing health care.

Barriers to accessing effective health care	
➢ Language concordance, including not being provided an interpreter,	➢ lack of transport options, not being confident or familiar with public transport,
➢ cost of health care,	➢ cost of transport to health care appointments,
➢ distance to services,	➢ long wait times for appointments, especially to see a medical specialist,
➢ difficulty making appointments, especially over the phone,	➢ difficulty filling in forms in English,
➢ caring responsibilities and not having access to childcare or respite,	➢ inability to request female health practitioners,
➢ multiple appointments across many services for new arrivals, and	➢ low health and service literacy.

[38] Victorian Refugee Health Network (2018) Submission to the Australian Government's Review into integration, employment and settlement outcomes for refugees and humanitarian entrants

[39] Milosevic, D., Cheng, I., & Smith, M. (2012) 'The NSW Refugee Health Service Improving refugee access to primary care'. *Australian Family Physician*. 41, pp 147-149;

[40] Russell G., Harris, M., Cheng I-H, et al. (2013). Coordinated primary health care for refugees: a best practice framework for Australia. Southern Academic Primary Care Research Unit: Melbourne;

[41] Cheng I-H., Drillich, A., Schattner P. (2015). 'Refugee experiences of general practice in countries of resettlement: a literature review'. *British Journal of General Practice*. 65(632) pp.171-6.

[42] Tyrrell, L., Duell-Piening, P., Morris, M., & Casey, S., op. cit.

[43] Victorian Refugee Health Network. (2018). *Service responses for people with disabilities form refugee backgrounds in northern Melbourne*. Retrieved from the Victorian Refugee Health Network website: http://refugeehealthnetwork.org.au/service-responses-for-people-with-disabilities-from-refugee-backgrounds-in-northern-melbourne/.

[44] Furneaux, S., Duell-Piening, P., Christensen, S., Jaraba, S., Loupetis, M., & Varenica, R. (2016). *Engaging and supporting general practice in refugee health: final report*. Retrieved from the Victorian Refugee Health Network website: http://refugeehealthnetwork.org.au/wp-content/uploads/Report_2016_August_Primary-Care-Report_FINAL-REPORT.pdf.

Conversely, enablers that assisted access to health care are identified in the table below.

Enablers that assisted access to health care[45,]	
• convenient location or proximity of the service to where a person lives,	• availability of public transport to get to the service,
• attending services that are co-located,	• attending services that employ bilingual GPs and/or other health professionals,
• drop-in clinics where appointments are not required,	• bi-cultural access workers,
• culturally competent health providers,	• translated appointment reminders, and
• welcoming front of house staff, including bilingual receptionists.	

People with complex health problems and disabilities need to attend more appointments and may have specific access issues related to their condition or disability. In addition to those listed above, specific barriers and enablers were identified for people with disabilities. [46]

Additional barriers for people with disabilities
• long waiting times for aids and equipment,
• long waiting times for allied health and psychology assessments and treatment (most newly arrived Refugee and Humanitarian Program entrants have low English proficiency. This limits referral options for allied health services as MBS funded allied health services do not qualify for Translating Interpreting Service (TIS) fee-free interpreting) and
• long waiting times for specialist assessments, for diagnosis necessary to access support services.

Strategies and services that supported access to health services for people with complex health problems or disabilities included: [47]
• case management,
• sharing of information between the professionals providing care,
• good quality, comprehensive on arrival assessment with a general practitioner with appropriate and supported referrals, and
• referral of children for specialist care and assessment by paediatricians.

[45] Tyrrell, L., Duell-Piening, P., Morris, M., & Casey, S., op. cit., p.23.
[46] ibid.
[47] ibid.

General Practitioner health care access and conduct

General practitioners (GP) have a key role to play in the delivery of on-arrival and ongoing care to Refugee and Humanitarian Program entrants as well as culturally and linguistically diverse members of the community.

The Network have been made aware of concerning reports that the refugee community, settlement teams and refugee health nurses are finding it increasingly difficult to find GP practices who will bulk bill. Limited options for bulk-billing GP clinics have put more pressure on community health centres and asylum seeker health service providers and this, combined with increases in cost of living (housing, rental arrears, utilities, and basic needs such as food), has meant that people's health has deteriorated as access to care is limited.

These barriers to accessing GPs directly impact on the undertaking of comprehensive refugee health assessments, access to primary health care, disability support provision, preventative health care options. This is especially significant for the refugee cohort who have reportedly poorer health outcomes with significant trauma backgrounds, no visibility of historical health issues and not having timely access to comprehensive health checks.

Without adequately resourced service provision in place that allows for early intervention, primary care and mental health care and support across the other social determinants of health (e.g., housing, medication and basic needs support for food and utilities), there will be an unnecessary increased burden on emergency departments and the broader health and hospital system, as well as other community service providers to respond to these needs.

Accreditation points for cultural competency for General Practitioners

GPs and other health providers require support to overcome a number of challenges they experience in working with people from refugee backgrounds, such as uncertainty of clinical knowledge, using interpreters, cross-cultural negotiation and health system barriers.[48] Making resources available to health providers can have a positive impact on 'patient care'.[49]

In an increasingly diverse and multicultural society, the provision of culturally sensitive healthcare is paramount. Australia, often celebrated for its multiculturalism, is home to a rich tapestry of ethnicities, languages, and traditions. To ensure equitable access to healthcare services and fostering trust between patients and healthcare providers, it is imperative that GPs in Australia receive comprehensive training in cultural competency. The Network believes there is a need to ensure accreditation points are allocated for cultural competency training in the professional development of GPs[50]. For GPs, possessing cultural competency is essential for providing patient-centred care where studies have shown that culturally tailored

[48] 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.
[49] ibid, p.805.
[50] RACGP (2023) Reaccreditation https://www.racgp.org.au/education/imgs/fellowship-pathways/fellowship-programs-for-imgs/fellowship-support-program/fellowship-support-program-resources/fsp-training-site-and-supervisor-handbook/accreditation/reaccreditation

interventions lead to improved health outcomes, increased rates of preventative care, and reduced health disparities[51].

By incorporating accreditation points for cultural competency, regulatory bodies can align their requirements with the evolving needs of the community and underscore the significance of this skillset in the provision of high-quality healthcare.

Recommendation 10: *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 and implementing accreditation points for cultural competency.*

[51] RACGP (2023) Healthcare for people from refugee backgrounds and people seeking asylum https://www.racgp.org.au/advocacy/position-statements/view-all-position-statements/health-systems-and-environmental/healthcare-for-refugees-and-asylum-seekers

IV. The use of interpreters in health care settings

"It is widely acknowledged and understood that the Australian health system does not adequately cater for people who do not have high proficiency in English (FECCA 2016). These language barriers in the health system have the potential to affect health negatively. A person's use of language, accent, dialect, repertoire and speech also plays a part in racism and institutional and interpersonal discrimination and can lead to long-lasting psychological trauma and distress" (Dovchin 2020)."[52]

Interpreter Access Issues for People of Refugee Backgrounds

The Network has recently held consultations and conducted a brief survey that was distributed to subscribed members with 119 responses from people who work across health, settlement, housing, legal and asylum seeker agencies.[53]

The Network have received numerous case study examples that have outlined challenges in accessing interpreters, certain language groups that have limited interpreters available and reports that health care professionals are reluctant to use interpreters. Australia has a world leading certification system for interpreters. Unfortunately, they are commonly underutilised in established health and human services delivery. Recent data on the uptake of free interpreting services through TIS National points to significant underutilisation of interpreters in primary and allied health service provision, owing either to lack of awareness about free TIS services, insufficient training and capability in use of interpreters and/or workload pressures.

In many cases when interpreters aren't being used, family or community members are encouraged by health professions to interpret at medical appointments. There are ethical, quality and safety issues associated with using family, friends, and non-credentialed staff who speak languages other than English to conduct clinical consultations. Conversely, there are also reports that GPs and health care professionals are determining whether the client needs an interpreter despite an explicit request for an interpreter from the patient.

When respondents to the Network's survey were asked if they were having issues booking an interpreter by phone, on-site or both, 80% of respondents from metro, rural and regional areas indicated difficulties across both systems. There were 20% of respondents answered 'other' with some stating they were not having issues or that there were "often problems if preference is for female interpreter".

> *"An older woman from refugee background was coming for her first ever cervical screening having to ask sexual health questions. A male over 50s was allocated, not suitable." (Health Service Provider, VRHN Survey Response 2023)*

[52] Australian Institute of Health and Welfare (2022) Reporting on the health of culturally and linguistically diverse populations in Australia: An exploratory paper, catalogue number PHE 308, AIHW, Australian Government.
[53] Victorian Refugee Health Network (2023) Interpreter Access Issues for People of Refugee Backgrounds in Victoria

The Network have received numerous reports regarding female interpreters not being available for important heath appointments that have been preferred by the client. Not securing the gender preference of the interpreter has significant cultural, social and health impacts on receiving suitable and culturally safe healthcare information. Ensuring women are supported and incentivised to access interpreting courses is crucial to adequately resource the industry and meet the needs of the population.

Recommendation 11: *That women are supported and incentivised to work as interpreters to adequately resource the industry.*

There have been reported concerns when language services are used in healthcare settings, particularly for less common language groups that there's a likelihood that the people know the interpreter, and/or that the interpreter will not maintain confidentiality in the community.

Currently TIS National has certain eligibility criteria that to become a practicing interpreter you must be an Australian resident or citizen. What this means is that people who speak certain languages that are in high demand and are on temporary visas such as people who are seeking asylum are not able to fill this gap in the industry.

Recommendation 12: *That TIS National expand their eligibility criteria to become a practicing interpreter. To be employed by TIS you must be an Australian resident or citizen meaning people on temporary visas who speak languages that are in high demand are not able to fill this gap in the industry.*

With a high number of people settling in Australia, it is important that the number of interpreters are also increasing to meet the needs of the local population.

> *"Client with hearing impairment – appointment was cancelled 3 times this year due to inability to get face to face interpreter. Clients from Dari and Dinka speaking background have no face-to-face interpreters available. This also impacts on information sessions and access to groups i.e., art therapy groups due to lack of face-to-face interpreters." (Mental Health Service Provider, VRHN Survey Response 2023)*

Interpreting Services for Allied Health Services

Translating and interpreting services are not funded for all allied health services including services such as Occupational Therapy, Physiotherapy and Speech Pathology which are often crucial in health care plans. It is the responsibility of these services to organise their own interpreting services, typically from fee-for-service language service companies or by directly employing accredited interpreters. This has meant significant language barriers for both refugees and asylum seekers when seeking support from allied health practitioners to conduct accurate assessments. Translating and Interpreting Service (TIS National) has recently

expanded the Free Interpreting Service (FIS) as part of a pilot program to select Local Government Areas (LGA) in each State or Territory[54]. This program does not include dental services as part of the eligible allied health services.

Allied health professionals within these LGAs require significant guidance and encouragement to opt in and register for TIS to ensure they are an accessible service for all Australians.[55] According to recent data that recorded the current number of services registered with FIS is below 220 services across these LGAs[56]. There is evidence that there are allied health professionals who have applied for the scheme however are ineligible based on the LGA the service operates in.

Recommendation 13: *The continuation and expansion of Free Interpreting Services (FIS) so that all allied health services and psychological services have access to free interpreting services including dental services.*

The Network recommend that FIS is continued and expanded so that all allied health services have access to free interpreting services including dental services. While the pilot project is running it would also be encouraged that TIS National implement a communication strategy and outreach to services who are eligible to encourage registration.

According to the Multicultural Access and Equity Policy, "barriers of culture and language should not impede the delivery of Australian Government programmes and services to those who are entitled to receive them."[57] The Network encourages the Department to employ an objective body to audit and review how these guidelines are upheld in Australian departments and institutions.

Recommendation 14: *That Language service providers are providing support options to interpreters for debriefing and referral into mental health services to support with reports of burnt out and experience of vicarious trauma.*

[54] Casey, Greater Dandenong, Hume, Wyndham, Brimbank, Melton, Greater Geelong, Greater Shepparton, Mildura, Wodonga

[55] 'Find out if you are eligible for the Free Interpreting Service' https://www.tisnational.gov.au/Agencies/Charges-and-free-services/Free-services-through-TIS-National.aspx

[56] FIS Data (2023) Supplied by the Free Interpreting Service (FIS) Team at Migrant English and Language Services Branch | Refugee, Humanitarian and Settlement Division

[57] Multicultural affairs (2018) Access and Equity. https://www.homeaffairs.gov.au/about-us/our-portfolios/multicultural-affairs/about-multicultural-affairs/access-and-equity#:~:text=The%20Multicultural%20Access%20and%20Equity,their%20cultural%20and%20linguistic%20backgrounds.

Opportunities for further inter-governmental collaboration

I. 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'.[58] 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[59]. 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[60]. Noting the existing pressures and resource challenges on State funded programs and this gap in 'mainstream' service provision, federal funding health practitioners specialised in refugee health in areas of primary care, infectious disease, paediatrics and psychiatry would complement the work of already established, State funded, specialised services.

Recommendation 15: *Improve coordination efforts between the Commonwealth Department of Health and State domains focusing on health.*

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

[58] 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.

[59] 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.

[60] 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

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%[61] 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. Commonwealth investment in refugee primary healthcare provision that is linked with State-funded programs provide preventative measures for the wellbeing of clients. By facilitating appropriate and more immediate linkages with specialised health care services at early stages of resettlement, clients are then more equipped to socially and economically participate. To support the economic and social participation of refugees, national objectives for good health outcomes are vital. These objectives (outlined under the National Framework from Refugee Health and Wellbeing) 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. It is of critical importance that there is a national level of coordination with States so that there is a coherent system and continuity of care when people move from primary to secondary settlement locations.

Data Flow between State and Federal Governments

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[62]. 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.

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.

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[61] 'Number of People Accessing the RHP' Evaluation of the Victorian Refugee Health Program, December 2021 pg. 139

[62] 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.

Case Study Example:

PRIME: Program for Refugee Immunisation, Monitoring and Education

PRIME is a Victorian Government initiative to support catch-up immunisation in refugee background and asylum seeker communities. Since PRIME began in 2016, 15,604 people have been notified into the program, 12,678 people have initiated catch-up and 10,786 people are now up to date on the Australian Immunisation Register (AIR) due to PRIME. PRIME is a critical program that, through early intervention, has delivered a targeted, culturally responsive and accessible catch-up immunisation service to thousands of people from refugee backgrounds. It has proven effective in improving vaccination rates, building community health literacy and knowledge, and improving health equity for people from refugee backgrounds.

PRIME addresses an important gap in immunisation and refugee health in Victoria. Outside PRIME, existing service delivery models do not achieve adequate catch-up vaccination for refugee background and asylum seeker cohorts. Baseline coverage has remained low – only 12.0% these cohorts are vaccinated for age at enrolment to PRIME, and coverage is less than 5% in adults, even in those living in Victoria for 12 months or longer. PRIME has delivered large scale catch-up vaccination for refugee and asylum seeker populations in Victoria. Overall, 13,944 people have now been connected to catch-up vaccination through PRIME and more than 9500 people are up to date on AIR, achieving protection against vaccine preventable diseases, meeting 'No Jab, No Pay' requirements, and contributing to health protection in Victoria. For people enrolled in PRIME 12 months or longer, we have completed vaccination in 92.7% in children, 89.3% of adolescents, and 78.8% of adults. These figures are comparable to coverage for children and exceed Victorian overage for adolescents.

On Friday 30th June 2023, the Department of Health advised that funding for PRIME will cease on 31st December 2023 and that from 1 January 2024, access to catch up vaccination services for people from refugee and asylum seeker backgrounds will be transitioned to primary care services.

Decommissioning PRIME forces teams to refer back into a system with gross disparity in immunisation outcomes for these populations – a system that achieves coverage of only 50% in children, 40% in adolescents, and less than 5% in adults. Refugee background Victorians will remain at risk of vaccine preventable diseases, families will lose Centrelink, access to early childhood education will be compromised, and health protection and local immunisation coverage will reduce. Decommissioning PRIME is at odds with Victorian and Commonwealth government policies on the need for targeted programs for diverse communities, and commitments to maintain frontline services. In the face of an increasing humanitarian intake there is a compelling case for ongoing program funding.

Inclusion strategies to promote a multicultural workforce

I. Improve the skills and qualifications recognition system of prior overseas studies and workforce experience.

There are many people who arrive in Australia with significant professional experience in their home country. People who have worked as health professionals in their home country face many barriers when trying to work in their profession in Australia. In a study run by Victorian Foundation for Survivors of Torture (Foundation House) it was highlighted that for health professionals who had equivalent qualifications and experience to those required in Australia, the barriers broadly related to two areas: the exams, and local experience [63]
The financial costs and the level of difficulty of the exam were some of the obstacles to receiving these qualifications. This is compounded by Job Networks not recognising study for professional exams as a job search activity, therefore a person studying loses their income from Centrelink if they do not apply for the minimum required number of jobs per week. For those who succeed with the exam, to progress in their professional registration they were required to gain Australian experience. Work placements were reportedly difficult to secure without networks to help identify work opportunities.
"Providing sustainable pathways to meaningful employment is key to supporting migrants and refugees to build a sense of belonging and inclusion in Australia," (Minister for Immigration, Citizenship and Multicultural Affairs, the Hon Andrew Giles MP)

A recent report released by Settlement Services International (SSI) highlight that skilled migrants and refugees are overlooked when trying to find a solution to Australia's skill shortages. Drawing on five solutions, this report provides a roadmap to promote inclusion in the workforce with the potential to bring in billions of dollars into the economy[64].

[65]

[63] Victorian Refugee Health Network (2018) Submission to the Australian Government's Review into integration, employment and settlement outcomes for refugees and humanitarian entrants
[64] Settlement Services International (SSI) 2023, Billion Dollar Benefit: A roadmap for unleashing the economic potential of refugees and migrants.
[65] Ibid

As noted in the Billion Dollar Benefit Report, Australia's Subsidy for Overseas Trained Professionals (ASDOT) should be restored to help fund people with overseas qualifications through the costly recognition process[66].

The Network recommends that the Australian government improve these skills and qualifications recognition system so that health professionals who arrive through the Refugee and Humanitarian Program have better opportunities to economically participate in and build a multicultural Australian workforce.

Recommendation 16: *The Network recommends that the Australian government improve the skills and qualifications recognition system so that health professionals who arrive through the Refugee and Humanitarian Program have better opportunities to economically participate in and build a multicultural Australian workforce. In particular, the Australia's Subsidy for Overseas Trained Professionals (ASDOT) should be restored to help fund people with overseas qualifications through the costly recognition process.*

Investment in a bilingual and bicultural Workforce

There are often limited support options for culturally diverse community members who are wanting to engage with health service providers who speak their same community language or are from the same cultural background. This is particularly challenging in regional and rural areas where there are already limited options for health and specialised support services.

Bi-Cultural Workers are an important resource for any service, using cultural knowledge, language skills, lived experience and community connections to work with people who share a lived experience[67]. Investment in bicultural workers is especially important to ensure health information, prevention, and health promotion activities are as effective as possible. Both State-based and National health services should be employing bicultural workers according to best practice standards as they are instrumental in facilitating effective community engagement. In addition to this, bicultural workers can relate to cultural norms and understandings of health and safely connecting refugee communities with the health service system. This was continuously demonstrated during the COVID-19 pandemic when bicultural workers were critical in relaying public health communication and assisting the community with the uptake of vaccinations[68].

[66] Settlement Services International (SSI) 2023, Billion Dollar Benefit: A roadmap for unleashing the economic potential of refugees and migrants. Page 11

[67] https://www.cohealth.org.au/get-involved/bi-cultural-work-program/

[68] Wild A, Kunstler B, Goodwin D, Onyala S, Zhang L, Kufi M, Salim W, Musse F, Mohideen M, Asthana M, Al-Khafaji M, Geronimo MA, Coase D, Chew E, Micallef E, Skouteris H. Communicating COVID-19 health information to culturally and linguistically diverse communities: insights from a participatory research collaboration. Public Health Res Pract. 2021;31(1):e3112105.

There are a number of resources that help explain the benefits of workforce mutuality and outlines what supports workplaces to recruit for diversity[69][70]. Stronger investment in bicultural workers would help develop organisational capacity to engage with people of refugee backgrounds who are looking for and accessing health care services.

Recommendation 17: *Both State-based and National health services should be employing bicultural workers and recruit for diversity to build an inclusive and multicultural workforce .*

[69] HealthWest (2023) Workforce Mutuality: The Workforce Mutuality Toolkit https://healthwest.org.au/projects/workforce-mutuality/

[70] https://healthwest.org.au/projects/recruiting-for-diversity/

The impact temporary visa status has on health

I. The impact of temporary visa status

For people seeking asylum in Australia, the exclusion from health services that other Australian residents can access, continues to have a negative impact on their physical and mental health. Without formal pathways to universal health services including access to Medicare, people seeking asylum in our community are structurally disenfranchised and excluded from basic support services based on their visa status. There are significant ongoing delays in visa processing, with an average of two years for primary decisions and over seven years for merits reviews of protection application decision. This means people are waiting up to nine (9) years for a decision on their asylum application. There are over 70,000 people nationally waiting for a decision, and an estimated 40-45% of this group reside in Victoria. There is no indication of when these backlogs will be rectified.

The impact of the "fast track" process, where 9,000 people nationally, half of whom reside in Victoria, are still on bridging visas awaiting an outcome of their protection claim. Most have been waiting at least ten years for their claim to be processed and may or may not become eligible for a permanent visa. They remain separated from family, often have no work rights or income support and consequently are presenting to services with mental health disorders, homelessness, and destitution. The significant reduction in the Commonwealth-funded Status Resolution Support Services (SRSS) for people seeking protection as well as the ongoing release of people from community detention and closed detention has shifted the responsibility of health care, housing and basic needs support onto state-based health and community services.

According to findings from a recent survey conducted by the Network and Foundation House for the Diverse Communities Mental Health and Wellbeing Project, health services highlighted the distress their asylum seeker clients are experiencing related to uncertainty and other issues related to the visa process[71]. The mental health effects of insecure visas on refugees have been documented noting that a state of prolonged insecurity is associated with poorer long-term mental health outcomes.[72] Social integration difficulties were also found among refugees who were on a visa with low security (temporary visas) however significant improvements were observed when they moved to a visa with high security (permanent protection).

[71] Victorian Refugee Health Network & Foundation House (2023) Understanding key issues in accessing mental health services for refugee background communities in Victoria Diverse Communities Mental Health and Wellbeing Project, Survey Report

[72] Nickerson A., Byrow Y., O'Donnell M., Bryant R. A., Mau V., McMahon T., Hoffman J., Mastrogiovanni N., Specker P., & J Liddell B (2023) The mental health effects of changing from insecure to secure visas for refugees. Australian & New Zealand Journal of Psychiatry 0 10.1177/00048674231177950

Conclusion

This report presents a series of recommendations aimed at enhancing healthcare access, service provision, and workforce development to improve the health outcomes of individuals from refugee backgrounds, while simultaneously dismantling barriers to their full inclusion in Australian society. The feedback provided highlights areas where improvements could be made including Commonwealth level policy enhancements, opportunities for inter-governmental collaboration, strategies for promoting a multicultural workforce, and an examination of the impact of temporary visa status on health.

Recognising that good health is a fundamental enabler of meaningful participation in a new community, the Network emphasises the importance of accessible healthcare as a critical indicator of successful integration. Existing gaps in health services and delivery models in Australia have a tangible impact on health access, literacy, and overall outcomes for individuals from culturally and linguistically diverse backgrounds, particularly those from refugee backgrounds. While the Multicultural Access and Equity Policy released in 2018 has set a commendable framework for government departments and agencies, the Network contend that a comprehensive review and update of its implementation is due. Objective assessment processes are vital to ensure that Australian institutions are upholding their commitment to serving the diverse needs of all Australians.