Executive Summary

# Queensland Refugee Health Service

## Service Plan

April 2008

health • care • people

Queensland Government
Queensland Health

# Acknowledgments

The Service Plan for the Queensland Refugee Health Service was directed by a Steering Committee comprising general practice, community and Queensland Health representatives. The Steering Committee was supported by reference groups established in the 'hub' and 'spoke' locations. Community consultation was undertaken to inform the objectives and strategies of the Plan. The generous contribution of time, skills and ideas of the people who participated in the development of this Plan is valued and appreciated

# Executive summary

## Background

The profile, number and origin of humanitarian entrants to Queensland over the past ten years have changed with increased numbers and poorer health status a trend since 2002. In response, in June 2007 Queensland Health allocated funding to develop a Queensland Refugee Health Service. $1.08 million was allocated in 2007/08 for the establishment of the service and $1.2 million was allocated recurrently from 2008/09. The Service Plan is a four year plan, covering the establishment of the service in 2007/08, service implementation 2008/09 to 2010/11 and review during 2010/11.

A three year implementation timeframe will ensure that the service is responsive to changes in:

- refugee intake areas and therefore health conditions
- settlement patterns/areas in Queensland
- the scope of operation or funding available in settlement agencies for humanitarian entrants.

The purpose of the Queensland Refugee Health Service is to provide:

- standard health assessments, including public health screening and catch-up vaccination
- coordination of short term health management with additional support for complex cases and
- supported referral to existing services for continuing care, in particular, general practitioners.

The priority group for the service are newly arrived humanitarian entrants during the first six months of settlement and asylum seekers.

## Policy and planning context

The Service Plan aligns with the *Queensland Health Strategic Plan 2007-12* and fulfils one of the 2007/08 actions in the *Queensland Health Strategic Plan for Multicultural Health 2007/12.*

A Steering Committee, appointed in August 2007, met monthly throughout the planning phase and provided expert advice. Reference groups involving more than 96 people were established in the geographical areas where humanitarian entrants are settled in Queensland – Brisbane, Logan, Toowoomba, Cairns and Townsville. Each reference group met monthly and provided local advice to the planning process. Reference groups also undertook community consultation. Additional planning and communication strategies took place including monthly teleconferences of Integrated Humanitarian Settlement Strategy (IHSS) services, consultation with refugee health services in other jurisdictions, updates and communiqués to key stakeholders and a literature review.

## Needs assessment

Each year the Queensland planning levels for humanitarian entrants are based on:

| Sub-program | Annual total Numbers |
|---|---|
| Refugee program | 1000 |
| Special Humanitarian Program | 540 |
| Onshore grants | 60 |
| Total | 1600 |

Refugees are settled in the following planned locations while special humanitarian settlers (who are 'proposed' by an eligible organisation or individual) are predominantly settled in Toowoomba and Brisbane.

| Region | Percentage of refugee settlement |
|---|---|
| Brisbane | 65% |
| Logan/Gold Coast | 17% |
| Toowoomba | 11% |
| Cairns | 4% |
| Townsville | 3% |

The following table provides a summary of the demographic characteristics of humanitarian entrants who arrived in Queensland between 2002 and 2007.

| **Demographic characteristic** | **Percentage of humanitarian entrant 2002-2007** | **Demographic characteristic** | **Percentage of humanitarian entrant 2002-2007** |
|---|---|---|---|
| Origin | Africa 79%<br>Asia 11%<br>Middle East 7%<br>Other 3% | Gender | Male 51.8%<br>Female 48.2% |
| English language proficiency | nil 53%<br>poor 27%<br>not stated 8%<br>good 7%<br>very good 5% | Household size | 5-7 people 42%<br>2-4 people 33%<br>8-10 people 14%<br>one person 9%<br>11 or more people 2% |

The most commonly reported health issues among newly arrived humanitarian entrants include[1]:

- infectious diseases
- under immunisation

[1] Australia. Blackwell Synergy. Zwi et. al. *Towards better health for refugee children and young people in Australia and New Zealand: The Royal Australasian College Physicians perspective* [online] 2007. [cited 20 February 2008] Available from: http://www.blackwell-synergy.com/doi/pdf/10.1111/j.1440-1754.2007.01152.x and Australia. Medical Journal of Australia. Tiong et. al. *Health issues in newly arrived African refugees attending general practice clinics in Melbourne,* [online] 2006 [cited 20 February 2008] Available from: http://www.mja.com.au/public/issues/185_11_041206/tio10360_fm.html and Australia. The Royal Australian College of General Practitioners. Benson and Smith *Early health assessment of refugees* [online] 2007. [cited 20 February 2008]. Available from: http://www.racgp.org.au/afp/200701/14811

- nutritional deficiencies
- gastrointestinal infections
- mental illness/distress
- oral health
- behaviour and development issues in children
- musculoskeletal problems
- upper respiratory infections
- skin infections.

In addition to facing language and cultural barriers, most humanitarian entrants also have little understanding of the array of services available, and how to access them.

## Current service arrangements

Every Australian State and Territory has developed a response to the unique challenges newly arrived humanitarian entrants bring to the health system by establishing a range of dedicated refugee health services and clinics.

In Queensland there are dedicated health clinics for humanitarian entrants in Brisbane South (QIRCH[2] Clinic – Mater Health Services), Logan (Logan Refugee Health Clinic – Southside Health Service District) and Brisbane North (Refugee Health Clinic – Royal Children's Hospital Health Service District). However, these are limited in scope, capacity and sustainability. In Toowoomba, Cairns and Townsville, there are currently no dedicated refugee health services. However, Toowoomba Health Service has become a centre of refugee health expertise as all newly arrived refugees undergo limited health screening at Kobi House and community general practitioners (GPs) often refer patients back to Kobi House for a wide range of health issues.

In May 2006 the Australian Government introduced a new Medicare item (Items 714) to remunerate general practitioners for conducting comprehensive health assessment for humanitarian entrants within twelve months of arrival. The uptake of this item in Queensland has been low, with the exception of Logan where the uptake has been high. The high uptake in Logan is undoubtedly directly related to the capacity building undertaken by the Logan Refugee Health Clinic and the partnerships built between health services, the GP Division, general practitioners and community groups.

## Key service issues

The existing services work in relative isolation and none provide a comprehensive health assessment and complex health case coordination to all new arrivals in a sustainable manner. The key limitations and issues the planning phase identified were:

| Key issue | Description |
|---|---|
| Coordination of services | • currently no coordination, planning and monitoring of services. This is a high priority<br>• one service needs to be responsible for coordination, planning, monitoring, service development, resource development, training and education |
| Pre-arrival | • pre-arrival planning is required at the statewide and local level |

[2] Queensland Integrated Refugee Community Health Clinic

| Key issue | Description |
|---|---|
| planning | • IHSS workers require a health checklist that can be used at the airport when greeting new arrivals to help determine if there are health needs that need immediate attention |
| Health assessment including screening | • none of the existing services have the capacity to undertake comprehensive health assessment and case coordination for all new arrivals<br>• this lack of a coordinated and systematic approach has increased the risk of serious conditions being missed or presenting late for treatment<br>• resources are required at each arrival location to provide a standardised health assessment to all new arrivals<br>• there are considerable barriers in Queensland for entrants to access community GPs and therefore flexible arrangements will be needed at each location to provide medical assessment (to complete the nursing assessment) |
| Referral to general practitioner for ongoing care | • currently all approaches use community GPs for ongoing care but there is little capacity to support GPs<br>• GPs require resources, information and training and practical support such as clinical advice and consultation<br>• a centrally placed medical officer is required to build GP capacity and skill to increase and sustain the GP referral network |
| Capacity to follow up referrals and undertake case coordination | • none of the approaches have the capacity to follow up referrals or undertake complex health case coordination (except QIRCH Clinic)<br>• It is the level of complexity of some clients that has led some GPs to be not willing to accept new referrals<br>• Complex health case coordination is a high priority to include in the new model. |

A standardised data collection system will also need to be in place to monitor the above issues.

## Service model and resource implications

### Goal

To develop and implement a coordinated statewide health service for refugees, special humanitarian entrants and asylum seekers, which provides:

- standard health assessments, including public health screening and catch -up vaccination
- coordination of short term health management with additional support for complex cases and
- supported referral to existing services for continuing care, in particular, general practitioners.

## Objectives

- To establish and implement an appropriate governance structure to oversee and guide the implementation of the Queensland Refugee Health Service
- To coordinate and support the spoke services to conduct standardised health assessments for humanitarian entrants and asylum seekers
- To provide early health assessments to humanitarian entrants and asylum seekers
- To coordinate transition of health care to mainstream health care providers, in particular, general practitioners
- To provide complex health case coordination to humanitarian entrants with complex health issues requiring multiple referrals
- To review service data for ongoing service development and to build capacity for effective service response.

## Service model

The Queensland Refugee Health Service uses a 'hub and spoke' model which involves a hub based in Brisbane and spokes which are autonomous services that are coordinated and networked by the hub. The spokes will be located in Brisbane north, Logan, Toowoomba, Cairns and Townsville.

The components and features of the Queensland Refugee Health Service are:

| **Component** | **Description** | **Annual resource allocation 2008/09, 2009/10 and 2010/11** |
|---|---|---|
| Governance structure | • Queensland Health will contract manage the hub and spokes<br>• spokes will report outputs and outcomes to the hub<br>• hub will report on outcomes to Queensland Health<br>• a clinical advisory committee and a statewide advisory committee will advise the new service | Mater Health Services – see hub allocation |
| The hub | o hub will comprise both statewide functions and clinical functions that will be co-located<br>o hub will lead planning, implementation, coordination and monitoring of new service<br>o hub will be co-located with the QIRCH Clinic which will provide complex health case coordination | Mater Health Services<br>$371,772 hub statewide<br>$439,107 hub clinical<br>$25,000 QIRCH operational costs |
| The spokes | • spokes will be autonomous services that report to the hub on outputs and outcomes<br>• spokes will participate in regular networking and provide | Brisbane north spoke – Royal Children's Hospital & Health Service District<br>$49,961<br>Logan spoke – Southside Health Service District |

| Component | Description | Annual resource allocation 2008/09, 2009/10 and 2010/11 |
|---|---|---|
| | standardised services<br>• services to be provided by spokes:<br>o pre-arrival planning<br>o initial health assessment including screening<br>o medical assessment and review<br>o referral to general practitioner<br>o complex health case coordination. | $161,858<br>Toowoomba spoke – Toowoomba and Darling Downs Health Service District<br>$77,082<br>Cairns spoke – General Practice Cairns<br>$43,689<br>Townsville spoke – James Cook University<br>$31,531 |
| | | **Total allocation: $1.2 million** |

The 2007/08 budget of $1.08 million was allocated to service establishment costs including planning, implementation staff, IT infrastructure, building infrastructure, clinical equipment, resources and training.

## Implementation and evaluation

A detailed implementation plan has been developed together with an evaluation plan that details a reporting framework, service outputs and outcomes, and performance data. A standard data collection system is proposed for the hub and spokes. The service outcomes to be reported to Queensland Health are:

1. Humanitarian entrants receive an assessment within specified time frames
2. The hub receives income commensurate with services provided that can be billed to Medicare
3. Humanitarian entrants and asylum seekers are referred to health services including community general practitioners for ongoing care
4. Humanitarian entrants and asylum seekers receive complex health case coordination
5. The frequency of health conditions identified by the service is commensurate with the country of origin of humanitarian entrants and asylum seekers
6. Clients and service providers are satisfied with the service.

The service is planned to be operational by 1st July 2008.