Managing the refugee patient

by Dr. Margaret Kay

Managing the refugee patient is a complex task. This article will touch on a number of issues, though the recommendations here should be considered within the context of the individual's presentation. The focus of this article is on refugees who have arrived in Australia with a permanent visa and are not asylum seekers. The management and care of asylum seekers presents other challenges which are not fully explored in this document.

Background issues

The federal government, after discussions with the UNHCR, determines how many people come from which countries to Australia.[1] Until 2006 a large percentage came from Africa, but more recently there are about 1/3 from Africa, SE Asia and the Middle East.[2] The large number of refugees from Africa arriving between 2001-2005 brought the issue of refugee health to the fore because health providers were confronted with a range of unfamiliar medical issues.

There are political, racial, ethnic and religious issues that provide the background to every consultation. When the doctor is providing care to the patient who is a refugee, these issues may be more apparent. Being adequately educated about these issues, rather than accepting the current discourse of the local media, is the only responsible approach. Doctors should be familiar with the terminology of the Department of Immigration and Citizenship (DIAC).[3] Refugees have been processed by Australian authorities and have permanent residency on arrival in Australia. This means they have access to Medicare.

There are Medicare item numbers (701,703,705,707) that can be used when providing a comprehensive assessment for refugee patients. These item numbers can only be used once for each refugee patient who arrives on the specific Visas as listed in the Medicare handbook. Proper consent is necessary for this process. The item number is very involved and requires the development of a management plan.[4]

Asylum seekers have different access to health care. Some have access to Medicare while others do not. Some have Medicare cards but they do not have access to a health care card. The Queensland Government will often provide free treatment within the Queensland Health system if acute care is needed.

Approaching the consultation with a refugee patient

As with all patients, it is essential that the patient's background is recognized when caring for the refugee patient. This background will affect the communication skills, expectations, cultural beliefs, and attitudes to medical care as well as the very illnesses that are likely to be confronted.

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[1] http://www.refugeecouncil.org.au/arp/stats-02.html

[2] http://www.minister.immi.gov.au/media/media-releases/2008/ce08080.htm

[3] http://www.immi.gov.au/visas/humanitarian/offshore/visas.htm

[4] http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&qt=ItemID&q=701

Attitudes to medical care vary greatly and it is important to be aware that some patients may have had very negative experiences with medical personnel. Previous experiences with government agencies overseas have often been disillusioning and some medical personnel have been complicit in participating in torture. Some refugees are concerned that, if a serious medical problem is diagnosed, they will not be able to stay in Australia. Sometimes fear can alter the presentation of illness in the initial consultation.

Some refugees are accepted as refugees with a 'health undertaking'. It is the responsibility of the settlement agency (HSS) to ensure that the refugee can access the government agency responsible for monitoring this health issue, but it is important for any GP to be aware of any other medical care that the patient may be undergoing and communicate with the appropriate authorities.

Many doctors feel a little overwhelmed when caring for a patient from a refugee background. It is not uncommon for the refugee patient to present with very complex health needs. It is never possible to address all of these issues in one consultation. Anyone who has been overseas recently may have an exotic illness, however it is important to remember that refugees usually present with the same health issues that the general community presents with, including arthritis, URTI and accidents. The general practitioner is usually the best placed person to respond to these needs initially.

Focusing on the main reason for presentation is essential in the refugee consultation. However, it is important to ensure that other health issues are followed-up at subsequent visits. Many refugees have only had access to acute care services in the past and education of the individual and their family about the need for continuing care and preventive health care, even when they feel well, is an important role for the practice.

Effective communication is essential to the delivery of quality health care. Many doctors avoid using interpreters. Some doctors are not aware that an interpreter is freely available over the phone through the Telephone Interpreter Service.[5] Recently pharmacists have also been given access to this service. Doctors need to be registered with this service (Doctor's priority line) and this takes a little effort. Staff need to be educated to ensure that they are familiar with the process to make an interpreter booking. If the patient does not need an urgent appointment then an on-site interpreter may be booked if one is available. It is important to be aware of the process involved and any potential costs but many of these services are free. There are some private services that provide interpreters. All interpreters should be accredited to ensure that they have been adequately trained in the interpreting process and to ensure that confidentiality is protected. Family members and friends should not be used as interpreters even though it may appear to be convenient. Sometimes a patient with reasonable social skills in English still needs an interpreter for the complexity of the medical consultation.

Reducing the language barrier using an interpreter is one part of providing a culturally sensitive consultation. Cultural sensitivity includes an assessment and awareness of the

[5] http://www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/#a

patient's health belief system and how their cultural and religious practices impact upon their health.

All refugee patients should have a comprehensive health assessment in the first few weeks after arrival in Australia. If the patient is acutely unwell then these issues should be prioritized prior to the health assessment. Consent for this health assessment is important and should be discussed with the patient. Blood tests that are arranged should be explained to the patient and the results should be explained in detail when they are available, even if they are normal. Some people forget to do this. It is often assumed that because there is a language barrier, the patient would not want complex information like test results. Although it may take longer when using an interpreter, this is important to build a trusting relationship with the patient and the community.

Prior to leaving a country, the Australian government does arrange for some basic health assessments. Investigations generally include a CXR for those >=11 years, HIV Serology if >= 15 years, HBV Serology for Pregnant women and unaccompanied minors, Syphilis Serology if >= 15 Years and urinalysis if >= 5 Years. These tests are often performed 6-12 months prior to departure and the person is often still in an at risk environment after this time. Until recently, most refugees who are HIV positive were not granted a Visa for Australia. Just prior to departure, pre-departure medical screening[6] (now called the Departure Health Check) may include a routine physical examination, a repeat CXR if deemed necessary. Active TB is treated and reviewed. A malaria antigen test is performed and treatment provided if positive. Empirical treatment of parasites and infestations with a stat dose of albendazole and a dose of MMR vaccine is often given. Sometimes a pregnancy test is performed. It is often difficult to access records of this medical information (the health manifest) from the DIAC. If the patient is found to have a significant health problem, for example TB or Hepatitis B, then they are often granted a Visa with a Health Undertaking that requires them to present for treatment within a specified time after arrival.

When the refugee arrives in Australia they are met by someone from the local Settlement Agency (HSS)[7] who arranges for their transport to their accommodation, helps arrange for banking, Centrelink and Medicare access and shows them where they can shop. If they have a Health Undertaking then they are assisted with these arrangements.

After a refugee arrives as a permanent resident in Queensland, they are entitled to the same health care as others in the community. Queensland Health does not provide a medical health assessment for refugee patients after they arrive. Many doctors have been under the false assumption that all refugees have had health screening on arrival. The reality is that most refugees who have arrived over the last 25 years have not had the opportunity to have a refugee health assessment and many remain inadequately vaccinated. Other states have different opportunities for health assessments and doctors should be aware of the situation in their community. Some states have an overarching Refugee Health Policy that helps to support a coordinated response to refugee health.

[6] http://www.immi.gov.au/media/fact-sheets/67a_pdms.htm
[7] http://www.immi.gov.au/living-in-australia/delivering-assistance/government-programs/settlement-programs/hss.htm