Early health assessment of refugees

This is the first in a series of articles looking at refugee health in Australian general practice. Each year approximately 13 000 refugees settle in Australia, mostly from countries with minimal public and personal health resources. They may present in a very different manner to the rest of the population and are at risk of unfamiliar and complex illnesses. Their health care can be difficult and time consuming and the general practitioners who supply this care need support, guidance and adequate remuneration. The new Medicare Benefits Schedule item numbers 714 and 716 are an acknowledgment by the Australian government of these concerns of community GPs who are seeing refugees for their initial health assessments. This article discusses, in the context of the new item number, some of the broader issues that are important when seeing refugees for the first time.

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In May 2006 the new Medicare Benefits Schedule item numbers 714 and 716 were introduced to provide Medicare funded initial health checks for refugees and other humanitarian entrants who have been in Australia less than 12 months. A one off payment of $195.50 can be charged if certain criteria are met, along the same lines as other Enhanced Primary Care (EPC) item numbers.[1] The information for the assessment can be a combination of information collected by a clinic nurse, immunisation provider and general practitioner. The aim of the item number is to assess the 'patient's health and physical, psychological and social function and whether preventive health care, education and other assistance should be offered'.[1]

There are some essential criteria that must be met before the assessment begins (*Table 1*) including confirmation of the appropriate visa status *(Table 2*). Asylum seekers living in the community on bridging visas with or without a Medicare card will not be eligible for this item number.

Refugees have often come from areas with minimal health care facilities, and even those who have had good health care may not have had it supplied by a GP. In the past, many refugees had their initial health assessment in Australia done by a specialised refugee or migrant health unit, but the current contracts with the Department of Immigration and Multicultural Affairs (DIMA) encourage community GPs to be involved in their care from early entry into Australia. Refugees and GPs may have to deal with many unfamiliar cultural differences such as appointment making and keeping, health literacy, body language, illness behaviour, timeframes, attitudes to medication and expectations of treatment. Part of the philosophy of refugees being seen from the beginning by community GPs is that there will be an early introduction into the Australian health care system; however, this transition may be slow and difficult for all concerned.

The use of interpreters from the appropriate ethnic group, dialect and gender is extremely important. General practitioners in Australia have access to free interpreters through the Translating and Interpreting Service (TIS) either with on-site interpreters or over the phone (see *Resources*). This is especially important for initial consultations that involve screening for mental health, gender specific problems, developmental issues in children, and other sensitive and complex problems.

Table 1. Initial assessment for items 714 or 716

- Use of appropriate interpreter
- Confirmation of visa status – 200–204, 447, 451, 786, 866, 785
- Time in Australia <12 months
- Informed consent to health assessment (must be documented)
- Agreement that nurse/health worker will begin health assessment
- Previous health checks/pre-departure medical records or treatment

* It is necessary to show that all relevant items have been considered and documented. They can be written on a template, in the notes or on computerised records. The combination of the nurses assessment, immunisation, and doctors notes should add up to the content of the assessment criteria

The health assessment

The health assessment must include:

- taking the patient's medical history
- physically examining the patient
- undertaking or arranging any required investigations
- assessing the patient using the information gained from the patient's medical history, physical examination and investigations, and
- developing a management plan to address any issues and/or conditions, including making/arranging any necessary interventions or referrals to other health care providers.[1]

General practitioners will need to have some awareness of the culture and disease profiles of the country of origin of the patient they are seeing, but are not expected to have in-depth knowledge (see *Resources*). General practitioners from a background similar to that of the refugee patient will be at an added advantage and have often been involved with patients from their country of origin for many years. Religion may play a greater part in the attitudes to health and its management for many refugees, and GPs will need to take this into account when developing a therapeutic alliance with their patients. It is important to develop a way of questioning that will sensitively reveal cultural and religious beliefs about health and illness.[2]

Table 2. Visa categories

- Offshore Refugee Category
  - 200 refugee
  - 201 in country special humanitarian
  - 203 emergency rescue
  - 204 women at risk
- Offshore – Special Humanitarian Program
  - 202 global special humanitarian
- Offshore – Temporary Humanitarian Visas (THV)
  - 447 secondary movement offshore entry temporary
  - 451 secondary movement relocation temporary
  - 786 temporary humanitarian concern
- Onshore Protection Program
  - 866 permanent protection visa (PPV)
  - 785 temporary protection visa (TPV)

Table 3. Conditions and investigations to consider when screening refugees*

- Tuberculosis – is there a need for further TB screening?
- Malaria – thick and thin films, antigen tests on blood (may be asymptomatic because of partial immunity)
- Schistosomiasis – titre on blood, microscopy of faeces if positive, and of urine if positive and have microscopic haematuria
- Other parasites (especially if anaemia or eosinophilia) – faeces, cysts, ova and parasites; specific antigen tests or antibody titres (eg. entaemoba histolytica or strongyloides if indicated)
- Vitamin D deficiency (especially in dark skinned and/or veiled women)
- Other nutritional deficiencies – especially if from a refugee camp
- Hepatitis B status – hepatitis B surface antigen will probably indicate chronic infection and further investigation will be needed to assess infectivity and morbidity
- Hepatitis C status – especially if time has been spent in Egypt where the prevalence is high
- Iron studies +/- haemoglobin variant analysis (if indicated from abnormal red cells)
- HIV (especially if pre-departure screening was a long time before and patient is from a high risk area). Appropriate pre- and post-test counselling must be provided
- Post-traumatic stress disorder – symptoms may not appear until a long time after arrival
- Other sequelae of torture and trauma (eg. physical injuries, behavioural problems in children)
- Under immunisation

* Dependant on region of origin, previous screening

As with any screening procedure, the main purpose of the health assessment is to look for illnesses that are likely to be asymptomatic or have minimal signs and symptoms. All GPs are familiar with maternal and child health screens, and diabetes, cholesterol, breast and cervical screening. The new item number also makes suggestions about screening for more 'exotic' conditions that are outside the usual expectations of a community GP.[1]

Investigations

The country of origin, transit countries, age, family background and location in which the refugee settles will all influence what are the most appropriate investigations to consider (*Table 3*). Many refugees come from countries where public health resources do not protect them from infectious diseases and deficiencies. Harris and Zwar[3] give an excellent overview of many of the illnesses GPs are likely to see in their refugee patients, such as malaria, tuberculosis, schistosomiasis and vitamin D deficiency. Some patients will have had treatment pre-departure for malaria and parasites; others may have signed health undertakings necessitating follow up, most commonly for latent tuberculosis. Issues such as compliance, inconsistent paperwork, a delay in leaving or logistic problems in the country of origin, mean that pre-departure treatment and investigations cannot always be relied upon to rule out disease.[4]

Large family size and issues such as malnutrition, hookworm and other parasites can play a part in the developmental delay of some children.[5] Many will have incomplete or at least undocumented immunisations and will need 'catch up' schedules. Hepatitis B is often contracted vertically as a neonate and the progression of the disease may be different from the horizontally transmitted hepatitis B that most Australian GPs are familiar with. The current immunisation schedule with combination vaccines containing hepatitis B vaccine should not be altered if a child is already hepatitis B immune or is a chronic carrier.[6]

Post-traumatic stress disorder

Post-traumatic stress disorder is also common and, as with other sequelae of torture and trauma or with mental health conditions, will make it

Case study

Mr I, 58 years of age, is a refugee from Sudan who was in Egypt for 4 years before coming to Australia with his wife (who is now pregnant) and his four children. He is living in a two bedroom unit in an outer suburb of a major city. As part of his initial assessment of eligibility for an item number 714 it is ascertained that he has a visa category 202 and has been in Australia for 3 months.

His only language is Sudanese Arabic and he is unable to read or write. He spent several months in jail in Sudan in 2001 where he was badly beaten across his neck and back. Since that time he has had back pain in his thoracic area, his lumbar area, in particular his neck. He has wasting of the extensor muscles of his hands and finds that the pain and dysfunction make many of his activities of daily living difficult. He has problems sleeping and some difficulty with vision but describes himself as otherwise being well.

On routine comprehensive screening by the nurse he is found to have sugar in his urine and BP of 160/95. Vision is difficult to assess because of literacy problems. Blood tests reveal a random glucose level of 13 nmol/L, vitamin D level of 29 nmol/L (60–160), an eosinophilia, and a positive schistosomiasis titre. His faeces and urine tests are negative. X-rays show multiple healed fractures throughout his entire spine and possible nerve compression in his cervical area. Tests for malaria and hepatitis B and C are all negative.

His problem list includes hypertension, diabetes, vitamin D deficiency, schistosomiasis, nerve damage to his cervical spine, pain, torture and trauma issues, housing concerns and limited family support. His management plan will include further investigations, advice and treatment about the hypertension and diabetes, review by an optometrist or ophthalmologist, treatment of the vitamin D deficiency and schistosomiasis after consultation with the medical officer at the local refugee health service, further investigation and referral to a major hospital outpatient service for his cervical spine and pain management, referral to the local torture and trauma service for counselling, and referral to a social worker or local migrant resource centre to assist with housing and community support.

Copies of the abnormal test results, the problem list and the management plan are given to Mr I, as there is a likelihood that he will see his wife's GP in the future.

more difficult to adjust to a new way of life. Those children who have been in detention, or kidnapped by armies to fight or be used as sex slaves, may appear to settle in initially but will need long term follow up regarding their wellbeing.[7] Each state/territory has a torture and trauma service where counsellors experienced in working with refugees can assist GPs (see *Resources*).

Follow up

As refugees settle into Australia they are likely to move house several times in the first few years. Hospital emergency departments and GPs other than the GP who did the initial assessment may be used for primary health care. Doctors using the 714 item number need to give the patient a 'written report about the health assessment', which should include a list of the physical, psychological and social problems encountered, any abnormal investigations and the initial management plan including medication, referrals, advice and follow up arrangements. This will help ensure that all those involved are working together, and will reduce duplication and confusion for doctors and refugee patients alike.

For many refugees, health care will be needed from a range of practitioners. Dental, hearing and eye problems are common. Torture and refugee trauma issues may be addressed by GPs, with referral to the local torture and trauma service, where available, in more problematic cases. Physiotherapists, massage therapists, psychologists, dieticians, podiatrists and other allied health professionals may be accessed more effectively using one of the chronic disease management EPC item numbers. The financial barriers for refugees needing health care must not be forgotten.

Conclusion

The new item numbers 714 and 716 aim for a smooth transition into the Australian health care system for refugees, and will assist the GPs who care for them. Further information is available from The Royal Australian College of General Practitioners and local refugee health providers, and up-to-date literature exists on current illnesses and issues, their investigation and treatment. Education and support for GPs is vital as they assist this marginalised group with appropriate and timely health care at the beginning of a challenging new life in Australia.

Resources

- Australian Government Department of Health and Ageing. Translating and Interpreting Service: www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/english-speakers/doctors-priority.htm
- Victorian Foundation for Survivors of Torture Inc. Caring for refugee patients in general practice – a desk-top guide: www.racgp.org.au/refugeehealth/gpresources
- Migrant Health Service of SA. Template for item 714: www.racgp.org.au/Content/NavigationMenu/Advocacy/RefugeeAsylumSeekerHealthResourceCentre/SupportOrganisationsAssistingWithAsylumSeekersHealthNeeds/default.htm
- Forum of Australian Services for Survivors of Torture and Trauma (FASSTT): www.fasstt.org.au/.

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