# COMPANION HOUSE
## Access to Primary Health Care

Companion House Medical Service provides health care for newly arrived refugees and asylum seekers in Canberra. It is the second oldest refugee health service in the country, and is staffed by four part-time doctors, an administrator and a full-time practice nurse. The service was recently chosen as a case study in exemplary practice for community-inclusive, multidisciplinary care in an academic paper reviewing best practice. We train medical students and registrars in refugee health, and have established partnerships with a number of other health services in the ACT. The service is unique in Australia in its integration with other services within a torture and trauma service, and it has had one of the most stable workforces of any refugee health service.

### Access to primary health care for refugees

When Companion House Medical Service was established it was envisioned that the health service would function as a transitional service, caring for patients in the first year of their resettlement. Refugees tend to be disproportionately high users of health services in their first year of resettlement[1], though after that there is some evidence that they use them less than the general public[2]. Companion House Medical Service has been able to protect mainstream services from being overloaded with complex health assessments and advocacy while providing targeted care in the first year of resettlement. This has been particularly important over the last ten years due to the large number of new arrivals who have spent decades in refugee camps with very restricted access to primary health care.

However, over the last two years, we have found it increasingly difficult to transfer our patients out to community GPs, due to the low numbers of GPs. Most community GPs who previously accepted our clients now have closed books. The Primary Health corporate model is suited to episodes of acute care among our clients, but not to those with complex or chronic care needs. Increasingly, we have had to expand our own service, as we find ourselves working as a parallel, rather than a transitional, service. We are likely to need extra nursing staff if this process continues, as the health needs of the cohort of refugees and asylum seekers over the last four years has been increased.

### Asylum seekers in Canberra

Canberra has not historically had a large asylum seeker population, compared with other capital cities, but this has changed. In 2008-9 Companion house provided services to 41 asylum seekers, 30 adults and 11 children. The ACT is a national leader in providing free, accessible health care in the public hospital system for asylum seekers. Companion House continues to be the service that provides medical care for asylum seekers, and we absorb the health cost of this. Problems continue with access to essential pharmaceuticals, which we do through accessing drug company samples. Because of their mental distress, asylum seeker populations place high demands upon this service, with counsellors and health workers working closely together.

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[1] Johnson DR et al. I don't think general practice should be in the front line: experiences of GPs working with refugees in South Australia. Aust NZ J Health Policy 2008; 5: 20; Sypek S, Clugston G, Phillips C. Critical health infrastructure for refugee resettlement in regional and rural Australia: case study of four rural towns Australian Journal of Rural Health 2008; 16:349–354

[2] Correa-Velez, I., Sundararajan, V., Brown, K. and Gifford, S.M. (2007) 'Hospital utilisation amongst people born in refugee-source countries: An analysis of hospital admissions, Victoria, 1998-2004'. Medical Journal of Australia, 186: 577-580.

**Specific health care needs for refugees**

*Interpreters* Like most of Australia, we continue to find that interpreters are underused for refugees, particularly when attending private specialists or some sectors of the public hospitals. In the case of the former, there continues to be ambivalence among some private specialists about arranging interpreters, even though this is a free service. The public hospitals, in our experience, go through cycles where the institution runs campaigns on how to use interpreters, and then this knowledge is lost with staff attrition. A second issue is the lack of elementary infrastructure for telephone interpreters, such as hands-free phones with speaker attachments in the emergency departments, and speaker phones in all outpatient departments. This means that refugees who attend the public hospitals for emergency care often are not provided with telephone interpreters even though these are more readily available in Australia than in any other country.

*Reproductive health care.* The experience of being pregnant, giving birth and raising young children in Australia can be profoundly difficult for newly arrived refugees. The fertility rate among refugee populations is higher than the general population, reflecting the fact that generally these are cultures that place a high premium on family. We have found that many of our clients become acutely depressed in the antenatal or postnatal period, as childrearing in Australia is conducted by one or two persons rather than by an extended family. Some young parents desperately miss the guiding hand of an older relative, which would have been available in their country of origin. Some find the process of giving birth in Australia very strange and disempowering. Because they live in overcrowded environments under conditions of poverty, the infants are more at risk of illness than the general population, and we have had a number of near-death incidents of refugee infants with diarrhoeal illnesses or pneumonia. Similarly, there have been a number of incidents where antenatal care has required active outreach by this service to save the lives of mother and baby. There is an urgent need for specific outreach services for young African, Burmese or middle Eastern mothers to provide antenatal, postnatal and neonatal support. Companion House would happily take on the services of a midwife if one could be found to undertake this outreach work!

*Vitamin D clinics.* Vitamin D deficiency is rife in Canberra among newly arrived refugee population. All Africans that we have tested become Vitamin D deficient over winter in Canberra, becoming symptomatically sore in their thighs, shoulders and lower back, and losing some of the strength in the large muscle groups. All women who wear hijab are vitamin D deficient, and newly arrived refugees who are reluctant to have sun exposure are at particular risk. We have had three cases of rickets in African children over the last three years, two of whom were infants born in Canberra. At present our approach is haphazard rather than population-based; we give a large dose of Vitamin D to whoever attends our clinic and is found to be low in vitamin D. More innovative approaches in Victoria have demonstrated that it is possible to run a community vitamin D dispensing clinic staffed by GPs. Vitamin D is cheap and can be compounded into large doses at low cost, but most newly arrived refugees cannot afford to buy it privately. In Canberra a feasible model may be to partner with the medical school and establish a teaching clinic for medical students in their community term that dispenses vitamin D.