

Questions

MR WAKERMAN: Thank you very much, Mitchell. I think the College is actually to be applauded, not just for this policy document, but I think other policy documents that it has come out with as well that have been very effective in terms of advocacy at the College of Physicians. We're running just on time. Before Daniel dashes off I thought, are there any questions or comments to either Mitchell or Daniel? We'll just have a few minutes. Could you please identify yourself?

DR HARRIS: Thank you, Mitchell. If I identify myself I'll probably give my question away. Bruce Harris, General Practitioner, Dubbo, New South Wales. It is the perception from where we practice that paediatricians and physicians are accessible by referral. It is also the perception from where we work that mostly medical services are done by general practitioners. While welcoming and not in any way criticising the work of the College of Physicians and that of paediatricians, I haven't heard much mention of either general practice or nursing or other health professional links, and I wonder how you might advise us on that.

DR SMITH: I think the next session might be where that comes to the fore, because we've got a - you'll have to listen to me again, but also a couple of general practitioners will be presenting as well and I think that's where we're going to talk about that. I mean, I think, and clearly in some parts of rural and regional Australia that might not be many paediatricians who will be implementing this, so. But I think it's got relevance for GPs as well, you know, the principles behind it and I guess there are similar documents perhaps less of a policy focus, but there are similar sort of documents that help guide GPs in terms of their approach to refugees, including refugee kids. So that sort of stuff is available.

DR HARRIS: Perhaps, to be more precise, could you recommend that our college and your college actually conjoin a policy on this?

DR SMITH: You're right. I think the College of GPs has been very good in pulling together resources like I said, but at that higher level in terms of policy, you're right. There could certainly be some issues. We're always advocating for interpreter use, which I know can be problematic, but we do need help at higher levels to help advocate for that, so the College of GPs would be a great place to start.

MR WAKERMAN: There was a comment about refugee health services in the two territories. Does anyone from the ACT or NT want to make a comment on that?

DR GRAY: I'm Natalie Gray. I'm one of the doctors in the Northern Territory who runs the refugee health clinic that we do have. Essentially we run a program which is entirely unfunded, so that is true, and have kind of been brought into the core business of the Centre for Disease Control where we try to run an initial health assessment clinic for all newly

arrived refugees. The main reasons we're able to do it, apart from, I guess, our own interests, are firstly that our IHSS service provider Melaleuca Refugee Centre are absolutely fantastic and go well beyond the call of duty in organising medical appointments, organising continuity of care and follow up for the refugees. I guess from that perspective the refugees resettling in the Northern Territory are very lucky.

Then, I guess, the second reason we're able to continue it is because of the informal links and the cooperation and enthusiasm of individual specialists in the Northern Territory, including some of our paediatricians and some of our adult medicine specialists as well who have been willing to become involved and sort of work on a very informal basis. But there's no doubt, you're absolutely right, it's an unsustainable, unfunded programme that is entirely person dependent and so funding is a continuing issue and will continue to be so until some kind of Commonwealth/Territory agreement is eventually hopefully reached.

MR WAKERMAN: Now, Daniel. John Wakerman. Can I ask you a question? You said that 70 per cent of refugees have, you know, family and other contacts and tend to settle where they are or you assist them to settle them where they are. Of the other 30 per cent you made mention of corresponding with State governments and local governments and making sure that they would support those refugees where they settle. It is not clear to me what choice refugees are given. What is their participation in deciding where they want to settle? What information are they given and what role do they play in the settlement process?

MR BOYER: In choice of settlement locations? It's a very good question. For that 30 per cent we recognise that as with all permanent residents of Australia they are all refugees free to move where they choose to. What we need to be aware of is we need to as much as we can try and control their initial settlement location because of the availability of support services in the current housing crisis because of the availability of housing. But often we will find that where we settle people in Launceston, in Wagga, in Geelong even, we will find that they will be moving to the cities within 12 months of arriving or even two years or three years. That's one of our great challenges.

In terms of the information that we provide for them beforehand, where we are looking at a direct rural or regional settlement pilot, we've actually just started providing location specific information to refugees offshore. So for Mount Gambier, for example, we developed a booklet which showed the accommodation that they'd be staying in, which showed the local church, which showed the support that they'd receive and the people that were there and those sorts of things. It went down exceptionally well and, as a result, we actually have a lot of other people who sat in on that particular class, that particular cultural orientation class, and said "Can we go to Mount Gambier please as well?"

So I think that a lot of the work that we do in selling the value of regional settlement offshore will actually come back to be quite beneficial in the future. It's certainly an

experience that we've learnt from. It's a very recent thing providing that location specific information but we think it will be pretty valuable in the future.

MS MUSS: Namanita Muss, [National Rural Faculty](#), RACGP. We have a number of GPs in the system who are refugees who have come out of the Middle East. They don't currently have access to Medicare cards or any of the health system and yet they are often one of the key sources of support to refugees coming into this country. Is there any initiatives around that area to support them?

MR BOYER: You're talking about people who would be here as temporary protection visa holders and permanent protection visa holders, I'm assuming.

MS MUSS: That's correct.

MR BOYER: I'm reminded of the public servants' prayer, "God give me the strength to change what I can to accept what I can't and the wisdom to tell the difference between the two." The issue of provision of any service and support to protection visa applicants and holders as opposed to offshore permanent humanitarian visa applicants is very much a government decision and not a public sector decisions. You can read between the lines in terms of my response, but it is not something - if we were looking at individual need, we understand that the bulk of people who potentially arrive illegally or even arrive legally and seek asylum in Australia go on to become permanent visa holders. I think the figure is about 94 per cent.

So we often see this as being denying services to people who need them when they first arrive when we are only going to be providing them three years later anyway when they become permanent visa holders. It's not a position that the government shares. The government's position is that these are temporary visa holders and, as such, we should not providing services which are potentially settlement support and should be encouraging them to stay. I think that's about all I can say without getting myself into too much trouble.

MR WAKERMAN: Okay. Can we thank Mitchell and Daniel?

(Applause)