Community-based asylum seekers’ use of primary health care services in Melbourne

Ignacio Correa-Velez, Vanessa Johnston, Joanne Kirk and Angeline Ferdinand

A ustralia’s humanitarian program for refugees and others with humanitarian needs consists of an offshore resettlement component for people who apply from overseas, and an onshore protection component for those who seek protection after entering Australia.1 Under the offshore resettlement program, people are granted permanent residency and unrestricted access to a range of government-funded services, including Medicare, through the Integrated Humanitarian Settlement Strategy.2 By contrast, those who claim asylum in Australia find their access to health and welfare services restricted by entitlements that depend on their visa category.3,4 Some are eligible for financial assistance and health care through the government-funded Asylum Seeker Assistance Scheme.5 However, the eligibility criteria for the scheme have been gradually restricted.4

In 1997, the Australian Government introduced regulations restricting work rights, income and Medicare access of asylum seekers living in Australia on Bridging Visa E. The conditions for the granting of this type of visa5,6 have caused hardship for asylum seekers (Box 1), and have significantly affected community-based agencies that provide services to this group.8

The gaps in empirical research documenting the health and welfare needs of asylum seekers in Australia9,10 have been compounded by the lack of reliable data on the number of them who have no work rights and no Medicare access, mostly owing to the reluctance of the federal government to provide these figures.11 In an audit of 102 consecutive asylum seekers attending a clinic in Sydney in 2000–01,9 the most common reason for presentation was psychological and social problems. Most cannot access government-subsidised health care. This must be addressed urgently by policy change at the federal and state and territory levels.

In this study, we retrospectively audited the files of all asylum seekers seen during the 2005–06 financial year at these clinics. The aims of the audit were to examine primary health care service utilisation and presentations among this population group.

METHODS

Ethics approval was obtained from the La Trobe University Human Ethics Committee. In late 2006, we audited the files of all asylum seekers who attended any of the three clinics between 1 July 2005 and 30 June 2006.

A member of the research team with expertise in coding health conditions in primary care extracted the data from the clinical files into a data collection form. The form was developed in consultation with the clinics, health care professionals and academics. It consisted of two sections: (1) demographic characteristics and immigration history; and (2) health issues recorded during the consultation (reasons for the encounter, tests, treatments, and referrals). Up to five reasons per consultation were recorded on the forms (if there were more than five reasons at any one visit, only the first five, as documented by the health provider, were recorded). Reasons for the encounter were entered verbatim from the clinical files. When individual asylum seekers had more than 10 consultations in the 1-year period, data from every second consultation were collected.

1 An asylum seeker’s experience with health care in Australia

A 46-year-old asylum seeker from Sri Lanka, who had been living in Australia on a Bridging Visa E for 6 years, presented to a clinic for asylum seekers in Melbourne. He had a 12-month history of abdominal pain and weight loss. He had been afraid to visit a general practitioner because he did not have access to Medicare and had no money to pay for treatment.

Through pro-bono health providers, he had an abdominal ultrasound, resulting in a diagnosis of pancreatic cancer. A hospital agreed to give him free treatment, and he had surgery that revealed that his cancer was inoperable.

He is now having palliative chemotherapy through the same hospital and has been given a poor prognosis. His lack of access to health care delayed his diagnosis, worsened his outcome and increased the eventual cost of the care he needed.
The Australian version of the International Classification of Primary Care, second edition (ICPC-2 Plus) database\textsuperscript{12–14} was used to codify the reasons for the encounter into broad categories according to body systems (with two additional categories for psychological and social problems) (so-called ICPC-2 chapters) and more specific reasons for encounters (symptoms and complaints). Where there was uncertainty about the true correct term to match to the reasons for the encounter as recorded by the medical practitioner, other health professionals in the project team were consulted, and a consensus was reached. A second member of the research team audited the data before analysis. Because of the high frequency of immigration-related issues reported in the consultations, a non-ICPC-2 code, “immigration issues”, was added to the list of specific reasons for the encounter. This code was categorised as part of the “social problems” ICPC-2 chapter.

Data were analysed with SPSS version 14 (SPSS Inc, Chicago, Ill, USA). Descriptive analyses of key sociodemographic characteristics and the immigration history of asylum seekers are presented.

### RESULTS
Patients had an average of 3.4 consultations (median, 2; range 1–35) during the 1-year period. A total of 202 patients (59%) visited the clinic for the first time during the study period. Data from 998 consultations corresponding to 341 files were collected. A summary of the sociodemographic characteristics of the population is shown in Box 2.

### DISCUSSION
This retrospective audit of all asylum seekers seen at three clinics in Melbourne during 2005–06 has shown that the clinics are delivering care to a significant number of asylum seekers.
people. Compared with the average number of visits to general practitioners in Australia (4.5 visits per person per year, paid by Medicare), the rate of visits by asylum seekers is substantial (3.4). This represents a considerable burden on small community-based organisations and volunteer health care professionals, who are trying to fill the gap for a marginalised population with complex care needs.

The most common reasons for an encounter with a health service were general and unspecified symptoms or problems, musculoskeletal conditions and psychological problems. The main specific reason was prescription-related. Most asylum seekers on a Bridging Visa E cannot work and have limited income to purchase medications. Additionally, they cannot access the Pharmaceutical Benefits Scheme through the Medicare system, which provides prescription drugs at low cost to all Australian citizens and permanent residents. The three clinics involved in this audit cover the costs of medication through limited funding and donations of samples.

Particularly significant was the number of asylum seekers presenting with psychological and social problems. Our findings are correlated with previous research that has found a high prevalence of mental health problems among asylum seekers. The relatively low rate of pathology tests requested may reflect medical practitioners’ awareness of the difficulties of arranging these tests because of their cost, Medicare ineligibility, and the need to acquire the tests without charge if possible. To provide the large number of pathology tests required, the largest clinic involved in this audit accesses pathology testing through a pro-bono agreement with a pathology provider.

Most referrals among the asylum seeker population were to allied health profession-
In 2005, the Victorian government directed its public hospitals and community health centres to provide health care free of charge to asylum seekers. Similar arrangements have been made more recently by the public dental program and ambulance services. The Australian Capital Territory has also made equivalent policy changes. This is not the case in the other Australian states and territories. Even though some general practitioners choose to provide pro-bono care to asylum seekers, lack of access to general practitioners, medication, pathology tests and other investigations is an ongoing problem for this population group.

Some limitations of the study need to be acknowledged. First, although the clinics are the main providers of primary care to asylum seekers in Melbourne, it is difficult to know whether our sample is representative of asylum seekers in Victoria or of the overall population of asylum seekers in Australia. To our knowledge, no information is available on the demographic characteristics of this population. Second, the coding exercise that used ICPC-2 Plus is complex and may have resulted in some miscoding of data in a small number of cases. For example, some reasons for an encounter can be categorised into more than one ICPC-2 Plus category. Team consultations, consensus and auditing were used to ensure the quality and consistency of coding. Despite these limitations, this study represents the most extensive file audit of the health conditions and use of primary health care services of asylum seekers in Australia to date. Using a standardised coding system and cross-checking within the research team increased the validity of the data (as compared with self-report measures or an unvalidated coding system).

For a sick asylum seeker with no work rights, no access to Medicare, and no source of income, the only option for getting adequate health care is through community-based organisations and health clinics that provide their services free. While these agencies have substantial expertise in targeted service provision, they are underfunded and underresourced to meet the complex needs of asylum seekers living on bridging visas. Health care of asylum seekers must be addressed by policy change at the federal and state and territory levels as a matter of urgency. Serious consideration needs to be given to extending Medicare access to this population. In the absence of policy change in the short term, the current eligibility criteria for the Asylum Seeker Assistance Scheme should be loosened and a significant boost given to the Scheme’s funding for health care provision.

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COMPETING INTERESTS

None identified.

AUTHOR DETAILS

Ignacio Correa-Velez, MB BS, PhD, Deputy Director and NHMRC Postdoctoral Research Fellow
Vanessa Johnston, MB BS, MPH, Postdoctoral Fellow
Joanne Kirk, RN, Health Program Coordinator
Angelina Ferdinand, BA, Research Assistant
1 Refugee Health Research Centre, La Trobe University, Melbourne, VIC.
2 Menzies School of Health Research and Institute of Advanced Studies, Charles Darwin University, Darwin, NT.
3 Asylum Seeker Resource Centre, Melbourne, VIC.
Correspondence: i.correa-velez@latrobe.edu.au

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