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

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ABSTRACT

Objective: To investigate primary health care service utilisation and health presentations among asylum seekers living in Melbourne.

Design and setting: Retrospective audit of files of people who attended three Melbourne asylum-seeker health clinics between 1 July 2005 and 30 June 2006.

Main outcome measures: Rates of reasons for the encounter, diagnostic tests or investigations required, treatments prescribed and referrals.

Results: Data were collected from 998 consultations corresponding to 341 people. Eighty-eight per cent of visits involved people with no Medicare access, owing to their visa status. The most common reasons for the encounter were general and unspecified symptoms or problems (rate, 59.9 per 100 encounters; 95% CI, 55–65), followed by musculoskeletal conditions (27.1; 95% CI, 24–30), and psychological problems (26.5; 95% CI, 23–30). The rate of referrals was 18.3 per 100 encounters (95% CI, 16–21).

Conclusions: The three clinics providing services to asylum seekers in Melbourne are delivering care to a considerable number of people with complex health needs. A substantial number of asylum seekers present to clinics with 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.

MJA 2008; 188: 344–348

Australia'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 visa[5,6] have caused hardship for asylum seekers (Box 1),[7] 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 Australia[9,10] 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 a significant proportion were reported to have trouble in paying for medication. A more recent Victorian study of 111 asylum seeker cases found that most were living in "abject poverty and [were] forced to rely on minimal handouts from agencies and charities".[7] A quarter stated that they had been refused medical treatment owing to "their lack of status, funds or eligibility for medical assistance".

In response to the lack of equitable access to health care, health professionals in Melbourne established three health care clinics for community-based asylum seekers.[3] 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. ◆

2 Sociodemographic characteristics of asylum seekers attending three Melbourne clinics, 2005–06 ($n = 341$)

Characteristic	%	Characteristic	%
Sex		**Main language spoken**	
Male	55.7	English	31.1
Female	42.2	Arabic	7.3
Unknown	2.1	Sinhalese	6.5
Age (years)		Tamil	5.0
0–15	14.7	Turkish	4.7
16–25	11.7	Other Asian language	13.8
26–45	49.0	Other European language	9.4
46+	23.8	Other Middle Eastern language	3.5
Unknown	0.8	Other African language	2.6
Region of birth		Other language	1.1
South-East Asia	41.9	Unknown	15.0
Africa	14.6	**Highest level of education**	
Middle East	14.4	Tertiary	25.5
Europe	10.5	Secondary	20.5
Australia or Oceania	10.0	Primary	7.9
North Asia	4.4	Unknown	46.1
Latin America	2.1		
Unknown	2.1		

The Australian version of the International Classification of Primary Care, second edition (ICPC-2 Plus) database[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 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.

3 Visa types of asylum seekers on their first visits to three Melbourne clinics, 2005–06 ($n = 341$)

Visa type	%
Bridging Visa E	57.2
Bridging Visa A	7.9
Temporary protection visa	2.3
Permanent visa	1.2
Other*	10.6
Not available	20.8

* Other types of visa included substantive visas that asylum seekers had when they sought asylum before a bridging visa was issued (eg, visitor, student, business) and other bridging visas. ◆

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. The mean age was 34.7 years (SD, 16.5; range, infancy–89 years). The birthplace of the largest group of asylum seekers (25%) was Sri Lanka. Seven per cent of asylum seekers were born in Australia, being children of parents who were applying for a protection visa.

The average time that people had spent in Australia was 57.9 months (median, 55; range, 0–302 months). Forty-six per cent had been in Australia for 5 years or more. Most people at their first visit were on a Bridging Visa E (Box 3). Eighty-eight per cent of the visits during the study period involved a person with no Medicare access.

Reasons for the encounter

The most common reasons for a first encounter and for any encounter were general and unspecified symptoms or problems, followed by musculoskeletal conditions, and psychological problems.

Specific reasons for encounters, including follow-up visits, are shown in Box 4. One reason for the encounter was identified in 26% of all consultations, two to three reasons in 52%, and four or more in 22%. Under the "general and unspecified" category, about one in five encounters were prescription-related (eg, request for review of medication previously prescribed). Social problems, which included immigration-related issues, and problems related to housing, health care access, work rights, food, and financial constraints were reported in one in 10 consultations.

Tests, treatments and referrals

At the first consultation, 53% of patients were prescribed medication ($n = 180/341$), 24% ($n = 82$) required pathology tests, 10% ($n = 35$) were investigated by imaging, 17% ($n = 58$) received psychosocial counselling from the medical practitioner, and 23% ($n = 79$) were referred to other health care professionals or services.

Medication was prescribed or recommended in half of all consultations (Box 5). Pathology tests were required in one of five. The overall rate of referrals was 18.3 per 100 encounters (95% CI, 15–21). Ten consultations involved a referral to a psychiatrist. In the largest clinic, patients were often referred to counselling by the nurse or through other programs before the general practitioner saw them. Similar arrangements were made for dental referrals.

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

4 Reasons for encounters with health care services, by ICPC-2 chapter and most frequent specific reasons within each chapter, of asylum seekers visiting three Melbourne clinics, 2005–06 ($n = 998$)

Reasons for encounter	Rate per 100 encounters*	95% CI
General and unspecified	59.9	55–65
Prescription (all)†	16.5	14–19
Follow-up, unspecified	12.1	10–14
Test results	8.5	6.7–10
Allergy	3.3	2.2–4.4
Check-up, general†	2.6	1.6–3.6
Health education	2.5	1.5–3.5
Weakness or tiredness	2.4	1.4–3.4
Musculoskeletal	27.1	24–30
Back complaint†	6.0	4.5–7.5
Injury, musculoskeletal, not specified	3.5	2.3–4.7
Knee symptom or complaint	2.8	1.8–3.8
Foot or toe symptom or complaint	2.7	1.7–3.7
Shoulder symptom or complaint	2.0	1.1–2.9
Psychological	26.5	23–30
Sleep disturbance	6.4	4.8–8.0
Psychological symptom or complaint	5.8	4.3–7.3
Depression†	4.5	3.2–5.8
Anxiety†	3.1	2.0–4.2
Respiratory	21.4	19–24
Cough	5.5	4.1–7.0
Acute upper respiratory tract infection	4.5	3.2–5.8
Sneezing or nasal congestion	3.1	2.0–4.2
Throat symptom or complaint	2.5	1.5–3.5

Reasons for encounter	Rate per 100 encounters*	95% CI
Digestive	19.0	16–22
Abdominal pain, other	3.3	2.2–4.4
Epigastric pain	2.4	1.4–3.4
Female genital	12.6	10–15
Menstrual problems†	4.2	2.9–5.5
Skin	12.2	10–14
Localised rash	2.3	1.4–3.2
Endocrine, metabolic or nutritional	12.2	10–14
Diabetes, non-gestational†	4.5	3.2–5.8
Cardiovascular	11.1	9.1–13
Hypertension	4.2	2.9–5.5
Cardiovascular check-up	2.4	1.4–3.4
Social problem	10.7	8.7–13
Immigration issue‡	4.6	3.3–5.9
Social welfare problem§	3.8	2.6–5.0
Neurological	9.5	7.6–11
Headache	5.7	4.2–7.2
Vertigo or dizziness	2.9	1.8–4.0
Urological	8.7	6.9–11
Haematuria	2.2	1.3–3.1
Eye	7.2	5.5–8.9
Male genital	4.7	3.4–6.1
Pregnancy or family planning	4.7	3.4–6.1
Contraception	2.1	1.2–3.0
Ear	2.1	1.2–3.0
Blood or immune mechanisms	0.9	0.3–1.5

ICPC = International classification of primary care.[12] * Only those individual specific reasons with a rate of ≥ 2.0 per 100 encounters are included. † Includes multiple ICPC-2 or ICPC-2 Plus codes (see *General practice activity in Australia 2005–06*, appendix 5[15]). ‡ Includes mainly medical assessments to support a protection visa application; not an ICPC-2 code. § Includes loss of Medicare and work rights, housing problems, lack of food, poverty or financial problems. ◆

people. Compared with the average number of visits to general practitioners in Australia (4.5 visits per person per year, paid by Medicare),[15] 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.[9,10,16,17]

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-

5 Tests required, treatments prescribed or recommended and referrals by medical practitioners at 998 consultations with 341 asylum seekers visiting three Melbourne clinics, 2005–06

Reasons for encounter	Rate per 100 encounters*	95% CI
Test or investigation type		
Pathology	21.3	19–24
Radiology or imaging	7.6	5.9–9.3
Other†	1.3	0.6–2.0
Treatment		
Medication	51.6	47–56
Education	28.5	25–32
Counselling	17.7	15–20
Other‡	4.8	3.4–6.2
Referral to		
Other allied health§	7.4	5.7–9.1
Specialist¶	6.5	4.9–8.1
Hospital or emergency	2.6	1.6–3.6
Counselling	1.8	1.0–2.6
Dental service	1.4	0.7–2.1

* Patients may have been referred for more than one type of test or investigation; more than one type of treatment may have been prescribed or recommended to individual patients; patients may have been referred to more than one health care professional or service. † Mainly hearing or vision testing, electrocardiography, gastroscopy or colonoscopy. ‡ Bandages, hot packs, ice packs, massage, exercise. § Mainly physiotherapy and optometry. ¶ Mostly ophthalmologist, psychiatrist or dermatologist. ◆

als and medical specialists. Referral patterns within a system such as this are influenced not only by the needs of patients, but also by the availability of specialist practitioners who will provide a pro-bono service. Referrals to counselling or psychology services were few, considering the high rates of mental health problems. Clinical staff at the clinics were forced to devote considerable energy to time-consuming negotiation of referrals and fee waivers for specialist services.[8]

The lack of health care provision for this population raises many issues for these individuals and their communities. One particular concern is health screening. Until recently, there was no systematic screening for infectious diseases (eg, tuberculosis, HIV, hepatitis B) until people were being granted protection visas; now, there is limited screening when the protection application is lodged. Thus, people who arrived before this policy change live in Australia for many years while their immigration status is decided upon without undergoing basic screening. The fact that almost half of the sample had been in Australia for 5 years or more is of concern, given that these visa regulations contribute to poverty, homelessness and social isolation.[7] This emphasises the need for review of immigration policies and the importance of health care structures that allow easy access and are adequately resourced for this vulnerable group.

In 2005, the Victorian government directed its public hospitals and community health centres to provide health care free of charge to asylum seekers.[18] Similar arrangements have been made more recently by the public dental program and ambulance services.[19] The Australian Capital Territory has also made equivalent policy changes.[20] 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.[3,17] 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.[8] 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.

ACKNOWLEDGEMENTS

The study was funded by the Myer Foundation. We thank: Dr Tim Lightfoot and other health care professionals and staff members at the participating asylum seeker clinics; the Family Medicine Research Centre at the University of Sydney for facilitating access to the ICPC-2 Plus coding system; Robert Buttrose for his assistance with constructing the database by using the ICPC-2 Plus codes; Dr Gillian Singleton for her helpful observations on an initial draft of the paper; and the anonymous reviewers for their valuable comments. Ignacio Correa-Velez is supported by a National Health and Medical Research Council Public Health Fellowship (grant no. 380845).

COMPETING INTERESTS

None identified.

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(Received 17 Sep 2007, accepted 5 Dec 2007) ❑