Reducing health inequities in asylum seekers with chronic non-communicable diseases: Australian Context

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What is known about the topic?

- Both healthcare workers and asylum seekers lack clarity on healthcare entitlements for asylum seekers. Asylum seekers end up not accessing healthcare services they are entitled to thereby compromising health outcomes for asylum seekers.

What does the paper add?

- Unrestrictive healthcare and working policies, food, English and pharmacy waiver programs and cultural competence have the potential to bridge the gap of inequities between asylum seekers and the host population.

Implications or impact of the discovery:

- More research is required on cogent health models that address, bridging the gap of inequalities in asylum seekers with chronic non-communicable diseases residing in the communities of high-income countries and the host population.

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Abstract:

Asylum seekers may develop Chronic Non-Communicable Diseases pre- and post- arrival due to poor living conditions, unhealthy lifestyles, restrictive and poor access to health services. Despite their need for constant and continuous healthcare access due to poor health, asylum seekers face restrictions on healthcare services access dependent on the conditions of their visa in Australia. Some visas only allow access to hospital services with restrictions on accessing primary health services such as General Practitioners or free /discounted pharmaceutical products. These restrictions are not favourable for asylum seekers with chronic diseases who require continuing healthcare access. Healthcare access restrictions mitigate addressing health inequities considering asylum seekers are already disadvantaged due to existing barriers such as culture / language differences, health illiteracy and unfamiliarity in navigating healthcare services /entitlements. In comparison host populations who are disadvantaged have access to free / discounted pharmaceutical products and unrestricted access to primary and secondary healthcare services.

Voices of those who engage with asylum seekers living in the community need to be heard to understand what services asylum seekers with chronic diseases would find of greatest benefit. Interviews were conducted with 10 frontline workers who constantly engage with asylum seekers from three large asylum seeker 'pro bono' services in Melbourne. These interviews were essential to understand in-depth challenges faced by asylum seekers and their recommendations on policies, initiatives and programs that could address health inequities that exist mainly between asylum seekers with chronic non-communicable diseases and the host population

Participants were recruited through an email invitation by service managers some of whom the researchers had previously engaged with. Participants contacted the interviewer directly to express interest and agree on convenient times and places for interviews. Interview were conducted over the phone and some in private rooms at

workplaces. The interviews audio-recorded, transcribed verbatim and data were analysed using a thematic analysis framework.

Though the data collection method utilised a small and purposive sample size, the findings were valuable as; despair, poverty, and poor health outcomes and prognosis, especially in those asylum seekers with chronic non-communicable diseases such as diabetes, hypertension, heart and respiratory diseases were exposed. From their evaluation of programs and initiatives such as pharmacy waiver program, provision of food through food banks, English programs and staff cultural competence training, they identified these as having the potential to bridge the gap of inequities between asylum seekers and the host population. Their recommendations based mainly on their experience were: (1) cultural competence training; (2) use of interpreters; (3) free access to health services and medication; (4) robust chronic non-communicable diseases screening; and (5) health promotion and accessible food programs.

Keywords: Asylum seeker friendly services, cultural competence, chronic non-communicable diseases, asylum seekers, frontline workers and health inequities.

Introduction

Globally by the end of 2019 79.5 million people were displaced from their homes mainly due to armed conflict which resulted in 4.2 million asylum seekers and 26 million refugees (UNHCR, 2020). The health systems of host countries need to adapt to be able to accommodate the influx of asylum seekers and refugees who may present with poor health due to high prevalence of chronic non-infectious diseases such as diabetes, hypertension and respiratory diseases. World Health Organisation (WHO) (2020) recommends unrestricted healthcare services for asylum seekers regardless of their legal status to reduce health inequities in host countries. The health of asylum seekers is already compromised by the journeys they make to reach host countries and healthcare access restrictions exacerbate their poor health following arrival (Eckstein 2011). Health inequities are differences in access to health resources between asylum seekers/refugees and host country populations which can be reduced favourable host country government policies (WHO, 2017). In Australia and other high-income countries, asylum seekers and refugees are known to have poorer health in comparison to host populations (Timlin et al. 2020; Spike et al. 2011). Findings from a scoping review on chronic non-communicable diseases in asylum seekers exposed that in comparison to host populations they have high incidences cardiovascular diseases and diabetes however, the exact statistics are quite fluid (Agyemang et al, 2018). Asylum seekers face numerous challenges in host countries such as language and cultural barriers, health illiteracy, poor housing and healthcare access and work restrictions and difficulties navigating healthcare services when move into communities where they have little or no assistance (Spike 2011; Fair et al. 2018).

Restrictive healthcare access when asylum seekers have multi-faceted healthcare needs, is detrimental to diseases prognosis and leads to higher health costs (Chuah et al. 2015). Many asylum seekers have chronic non-communicable diseases (CNCDs) such as diabetes, hypertension, cardiovascular disease and end-stage renal disease which require ongoing treatment but there is little research on addressing chronic illnesses in this populace because of health inequities (Adams, Gardiner & Assefi, 2004; Spike 2011). Therefore, it is important to identify strategies that reduce the gap of health inequities between asylum seekers and the host population. To address this issue, we conducted

semi-structured in-depth interviews with frontline workers to identify challenges asylum seekers may face and also to seek recommendations on programs, initiatives or policies, that could reduce health inequities.

The aims of the study were to identify challenges and health inequities encountered by asylum seekers living in the community especially those with CNCDs and document recommendations from those who engage with asylum seekers in bridging this gap of health inequities. When the study was conducted between November 2019 and January 2020 there were over 45,000 asylum seekers mainly from China, Malaysia, Libya, Syria, Afghanistan, Iran, Turkey, Iraq and Pakistan awaiting deportation and over 35,000 awaiting refugee status determination in Australia (Refugee Council Australia, 2020). Frontline workers are people who provide services to asylum seekers on a pro-bono or paid basis. Frontline workers of interest in this study were those who provide services to asylum seekers living in the community. Frontline workers are in constant contact with asylum seekers and are acutely aware of their health care needs. Their recommendations are essential because they are well informed through programs and the initiatives that they undertake.

Methods

Participants were recruited through invitation email disseminated by the service managers some of whom had previous contact with researchers. Participants contacted the researcher to arrange interviews either by phone or face to face. Face to face interviews were conducted in private rooms of participants' workplaces. To preserve anonymity, those who were interested in participating contacted the interviewer directly either by email or telephone call, making sure service managers were not aware they had expressed interest to participate.

Interviews were conducted between November 2019 and January 2020 and purposive sampling was implemented to recruit frontline health workers identified through three Melbourne's major community asylum seekers' services. The 10 interviewees included a one GP doctor, one psychiatrist, one psychologist, two nurses, two project workers (one of whom was previously an asylum seeker), two service managers and one social worker. To achieve a balanced representation of key workers who engage with asylum seekers,

we sought to interview frontline workers from various professional backgrounds. Data saturation was achieved after interviewing 10 participants from three sites. Some of the participants had worked across more than one site.

Inclusion and Exclusion Criteria

To meet inclusion criteria, interviewees were expected to be currently working with asylum seekers in the community for at least two years and to previously or currently been involved in running or managing one or more asylum seekers' programs in the community. Workers who did not fit or only partially fitted the inclusion criteria were excluded.

The majority of asylum seekers seen by the interviewed frontline workers were from Iran, Iraq and Syria. Most of them were between 24-44 years of age. A majority of the asylum seekers presented with diabetes, hypertension, heart diseases and respiratory, with a smaller number with end stage renal disease.

The interviews were qualitative, semi-structured, in-depth in nature and questions were derived from a topic guide which was informed by the study aims. The topic guide was ideal as questions were open ended and allowed refining of questions to make sure research questions were answered and relevant emerging recommendations were pursued in depth (Pope, Ziebland and Mays, 2000). The interviews were conversational to reduce high researcher bias which can occur with more structured questions. It is known that qualitative interviews, though characterised by a small sample size, are useful for attaining large amounts of rich data (Ritchie & Lewis 2003). The semi-structured, in-depth approach allowed the interviewer the opportunity to uncover detailed complex and sensitive phenomena (Barriball & While 1994). Ethics approval was obtained from the Royal Melbourne Institute of Technology, Human Ethics Committee (Approval Number: 75-19/22416).

A framework was designed informed by The Framework Method (Ritchie & Lewis, 2003). Themes were derived through the use of The Framework Method by an independent researcher (IS). The other two researchers (GN & CL) reiterated the process of deducing themes and rated them according to their relevance to the study aims. Where they were inconsistencies the second independent researcher (GK) assisted in reaching consensus.

Interviews were audio-recorded and transcribed verbatim. Three pre-derived themes were induced into the data collected. These themes were matched with views, experiences and recommendations from the data collected (inductive approach). Researchers chose quotes that elucidated the researchers' prior derived themes. Throughout the analysis process the researchers discussed conflicting themes, differences and identified appropriate quotes to reach the final selection of data that fitted the themes. The use of three other researchers who did not conduct the interviews to reiterate the data analysis process was important for reducing bias and enhancing consistency and reliability (Daly, McDonald & Willis 1992; Waitzkin 1991).

Results

The three main pre-derived themes were health inequities specific to CNCDs and challenges, bridging the gap and asylum seeker friendly services and policies.

Health inequities specific to CNCDs and challenges,

Current perceived challenges

Professionals raised concerns on the challenges asylum seekers face in catering for their healthcare needs such as not having access to Medicare (Australian universal health insurance scheme accessible to Australians and those with visas which fit criteria to use healthcare services at low or no cost), the Pharmaceutical Benefit Scheme (PBS) (government scheme that give access to medicines at subsidised price to those eligible such as; citizens and those with eligible visas) and State Resolution Support Services (SRSS) (financial and welfare support provided by the government to those who are eligible). These factors were raised as the main obstacles in addressing health inequities. In comparison permanent residents, Australian residents and Humanitarian permanent visa holders (refugees) have access to Medicare, PBS and social welfare benefits. These allow them access to unrestricted healthcare, free or discounted medicines and welfare services. Refugees upon arrival receive high level support such as English language lessons, housing, education and local community orientation.

"Some of them can access health services, some of them cannot access health services in terms of Medicare depending also on their legal status at that time".

"It's really common for clients that we see to be in very difficult financial positions, and most have no income at all, never mind some services to access both healthcare and PBS. This is confusing because there's also this Medicare eligibility, about half our clients have no eligibility so don't have any choice about where they go."

"SRSS payments when they are stopped, it takes some time, and it's quite a lot of challenge to get it".

"Several are not going to the GP. Even if they could access the GP, they knew that they would be prescribed something they couldn't access so they didn't bother going to the GP, they thought it was pointless actually even getting there".

"Not being able to pay for services causes a lot of stress for people that's really unnecessary. It makes people reticent to go to a hospital or call an ambulance actually is another problem we have. The other day we saw one who had severe chest pain and was worried about calling an ambulance because last time he did, he actually had to pay. Who knows he may have been experiencing a mild heart-attack?"

Disease screening priorities

Current disease screening protocol

There was questioning and dissatisfaction on why CNCDs, excluding mental health illnesses, are not robustly screened in the same way as infectious diseases. It emerged that mental health conditions are highly prioritised at entry and refugees would receive a full health check compared to some asylum seekers who were only screened for infectious diseases. Disease screening for asylum seekers is mainly for disease which are a risk to public health. For example, upon entry the mandatory screening is for tuberculosis, sexually transmitted infections such as syphilis and HIV, other screenings maybe done on the doctor's discretion. Services highlighted issues around capacity and capabilities in terms of funding and qualified professionals to carry out comprehensive health assessments for CNCDs, other than the presenting health issues and medication needs.

"They get screened fully for diseases such as Tuberculosis and not chronic illnesses such as heart disease or diabetes. They need help with chronic illnesses diagnosis, support and management by referring them to the right services."

"It's hard to, sort of build the capacity. It's not the case management sort of service, you don't get a sort of in-depth assessment process for CNCDs such as heart disease in comparison to mental health conditions such as post-traumatic stress disorder (PSTD)."

Bridging the gap

Considerations to bridge the gaps

There were recommendations for programs and initiatives that they viewed as essential in reducing the gap of accessibility of healthcare services especially for CNCDs.

"The pharmacy waiver program just makes, prescription medicine available where it's not otherwise. It takes a huge burden off people worrying about, particularly their children. It's a targeted issue, it's a gap, and we've tried to fill it with this pharmacy waiver program".

"If you're talking about bridging the gap, access to Medicare would be a big thing. But also access to culturally sensitive and asylum-seeker sensitive practitioners, where people are going to be open to exploring the best way to assist the person, which I don't think is always the case in services in the community".

"There are restrictions, for example, in dealing with health around food. There are food banks or emergency relief services, but normally they're restricted to say, you might be able to only access them three times a year".

"Not putting those restrictions of limits as to how often you can come and access the service. Needs to be welcoming, be able to communicate effectively, and meeting needs of those asylum seekers and being able to bend or change policy when people require a higher level of service because of the situation that they find themselves in".

Health professionals agreed that asylum seekers with poor health should be allowed access to healthcare services without restrictions especially those with CNCDs.

Asylum seeker friendly services

Favourable delivery processes

There was a common consensus on what health professionals, thought would be defined as an 'asylum seeker friendly service'. They agreed that they should have the following features; use of interpreters, be comprehensive in nature, be run by culturally competent staff, have referral services, have free access to services and pharmacy products, include health promotion and food programs and be child friendly.

"It needs to be affordable, comprehensive and to be provided in a culturally-appropriate environment, services that understand the impact of trauma sensitisation and also services that use interpreters and who have an understanding of the complex health issues that people of that background might be facing".

"One that has good skills in using interpreters and using them consistently. One that addresses not only the primary health needs, but also Maslow's hierarchy of needs. One that addresses housing and access to food, because we can't address health needs unless we've addressed physiological needs."

Deduced themes Cultural, sensitivity, awareness and competence; who takes over from us?

Strategies that improve interventions/services uptake for CNCDs

There were concerns raised about how some community services do not have the capacity to practice with cultural competence. The process of transitioning from asylum seeker-based services into the community services was seen as failing asylum seekers. Community health workers were said not to be aware of what help to give them mainly due to not being able to understand their cultural needs which require tailoring to their CNCDs. Increased interventions and services uptake compliance were highly attributed to good cultural competence skills, especially when giving service to minority populations with long-term conditions (CNCDs). Practicalities of handing over asylum seekers to mainstream community services was cited as a big challenge due to lack of skills and capacity.

"If you're coming from a country where there isn't a tradition, you know. Then the kind of Western medical system where you go to a GP who doesn't use interpreters. Some people might just put up with their pain at home because the service providers don't understand their culture that should be embedded in the care they expect to receive."

"Due to conflicting ideas about treatment adherence and culture such as fasting and taking medication with food. Repercussions may not be fully explained and they don't fully comprehend what the condition is or why they should take medication or engage in any kind of treatment, mainly because professionals lack cultural sensitivity, awareness and competence to deal with these issues."

"They'll need to have a really high level of understanding of working with this group of people. Training needs to be ongoing. It needs to continually change as well, as new groups arrive. Culture is different."

Frontline workers raised concerns on the need to share patient information, knowledge and skills on how to care for asylum seekers in the community especially those with CNCDs and may have restricted healthcare access. They perceive as their work of trying to provide holistic service gone to waste when asylum seekers come back to them with deteriorated health. This is mainly due to incompatible community services short of meeting asylum seekers' needs, resulting in loss of continuation of health services access.

Discussion

The main concern raised by participants was that; healthcare access restrictions on asylum seekers worsen their health outcomes in comparison to the host population especially those with CNCDs such as heart disease, diabetes, kidney disease, hypertension and respiratory diseases. The need to provide asylum seekers with health cards to access medical services and pharmaceutical products was voiced unequivocally by all frontline workers. They justified this initiative as a way to reduce health inequities and to promote better health outcomes for this population. SRSS scheme (which is the government social benefit scheme for asylum seekers) was identified as too complex and very bureaucratic which makes this populace vulnerable to compromised healthcare services. Challenges presented by complex healthcare entitlements system for asylum seekers and denial of healthcare access which they sometimes deserve was evidenced in a study in Canada by

Chase et al. (2017) and Timlin et al. (2020). Policies that govern healthcare services access for asylum seekers were thought to be harsh and made life unbearable for some them who did not have working rights or of poor health. The Australian government has committed to increase funding to foster community integration and improved healthcare services in the community (Refugee Council, 2020). This would benefit those who are eligible to entitlements in comparison to those without or have restricted entitlements.

Some food programs provided by charities and well-wishers were seen to be very good in promoting healthy lifestyles but unfortunately some locations which provided these services were not accessible by public transport. This in turn rendered these services non-beneficial due to being inaccessible to the targeted populace.

Programs such as the pharmacy waiver programs were said to be very beneficial especially to those with CNCDs who required constant supply of pharmaceutical products. Services reported that they put a lot of effort in promoting good health in asylum seekers through food programs and health promotion activities. English lessons were seen as a pillar for understanding better their health needs and diseases diagnosis which could later translate to health literacy. Asylum seekers could then advocate for themselves and possibly integrate better into their local communities' health services when they speak and understand English. This is important because essentially when you go to a new country you eventually do need to fit in enough to survive and fit in more if you want to do well. Therefore, in addition to providing asylum seeker friendly services we also need to be engaging them in education that will eventually enable then in the general community.

Frontline workers' main concern was continuity of services they provide when asylum seekers were expected to transition to other services, that are not specifically for asylum seekers. They encounter health relapses due to the absence of a systematic way of handing over asylum seekers to community services. A number of them end up coming back with deteriorated health to utilise asylum seekers' services thereby putting a lot of pressure on the already overstrained services and obviously they cannot turn them away. This was evidenced in a number of previous studies were asylum seekers failed to integrate into their local community services such as GP or maternal health services from using asylum seekers specific services (Fair et al. 2018; Spike 2011).

The use of interpreters, culturally competent professionals were the common traits that were attributed to services they would term as 'asylum seeker friendly services.' Use of interpreters and understanding cultural needs of asylum seekers were reported to be of main priority since they were seen to be essential in building trust and promoting health services uptake increase. Asylum seekers kept coming back to these asylum seeker services because they did not trust their local community health workers and mainly because of the absence of interpreter services, cultural sensitivity, awareness and competence within these services. The importance of having culturally competent healthcare workers in enhancing comprehensive healthcare for asylum seekers and refugees has been acknowledged in a number of studies carried out in culturally diverse societies such as United Kingdom and United States of America (Quickfall 2014; Baumann 2009).

Frontline workers recommended that for services to reduce health inequities, bridge the gap and be asylum seeker friendly, the services should be free, accessible, comprehensive in nature, use interpreters, provide programs and initiatives that promote good health, empower asylum seekers so to become employable and advocate for themselves and be child friendly. It is important that host countries healthcare policies are inclusive in promoting affordability of healthcare services by asylum seekers, and this coupled with programs and initiatives which address healthcare needs of this populace may reduce the gap of healthcare inequities with host populations.

If needs are to be addressed, efforts need to be channelled towards programs, initiatives and restructuring and evaluating of social benefits policies favourable to addressing social, economic and cultural determinants that impede positive health outcomes. Programs and initiatives on health education and health promotion and culture orientation and awareness could break down communication and language barriers and promote inclusivity (Foundation House 2018; Eckstein 2011). The use of interpreters and cultural awareness education amongst healthcare professionals who engage with asylum seekers could bridge the cultural differences gap between them and the host population (Joshi et al. 2013). By promoting these, asylum seeker friendly services, they become health literate and appreciate the importance and benefits of interventions adherence to treatment, which is crucial for the management of CNCDs. Asylum seekers face major

barriers in accessing healthcare services which translates to poor health outcomes due to cultural and language barriers, poor health literacy, uncertainties around healthcare entitlements, incapacity to afford medical bills and undetermined migration status (Mahimbo et al. 2017; Mishori et al. 2017).

Limitations of the study

It is important to consider limitations to this study; the sample was purposive and small. However, using a small sample size is common in qualitative research.. Little or no English at all was spoken by the asylum seeker population that these health workers worked with. . The findings would not necessarily translate to asylum seekers who speak good English, are health literate and have healthcare services access.

The topic guide which was an unvalidated tool was used to initiate conversation and direct towards the researcher's interest which presented potential researcher bias. There is potential of both researcher and participant bias towards asylum seekers as they are a subject of interest to both, with the possibility of over-estimating the margin of health inequities.

However, frontline workers were from different professions and some of them had more than 10 years' experience working with asylum seekers.. They have provided services for a large population of asylum seekers (up to 1000), which makes their recommendations important and generalisable to most asylum seekers who have CNCDs and with no access to free healthcare services.

Conclusion

Frontline workers voiced the following: those with CNCDs require undisrupted continuous healthcare, recommending healthcare access should be provided continuously regardless of their claim status. They suggested that policies that are restrictive on healthcare access for asylum seekers should be replaced by favourable ones that promote better health outcomes through awarding non-restrictions on health services, pharmaceuticals and food banks. Cultural competence was recommended in improving interventions uptake and community integration which promotes increase in uptake for community non-specific asylum seekers' healthcare services.

More research is needed on health models that are effective in promoting health in asylum seekers with CNCDs living in communities of high-income nations. Research should focus more on CNCDs such as hypertension, heart diseases, respiratory diseases and renal diseases as these are often neglected, yet they badly jeopardise prospects of asylum seekers contributing to the host country's workforce. There is a need for more studies on strategies to build cultural competence capacity in community non- specific asylum seeker services to help build trust, increase interventions and services uptake in order to adequately address the needs of this populace.

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