The physical health status, service utilisation and barriers to accessing care for asylum seekers residing in the community: a systematic review of the literature

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Abstract

Objective. To document physical health problems that asylum seekers experience on settlement in the community and to assess their utilisation of healthcare services and barriers to care, in an international context.

Methods. A systematic review of quantitative and qualitative studies was undertaken according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses. MEDLINE, PsycINFO, Embase and CINAHL databases were searched from 2002 to October 2012, focusing on adult asylum seekers residing in the community in high-income countries.

Results. The search yielded 1499 articles, of which 32 studies met the inclusion criteria – 23 quantitative and nine qualitative. Asylum seekers had complex health profiles spanning a range of infectious diseases, chronic non-communicable conditions, and reproductive-health issues. They appeared to utilise health services at a higher rate than the host population, yet faced significant barriers to care.

Conclusion. The findings of this study highlight the health inequities faced by asylum seekers residing in the communities of host countries, internationally. National data on asylum seekers’ health profiles, service utilisation and barriers to care, as well as cross-country policy comparisons, are urgently required for the development of effective Australian health programs and evidence-based policy.

What is known about the topic? The clinical and political focus of asylum seekers’ health has largely been on the higher incidence of mental disorders and the impact of immigration detention. Since policy changes made in late 2011, an increasing number of asylum seekers have been permitted to live in the community while their claims are processed. There is a paucity of research exploring the physical health needs of asylum seekers residing in the community.

What does this paper add? The international literature highlights the complexity of asylum seekers’ health profiles. Although they appear to utilise health services at a higher rate than the host population, they continue to face many barriers to care.

What are the implications for practitioners? Studies that explore policy options, including cross-country comparisons of health policy and guidelines that improve health outcomes, to foster equity of access and reduce health inequalities between asylum seekers and the host population are urgently required.

Additional keywords: community, healthcare utilisation, physical health.

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Introduction

According to the 1967 Protocol of the 1951 Convention Relating to the Status of Refugees, a refugee is any person owed protection outside the country of their nationality or birth because they have a well-founded fear that they will be persecuted because of their race, religion, nationality, political opinion or membership of a particular social group. When that person’s claim for protection is not approved and/or still being assessed, they are referred to as
asylum seekers. At the end of 2011, there were 42.5 million forcibly displaced people worldwide, of which 15.2 million were refugees and 895 000 were asylum seekers.5 Australia, a signatory of the 1951 Refugee Convention, is one of 26 countries participating in the United Nations High Commissioner for Refugees (UNHCR) resettlement program,3 granting 13 759 visas under the Refugee and Humanitarian Program in the financial year 2011–12.6 Although the majority of people seek protection through the UNHCR ‘offshore’, there are also a significant number of people arriving by plane or boat who claim asylum once in Australian territory (‘onshore’). Onshore asylum seekers who arrive by plane are granted bridging visas, which allow them to remain lawfully in the community while their refugee claims are assessed, unlike asylum seekers arriving by boat, who are more likely to be detained.

Since November 2011, the Australian government has been releasing some asylum seekers from detention centres into the community with a bridging visa, while their applications are being processed.5 More recent policy changes have resulted in the withdrawal of work rights for some community-residing asylum seekers,6 and the reintroduction of offshore processing – both conditions related to the means and time of arrival. Complex conditions around permission to work mean there are some asylum seekers on bridging visas, including some arriving by plane, that are denied Medicare.7 Complete data on the number of Medicare-ineligible asylum seekers (at all stages of processing) in the community are very difficult to determine.

Allowing some asylum seekers to reside in the community is welcomed by many health and community groups, who have persistently lobbied to reduce the harms incurred in detention centres. However, it now means there are increasing numbers of asylum seekers in the community with complex health needs and relatively little material or social support. Many face difficulties paying for health-related needs and rely on the generosity of pro-bono services and other fee-waivers.8 For some asylum seekers, poverty, unsanitary and crowded living conditions, inadequate nutrition and poor access to healthcare services before coming to Australia may contribute additional health burdens.9,10 Existing health issues may be further exacerbated by post-migration experiences such as immigration detention before being released in the community, the indeterminate visa status, social isolation, language barriers, financial instability and poor service access.8,11

In the current political context, with a dramatic increase in the number of people living in the community while seeking asylum in Australia, it is imperative that we have a clear understanding of their health-related needs in order to develop appropriate services. The health of asylum seekers in the community is likely to reflect environmental and social factors, and they face unique challenges navigating the host country’s health system. The policy environment around healthcare and social service entitlements in Australia and internationally is constantly evolving and highly politicised, which impacts on the ability to conduct proper research and translate it into evidence-based practice. To date, however, there has been a predominant focus on the mental health implications of immigration detention, with several systematic reviews having already been conducted.12–14 Research with asylum seekers in Australia’s community is currently lacking due to reluctance by the government to provide statistics or registers of those living in the community15 as well as ethical issues and recruitment difficulties in gaining access to ‘hidden’ populations that may be fearful of authority.16 Drawing from the international literature, the aim of this systematic review was to document physical health problems that asylum seekers experience on settlement, to assess the utilisation of healthcare services and barriers to care.

Methods
Search strategy
The conduct of the systematic review was guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses statement.17 MEDLINE, PsycINFO, Embase and CINAHL databases were searched. Search terms included: (asylum seek*, seek* asylum, refugee claimant* or forced migrant*) and (health, health disparity, health care access, health care utilisation, primary health care or tertiary health care).

Mesh keywords, indexed terms and subheadings were used as appropriate, depending on the specifications of the database.

Study selection
All studies yielded from the database search were reviewed and assessed for eligibility based on the following criteria: (i) the primary participant group were adult asylum seekers or failed asylum seekers residing in the community (i.e. not a closed detention facility); (ii) the studies were conducted in a high-income country (World Bank Organisation for Economic Co-operation and Development criteria18); and (iii) the results were published in a peer-reviewed journal in English between 2002 and October 2012. In studies where the sample included refugees, the study was included if the proportion of asylum seekers was greater than 50% of the sample. Physical health was defined as any condition affecting the functioning of the body and involving symptoms or diagnoses related to disease or injury of the body. It did not include articles focusing on mental health problems or studies that were not concerned with assessment of disease burden in asylum seekers to inform service provision, for example studies assessing the effectiveness of tuberculosis screening.

The systematic review included both quantitative and qualitative studies. Quantitative studies were examined to assess physical health status, correlates of physical health and utilisation of health services, whereas qualitative studies were included to explore barriers and facilitators to service access. The inclusion of qualitative studies in systematic reviews is becoming increasingly common, as it may enable triangulation of findings or offer alternative explanations.19

Data extraction and quality appraisal
All data extraction and appraisals of retrieved studies were primarily undertaken by the first author (EH) and independently verified by the second author (AR), and there was no disagreement between the two reviewers. The extraction of the data followed a tree-stepped process filtering first by title, then the abstract and finally full text were obtained and reviewed. In addition, the reference lists of included articles and any relevant reviews were manually scanned to identify any additional studies that our search strategy could have missed (Fig. 1).
1499 records identified through database searching

695 records after duplicates removed

804 records screened

77 full-text articles assessed for eligibility

31 studies met eligibility criteria

Reference lists scanned and key articles searched through Scopus

13 additional articles assessed for eligibility

1 additional article included.

32 studies included:
- 23 quantitative
- 9 qualitative

46 articles excluded. Reasons:
- Adult asylum seekers not primary participant group
- Study not in community setting
- Didn’t address study aim
- Reporting only accuracy of TB screening
- Duplication of results (1)
For quantitative studies, data extraction and critical appraisal of the quality of studies were informed by the ‘Strengthening the Reporting of Observational studies in Epidemiology’ guidelines. Eight quality-appraisal criteria were generated: study objective; representativeness; size of the sample; instrumentation/outcome measures; statistical analyses used; control for confounding; study limitations acknowledged; and ethical considerations. Qualitative studies were appraised using a critical review form informed by several guidelines and included: study objective; the use of theoretical perspective to inform the study design and data analysis; sampling technique and size; procedural rigour; triangulation of data analysis and reporting (i.e. consistency); reflexivity; limitations of the study acknowledged; and ethical considerations. The quality of the studies was rated according to their summary score: poor (0–3), adequate (4–6), or high (7–8) quality.

Data synthesis and analysis

Due to the heterogeneity of study designs, measures of physical health and settings, a meta-analysis was not appropriate. For quantitative studies, an integrative approach to content analysis was achieved by identifying key concepts a priori. These findings were then reported in a narrative style based on similarities and dissimilarities observed between studies utilising similar outcome measures. Synthesis of evidence from qualitative studies was undertaken using a thematic analysis approach by the two authors, which involved identifying prominent and recurring themes across study findings exploring barriers and facilitators to healthcare. A summary table was employed to improve transparency, assist with reflecting on the frequency or weight of themes and conduct cross-study analysis.

Results

The initial database search yielded 1499 articles (Fig. 1), of which a total of 32 studies met the inclusion criteria (23 quantitative and nine qualitative studies), of which only three were in Australia (Tables 1, 2). All of the quantitative studies were cross-sectional and included mostly audits of medical records or clinical databases (15 studies), or questionnaires (eight studies). Of the qualitative studies, five involved focus group interviews and four employed both focus groups and in-depth interviews. The quality of the 32 studies varied significantly. For quantitative studies, three were of poor quality, 10 were of adequate quality and 10 were of high quality. The majority of qualitative studies were of adequate quality (six), with two of poor quality and only one of high quality.

Physical health status

Of the 23 quantitative studies included in the review, 18 provided data on the physical health status of asylum seekers (eight based on self-report and 10 based on medical record or clinical database data with standardised diagnostic criteria as summarised in Table 1 under ‘outcome measure’).

Compared with other population groups using the same outcome measures, perception of poor general health status was much worse among asylum seekers (around 60%32,42) than comparative refugee samples (around 42%32,42), immigrants (39%32) or a general, non-immigrant population (18%32).

Overall, chronic physical symptoms or complaints were self-reported by 49–77% of asylum seekers. Prevalence differed between study populations, but symptoms and medical diagnoses were commonly noted for the following conditions: dental; headache or migraine; musculoskeletal; neck, back or shoulder pain; dermatological; respiratory; and gastrointestinal problems. Four studies focussed specifically on sexual and reproductive health issues.33,35,41,43 These studies showed that asylum seeker women faced a range of complex gynaecological diagnoses and obstetrical issues, including an incidence of severe acute maternal morbidity 4.5 times higher than the general population. Asylum seekers were also more likely to have experienced sexual assault35,41 and had higher rates of unwanted pregnancies and induced abortions33,35 than the host population.

Hobbs et al. reported the results of a physical health screening program. The study found a high prevalence – compared with the host population – of infectious diseases including active tuberculosis, HIV, Hepatitis B and C, gastrointestinal infections, and helminths.34 Bischoff et al. identified eight International Classification of Diseases (ICD) categories: musculoskeletal, respiratory, mental, skin, injury, infectious and parasitic, cardiovascular and pregnancy/childbirth. Of these, infectious and parasitic diseases accounted for only 6.3% of individual diagnoses, which was among the lowest frequency of the eight ICD categories and required the least number of clinic visits per person diagnosed, whereas musculoskeletal and respiratory had the highest frequencies of diagnosis.38 Only one study reported on dental needs, and found that 68.5% of asylum seekers self-reported a need for dental consultation.

Sociodemographic determinants of physical health

Of the 23 quantitative studies included in the review, 11 studies examined the association between sociodemographic factors and physical health.26,28,32–34,36,37,42–45 The findings suggest that older age is associated with an increased risk of all ICD diagnostic categories (excluding reproductive health issues).28 Poorer self-reported general health status,32 functional disability,37 chronic conditions,32,37 and a higher medical referral rate.26 Female gender was associated with a greater likelihood of reporting chronic conditions32,37 and physical symptoms26 but not with any specific ICD diagnoses.28 Ethnicity was another sociodemographic characteristic affecting health outcomes; however, due to heterogeneity of sample characteristics, it was too methodologically complex to draw comparison between different ethnic groups or source countries.26,28,32,34 One study found that participants from countries experiencing violent conflict had higher frequencies of several ICD diagnoses as well as requiring a greater number of consultations and higher healthcare costs.45 Compared with those who had arrived within the previous 6 months, asylum seekers with a longer length of stay had a higher level of disability, greater physical complaints, perceived lower physical health status and lower quality of life.36,37 Longer length of stay was also associated with a lower live birth and abortion rate among asylum seekers.33 A greater number of pre-migration traumatic events resulted in higher medical referral rates.26 and was associated with chronic conditions and poor general health status.32 Similarly, post-migration living conditions and stressors were
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<tr>
<td>Bischoff <em>et al.</em> 2003,26 Switzerland</td>
<td>To examine the effect that language concordance has on reporting of health symptoms and referral for asylum seekers</td>
<td>Cross-sectional Self-report questionnaire Health facility Consecutive sampling, 6 months</td>
<td>n = 723 Many different geographic regions 72% male Time since arrival: N/S (soon after arrival) Age range: N/S (median 26.5 years)</td>
<td>Demographic data % reporting and type of physical symptoms (categorisation method N/S) % referred to medical service Four aspects of language concordance</td>
<td>One or more severe physical symptoms: 19% Common symptoms: headache (6%), abdominal pain (6%), backache (5%), loss of appetite (3%), dyspnoea (3%), dysuria (2%), palpitation (1%) 36% referred to further medical services Higher language concordance, female gender and ethnicity associated with greater reporting of physical symptoms</td>
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<tr>
<td>Bischoff <em>et al.</em> 2009,28 Switzerland</td>
<td>To investigate the burden of disease among asylum seekers</td>
<td>Cross-sectional (retrospective) Hospital database audit Specialist primary care service Consecutive sampling, 3 years</td>
<td>n = 979 &gt;50 countries 62% male Time since arrival: range N/S (median 7 months) Age range: N/S (mean 22.1 years)</td>
<td>Demographic data Diagnoses (number, type): ICD-10 diagnostic codes classified into 8 categories Annual number of clinic visits % enrolled that used services over the study period</td>
<td>One or more ICD diagnoses: 39% Diagnosis rates (% of sample, mean number of clinic visits per person with diagnosis): musculoskeletal diseases (14.5%, 24); respiratory diseases (14.1%, 19.5); skin diseases (8.8%, 19); injuries (8.6%, 25.5); infectious and parasitic diseases (6.3%, 26); cardiovascular diseases (4.4%, 45); pregnancy, childbirth and puerperium (4.5%, 40.5) % that used service: 81.2% Median number of clinic visits per year (any type): 5.8 Increasing age a significant predictor of 7/8 ICD categories (all except pregnancy-related) Country of origin associated with some diagnostic categories</td>
<td>6/8</td>
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<tr>
<td>Bischoff <em>et al.</em> 2009,27 Switzerland</td>
<td>To compare the healthcare costs of asylum seekers with the local population</td>
<td>Cross-sectional (retrospective) Hospital database audit Specialist primary care service Consecutive sampling, 3 years</td>
<td>n = 490 (&gt;173 local residents as comparison) &gt;50 countries 59% male Time since arrival: N/S Age range: N/S (mean 31 years)</td>
<td>Demographic data Number of consultations Duration of treatment in healthcare facility Monthly costs of healthcare provision (in Euros) Diagnoses (number, type): ICD-10 diagnostic codes classified into 8 categories</td>
<td>Compared with the host population, asylum seekers had: higher mean number of ICD diagnoses (1.7 v. 1.2), lower mean number of consultations (27.0 v. 33.9), shorter duration of care (487 v. 1028 days), less than half the monthly costs (295 v. 644 Euros) With post-hoc tests, costs were statistically different between the two groups up to the age of 50 years, or if patients had less than 3 ICD diagnoses</td>
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(continued next page)
### Bischoff et al. 2010, Switzerland

**To Investigate the Association Between Language Barriers and the Costs of Healthcare for Asylum Seekers**

- **Methodology:** Cross-sectional (retrospective)
- **Data Collection:** Hospital database audit, Specialist primary care service
- **Sampling:** Consecutive sampling, 3 years
- **Participants:**
  - n = 486 >50 countries
  - Gender: N/S for total sample (around 53%)
  - Time since arrival: N/S
  - Age: N/S for total sample

**Demographic Data**
- Language barriers (physician-reported)
- Annual number of clinic visits
- Healthcare consumption/costs (consultations, examinations, interventions, admissions, medication, interpreters)
- Diagnoses (number, type): ICD-10 diagnostic codes classified into 8 categories

**Costs and Usage**
- Compared with asylum seekers with no language barriers, those with a language barrier had:
  - Higher median number of consultations annually (23.0 v. 10.8),
  - Higher median consumption of healthcare (0.36 v. 0.17),
  - Higher median monthly costs (3195 v. 1278 Euros),
  - Higher median number of ICD diagnoses (2 v. 1)

### Bischoff et al. 2011, Switzerland

**To Explore Differences in Healthcare Costs for Asylum Seekers from Countries Experiencing Violent Conflict or No Conflict**

- **Methodology:** Cross-sectional (retrospective)
- **Data Collection:** Hospital database audit, Specialist primary care service
- **Sampling:** Consecutive sampling, 3 years
- **Participants:**
  - n = 969 (90% asylum seekers) >50 countries
  - Gender: N/S for total sample (around 60%)
  - Time since arrival: N/S
  - Age: N/S (median 22 years)

**Demographic Data**
- Country of origin (violent conflict/no violent conflict)
- ICD-10 diagnostic codes classified into 8 categories
- Healthcare costs (consultations, examinations, interventions, admissions, medication, interpreters) in Euros

**Costs and Usage**
- Compared with other asylum seekers, those who were from countries experiencing violent conflict had:
  - Higher frequencies ($P < 0.05$) of respiratory diseases (23 v. 13%)
  - Skin diseases (13 v. 8%), injuries (13 v. 8%),
  - Pregnancies (9 v. 4%), blood diseases (5 v. 2%) and endocrine diseases (11 v. 7%),
  - Higher median healthcare costs (974 v. 449 Euros),
  - Higher median number of healthcare visits annually (8.2 v. 4.7)

### Blackwell et al. 2002, United Kingdom; England

**To Assess Health History and Healthcare Needs of Newly Arrived Asylum Seekers**

- **Methodology:** Cross-sectional
- **Data Collection:** Self-report questionnaire, Specialist health service
- **Sampling:** Consecutive sampling, 12 months
- **Participants:**
  - n = 397
  - 39 countries (Iran 47%)
  - Gender: N/S (73% male)
  - Time since arrival: N/S (soon after arrival)
  - Age range: 16–58 years (mean 29.7 years)

**Demographic Data**
- Health history
- Present healthcare needs
- Symptoms: categorised according to British National Formulary chapters
- Medication use (regular or ad hoc; prescription or over-the-counter)

**Healthcare利用**
- Asylum seekers with current symptoms:
  - Requiring medical consultation, 54.4%;
  - Requiring dental consultation, 68.5%; no symptoms at all, 23.7%
- Of those symptoms that were reported (300),
  - The majority of complaints were: related to the central nervous system (23%), musculoskeletal (16.7%), skin (13%),
  - Ear/nose/throat (9.3%), obstetric/gynaecological (9%), endocrine (6.3%), respiratory (3.7%)
- 51% complained of dental pain

Since arrival, asylum seekers had accessed:
- Primary care, 38.5%; hospital treatment, 8.1%; had a pap smear (female only) 24.5%
- Currently taking one or more medications, 29.2%
- Used one or more medicines regularly, 11.3%
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<tr>
<td>Bradley and Tawfiq 2006, United Kingdom; England</td>
<td>To document the physical and psychological effects of torture on Kurdish asylum seekers</td>
<td>Cross-sectional (retrospective) Medical record audit Legal practice for asylum seekers (referred for medical evaluation of allegations of torture) Sampling method unclear</td>
<td>n = 97 All from Turkey 86% male Time since arrival: N/S Age range: 16-64 years (mean 30 years)</td>
<td>Demographic data Current chronic pain, disability or physical injuries (reported voluntarily during physical examination)</td>
<td>Asylum seekers with physical injuries as a result of torture: 99% (note study design) Most common type of injury: facial or dental (65%); fracture (29%); and scars from burns (18%) Asylum seekers unable to carry out activities of daily living or work unassisted, 12%; with chronic pain, 22%</td>
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<tr>
<td>Cook et al. 2006, United Kingdom; England</td>
<td>To assess the stage of disease and use of services for HIV-positive asylum seekers compared with non-asylum seekers</td>
<td>Cross-sectional (retrospective) Medical record audit Hospitals and specialist HIV service Consecutive sampling, 3.5 years</td>
<td>n = 409 (+1795 local residents as comparison) Country of origin: N/S 32% male Time since arrival: N/S Age range: N/S (median 33 years)</td>
<td>Demographic data Stage of HIV disease on first presentation Hospital in-patient admissions Number of clinic visits per year Use of antiretroviral therapy</td>
<td>Compared with host population, asylum seekers were: no more likely to seek treatment at a later stage in the HIV disease process or require inpatient stay; have slightly higher median number of outpatient appointments annually (7 v. 6)</td>
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<tr>
<td>Correa-Velez et al. 2008, Australia</td>
<td>To assess primary healthcare utilisation and presentations among asylum seekers</td>
<td>Cross-sectional (retrospective) Medical record audit 3 specialist primary care clinics Consecutive sampling, 12 months</td>
<td>n = 341 (&gt;76% asylum seekers) Many different geographic regions 56% male Time since arrival: 0-302 months (median 58 months) Age range: 0-89 years (mean 34.7 years)</td>
<td>Demographic data Reason for presentation: ICPC-2 diagnostic codes (modified for study purposes) Number of clinic visits</td>
<td>Reasons for clinic attendance (physical health problems, rate per 100 encounters): musculoskeletal complaints (27.1), respiratory (21.4), digestive (19.0), female genital (12.6), skin (12.2), endocrine/metabolic/nutritional (12.2), cardiovascular (11.1), neurological (9.5) Mean number of clinic visits annually: 3.4 Consultations for ≥4 complaints, 22% Encounters where medication prescribed or recommended, 51.6% Encounters for preventative assessment, general check-up or health education, 5%</td>
<td>7/8</td>
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Gerritsen 2006, The Netherlands

**To assess the burden of physical and mental morbidity among asylum seekers and make comparison with refugees of similar background.**

**Methods:** Cross-sectional Self-report questionnaire Register of asylum seekers Random sampling

- **n = 232 (+178 refugees as comparison)**
- **3 countries: Afghanistan, Iran, Somalia**
- **61% male**
- **Time since arrival: range N/S (mean 3.4 years)**
- **Age range: N/S (mean 34.4 years)**

**Demographic data**

- **General health status (Short Form-36)**
- **Physical health: list of chronic conditions (classification N/S), modified Traumatic events, post-migration stress symptoms (Harvard Trauma Questionnaire)**

**Compared with refugees, asylum seekers had: increased reporting of poor general health status (59.1% vs. 42.0%); higher proportion with >1 chronic conditions (48.4% vs. 46.5%).**

For asylum seekers, the most frequently reported chronic conditions were:

- Dental problems (44.9%),
- Severe neck/shoulder problems (33.4%),
- Eye problems (33.1%),
- Severe/chronic back complaints (32.7%),
- Severe headache/migraine (32.6%)

Asylum seekers from Iran reported poorer general health status than those from Afghanistan or Somalia.

Factors associated with poor general health status: increasing age, number of traumatic events experienced, post-migration stress, not feeling at home.

Factors associated with reporting of chronic conditions: Female gender, increasing age, number of traumatic events experienced.

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Gerritsen 2006, The Netherlands

**To assess health service usage and factors affecting access for asylum seekers and make comparison with refugees of similar background.**

**Methods:** Cross-sectional Self-report questionnaire Register of asylum seekers Random sampling

- **n = 232 (+178 refugees as comparison)**
- **3 countries: Afghanistan, Iran, Somalia**
- **61% male**
- **Time since arrival: range N/S (mean 3.4 years)**
- **Age range: N/S (mean 34.4 years)**

**Demographic data**

- **General health status (Short Form-36)**
- **Use of healthcare services: on-site nurse, GP, medical specialist, hospital admissions, medication use**

**No statistically significant differences between asylum seekers and refugees with regards to health service use (not reported below).**

Of the asylum seeker population:

- Visited on-site nurse in previous 2 months, 63.4%; mean number of nurse visits per person, 1.22; visited GP in previous 2 months, 46.1%; mean number of GP visits over 2 months, 0.96; seen an outpatient medical specialist in previous 2 months, 22.5%; hospitalised in the last 12 months (one or more nights), 12.2%; taken medication in the last 14 days, 57.8%

Higher GP use by asylum seekers from Afghanistan than Somalia.
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<tr>
<td>Goosen et al. 2009, The Netherlands</td>
<td>To estimate the incidence of induced abortions among asylum seekers and assess factors associated with induced abortion</td>
<td>Cross-sectional (retrospective) Clinical database audit, nurse-reported data Community health services, asylum seeker agency Census</td>
<td>9931 (787 women who had induced abortion or live birth) N/S (many different geographic regions) All female Time since arrival: range N/S (93% &gt;9 months) Age range: 15–49 years (average N/S)</td>
<td>Demographic data Reproductive health indicators: number of live births; midwife recorded and ICD-coded data on number of abortions Length of stay</td>
<td>Compared with the host population, asylum seekers had a higher rate of abortions per 1000 live births per year (14.4 v. 8.6) Longer length of stay associated with decrease in abortion rate and live birth rate Strong correlation between higher abortion rate and younger age Some ethnic groups associated with higher abortion rate</td>
<td>7/8</td>
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<tr>
<td>Hobbs et al. 2002, New Zealand</td>
<td>To report the findings of voluntary health screening initiatives for asylum seekers</td>
<td>Cross-sectional Medical record audit Specialist hospital service Consecutive sampling, 2 years</td>
<td>n = 900 &gt;7 countries (‘other’ not specified) 68% male Time since arrival: N/S Age range: 0 to &gt;60 years (average N/S)</td>
<td>Demographic data Standardised infectious disease testing (Mantoux tests, chest X-rays, selected screening blood tests and faecal testing) Medical referrals made</td>
<td>Positive result from infectious disease screening in those screened (n = 850–900): Schistosomal Ab (3.2%); current Hepatitis B infection (HBsAg; 2.9%); current Hepatitis C infection (Anti HCV; 1.1%); HIV Ab (1.1%); Syphilis (Treponema Ab; 1.0%); Tuberculosis (TB) Mantoux test (36.4%); Active TB (chest X-ray) (0.6%) Asylum seekers with: helminths/parasites (range for different types) (0.8–5.7%), anaemia (3.5%), low ferritin (23%) 65.4% referred to a GP, 32.6% to other service types Some variations in ethnicity for various infectious diseases</td>
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</tr>
<tr>
<td>Kurth et al. 2010, Switzerland</td>
<td>To identify the reproductive healthcare needs of asylum seekers and assess the care they receive</td>
<td>Cross-sectional (retrospective) Hospital database, medical record audit Specialist hospital service Consecutive sampling, 3 years</td>
<td>n = 80 Many different geographic regions All female Time since arrival: N/S Age range: 19–60 years (mean 28 years)</td>
<td>Demographic data Reproductive health diagnoses and interventions (method of categorisation N/S)</td>
<td>Most frequently reported gynaecological diagnoses: urogenital infections (41%), lower-abdominal pain (25%), spontaneous abortions (8%), dysmenorrhea (5%), hydromenorrhea/menorrhagia (5%) Asylum seekers that reported: previous sexual assault (10%), unwanted pregnancies resulting in induced abortion (22.5%) Most common obstetric issues: premature labour (15%), bleeding (11%), gestational diabetes (9%), intraterine growth retardation (7%), anaemia (7%) Compared with host population, asylum seekers had a higher induced abortion to live birth ratio (1 : 2.5 v. 1 : 7.5), but no significant differences observed for mode of delivery</td>
<td>6/8</td>
</tr>
</tbody>
</table>
To measure health service use among Iraqi asylum seekers and assess factors affecting this

Cross-sectional
Self-report questionnaire
National register of asylum seekers
Random sampling (Iraqi only)

n = 294
All from Iraq
65% male
Group 1: <6 months (mean 2.5); Group 2: >24 months (mean 36.8)
Age range: 18 to >64 years (average N/S)

Demographic data
Health service use (previous 2 months)
Physical health status (method of categorisation N/S)
Quality of life (World Health Organization Quality of Life short version; WHO QOL-BREF)
Brief Disability Questionnaire
PMLP

For the total asylum seeker sample:
mean score for perceived general health, 2.89 [range: 1 (very bad) to 5 (very good)];
mean number of physical diseases, 0.85 (range 0–12); mean number of physical complaints, 1.23 (range 0–6)
In the last 2 months: accessed health service (any type), 71.4%; accessed curative outpatient services, 37.4%; accessed preventative outpatient services, 55.4%; accessed a GP, 29.3%; accessed a medical specialist, 15.3%; admitted to hospital for physical health problem, 2.7%; taken medication (any type), 39.1%
Compared with those who had arrived within the previous 6 months, asylum seekers with a longer length of stay had: higher level of disability, greater physical complaints, lower quality of life, greater medication use

To explore quality of life, disability and physical health among Iraqi asylum seekers and their association with psychopathology and pre- and post-migration variables

Cross-sectional
Self-report questionnaire
National register of asylum seekers
Random sampling (Iraqi only)

n = 294
All from Iraq
65% male
Group 1: <6 months (mean 2.5); Group 2: >24 months (mean 36.8)
Age range: 18 to >64 years (average N/S)

Demographic data
Physical health status (method of categorisation N/S)
Traumatic experiences/adverse life events (Harvard Trauma Questionnaire)
PMLP
Quality of life (WHO QOL-BREF)
Psychiatric disorders (CIDI)
Brief disability questionnaire

For the total asylum seeker sample:
mean days in bed due to ill health, 4.2; mean days of disability, 6.6;
mean score for perceived physical health, 3.1 [range: 1 (very good) to 5 (very bad)]
% asylum seekers with ≥1 chronic physical complaint: 52.6%
Most common physical complaints: dizziness with falling (25.2%), headache for >3 months (24.8%), back problem >3 months (21.8%), stomach problem (21.4%), joint problem >3 months (20.7%), intestinal problem >3 months (9.5%), physical handicap (6.8%)
Longer length of stay associated with: perceived lower physical health status, higher prevalence of chronic physical complaints and lower quality of life
<table>
<thead>
<tr>
<th>Author, country</th>
<th>Stated study objectives</th>
<th>Study design, setting</th>
<th>Sample size, participant characteristics</th>
<th>Outcome measures related to findings</th>
<th>Findings</th>
<th>Quality rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maier et al. 2010, Switzerland</td>
<td>To determine mental health status and patterns of healthcare utilisation among asylum seekers</td>
<td>Cross-sectional (retrospective) Health insurance data audit Register of asylum seekers Consecutive sampling, to reach sample size</td>
<td>n = 78 (91% asylum seekers) 18 countries 73% male Time since arrival: range N/S (mean 14 months) Age range: 18–63 years (mean 29.9 years)</td>
<td>Demographic data</td>
<td>Functional disability associated with: age, having one or more psychiatric disorders, PMLP-family issues and previous torture Chronic physical disease associated with: higher age, PMLP (family issues and socio-religious aspects). Chronic physical complaints associated with: psychiatric disorders, female sex and adverse life events</td>
<td>7/8</td>
</tr>
<tr>
<td>McMahon et al. 2007, United Kingdom; Ireland</td>
<td>To compare GP service utilisation, morbidity patterns and consultation outcomes of asylum seekers with matched Irish citizens</td>
<td>Cross-sectional (retrospective) Medical record audit 2 general practice clinics Consecutive sampling, 12 months</td>
<td>n = 171 (+342 local residents as comparison) 23 countries 54% male Time since arrival: N/S Age range: 0–60 years (median 26 years)</td>
<td>Demographic data Diagnoses (number, type) ICPC coding Number of clinic visits Outcome of visit: medication prescription and referrals</td>
<td>Compared with the host population, asylum seekers had: higher healthcare costs (2445 v. 1366 Swiss Francs), more than double the mean number of visits to GP or specialist annually (10.7 v. Actual figure not provided) Health reason for asylum seeker presentation to GP (% of visits): Obstetrics and gynaecology (10.5%); Dermatology (9%); gastrointestinal (9.6%); vaccination (6%); investigations (1.5%)</td>
<td>2/8</td>
</tr>
<tr>
<td>Pförtmueller et al. 2012, Switzerland</td>
<td>To assess the reason for presentation to an emergency department among asylum seekers from African countries</td>
<td>Cross-sectional (retrospective) Hospital database audit Hospital emergency department Consecutive sampling, 12 years</td>
<td>n = 3675 6 African countries 66% male Time since arrival: N/S Age range: 16 to over 80 years (average N/S; 75% of sample &lt;40 years)</td>
<td>Demographic data Cause of presentation (categorised into: internal medicine, injury, surgical, psychiatric, undefined)</td>
<td>Of all recorded emergency department admissions involving asylum seekers: cause of presentation related to internal medical problems (45%), injuries (40%), surgical problems (8%), psychiatric or undefined (7%)</td>
<td>4/8</td>
</tr>
<tr>
<td>Study</td>
<td>Country</td>
<td>Objective</td>
<td>Design Type</td>
<td>Sample Size</td>
<td>Sample Characteristics</td>
<td>Data Collection</td>
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<tr>
<td>Redman et al. 2011, 40</td>
<td>United Kingdom; Wales</td>
<td>To explore the self-reported health problems, perception and understanding of the national health system among recently arrived asylum seekers</td>
<td>Cross-sectional Self-report questionnaire Accommodation centre for asylum seekers Convenience sampling</td>
<td>n=30</td>
<td>11 countries Gender: N/S Time since arrival: N/S (70% of sample &lt;4 weeks) Age: N/S</td>
<td>Demographic data Researcher-devised questions on medical problems</td>
</tr>
<tr>
<td>Rogstad and Dale 2004, 41</td>
<td>United Kingdom; England</td>
<td>To compare the needs of asylum seekers attending a genitourinary clinic with those of matched British patients</td>
<td>Cross-sectional (retrospective) Medical record audit Specialist hospital service Consecutive sampling, 12 months</td>
<td>n=43 (+43 local residents as comparison)</td>
<td>Many different geographic regions 51% male Time since arrival: N/S Age range: 15–56 years (mean 27.9 years)</td>
<td>Demographic data History of previous sexually transmitted infection Number of clinic visits Number of missed appointments Reason for attendance History of sexual violence</td>
</tr>
<tr>
<td>Toar et al. 2009, 42</td>
<td>United Kingdom; Ireland</td>
<td>To compare the health status and service utilisation of refugees and asylum seekers</td>
<td>Cross-sectional Self-report questionnaire Accommodation centres for asylum seekers Random sampling</td>
<td>n=60 (+28 refugees as comparison)</td>
<td>30 countries 67% male Time since arrival: range N/S (mean 18.3 months) Age range: 18 to &gt;48 years (mean 32.8 years)</td>
<td>Demographic data General health status (Short Form-36) Number of chronic conditions (past 12 months) Pre-migration stressors (Part I Harvard Trauma Questionnaire) Post-migration stressors Utilisation of healthcare services Psychiatric status (Harvard Trauma Questionnaire part IV; Hopkins Symptom Checklist-25)</td>
</tr>
</tbody>
</table>
Table 1. (continued)

<table>
<thead>
<tr>
<th>Author, country</th>
<th>Sample size, participant characteristics</th>
<th>Study design, setting</th>
<th>Outcome measures related to findings</th>
<th>Findings</th>
<th>Quality rating*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Van Hanegem et al.</td>
<td>Female: 485, Male: 154</td>
<td>Cross-sectional</td>
<td>Demographic data, cases of SAMM, pregnancy characteristics</td>
<td>Compared with the host population, asylum seekers had higher incidence of SAMM (31.0/626 v. 6.8 per 1000 births); higher incidence of uterine rupture (15.8% v. 8.4%) and incidence of obstetric haemorrhage (12.5% v. 9.1%); but lower incidence of obstetric haemorrhage (42.5% v. 63.3%); Of those asylum seekers with SAMM, 22.9% had another serious underlying condition. Factors associated with SAMM: HIV positive status, unemployment, low socioeconomic status, major language barrier, shorter stay in the Netherlands, late booking, multiparity, prior Caesarean section.</td>
<td>8/8</td>
</tr>
</tbody>
</table>

**Health service utilisation**

Of the 23 quantitative studies included in the review, 11 provided data on asylum seekers’ utilisation of health services, of which five were based on self-reported measures,29,36,41,42,46 and six studies used objective measures (medical records or clinical data).27,28,31,38,47,48 The proportion of asylum seekers accessing primary care services (facilitated by a nurse or general practitioner) ranged from 55 to 73% in the last 2 months27,45,42,46 to 81% over a 3-year timeframe.27 Asylum seekers’ annual primary care attendance averaged 5.8 visits per year in Switzerland,28 5.2 in the UK (double that of the host population)38 and 3.4 in Australia.31 Annualised hospitalisation rates reported in two studies, as measured by the number of admissions in the previous 12 months, varied from 12.46 to 20.56 compared with 7% reported in the general population.46 Medication prescriptions (any type) were a frequent outcome of primary care visits, with over half of encounters involving the recommendation or prescription of medication.31,38 The proportion of asylum seekers reporting recent medication use ranged from 39 to 72%.36,42,46

Asylum seekers’ utilisation of preventative health services, such as screening, health education and immunisation, as well as dental care, allied health and other specialist services were limited or not commonly measured. The few available data suggest that less than 25% of female asylum seekers in Blackwell et al. and Rogstad and Dale reported having undergone a cervical pap screening test (v. 62% reported in the host population).29,41 and overall preventative assessment, including general check-up and health education, occurred in 1 out of 20 encounters in Correa-Velez et al.’s study in Australia.31

Finally, in comparing the consumption and costs of health services by asylum seekers with a local comparable sample, Bischoff et al.27 found that the mean (+ s.d.) number of consultations over a 3-year period was 27 ± 50.9 among asylum seekers compared with 33.9 ± 26.7 among the host population. In addition, asylum seekers received shorter duration of care. Therefore, in economic terms, asylum seekers’ average monthly cost to the health system was less than half that of the local population. In contrast, Maier et al.’s study into asylum seekers’ use of health services found that they were more than twice as likely to consult a general practitioner or a specialist and their healthcare costs were 1.8 times higher than that of the local population.46

**Barriers and facilitators to healthcare**

Nine qualitative studies were identified that provided information on barriers and facilitators to healthcare.8,49–56 Six major themes were identified within these studies.

**Affordability**

Inability to pay for medical consultation was cited as an inhibitory factor in some contexts where, at the time of the study, access to free healthcare was not universal.8,49,55,56 Aside from consultation fees, there appear to be other costs that serve as barriers, including the cost of transportation to appointments, difficulties paying for pharmaceuticals and other health-related expenses,8,52–56 including contraception.35
Table 2. Qualitative studies: general study characteristics and quality appraisal

<table>
<thead>
<tr>
<th>Author, country</th>
<th>Stated study objective(s)</th>
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<th>Quality ratinga</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asgary and Segar 2011,49 United States of America</td>
<td>To better understand asylum seekers’ experiences of poor access to healthcare</td>
<td>Focus groups and in-depth, semi-structured interviews 2 Human Rights Clinics Purposive sampling</td>
<td>n = 35 (+14 physicians: data not included) 19 countries 86% male Time since arrival: N/S; all &lt;24 months Age: N/S; all &lt;40 years</td>
<td>7/8</td>
</tr>
<tr>
<td>Bernades et al. 2010,50 United Kingdom; England</td>
<td>To assess asylum seekers’ symptoms of psychological distress, and subjective experiences of the asylum process and mental health needs</td>
<td>Mixed methods: Mental health screening questionnaire (data not extracted) and in-depth, semi-structured interviews General health clinic and specialist mental health clinic</td>
<td>n = 29 (only 8 interviewed) 13 countries 90% male Time since arrival: 0 to &gt;84 months (mean 19.8 months) Age: N/S</td>
<td>3/8</td>
</tr>
<tr>
<td>Bhatia and Wallace 2007,51 United Kingdom; England</td>
<td>To explore asylum seekers’ and refugees’ experiences of primary care</td>
<td>In-depth, semi-structured interviews Refugee support service Convenience sampling</td>
<td>n = 11 (73% asylum seekers) 7 countries 18% male Time since arrival: N/S; all &lt;10 years Age range: 22–65 years (average N/S)</td>
<td>5/8</td>
</tr>
<tr>
<td>McLeish 2005,52 United Kingdom; England</td>
<td>To describe the maternity experiences of asylum seekers</td>
<td>In-depth, semi-structured interviews Publicised through a range of health and welfare providers Convenience and snowball sampling</td>
<td>n = 33 19 countries All female Time since arrival: N/S Age range: 16–40 years (average N/S)</td>
<td>3/8</td>
</tr>
<tr>
<td>O’Donnell et al. 2007,53 United Kingdom; Scotland</td>
<td>Explore healthcare needs and barriers and facilitators to access for asylum seekers</td>
<td>Focus groups and in-depth, semi-structured interviews Community-based asylum seeker support groups Convenience sampling</td>
<td>n = 52 16 countries 40% male Time since arrival: N/S (most of the sample more than 3 years) Age: N/S</td>
<td>6/8</td>
</tr>
<tr>
<td>O’Donnell et al. 2008,54 United Kingdom; Scotland</td>
<td>To explore how asylum seekers’ previous knowledge and experience of health care influences their current expectations</td>
<td>Focus groups and in-depth, semi-structured interviews Community-based asylum seeker support groups Convenience sampling</td>
<td>n = 52 16 countries 40% male Time since arrival: N/S (most of the sample more than 3 years) Age: N/S</td>
<td>6/8</td>
</tr>
<tr>
<td>Rees 2003,55 Australia</td>
<td>To summarise findings on the experiences of asylum seekers and the effect of prolonged asylum status</td>
<td>Mixed methods: cross-sectional questionnaire (not included) and in-depth, semi-structured interviews Recruitment site: N/S Purposive sampling</td>
<td>n = 23 All from East Timor All female Time since arrival: N/S Age: N/S</td>
<td>4/8</td>
</tr>
<tr>
<td>Spike et al. 2011,8 Australia</td>
<td>To explore difficulties asylum seekers face in accessing primary care services</td>
<td>In-depth, semi-structured interviews Asylum seeker support centre Purposive sampling</td>
<td>n = 12 (1 refugee; +5 stakeholders: data not included) Many different geographic regions 67% male Time since arrival: range N/S (mean 3.4 years) Age range: N/S (more than half 40–59 years)</td>
<td>4/8</td>
</tr>
</tbody>
</table>

(continued next page)
Poor health literacy and understanding of the health system

Many asylum seekers originate from low- and middle-income countries where the structure of the health system is very different to that of highly industrialised countries. The participants in the majority of the studies found navigating the healthcare system to be problematic due to inadequate knowledge of the availability of, and their eligibility for, health services. Problems cited were a lack of provision of health service information on arrival in the country, poor understanding of the concept of primary healthcare and referral pathways, and logistical difficulties in accessing a service. Social and community supports were seen as integral for providing information and resources to facilitate service access.

Perceived effectiveness and quality of health services

Participants complained of long waiting times for all types of services and a lack of continuity of care, which served as deterrents for future help-seeking. Continuity of care was perceived to be a facilitator to service access because it improved asylum seekers’ trust and confidence in health professionals. Some asylum seekers were concerned about the ‘generalist’ role of doctors in primary care. They felt that GPs were not specialised enough or did not have sufficient knowledge about refugee health issues to be able to provide adequate care.

Medical mistrust

The participants in Asgary and Segar’s study held concerns over the degree of confidentiality and security that was maintained with their health information. This appeared to be linked to the perception that the immigration and health systems were interconnected, and that their health information, lack of documentation or inability to pay would have an effect on the asylum process, or increase their risk of deportation or detention. The participants of other studies expressed issues of trust relating to the presence of interpreters during consultations, as they could not be assured of the accuracy and quality of translation and whether confidentiality was upheld.

Discrimination and health professionals’ attitudes

Themes of discrimination were highlighted in multiple qualitative studies. This included witnessed or observed hostility from staff, feeling that they weren’t being respected, were being denied care or were offered a poorer quality of care as a result of their race or immigration status. In contrast, staff that demonstrated kindness, listened carefully and built rapport with asylum seeker patients fostered a sense of trust and facilitated service access.

Linguistic and cultural factors

In most countries, asylum seekers are eligible for interpreter services in a range of health settings but communication and linguistic barriers were consistently described as major barriers to healthcare. Asylum seekers frequently encountered a lack of available, professional or culturally appropriate interpreters, resulting in the inappropriate use of family or friends as informal interpreters.

Discussion

Studies utilising both patient- and physician-reported data consistently demonstrate that asylum seekers have a high prevalence of one or more medical conditions, and where a comparison group is available, this is significantly greater than the host population. This is not limited to infectious diseases, as is commonly thought, but encompasses a complex array of acute and chronic medical conditions, reflected in asylum seekers’ tendency to report their general health as poor. Cross-sectional studies correlating demographic risk factors, albeit limited, indicate that female gender, a history of experiencing violent conflict or pre-migration trauma, and a lengthy asylum process are associated with poorer health outcomes.

Patterns of healthcare consumption appeared to be high in most studies but varied between settings; heterogenous study designs and the absence of a comparative host sample in many studies made it difficult to contextualise these findings. Utilisation rates can reflect both morbidity patterns and health service entitlements or access, making interpretation somewhat challenging. Bischoff et al. found that despite a higher number of diagnoses, asylum seekers had fewer medical consultations, shorter duration of care and lower costs than the host population, suggesting that they face barriers in seeking care. These findings conflict with another study from the same country concluding that asylum seekers had more frequent consultations and higher costs. The contradictory findings could be a result of different study methodology and costing models, but nevertheless highlight the difficulties in examining healthcare consumption.

Of the studies included in the review, only one quantitative and two qualitative studies were undertaken in Australia. Therefore findings from research conducted with asylum seekers
in other host countries should be considered in the context of
the healthcare system, entitlements, socio-environmental factors,
and other humanitarian policy such as the profile of asylum
seeker intakes. For example, all countries identified in the re-
search appear to have a health screening process for asylum
seekers on arrival and most provide healthcare beyond
emergency needs, but there are important differences in the
extent and delivery of services. In the Netherlands a gatekeeper
system is in place, where on-site in government-provided resi-
dences asylum seekers have access to a doctor or nurse whom
they are required to see before being referred externally. In
Switzerland and the UK, asylum seekers are allocated to or
register with a primary care service in the community and
provided with free, comprehensive health coverage. The Swiss
example is particularly unique where research was embedded
within a specialised, integrated primary care service founded
within a tertiary teaching hospital, specifically to provide com-
prehensive primary care for asylum seekers. Data collected
over a 3-year period were used to monitor the needs of asylum
seekers attending the service and make improvements
accordingly.

Implications for the Australian context

The above examples of other host countries are in contrast to
Australia, where health services are fragmented and increasingly
difficult to navigate for asylum seekers and health providers
alike, and very limited data are collected on asylum seekers
attending public health services. The findings from qualitative
data suggest that asylum seekers face many barriers in accessing
care, which presents opportunities for improvements that could
be adopted in the Australian context. Due to their unique and
diverse health profiles, linguistic barriers, cultural differences
and longer consultation requirements, some health professionals
may be under-resourced or reluctant to provide care to asylum
seekers.59 The continued development and wide dissemination
of evidence-based clinical guidelines, innovative service models
and incentives for professional development need to be comple-
mented with a national cultural competence framework to assist
health professionals to better meet the needs of asylum seekers.
Specialist refugee health roles, such as Refugee Health Fellows
and Refugee Health Nurses, as well as bicultural health and
welfare workers can be integral resources for other health profes-
sionals seeking advice and support.

Other policy considerations to improve access and health
outcomes for asylum seekers in Australia include the adoption
of universal access to Medicare, the Pharmaceutical Benefits
Scheme and the provision of Health Care Cards to those meeting
eligibility criteria. This would make healthcare and medications
more affordable, reduce the burden on community services
willing to provide fee-free consultations60 and address the inconsis-
tencies between state fee-waiver directives for Medicare-
ineligible asylum seekers.61,62 Reducing such inequities for
asylum seekers is likely to prevent long-term health complica-
tions due to delayed intervention63 and perhaps provide greater
uptake of preventive services.

In Australia, asylum seekers are not eligible for many of the
settlement services provided to refugees, such as extensive
information and orientation, language classes, Centrelink income
benefits, skills training and employment services. Being largely
dependent on community welfare organisations disempowers
individuals and exposes them to greater health risks as they face
poverty and homelessness.64,65 More research into social and
environmental factors that may increase the susceptibility of
asylum seekers to poor health is urgently required. Addressing
such determinants of asylum seeker health requires a framework
that seeks greater collaboration between health and welfare
organisations and policy makers.

Limitations

There were several limitations in the quality of the studies
reviewed, which should be acknowledged. Although a few
studies did use random sampling from non-clinical settings,
there was a tendency to recruit convenience samples through
health and support centres. This may have resulted in an over-
representation of health problems, or a bias toward those already
seeking care and with greater social supports, rather than the
more marginalised asylum seeker population. Other limitations
include the predominance of cross-sectional methodology,
reliance on self-reported health data, inadequate survey instru-
m ents that were not always cross-culturally validated and back-
translated, and a lack of testing of the reliability of interpreters.

There were also some challenges and limitations in conducting
this systematic review. Incorrect or inexplicit use of the correct
legal terminology related to asylum seekers may have resulted in
the unintended exclusion of some articles, as the broader term
‘refugees’ was not used in the database search. Despite the
heterogeneity of study designs, inclusion of qualitative studies
enabled the assessment of complex concepts and triangulation
of data.

Conclusion and policy implications

Asylum seekers residing in community settings while they await
a decision on their refugee status have a disproportionate burden
of physical morbidity that is not only limited to infectious
diseases, but also chronic, non-communicable conditions and
sexual and reproductive health issues. There are several unique
factors that place them at greater risk of poorer health outcomes,
some of which are related to the host country environment and
amenable to intervention. There are a multitude of barriers that
continue to impede healthcare access for asylum seekers. Despite
increasing numbers of people seeking asylum in many countries
throughout the world, little research has been conducted to help
us understand the health needs of this vulnerable group. Further
studies are urgently required to promote the development of
policy and a national cultural competence framework to guide
the provision of healthcare to asylum seekers and to address the
current health inequities they face.

Conflicts of interest

The authors report no conflicts of interest.

Acknowledgements

The study was undertaken as part of Emily Hadgkiss’s thesis for the fulfilment
of the Master of Public Health Degree. Emily Hadgkiss conducted the initial
search and data extraction as part of her studies. Andre Renzaho supervised
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verified the data extraction, made intellectual input into the data analysis and summary, the drafting of the article, and critically reviewed the manuscript. All authors have approved its submission. Associate Professor Andre Renzaho is supported by an ARC Future Fellowship.

References


7 Department of Immigration and Citizenship. Form 1024i: bridging visas. Canberra: DIAC; 2010.


Physical health of asylum seekers: systematic review

41 Rogstad KE, Dale H. What are the needs of asylum seekers attending an STI clinic and are they significantly different from those of British patients? *Int J STD AIDS* 2004; 15(8): 515–8. doi:10.1258/095646201558230
53 O’Donnell CA, Higgins M, Chauhan R, Mullen K. ‘They think we’re OK and we know we’re not’. A qualitative study of asylum seekers’ access, knowledge and views to health care in the UK. *BMJ Health Serv Res* 2007; 7: 75. doi:10.1186/1472-6963-7-75