

Costs of asylum seekers' difficulties accessing health care and who bears the costs: responses of health professionals working with asylum seekers

Theme	Illustrative quote
<i>Tangible costs</i>	
Insufficient voluntary aid to address all health needs	"We have one patient ... with a urinary infection, and it was decided that ... he needed a TURP [transurethral resection of the prostate], and then they realised he didn't have any funds and they discharged him ..."
Inconsistent attitudes of hospitals	"There's quite a difference between different hospitals. For example, the X hospital at Y is very tough. ... much tougher than the hospital here, on refugees. ... They are different Area Health Services ... it may not even be the Area Health Service directors, but the hospital manager's idea that these people should pay."
More costs in the long term	"I have a lot of patients with diabetes and high blood pressure ... Now if their diabetes or their blood pressure or their cholesterol is not managed properly, then they get heart disease or strokes. So, I have a patient who has had a stroke ... high blood pressure and so on ... if he had [had] better access to health care, would he have had the stroke? ... So [now], the government has had to pay ... it doesn't make any sense really."
<i>Intangible costs</i>	
To the asylum seeker (recounted by a health professional)	"If you say to someone, I really think you need to have this test, but, if I refer you, you have to pay a lot of money, so I'm not going to refer you, how does that make you feel? It makes you feel worried and powerless."
To health professionals	"... if someone came in complaining about it [diarrhoea, losing weight], you would do a whole lot of checks, and with that particular lady ... we were able to negotiate to get a couple of tests done free, and the family and she paid a certain amount of money to get some others [done] ... if the person had Medicare, you'd take it that step further and do extra just to be 101% sure. So, there is that real ethical dilemma ..."
To the Australian society	"... if people actually knew on a face-to-face level ... what it meant to deny a newborn baby the right to health care, [or] ... turn away someone who is extremely depressed ... [Would they] actually be able to say 'No, they don't [have a right to health care]'." ◆

Some individuals and institutions sympathetic to the plight of asylum seekers give their professional time or donate money to pay for health care, but are not able to address the full range of health care needs. Obtaining access to secondary care, particularly admission to hospital, is very difficult. There is no uniform approach to charges, either between hospitals or within any one hospital on different occasions. The approach seems to depend on the decision-maker present.

Such difficulties in accessing care may lead to uncomplicated health problems developing into chronic and more serious ones. The attempt to save costs is likely to lead to higher costs in the future. The effect on asylum seekers is increased physical, psychological and social disadvantage and diminished opportunities for a healthy life.

Health professionals are faced with the dilemma of turning these people away, or aiding them without financial compensation. In either case, they cannot provide the necessary standard of care.

Although many Australians are conscious of the hardship of these people, the society as a whole seems unaware of it or of the impact that its unfairness may have on the social fabric of their communities.

If all Medicare-ineligible asylum seekers in NSW were to have the same access to health services as other Australians, we estimate that the total annual cost would be about \$3.4 million.⁵ This is about 0.015% of the total annual recurrent health expenditure in NSW in 2000–01.⁶ This economic cost, some if not most of which will be spent regardless, does not justify the disadvantage created by the Australian Government's immigration rules.

We suggest that state governments consider giving this small group of asylum seekers free access to public hospital services.

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- 1 Shields L, Stathis S, Mohay H, et al. The health of children in immigration detention: how does Australia compare? *Aust N Z J Public Health* 2004; 28: 513-519.
- 2 Correa-Velez I, Gifford S, Bice S. Australian health policy on access to medical care for refugees and asylum seekers. *Aust N Z Health Policy* 2005; 2: 23. Available at: <http://www.anzhealthpolicy.com/content/2/1/23> (accessed Nov 2005).
- 3 Sinnerbrink I, Silove D, Manicavasagar V, et al. Asylum seekers: general health status and problems with access to health care. *Med J Aust* 1996; 165: 634-637.
- 4 Telfer B. Hostility and hospitality: a qualitative analysis of three, key perspectives on barriers to and opportunities for community based asylum seekers accessing health services in Australia, 2001-2003 [MPH treatise]. Sydney: University of New South Wales, 2003.
- 5 Kardamanidis K. Tangible and intangible costs of the "No work – no Medicare" policy for community based asylum seekers in New South Wales, Australia [MPH thesis]. Sydney: University of Sydney, 2004.
- 6 Australian Institute of Health and Welfare. Interactive expenditure data. Select State health expenditures, current and constant prices, 1996-97 to 2002-03. Available at: <http://www.aihw.gov.au/expenditure/datacubes/index.cfm> (accessed Dec 2005). □

Hospital in the home: what next?

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TO THE EDITOR: British authors Wilson and Parker in their editorial on hospital in the home¹ acknowledge the outdated Cochrane review of 2001² in relation to costs of hospital in the home. More recent research in New South Wales provides compelling evidence of cost saving in excess of 50% when community costs are compared with inpatient costs for certain diagnosis related groups.^{3,4} Patient selection for these services is based on safety, functional ability, carer support, and consent. The treatment regimens are based on evidence and governed by strict quality assurance. These elements form the foundations of successful acute and post-acute care programs.

Amendments to the *National Health Act 1953* (Cwlth) in 2001 endorsed the provision of acute care in places other than hospital beds.⁵ The Macarthur Health Service in south-western Sydney received Commonwealth acute outreach accreditation in 2004 and currently supplies at least 13% of total bed-days in the specialties of medicine, surgery and paediatrics. An added benefit is

a system that allows people to choose a private outreach service instead of a hospital bed and have expenses covered by their health fund, which pays a bed-day rate for this care in the community.

Patient quality of care, choice and satisfaction have been the drivers for hospital in the home. Demonstrated savings for ambulatory sensitive diagnoses and the opportunity for revenue from private patients should be appealing to hospital administrators in an environment of chronic bed shortages.

1 Wilson AD, Parker SG. Hospital in the home: what next? *Med J Aust* 2005; 183: 228-229.

2 Shepperd S. Hospital at home versus in-patient hospital care. *Cochrane Database Syst Rev* 2001; (3): CD000356.

3 Board N, Brennan N, Caplan GA. A randomised controlled trial of the costs of hospital as compared with hospital in the home for acute medical patients *Aust N Z J Public Health* 2000; 24: 305-311.

4 Wilson SF, Shorten B, Marks R. Costing the ambulatory episode: implications of total or partial substitution of hospital care. *Aust Health Rev* 2005; 29: 360-365.

5 *Health Amendment Act (no.1) 2001*, pursuant to section 5D of the *National Health Act 1953*. □

Editor's note: The Cochrane review was updated after Wilson and Parker submitted their editorial: Shepperd S, Iliffe S. Hospital

at home versus in-patient hospital care. *Cochrane Database Syst Rev* 2005; (3): CD000356. Available at: <http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD000356/frame.html> (accessed Dec 2005). □

Safety of hospital in the home

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TO THE EDITOR: We note with interest the studies published in the Journal by Richards et al and Ong et al.^{1,2} The authors conclude that treating pneumonia and pulmonary emboli in an ambulatory setting is safe for selected patients. However, this represents a large change in the conditions traditionally treated on this basis, from conditions that are associated with a very low mortality (such as cellulitis) to a subgroup of patients with potentially serious infections

that are identified as being of low risk. We feel that safety is of prime importance in hospital-in-the-home programs because of limited or delayed access to acute medical care, and that both studies were underpowered to define this endpoint.

Both studies incorrectly quote previous work that suggests that the groups they have identified have mortality rates of up to 5% (for pulmonary emboli) and up to 9.2% (for mild to moderate pneumonia). Published data suggest that the mortality of mild pneumonia (with CURB-65 scores ≤ 2) is in the range 1.7%–3%,^{3,4} and that mortality from treated sub-massive pulmonary emboli is in the range 1.0%–1.3% within the first week.⁵ These rates, although seemingly small, are still much higher than that associated with the treatment of soft tissue infections on ambulatory care programs. Recurrent pulmonary embolus, in particular, may be sudden and unexpected. Although admission to hospital may not necessarily prevent these deaths, the additional trauma of a death at home, particularly soon after transfer to ambulatory care, may carry a higher significance in the minds of patients, their families and the public than a death in hospital.