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REVIEW

Public health policy for temporary seasonal workers with chronic hepatitis B in high-income countries: A comparative analysis

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Abstract

Issue Addressed: This study examines Australia's Hepatitis B public health policies with a focus on the Pacific Australia Labour Mobility scheme seasonal workers as a priority population. The aim is to evaluate if Australia's Hepatitis B public health policies adequately address health disparities and equitable access to health care for seasonal workers as a priority population. We draw comparisons with the public health policies of New Zealand and Canada, to understand how these nations approach similar health concerns among their temporary seasonal workers.

Methods: A health policy analysis was conducted on the public health Hepatitis B policies in Australia and then compared with those in Canada and New Zealand. Due to the nature of the study question, the review had a major focus on grey literature. The search was undertaken in two stages, including (1) Google search engine and (2) targeted websites. Basic document data was produced in descriptive summaries. Any data either explicitly or inexplicitly relating to the elimination of hepatitis B or equity towards the inclusion of seasonal workers was produced as analytical summaries through multiple revisions.

Results: Nineteen documents were identified, predominantly from Australia. Although Hepatitis B public health policies emphasised testing and awareness in priority populations, specifically mentioning seasonal workers as a priority population was absent in all three countries.

Conclusions: The study underscores the exclusion of temporary seasonal workers in public health policies and strategies as a human rights issue, conflicting with principles of equity and equitable access to health care. Despite acknowledging challenges for temporary visa holders, policies lack specific provisions for seasonal workers. Addressing this gap is crucial for health equity and inclusive health systems.

So What? Our findings highlight the need to prioritise equity for temporary seasonal workers to achieve hepatitis B elimination goals by 2030. Exclusion from public health policies is a human rights concern, impacting access to quality health care. This study advocates for inclusive policies explicitly recognising temporary seasonal

workers as a priority population, aligning with international human rights commitments to health care for all.

KEYWORDS
blood-borne viruses, health equity, health policy, hepatitis B, Pacific Island peoples

1 | INTRODUCTION

In 2008, the Australian Government announced a new labour mobility scheme for Pacific Island workers, with the two objectives of meeting seasonal demand for low-skilled labour, predominantly in the horticulture industry and promoting economic development in Pacific Island countries. Each year, more than 37 000 people from Pacific Island countries migrate to Australia for up to 9 months to engage in seasonal work under the Pacific Australia Labour Mobility (PALM) scheme.[1] Seasonal workers (defined as those who are in a country that is not their country of citizenship or residency for the sole purpose of employment) are hired by host country employers for a limited duration and return to their country of origin at the end of their employment period.

The Pacific region—a major source of temporary seasonal workers (hereafter referred to as seasonal workers) for Australia—has a high prevalence of chronic hepatitis B (CHB) compared to other regions in the world. In 2022, an estimated 205 549 people were living with CHB infection in Australia representing .78% of the population,[2] with an estimated 60 000–100 000 people unknowingly living with CHB.[3] Of the new CHB cases each year in Australia, over 70% are attributable to migration, with 4.6% of all people with CHB in Australia born in Oceania (excluding Australia).[2] The Pacific region, where Australia's seasonal workers come from, carries a high prevalence of CHB.[4,5] The prevalence in the Pacific region ranges from 4.4% in Samoa to 9.7% in Timor Leste.[6] Thus, many seasonal workers may be at risk of CHB or potentially living with the condition unknowingly.[7]

Seasonal workers from Pacific Island countries where endemic levels of hepatitis B are present, often engage in the seasonal work cycle between Australia and their home country for decades, spending up to 75% of their time in Australia each year.[8] Although equity is one of the primary objectives of Australia's health system, seasonal workers are not eligible to access health services via Australia's publicly funded universal health scheme, Medicare.[9]

This article critically analyses the existing public health Hepatitis B policies to address health disparities related to seasonal workers as a first step towards ensuring inclusive health care in Australia. Public health policy is crucial in promoting equitable access to health care by addressing systemic barriers and disparities hindering individuals' abilities to obtain the necessary health care services. We review current hepatitis B public health policies for seasonal workers focusing on gaps that result in a lack of access to hepatitis B health care for this population group in Australia. Due to the various historical, political and economic similarities,[10] we chose to compare Australia's public health policies on hepatitis B with New Zealand's and Canada's policies. These three countries share similar colonial pasts, with immigration policies focusing on meeting internal labour demand in essential industries.[11] Although the health care systems of each county have unique characteristics, they share some key commonalities. All countries have a two-tiered health system including both public and private health care.

Australia, New Zealand and Canada are all high-income countries whose economies rely heavily on the agricultural sector.[10] To meet labour demands, national temporary migration schemes have been established to recruit seasonal workers to fill labour shortages, particularly in the agricultural and horticultural sectors.[12–14] Canada and New Zealand have a seasonal worker program similar to Australia's, with Canada's seasonal workers predominantly coming from Mexico and the Caribbean and New Zealand's workers also coming from Pacific Island countries.[13,14] The Recognised Seasonal Employer (RSE) scheme in New Zealand has been modelled on Canada's Seasonal Agricultural Workers Program (CSAWP), with all three countries having concerns about workers accessing health care.[15]

While living, working and paying taxes in their host countries, seasonal workers are ineligible to receive free access to the national public health care system. As a condition of entry, Australia and New Zealand require seasonal workers to obtain private health insurance at their own cost, which must be maintained for the duration of their stay. In Canada, access to health care and coverage for seasonal workers is inconsistent and can vary depending on the province or territory and the nature of their work permit, leaving this population highly vulnerable when needing access to health care. Seasonal workers in Canada often have to purchase private medical insurance which covers medical expenses such as certain diagnostic services and prescription drugs that fall outside of the services and drugs covered under the provincial health insurance.[15]

Including seasonal workers in public health policy is essential for several reasons. A lack of consideration as a priority population means that the issue of inequitable access to health care and health outcomes is not addressed. Seasonal workers are a vulnerable population group for many reasons including temporary migration to a country, residing in rural and remote areas whilst in the host country, poor health and health system literacy, low socioeconomic status, language and cultural barriers, no access to public health care, economic barriers associated with minimum wage incomes, out-of-pocket health care costs and poor or no access to transport.[16] Not including seasonal workers as a priority population means that there is no attention given to or accountability towards addressing the unique barriers that seasonal workers face in accessing essential health services including the distribution of health care resources. The lack of commitment

from host countries to guarantee access to health care resources further exacerbates the vulnerability and inequity of seasonal workers.[17] Furthermore, in Australia, both the Commonwealth and State/Territory public health systems and Private Health Insurance companies hold health care data on the seasonal worker population, which could be utilised to better understand health care access and needs for this population group. Therefore, a lack of data is not reason enough to exclude this cohort as a priority population.

Finally, the right to the highest attainable standard of health, regardless of citizenship or immigration status, is enshrined in the World Health Organisation (WHO) constitution and numerous human rights instruments.[18,19] Australia is a party to seven core international human rights treaties that contain the right to health, alongside the 2030 Agenda for Sustainable Development.[20] A lack of access to universal health care for certain population groups—such as seasonal workers in Australia—is, therefore, a human rights issue.

Considering these factors, the objectives of the analysis are as follows:

1. Review Australia's hepatitis B public health policies and their inclusion of seasonal workers.
2. Conduct a comparative analysis between Australia's hepatitis B public health policies regarding seasonal workers with the policies in place for Canada and New Zealand.
3. Identify policy gaps in Australia that should be addressed.

To the best of our knowledge, this is the first study that draws attention to the gaps in public health policy on hepatitis B virus in seasonal workers in Australia, New Zealand and Canada.

1.1 | Seasonal workers and the Pacific Australia labour mobility scheme

In Australia, a seasonal worker refers to an individual employed temporarily to meet the demand for labour during specific seasons or periods of increased activity in certain industries such as agriculture and horticulture.[12] In 2008, the Australian Government introduced the PALM Scheme to bring seasonal workers to fill labour shortages in Australia.[21]

Under the PALM Scheme, workers from nine Pacific Island countries (Fiji, Kiribati, Nauru, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu) and Timor-Leste are permitted to work in Australia for 9 months (short-term seasonal visa) or 4 years (long-term visa). Seasonal workers granted a long-term visa will have a condition on their visa that means they must return home after each seasonal work period.[12] After this period, visa holders must spend 3 months outside Australia before returning to Australia on another seasonal work placement. Specific tax obligations, including any possible exemptions or variations depend on individual circumstances such as the duration of stay, their residency status for tax purposes and whether their employer is registered as an 'approved employer' under the PALM scheme. Short-term workers are likely to be classified as 'foreign residents for tax purposes', paying a flat tax rate of 15%. Long-term PALM scheme workers are likely to be classified as Australian residents for tax purposes and are subject to the same tax obligations as Australian residents and citizens including needing to pay the Medicare levy, which helps fund the public health care system.[22] The PALM scheme is managed by the Department of Employment and Workplace Relations with the support of the Pacific Labour Facility, as part of the Department of Foreign Affairs and Trade.[21]

1.2 | The Australian health system

The funding, operation, management and regulation of the health system in Australia are shared among the Australian federal, state and territory governments and private for-profit and not-for-profit sectors. These sectors are involved in running both public and private hospitals, pharmacies and medical practices, and they also offer private health insurance. Australia's health system is supported by Medicare, a universal health insurance scheme.[23]

Medicare offers reimbursements for medical services provided by private practitioners in the community, such as general practitioners and other medical professionals. It also ensures that eligible individuals have access to free hospital services in public hospitals and subsidised prescription medications through the Pharmaceutical Benefits Scheme.[24] The funding for Medicare comes from the Australian government through taxation revenue, which includes co-payments, the Medicare Levy and Medicare Levy Surcharge.[25] Currently, Medicare is available to Australian and New Zealand citizens, permanent residents in Australia and individuals from countries with reciprocal agreements. Those outside these categories must usually pay full health services fees or obtain private health insurance.[25] As part of the visa requirement, PALM workers need to maintain private health insurance whilst they are in Australia. Within generally all private health insurance policies, there is an exclusion clause for the coverage of pre-existing health conditions such as CHB and also pregnancy-related care in the first 12 months, which means any related health care costs will have to be covered by the individual.

Private health insurance, with its variations in coverage, leaves significant gaps in care for seasonal workers, especially regarding chronic health conditions such as hepatitis B. Depending on the insurance policy and level of coverage, however, based on NIB online quotes[15] (as the insurance company that holds the tender for the PALM scheme) and through anecdotal information collected from seasonal workers, private health insurance costs a minimum of approximately $70–$80 per month at the basic level, which excludes GP appointments, pharmaceutical prescriptions, outpatient specialist services, any health care related to pre-existing health conditions and pregnancy, birth and postpartum. Comprehensive insurance policies, costing approximately $200 per month typically do not include pre-existing health conditions (for the first 12 months) and pregnancy-related services and care. Unless a higher monthly premium is paid, most private health insurance policies have an excess of around $500,

which seasonal workers would need to pay to access insurance coverage.[26] Any level of private health insurance will result in additional out-of-pocket costs on top of the monthly payments, particularly if a seasonal worker has a pre-existing health condition. The level of out-of-pocket fees has attracted widespread critique[27,28] and makes accessing health services costly for seasonal workers, resulting in a potentially significant impact on their weekly income. These costs impact their overall take-home salary, as seasonal workers are generally on a minimum wage and are casually employed. This means that they would not be entitled to paid sick leave time to seek health care and would, therefore, lose some of their salary to attend medical appointments or to take time off due to illness.

2 | METHODS

2.1 | Search strategies

This study adopts the WHO's definition, which states that health policy is an agreement or consensus on the health issues, goals and objectives to be addressed, the priorities among those objectives and the plans and actions that are undertaken to achieve the specific health care goals within a society.[29] Health policies can be set at national, state, provincial, regional or territory government levels or developed at a health service provider level. Based on this, in this article, the term 'policy' will refer to any framework, guideline, action plan or strategy that falls within this comprehensive definition.

Due to the objectives of this study, this literature review focused on searching primary literature sources commonly referred to as 'grey literature'. Grey literature includes 'that which is produced on all levels of government, academics, business and industry in print and electronic formats, but is not controlled by commercial publishers'.[30] No gold standard for grey literature searching has been developed. The Cochrane Handbook, an official guide for undertaking systematic reviews, provides insufficient guidance for searching grey literature.[31] To ensure transparency of study findings, the authors drew on one methodological study,[32] which provided the most comprehensive details for applying systematic review search methods to the grey literature.[33]

The document search incorporated two different search strategies. The first strategy included searching the Google search engine and targeted websites where the first 5 pages (50 pages per search) were reviewed for relevant documents. Searching methods combining the following keywords and phrases (Table 1) were used in the search:

The second search strategy involved searching specific websites of applicable government health departments, research and other organisations. First, H.F. searched Google to identify websites containing relevant information to address the research question. Each website was then hand-searched via the website's search bar to identify the document of interest. This search was conducted between June and August 2023. A secondary search was then conducted by author W.M. to ensure no documents were missed in the initial search.

TABLE 1 Keywords and search strategies.

Condition name/ group	Document name	Target location
Hepatitis B OR blood-borne viruses OR sexually transmitted infections	Strategies OR action plan, framework OR statement of priorities OR implementation plan OR operational plan OR testing policies	New Zealand OR Australia OR Victoria OR New South Wales OR Western Australia OR South Australia OR Queensland OR Tasmania OR Northern territory OR Australian Capital territory OR Canada OR Ontario OR Quebec OR Alberta OR Saskatchewan OR British Columbia OR Nova Scotia OR Manitoba OR New Brunswick OR Northwest Territories OR Prince Edward Island OR Nunavut OR Prairie provinces OR Yukon OR Newfoundland and Labrador.

2.2 | Inclusion and exclusion criteria

Three inclusion criteria were used to screen the documents. First, documents were included in the study if they focused on viral hepatitis B. Only documents that were written in English were included. For Canada, it was assumed that any documents written in French would be translated into English, thus identifying essential policy documents for the purpose of this analysis. Further, the documents had to meet the WHO definition of 'health policy' as previously described.

2.3 | Data extraction and synthesis

Initially, basic information about the documents such as date, title, author, country, time period of the policy, context, objectives, priority populations and whether there was any mention of allocation of resources were used to produce descriptive summaries, which were entered into an Excel file. Following basic data extraction, the critical analysis was structured around two main questions:

1. Do public health hepatitis B policies demonstrate an agenda for eliminating[i] hepatitis B virus in priority populations?
2. Are public health hepatitis B policies inclusive of and equitable towards seasonal workers?

Health equity is defined by the WHO as 'the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or

geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability, or sexual orientation)'.[34] Based on this definition, we determined whether health policies were equitable towards seasonal workers by whether they were included as a priority population group and whether there was mention of the allocation of health care resources towards seasonal workers.

These two questions were used as categories to produce descriptive and subsequently analytical summaries that were refined through several phases of discussion and writing between H.F. and W.M. The two authors discussed any discrepancies and divergences to reach a consensus. Documents that did not address (either explicitly or inexplicitly) these two questions were excluded at this stage. All of the co-authors reviewed and provided feedback on the analysis.

3 | RESULTS

We identified nineteen documents. Sixteen of the documents were Australian based, while two were from Canada and one was from New Zealand. See Table S1 for the complete list of documents and their extracted data. We present the results in three sub-sections. First, we summarise the data about the elimination of hepatitis B in Australia. Second, we summarise the data about equity and hepatitis B and priority populations in Australia, focusing on seasonal workers. Third, we compare Australia's hepatitis B public health policies on seasonal workers with Canada and New Zealand's policies.

3.1 | Elimination of hepatitis B in Australia

The document analysis found that there was general interest in preventing transmission and reducing new infections of the hepatitis B virus in priority populations. For example, many of the policy documents stated that they aim to eliminate hepatitis B as a public health threat by a specific target date, often set for 2030[34,35] and to reduce mortality and morbidity related to the disease.[34,36,37] This includes making significant progress towards elimination, reducing transmission and minimising the personal and social impacts of hepatitis B. The documents revealed a strong focus on increasing testing and diagnosis rates,[38–42] particularly in priority populations and primary care settings,[35,43] to ensure early detection of hepatitis B. Ensuring that individuals with hepatitis B have access to best practice and evidence-based treatment, mainly primary health care services, were identified as a necessity towards transmission prevention and the elimination of hepatitis B in Australia. Ensuring access to best practice included co-designing treatment pathways,[40,43] improving screening[34,43] and providing care in the community. Encouraging vaccination, particularly in children and reducing the risk of acquiring hepatitis B were shared priorities to reach the elimination goal.[36,43] Many policies recognise that addressing and eliminating stigma,[34,36,40–43] racism and discrimination[37,43,44] is essential, as these factors can be barriers to achieving hepatitis B elimination. Australian hepatitis B policies stress the importance of community engagement, partnership with affected communities and improving health literacy if the elimination of hepatitis B in the Australian population is to be achieved.[35]

3.2 | Priority populations and equity

Despite the public health policy efforts to address the issue of hepatitis B in the Australian population, the existing policies at both the federal and state government levels generally lack information on equity concerns of people who are ineligible for Medicare, including seasonal workers. Equity concerns are usually addressed by focusing on priority population groups, including Aboriginal and Torres Strait Islander peoples, pregnant women and children, men who have sex with men, people who inject drugs, sex workers, people in custodial settings and health care workers. There are priority population groups mentioned in the documents that encompass seasonal workers, such as (Culturally and Linguistically Diverse) CALD communities,[35,36,38,40] unvaccinated adults at higher risk of infection,[36–38,43–45] people from high-prevalence countries,[38] mobile populations,[38,45] people living with CHB,[35,40] people not eligible for Medicare,[43,46,47] travellers[38,45] and migrants from areas with a high prevalence of CHB. Some documents acknowledge that temporary visa holders,[46,47] (which can include seasonal workers), may be at an increased risk of hepatitis B infection. However, the hepatitis B public health policy documents in Australia do not explicitly state seasonal workers as a priority population group. There is limited information on the resources and obligations to provide seasonal workers in Australia with health care services without any barriers to ensure equitable access to hepatitis B health care.

Seasonal workers were not explicitly identified in any of the reviewed documents as a priority population. Some of Australia's national and state policies[43,46,47] note that the policies were intended to serve only Medicare-eligible people. Some of the policy documents have acknowledged that hepatitis B virus is a significant issue in communities from countries with a high prevalence[34,38] and that there are challenges and difficulties in accessing hepatitis B services and care by people on temporary visas. However, the documents did not provide information on what services and care are available for seasonal workers from high-prevalence countries and how the issue of access to hepatitis B care and treatment can be addressed for these populations to achieve equitable access to care. Therefore, despite a stated acknowledgment and interest in overcoming inequity, several of these documents were not informed by the principles of individual rights to access health care and achieve health care equity.

Multiple policy documents and strategies addressing hepatitis B in Australia have recognised the challenges faced by individuals on temporary visas when accessing treatment and care for CHB.[46,47] These challenges include limited access to health care services due to their visa status,[34,37,46] potential barriers related to language[34,38] cultural differences[34,37,38,40–45] and the absence of clear pathways to care. Of note, although the Third National Hepatitis B Strategy[36] does not address the issue of Medicare-ineligible populations, the draft

Fourth National Hepatitis B Strategy 2023–2030[34] addresses this issue, highlighting the importance of removing barriers for those who are Medicare ineligible.

3.3 | Comparison between Australian, New Zealand and Canadian hepatitis B public health policies

When reviewing and comparing hepatitis B policies between Australia, New Zealand and Canada, we identified some similarities regarding specific priority population groups. Priority population groups for hepatitis B often include Indigenous populations[35,38,48,49] (such as Aboriginal and Torres Strait Islander peoples in Australia, Māori in New Zealand and First Nations Peoples in Canada), as well as other population groups like people with HIV,[34,38,42,46–49] people who inject drugs,[39,45,48] men who have sex with men[38–40,45,48] and people living with hepatitis B.[34,36,43,48] Like Australia, neither New Zealand nor Canada mentions seasonal workers as a priority population group. The New Zealand policy, however, includes migrants from areas with a high prevalence of blood-borne viruses (BBV).

While there is some overlap in priority populations across the three countries, there are also population groups unique to each country. For example, Canada explicitly mentions members of the Canadian Armed Forces and federally incarcerated individuals as priority populations,[49] whereas New Zealand mentions Pacific peoples. New Zealand's policy states that migrants from areas with a high prevalence of BBVs may not be eligible for publicly funded health care, indicating that access may be limited for specific migrant populations.[48] It is important to note that migrants are not necessarily seasonal workers; migrants can include a wide range of individuals such as permanent residents, refugees, students and temporary workers, some of whom may not engage in seasonal work. In contrast, Australia and Canada do not explicitly address the issue of access to hepatitis B health care and services of seasonal workers in their policy documents, suggesting a gap in coverage for this group.

New Zealand's policy[48] reflects the unique health needs of Pacific populations, which may not be as prominent in the policies of Australia and Canada. Australia's policies often mention international students as a priority population,[38] which may not be as significant in New Zealand or Canada. Each country has specific programs and funding arrangements to provide health care to their priority populations. The details of these programs and funding mechanisms differ among the three countries. While all three countries have committed to eliminating hepatitis B in principle, the specifics of monitoring and evaluation can vary in line with broader partnership or policy agreements. Canada mentions working with various partners and communities to develop BBV targets and indicators.[49] At the same time, New Zealand emphasises the role of *Te Tiriti o Waitangi* (treaty) in making decisions about priority groups. It is important to note, however, the Te Tiriti o Waitangi primarily focuses on the Maori population.[48] Australia mentions ongoing evaluation of its policies, but specific details may vary from one State or Territory to another.

4 | DISCUSSION

This analysis reveals that hepatitis B public health policies in Australia, New Zealand and Canada lack consideration for equity concerns related to seasonal workers accessing hepatitis B prevention, care and treatment. The exclusion of seasonal workers from hepatitis B public health policies impedes efforts to ensure equitable access to hepatitis B care and treatment for this population group. To address these equity issues, this study recommends including seasonal workers in national and state Hepatitis B strategies as "priority populations" and aligning with Australian Government priorities to reduce CHB burden and associated morbidity and mortality. Identifying seasonal workers into national and State/Territory policies for hepatitis B testing and management is of utmost importance. Nevertheless, when prioritising seasonal workers in hepatitis B public health policy, it is critical to approach management and testing with a sincere intent to improve health outcomes, without disqualifying potential workers who may have hepatitis B from their work opportunities in Australia.

Seasonal workers play vital roles in regional centres, contributing to the social, cultural and economic vitality of towns in Australia, New Zealand and Canada.[50] Despite contributing through taxes to support public goods and services, seasonal workers often face barriers to accessing health care services.[51–53] The results from this policy analysis underscore the current lack of hepatitis B policies addressing the health needs of seasonal workers relating to regular testing and management of hepatitis B, demonstrating limited evidence of efforts from policymakers to enhance the engagement of seasonal workers with hepatitis B health care and services.

As private health insurance leaves significant gaps in care for seasonal workers in Australia, New Zealand and Canada; policies that ensure all individuals, irrespective of immigration status, have access to public health care services are needed to address the gaps and limitations of private health insurance. While Australia expresses commitment to eliminating hepatitis B by 2030, policies at both state/territory and federal levels overlook concerns for seasonal workers who face barriers due to language, cultural differences and limited access to Medicare. Providing seasonal workers access to Medicare, as opposed to visa-mandated private health insurance, would allow for access to public health services for all health conditions and Medicare rebates on GP consultations. The Australian Government has recently made strides in providing free or affordable access to HIV treatment to Medicare-ineligible populations[54]; advocating for a similar scheme for hepatitis B is crucial given the equally high cost of care and associated burdens. Many workers return to regions where hepatitis B treatment is not readily available, particularly in isolated areas across the Pacific.[7] To minimise the risks of discontinuing and restarting medication, therefore, advocating for 'continuity of care' once seasonal workers return home, would also be a positive step forward.

Current policy documents in Australia fall short of addressing the unique health care needs of seasonal workers, a gap observed in New Zealand and Canada as well. Seasonal workers are already less likely to seek medical help when sick, primarily due to factors like costs, private insurance exclusions, cultural disparities, a lack of in-

language services and a lack of services in regional areas where seasonal workers primarily live.[52,55] The lack of inclusion or prioritisation of seasonal workers in public health hepatitis B policies further compounds these determinants and health care access, emphasising the necessity for more comprehensive and inclusive approaches. While Australia has a strong sense of human rights and freedoms, basic human rights are not well protected in Australian law. In one State, the Queensland Human Rights Act (2019)[56] highlights that 'every person has the right to access health services without discrimination'. However, as part of the Commonwealth, Australia stands alone in not having a national act or charter of rights.[57] Furthermore, this lack of national legislation is at odds with Australia's international commitments to the 2030 Agenda for Sustainable Development and other human rights treaties and declarations. These international frameworks are grounded in the principle of universality, asserting that all individuals, irrespective of their nationality or immigration status, should have access to health care as a basic human right.[58–60] Recently, the United Workers Union in Australia launched a campaign advocating for Medicare coverage for Pacific seasonal workers.[61] This campaign underscores the right to the highest attainable standard of health, irrespective of citizenship, thereby highlighting the need for alignment between domestic and international human rights standards.

Although hepatitis B public health policies exist on paper, their effective implementation is crucial in terms of impact. A limitation of this study is that it does not review the extent to which the policies were implemented and how they impacted the targeted population. Finally, although there are great similarities between the health systems of Australia, Canada and New Zealand, alongside similar immigration policies for seasonal workers, these countries are not completely homogenous. Therefore, when comparing public health policies, there are variations in political, social and economic contexts between countries. This study acknowledges these differences but may not fully capture policy decision nuances.

5 | CONCLUSION

In summary, Australia's public health hepatitis B policies lack the inclusion of seasonal workers as a priority population group, hindering efforts to ensure equitable access to hepatitis B care and treatment. This lack of inclusion conflicts with the right to the highest attainable standard of health enshrined in the WHO constitution and numerous human rights instruments. This article calls for the development of more comprehensive policies on hepatitis B and strategies to address the unique health care needs of seasonal workers including the provision of accessible health care services, resources and information. The study also calls for the representation of seasonal workers in shaping health policies to ensure equitable access to care and treatment, including hepatitis B, which will help reduce infections in Australia, New Zealand and Canada and strengthen their human rights accord. The analysis sheds light on the importance of prioritising equity concerns to achieve the goal of eliminating Hepatitis B by 2030 and ensuring that vulnerable and marginalised groups such as seasonal workers have access to quality health care services, including regular hepatitis B testing and clinical management.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analysed in this study.

ETHICS STATEMENT

Ethical approval was not required for this study as this was a document analysis using publicly available documents.

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ENDNOTE

[i] Elimination is defined by the WHO, in which Australia, Canada and New Zealand are all member states, as a reduction of new hepatitis infections by 90% and deaths by 65% by 2030.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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