Seasonal Labour, Systemic Injustice:

A Research Report on Health Inequities in the Pacific Australia Labour Mobility Scheme

2025

Haylee Fox, Geraldine Vaughan, Catherine O'Mullan, Robyn Preston, Chris Doran, Billingsley Kaambwa, Isaac Livai & Kris McBain-Rigg

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Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
AIHW	Australian Institute of Health and Welfare
BBV	Blood-Borne Virus
CALD	Culturally and Linguistically Diverse
CC	Compensated Cirrhosis
DC	Decompensated Cirrhosis
CHB	Chronic Hepatitis B
CHEERS	Consolidated Health Economic Evaluation Reporting Standards
DFAT	Department of Foreign Affairs and Trade
DHA	Department of Home Affairs
DEWR	Department of Employment and Workplace Relations
FTE	Full-Time Equivalent
FWO	Fair Work Ombudsman
GESA	Gastroenterological Society of Australia
HCC	Hepatocellular Carcinoma
HILM	Health Insurance Literacy Measure
HIV	Human Immunodeficiency Virus
HREC	Human Research Ethics Committee
ICER	Incremental Cost- Effectiveness Ratio
ILO	International Labour Organization
LSU	Labour Sending Unit
LT	Liver Transplant
MBS	Medicare Benefits Schedule
CEAC	Cost-Effectiveness Acceptability Curve
NGO	Non-Governmental Organisation
NMB	Net Monetary Benefit
OECD	Organisation for Economic Co-operation and Development
PBS	Pharmaceutical Benefits Scheme
PALM	Pacific Australia Labour Mobility (Scheme)
PHI	Private Health Insurance
QALY	Quality-Adjusted Life Year
QH	Queensland Health
sAgLoss	Hepatitis B surface antigen loss
SDG	Sustainable Development Goals
SRH	Sexual and Reproductive Health
STI	Sexually Transmissible Infection
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization
WTP	Willingness to Pay

Glossary of Terms

BBV (Blood-Borne Virus)
A virus that is transmitted through blood-to-blood contact. In the context of this report, this primarily refers to hepatitis B, hepatitis C, and HIV.

Culturally Safe Care
Healthcare that respects and responds to the cultural identities, values, and practices of individuals and communities. It prioritises trust, confidentiality, and non-discrimination.

Deed of Agreement (PALM Scheme)
A legal agreement between the Australian Government and Approved Employers outlining the obligations of each party under the PALM Scheme.

DEWR (Department of Employment and Workplace Relations)
The Australian Government department responsible for domestic administration and oversight of the PALM scheme.

DFAT (Department of Foreign Affairs and Trade)
The Australian Government department responsible for international administration and oversight of the PALM scheme.

DHA (Department of Home Affairs)
The Australian Government department responsible for the PALM scheme immigration framework and processes.

Employer Wellbeing Officer
A role commonly appointed by employers under the PALM Scheme to provide pastoral care and support to workers, including assistance with health, accommodation, and general welfare.

Hepatitis B (CHB: Chronic Hepatitis B)
A viral infection that affects the liver and can become chronic, requiring ongoing care and monitoring. It is highly prevalent in many Pacific countries.

Medicare
Australia's publicly funded universal health insurance scheme, providing access to medical and hospital services to Australian citizens and permanent residents. PALM workers are currently ineligible.

Minimum Conditions of Employment (PALM Scheme)
The required minimum employment standards set by the Australian Government for workers under the PALM Scheme, covering pay, hours, accommodation, and welfare.

NIB
The preferred provider of private health insurance for PALM workers that has held the Commonwealth government tender for the PALM Scheme since 2009.

PALM (Pacific Australia Labour Mobility) Scheme
An Australian Government program that allows citizens of Pacific Island countries and Timor-Leste to work in Australia in designated sectors (e.g., agriculture, hospitality) on a temporary basis.

PALM participant
Pacific Australia Labour Mobility participants are temporary migrant workers from Pacific Island nations and Timor-Leste who are engaged in Australia's structured labour mobility scheme to fill workforce shortages in specific industries.

Pasifika
A collective term used to describe people of Pacific Island heritage living in Australia or New Zealand. In this report, it refers to cultural identity relevant to PALM participants.

PHI (Private Health Insurance)
Insurance coverage purchased privately or provided by employers for medical services not covered by Medicare. PALM participants are required to hold PHI, but coverage is often inadequate.

STI (Sexually Transmissible Infection)
Infections passed from one person to another through sexual contact, including Chlamydia, Gonorrhoea, Syphilis, and HIV.

TRUE
TRUE (formerly Family Planning Queensland) is a state-wide, profit-for-purpose organisation and a leading provider of specialist sexual and reproductive healthcare.

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We acknowledge the Traditional Owners of the lands on which this research was conducted and pay our respects to Elders past and present. We recognise Aboriginal and Torres Strait Islander peoples continuing connection to land, waters, skies, and community, and extend that respect to all Aboriginal and Torres Strait Islander peoples.

We acknowledge and honour the people and cultures of the Pacific Islands and Timor-Leste who contributed to this research. We recognise the strength, knowledge, and deep cultural heritage they bring to Australia, and the important role they play in our communities. We especially acknowledge participants from Vanuatu, Fiji, Timor-Leste, Solomon Islands, Tonga, Samoa, Papua New Guinea, Kiribati, Tuvalu, and Nauru. Your voices and stories are at the heart of this report. We extend our deepest gratitude to the PALM Scheme participants who generously shared their time, experiences, and perspectives, as well as to the health providers and employers who contributed their time, knowledge, and insights.

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Executive Summary

This report presents the findings and final recommendations of the research project *"Seasonal Labour, Systemic Injustice: A Research Report on Health Inequities in the Pacific Australia Labour Mobility Scheme"*. The study explored the barriers to healthcare access experienced by participants of the PALM Scheme, particularly in relation to BBVs such as hepatitis B and sexual health and identifies strategies to improve equity and responsiveness.

PALM participants from the Pacific Islands and Timor-Leste make a vital contribution to Australia's regional industries. However, they face significant structural, social, and policy barriers to accessing the healthcare they need while living and working in Australia. These include ineligibility for Medicare, inadequate private health insurance, limited access to transport and after-hours care, and culturally unsafe services. The project adopts a health equity lens, underpinned by human rights principles, to understand these challenges.

The study was conducted in four phases:

1. Qualitative interviews with PALM participants, health providers, and employers (employer welfare officers)
2. Surveys with PALM participants, health provider and employers
3. Cost-benefit analysis of a hepatitis B intervention and the current model of care
4. Co-design workshops with PALM participants, employers, health professionals, and key industry stakeholders to test and refine policy and service-level recommendations

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Key findings

- Medicare ineligibility creates significant financial barriers, causing PALM participants to delay or avoid care.
- PALM participants' gap in health understanding combined with a lack of routine testing contribute to an invisibility of hepatitis B in the population.
- Casual employment and no paid sick leave mean PALM participants often delay healthcare or endure illness to avoid losing income.
- Language barriers, compounded by a lack of professional interpreters, translation tools, and in-language health information, alongside cultural stigma, are major barriers to culturally safe healthcare access for PALM participants.
- Employers are pivotal for healthcare access, but their variable support can lead to gatekeeping and delayed care for workers.
- Regional locations mean limited healthcare infrastructure, GP shortages, and poor transport, often forcing PALM participants to emergency departments.
- Fear of job loss/deportation leads PALM participants to conceal illnesses, avoiding crucial medical care.
- Mandatory private health insurance creates a barrier and fragmented care due to its inadequate coverage of preexisting health conditions, out of pocket costs, confusion amongst PALM participants and healthcare providers, inconsistent coverage and billing.
- Systemic gaps leads to reliance on individual goodwill and informal workarounds by health providers and employers.
- Proactive hepatitis B screening/treatment for PALM participants is a cost-effective intervention, yielding significant health and economic benefits.

Key recommendations

- Extending Medicare eligibility for all PALM participants.
- Reforming private health insurance policy and education.
- Introducing paid sick leave entitlements under the PALM Scheme.
- Funding after-hours and onsite care models, especially in regional areas.
- Standardising consensual screening and vaccination for hepatitis B and STIs.
- Improving health literacy and system navigation through co-designed education.
- Strengthening cultural safety, interpreter access, and multilingual resources.
- Enhancing regional service coordination and establishing cross-national referral pathways.
- Implement funded, standardised hepatitis B screening and treatment for all PALM participants.
- Invest in independent, participatory research to monitor, evaluate, and strengthen health, equity, partnerships, and policy settings across the PALM scheme.
- Establishing an independent PALM Health Advisory Panel to oversee reform implementation.
- Ensure PALM participants are involved in all next steps of healthcare and policy development (where appropriate), shifting from top-down models to ones that recognise their agency, assets, and community expertise.

This report presents a compelling case for urgent reform. Without action, PALM participants will continue to experience avoidable illness, stigma, and exclusion from essential services, despite their contribution to Australia's workforce and economy. While employer welfare officers often do an outstanding job in challenging circumstances, the responsibility for PALM worker wellbeing cannot rest with them alone. The recommendations put forward here are evidence-based, stakeholder-informed, and actionable. They call for cross-sectoral commitment from government, employers, health services, and communities, to ensure that PALM participants are afforded dignity, safety, and the right to good health while living and working in Australia.

Chapter 1 – A Research Study to Improve Hepatitis B and Sexual Health Outcomes for PALM Participants

PALM Scheme Background

Australia's approach to labour migration has evolved over several decades, particularly in response to the growing demand for seasonal labour in key industries such as agriculture and meat processing. Australia has a long history of employing seasonal workers from Pacific Island nations to fill domestic shortages, mostly in the horticulture and agriculture industries. The first major step towards structured seasonal labour migration from the Pacific Islands began in the 1960s and 1970s with informal and small-scale agreements, primarily focused on the horticulture industry. However, it was in the 1990s that Australia started formalising its seasonal worker schemes in response to the increasing demand for workers in agriculture, horticulture, and other sectors. This was a significant shift in policy as it contrasts with the system of permanent migration that prevailed in Australia throughout much of the 20th century (1). Australia's shift towards a 'guest-worker' system of temporary migrant labour and its associated policies has left migrant workers with restricted rights whilst in Australia, such as access to social welfare, education, childcare, and healthcare. Seasonal workers have been crucial in filling labour gaps, particularly in Australia's regional and rural areas.

In 2008, the Australian Government introduced the Seasonal Worker Program (SWP), marking a significant milestone in formalising seasonal labour migration from Pacific Island nations. The SWP was designed to provide a solution to labour shortages in the agricultural sector. Under the SWP, workers from nine Pacific Island countries and territories: Fiji, Kiribati, Nauru, Papua New Guinea (PNG), Samoa, Solomon Islands, Tonga, Tuvalu, and Vanuatu, as well as Timor-Leste, were eligible to work in Australia for a period of up to nine months. The primary goals of the SWP, stated by the Commonwealth Government, were twofold: meeting the seasonal demand for low-skilled labour in agriculture and promoting economic development in the participating Pacific Island nations by providing workers with temporary employment opportunities in Australia (2).

In 2018, Australia expanded the scope of the SWP beyond agriculture, particularly as the demand for seasonal labour grew across other sectors such as meat processing. This led to the introduction of the Pacific Labour Scheme (PLS), which allowed approved employers to engage seasonal workers not only in agriculture but in any industry in regional and rural Australia (3). The PLS aimed to provide a broader range of employment opportunities for Pacific workers and further support the economic development of Pacific Island nations by fostering stronger connections between Australia's workforce needs and the development of the workers' home economies.

The introduction of the PLS was a significant shift in policy, as it expanded the types of employment sectors eligible to employ Pacific workers. The expansion also included the ability for employers in regional and rural Australia to access a larger pool of labour, helping to mitigate ongoing workforce shortages in these areas.

In September 2021, Australia consolidated the SWP and PLS into the Pacific Australia Labour Mobility (PALM) Scheme, streamlining the administration of these two programs under one unified system. The PALM scheme brought together the aims of the SWP and PLS to provide a comprehensive approach to addressing labour shortages in rural and regional Australia while also enhancing the economic prospects of Pacific Island nations (3). Under the Temporary Work (International Relations) visa (subclass 403) - PALM scheme, seasonal workers can be employed on either a short-term or long-term contract.

The short-term visa allows workers from Pacific Island Countries and Territories (PICTs) to engage in up to nine months of work, and under the long-term visa, this allows workers to engage in four years of work (4). The PALM scheme is managed by the Department of Foreign Affairs and Trade (DFAT) and the Department of Employment and Workplace Relations (DEWR) with the support of the Pacific Labour Facility (PLF) (5).

As of the latest figures (January 2025), over 30,000 seasonal workers (hereafter referred to as PALM participants) are currently in Australia, spread between 494 Approved Employers, with approximately 35% of PALM participants in Australia being employed in Queensland.

PALM participants are critical to the agricultural sector in Queensland, where the demand for seasonal labour is particularly high. Out of the 30,795 PALM participants, 20% are from Vanuatu, 17% from Fiji, 16% from Timor-Leste, 15% from the Solomon Islands, 10% from Tonga, 9% from Samoa, 7% from Papua New Guinea, 5% from Kiribati, 1% from Tuvalu, and <1% come from Nauru. In terms of participation by industry, agriculture makes up the largest portion with 54% of PALM participants, followed by the meat processing industry

with 38%, 4% in health care, and 2% in accommodation and other industries. While PALM participants contribute significantly to Australia's economy, there are concerns regarding work conditions, exploitation, living conditions, (6) health, safety and wellbeing (6-8). Health-related issues and access to healthcare services among PALM participants are critical areas of concern.

Rationale for Study

The Pacific region 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, with an estimated 60,000-100,000 people unknowingly living with CHB. 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) (9-11).

The prevalence in the Pacific region ranges from 4.4% in Samoa to 9.7% in Timor-Leste (12). Thus, PALM participants may be at risk of CHB or potentially living with the condition unknowingly (13). Hepatitis C has a prevalence of 1.2% in the Pacific Islands, with 24 deaths per/100,000 people, which is the highest out of any region in the world (14). Increasingly high rates of HIV are found across the region, with PNG having the highest, with 0.9% per cent of the general population living with HIV. At the time of writing this report, a HIV outbreak is present in Fiji, with 1,583 cases reported in the last year. The rates of BBVs are higher among sex workers (19%) and men who have sex with men (9%) (15). Vertical transmission from parent to child remains high at around 23% (15). The Pacific region also has some of the highest incidences of Chlamydia, Syphilis and Gonorrhoea in the world. Amongst the adult population, 4% have Chlamydia, 0.1% have Syphilis, and 1.4% have Gonorrhoea (16, 17).

A recent prevalence study conducted in the PALM scheme population in Queensland reported a high prevalence of STIs and positive treponemal serology, with 59.3% of participants testing positive to at least one condition (Chlamydia, Gonorrhoea and Syphilis) and treponemal infection (18). The healthcare needs of PALM participants, such as those with BBVs and sexual health needs, are often overlooked in discussions surrounding healthcare access in Australia. However, Australia's health system, particularly the health services in regional and rural areas where PALM participants predominantly live, needs to be able to meet the BBV and sexual health care needs of this population.

Context

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 (19).

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 (PBS) (20). The funding for Medicare comes from the Australian government through taxation revenue, which includes co-payments, the Medicare Levy and Medicare Levy Surcharge (21). 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 as per Australian visa requirements (21). To be eligible for the Temporary Work Visa, PALM participants are required to have private health insurance the entire time they work in Australia and are not eligible to access Medicare. Maintaining adequate health insurance for the duration of their time in Australia is a condition (#8501) of the Temporary Work (International Relations) visa (subclass 403). Generally, within all private health insurance policies, there is an exclusion clause for the coverage of pre-existing health conditions (such as hepatitis B) and antenatal, birth and postnatal care in the first 12 months, which means any related healthcare costs will have to be covered by the individual.

NIB is the preferred provider of private health insurance for PALM workers and has held the Commonwealth government tender for the PALM Scheme since 2009 (22).

Depending on the insurance policy and level of coverage, private health insurance costs a minimum of approximately $78 per month at the basic level, which typically excludes GP appointments, outpatient specialist services, pre-existing health conditions and antenatal, birth and postnatal-related care. PALM participants can claim up to $500 per calendar year of pharmaceutical prescriptions upon obtaining an official receipt from the pharmacist, which details the PBS codes and can be claimed after a 2-month waiting period. Any level of private health insurance will result in additional out-of-pocket costs on top of the premiums, particularly if a PALM participant has a pre-existing health condition and therefore, isn't covered by their insurance policy.

This can make accessing health services costly for PALM participants, resulting in a potentially significant impact on their weekly income. These costs could impact their overall take-home salary, as this group of people are generally on a minimum wage and many are casually employed. This means that casually employed PALM participants would not be entitled to paid sick leave to seek health care and would, therefore, lose some of their salary to attend medical appointments or to take time off due to illness.

Health Inequities and the PALM scheme

While the PALM scheme has provided much-needed labour for various sectors in Australia, it also highlights the systemic inequalities faced by PALM participants, particularly concerning their right to access healthcare.

PALM participants are not entitled to the same healthcare benefits as Australian residents and citizens and other visa holders, which places them at a disadvantage, especially when they need treatment for chronic conditions like hepatitis B, which is prevalent in their home countries. The right to access healthcare is recognised as a fundamental human right under international law, with various frameworks affirming that everyone, regardless of their immigration status or nationality, should be able to access necessary healthcare services.

This exclusion from Medicare raises a human rights issue, as it denies PALM participants the same access to essential health services that others in Australia receive, undermining their right to the highest attainable standard of health. When PALM participants cannot access the care they need, particularly for chronic health conditions like hepatitis B, the consequences could be severe. Untreated hepatitis B can lead to long-term health complications, including liver damage, cirrhosis, and an increased risk of liver cancer. The mortality rate is high for those with hepatitis b, with up to 25% dying from complications of cirrhosis, liver failure and liver cancer.

These complications and their associated healthcare costs are largely preventable. Regular clinical monitoring is therefore critical to prevent and manage hepatitis B progression (23). The frequency of this monitoring varies according to the phase of infection, the extent of liver damage present, whether the person is receiving treatment, and the presence of other complicating factors such as co-infections, immunosuppression and other causes of liver disease (24).

Monitoring and management can include taking medications such as antiviral therapy; health and physical examinations with a General Practitioner (GP); regular monitoring of the virological response to the treatment and other blood levels via pathology testing; appointments with specialist medical practitioners such as a hepatologist; liver ultrasounds, and potentially emergency department and hospital admissions (25). People with hepatitis B in Australia who are ineligible for Medicare and without care could also act as a potential reservoir for hepatitis B in the community if barriers to accessing health services for testing and diagnosis exist'. This often-undetected communicable disease is a public health concern for Australia.

Similarly, other BBVs such as Hepatitis C and HIV, and sexually transmitted infections (STIs) such as Chlamydia, Gonorrhoea, Syphilis and Trichomoniasis, if left untreated, can result in persistent health issues, increased transmission risks, and a decline in the overall well-being of individuals. International evidence suggests that when away from home, temporary migrant workers may have new partners, engage with sex workers, and face lower access to condoms, with some studies reporting higher STI rates than permanent populations (26, 27).

Canada's experience also shows temporary migrant workers require gender- and culturally specific sexual health services not met by generic programs (28) , which is an issue likely to be replicated for PALM participants in Australia. One Australian study identified sexual and reproductive health as the second-highest concern for PALM workers and employers (7) . For PALM participants already facing the challenges of temporary employment, limited financial resources, and Medicare ineligibility, these barriers to care can lead to worsened health outcomes, long-term complications, and a continued cycle of health inequity.

While cost-effectiveness data exists for hepatitis B screening and treatment in other Australian populations, there has been no economic modelling focused on PALM participants, despite their origins in high-prevalence countries. This represents a critical gap in the evidence base, limiting policymakers' ability to assess the long-term value of proactive hepatitis B care in this group. Economic analysis specific to the PALM cohort would help clarify the costs and benefits of early detection and treatment and support more equitable, evidence-informed health policy aligned with national elimination goals.

Study Design and Methods

Objective

As the number of PALM participants continues to grow in Australia, understanding how health systems can better meet the needs of this population is key to ensuring equitable healthcare access and outcomes. The objective of this study was to identify opportunities for improving hepatitis B-related healthcare in the areas of public health policy, health system and service delivery and clinical healthcare and support for PALM participants in regional Queensland, and more broadly, Australia. As the study progressed, and in line with the funding stream, this was broadened to all BBVs and sexual health care.

Due to factors such as unknown diagnosis due to a lack of routine testing of hepatitis B both in PALM participants home country and Australia, low health literacy around the condition and potential stigma, it was challenging to speak to PALM participants who specifically had a confirmed diagnosis of hepatitis B. Therefore, to get insight into barriers faced in terms of accessing health care for PALM participants, we gathered data from PALM participants who had experienced a health condition whilst in Australia and focused our research questions on understanding PALM participants' knowledge of BBVs (specifically hepatitis B) and sexual health. We were able to speak to health providers working directly with PALM participants in the BBV and sexual health field, to gain specialised insights on the experiences of providing care to PALM participants.

Research questions

1. What are the experiences of PALM participants accessing health care in regional Queensland?
2. What are the experiences of healthcare and service providers providing health care to PALM participants in regional Queensland?
3. What are the experiences of employer representatives assisting PALM participants to access health care and services in regional Queensland?
4. How do PALM participants in regional Queensland access and use BBV and sexual health care and services?
5. What are the barriers and enablers experienced by PALM participants regarding the access and use of BBV and sexual health services in regional Queensland?
6. What are the barriers that healthcare and service providers face in providing adequate BBV and sexual health care and services to PALM participants in regional Queensland?
7. Can the cost of screening and treating PALM participants for hepatitis B infection be offset by costs avoided by delaying serious sequelae through early medical intervention?

Methods

This study was designed by the research team in collaboration with the project steering committee. The steering committee is composed of industry professionals who are key stakeholders in migrant health and/or the hepatitis B field in Queensland. The research team met with the steering committee biannually throughout the project and received valuable guidance on the project design, methodology, interpretation of results and developing recommendations. The project employed a mixed-method sequential research design incorporating qualitative and quantitative research methods to address the objective and research questions.

Figure 1: *Qualitative to quantitative sequential research design.*

1

Qualitative interviews were conducted with PALM participants, healthcare providers, and employer representatives (employer welfare officers) to explore their experiences in accessing and providing healthcare. The goal was to identify the barriers and enablers to accessing BBV and sexual health services in regional Queensland.

2

A mixed methods (qualitative and quantitative) survey was conducted with PALM participants, healthcare providers and employer welfare staff based on the interview results.

3

A cost-benefit analysis that compares whether the costs of screening and treating PALM participants for hepatitis B infection will be offset by costs avoided by delaying serious sequelae through early medical intervention.

4

Convergence of data with PALM participants, employer welfare staff, health providers, policymakers and other key industry stakeholders in the form of co-design workshops was conducted to develop recommendations and a model of care that is tailored to the specific needs of PALM participants.

This project took place across regional Queensland, which is defined by the Australian Bureau of Statistics in Figure 2.

Figure 2: *Queensland remoteness areas. Source: Australian Bureau of Statistics.*

PALM participants in regional Queensland were invited to participate in a 1-hour face-to-face interview via existing and newly established networks, including via employers, community members and participant snowballing. Due to the limited availability of translation services, a basic proficiency in English was required to participate in the interview. Potential PALM participants were given a printed project information sheet that was also verbalised. Each person was given the opportunity to ask any questions to the researcher before signing a consent form to be interviewed. PALM participants' time and contributions were acknowledged with gift vouchers.

Semi-structured interviews allowed participants to express their thoughts and experiences in depth while providing a structured framework for the conversation. Interviews were conducted in person and audio-recorded by one of the research team members, using an interview guide based on existing literature and tailored to address the specific health-related topics relevant to PALM participants. Questions focused on participants' understanding of hepatitis B, other BBVs and sexual health, their health status regarding these infections, and their experiences in seeking assistance and utilising the healthcare system in Australia.

PALM scheme employers (approved employers) are businesses that the Australian Government has approved to hire workers under the scheme. The employers are responsible for sponsoring and supporting Pacific Island and East Timorese people to come to Australia for temporary employment. Under the PALM Scheme Approved Employer Deed, 'it is a requirement (14.1) that the approved employer must appoint a suitable Welfare and Wellbeing Support Person/s to provide welfare and wellbeing support to Workers' (29). Through Approved Employers of Australia (an association representing employers participating in the PALM scheme), we contacted employers via phone and email to request an interview with the relevant Welfare Support Person. Potential participants were given a project information sheet and were given the opportunity to ask any questions to the researcher before signing a consent form to be interviewed. One-hour semi-structured interviews were conducted via Zoom, allowing welfare staff to describe their experiences in their role as the primary person assisting PALM participants access to health services.

Health providers, specifically those working in the BBV and sexual health field with PALM participants in regional Queensland were approached through the research team's existing network. From there, snowballing took place to ensure we spoke to key healthcare workers in the field. Potential participants were given a project information sheet and were given the opportunity to ask any questions to the researcher before signing a consent form to be interviewed. One-hour semi-structured interviews were conducted via Zoom, allowing health professionals to describe their experiences providing BBV and sexual health care to PALM participants.

Approximately 150 **stakeholders** were engaged throughout this project, ranging from health professionals, policymakers, approved employer staff, not-for-profit staff, lawyers, pastors, and government (DEWR, DAF, DHA and DFAT) whose roles involve working directly with PALM participants. Out of these stakeholders, we conducted **interviews** with a total of 45 people (27 health workers and wellbeing staff and 18 PALM participants) across regional Queensland.

Interview recordings were transcribed verbatim and thematically analysed (30), by two co-investigators using NVivo 14 (Lumivero, 2023), with subsequent development and consensus of themes by four co-investigators. To protect participant confidentiality, identifying information was removed from the transcripts.

As part of the sequential mixed-methods design and following the analysis of the interview data, the research team developed **three online surveys**, one each for PALM participants, healthcare workers and approved employers. The surveys comprised both multiple-choice and free-text responses. The health professional and approved employer surveys were distributed electronically via email through the research teams' network that was built during the interview phase of the project. Twenty-one health professionals and eight approved employer staff members undertook this survey. Surveys with PALM participants were conducted face-to-face with the researcher verbalising the survey and electronically recording the responses. Survey participants were recruited through workers' accommodation sites and places of employment, with the researcher providing information to the workers about survey participation. Twenty-three PALM participants completed the survey.

A **decision tree**, incorporating a Markov model to indicate the different states of hepatitis B infection was developed to estimate the comparative costs and benefits of the current hepatitis B management in PALM participants against proposed hepatitis B screening serology and management strategies.

Finally, **four co-design workshops** were held with 56 key stakeholders, including two workshops with PALM participants and two workshops with a mixture of employers, health professionals and other key industry stakeholders. Co-design in research refers to a collaborative approach where researchers work alongside stakeholders, such as participants, communities, service users, or practitioners, to design and develop research projects, interventions, or solutions. This approach values the knowledge and experiences of those directly impacted by the research, aiming to create more relevant, effective, and sustainable outcomes. In a co-design process, stakeholders are not just participants but active contributors in every stage of the research, including planning, designing, implementing, and evaluating the research. This partnership is based on the recognition that local knowledge and expertise from those who will benefit from or be affected by the research are vital to ensuring that the project addresses their needs and concerns.

The co-design process used in this study was based on the NSW government co-design process (31) (Figure 3). As part of this project and as previously mentioned, a steering committee was established with key industry stakeholders, who contributed to the study design (Stage 1). Understandings of lived experiences took place through the qualitative interviews with service providers, approved employers and PALM participants, whereby the interview questions were framed to better understand the areas where there are opportunities for improvement of health care delivery for PALM participants (Stage 2). In the co-design workshops, we moved into the phase of developing recommendations and designing a model of care (Stage 3).

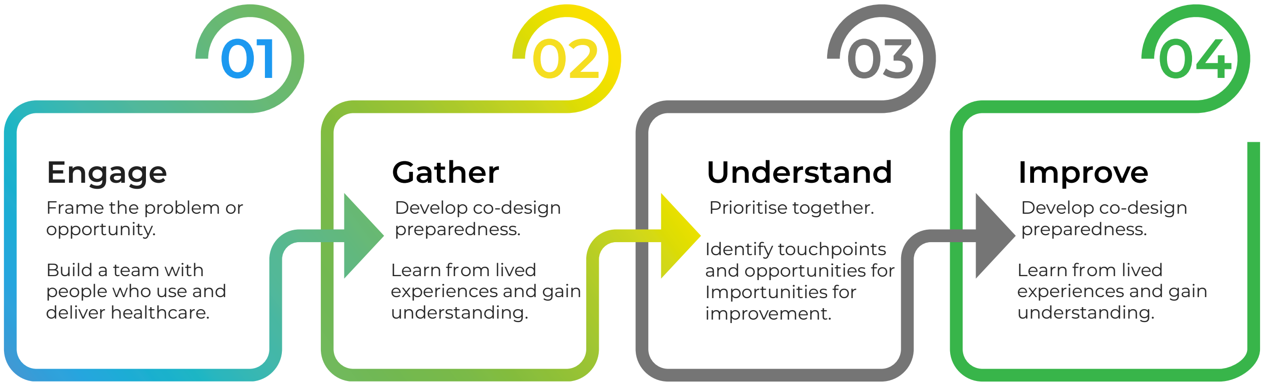

Figure 3: *The co-design process. Source: The NSW government, Agency for Clinical Innovation*

Finally, a **policy analysis** was conducted to contribute to our understanding of macro-level factors influencing the access and use of hepatitis B health care to seasonal workers in Australia (32). The policy analysis examined state and Commonwealth public health hepatitis B policies in Australia, with a specific focus on the inclusion of seasonal workers as a priority population. The study compares Australia's approach with the policies of Canada and New Zealand (33). The analysis identified gaps in policies regarding in the inclusion of PALM participants and whether the policies demonstrated a commitment to equitable hepatitis B healthcare access for PALM participants.

Ethical Approvals

Ethics approvals were sought and granted for the project from multiple human research ethics committees (HRECs): CQUniversity HREC (24035) and Queensland Health (HREC/2023/QTHS/92486)

Limitations

Our study has several limitations that should be acknowledged. Firstly, due to finite resources within the project budget, we did not have any in-language research team members. Therefore, this meant that the inclusion criteria for interviews, which were conducted in English, did not capture the experiences of PALM participants with limited English language proficiency. This group may face even greater challenges in navigating health systems and accessing care, potentially leading to an underrepresentation of their experiences and needs. In our co-design workshops, we had PALM participants with limited English language attend, who received translation from other PALM participants who spoke the same language.

Second, conducting a survey with PALM participants poses certain limitations, particularly when examining complex issues like sexual health and BBVs. This was highlighted in the Pacific Labour Mobility Study (33), which noted that surveys, while useful for gathering broad data, often fail to capture the complexity of PALM participants' experiences. Surveys often rely on predefined responses that may not allow people to fully articulate the nuances of their health concerns, which limits the depth and richness of understanding required for issues as sensitive as sexual health and BBVs. These factors suggest that while surveys can provide important quantitative insights, they may not fully capture the complexities of the sexual health challenges faced by PALM participants and may underestimate the scale of issues related to BBV prevention and care. Considering this, our survey was designed based on the findings from in-depth interviews with PALM participants, which allowed for deeper conversations on the research topic and the findings from the survey validate what was revealed in the interviews.

Third, the employers that participated in the study are more likely to be those who are genuinely dedicated to the health and well-being of their staff and are proactive in ensuring the best health outcomes for the workers. It is our understanding that employers who are less engaged in ensuring positive health and wellbeing outcomes for their workers were those who were less likely to engage in our research. Further, throughout the project, the research team members spoke to many employers, and other government and non-government stakeholders who are directly involved with PALM participants or the PALM scheme, who were happy to have "off-record" conversations but were not willing to participate in formal interviews, mostly due to fear surrounding their job and involvement in the PALM scheme.

Fourth, this report is based on qualitative data collected through interviews with PALM participants, employers, and health providers. We acknowledge that we are unable to verify the accuracy of all accounts shared during interviews independently. However, the purpose of this work is not to adjudicate factual correctness, but to capture and elevate the lived experiences and perspectives of PALM participants, whose voices are too often excluded from policy and systems-level discussions. These narratives provide critical insights into how healthcare access is understood, experienced, and navigated from the standpoint of PALM participants themselves, and should be considered valuable in shaping more inclusive and responsive health systems.

Finally, due to the potential to identify individuals within this study, we have chosen to leave identifying details such as location or job title vague to protect individuals and organisations who were interviewed as part of this research.

A Guide to this Report

Chapter 1 – Study Overview:

Introduces the PALM scheme and outlines the study's rationale, design, and methods for investigating health inequities among PALM participants, particularly regarding hepatitis B and sexual health.

Chapter 2 – PALM Participants' Experiences:

Presents qualitative findings on PALM participants' lived experiences accessing healthcare, highlighting barriers such as cost, transport, language, and fear of job loss.

Chapter 3 – Health Providers and Employers:

Explores the perspectives of clinical service providers and employer welfare staff, revealing systemic gaps and the reliance on informal support to navigate healthcare access.

Chapter 4 – BBV and Sexual Health Access:

Details how PALM participants engage with health services for BBVs and sexual health, with a focus on private health insurance limitations, service availability, and health literacy.

Chapter 5 – Macro-Level Barriers:

Examines structural and policy-level barriers, including Medicare ineligibility, PHI exclusions, and the lack of national recognition of PALM participants in public health strategies.

Chapter 6 – Meso-Level Barriers:

Analyses health system-level challenges in regional areas, such as workforce shortages, reactive care models, and inconsistent service delivery.

Chapter 7 – Micro-Level Barriers:

Highlights interpersonal and individual-level factors like trust, stigma, employer relationships, and health literacy that shape healthcare access for PALM participants.

Chapter 8 – Cost-Benefit Analysis:

Demonstrates that proactive hepatitis B screening and treatment for PALM participants is a highly cost-effective intervention with significant health and economic benefits.

Chapter 9 – Recommendations and Co-Design:

Synthesises stakeholder and participant input into a comprehensive set of recommendations for improving healthcare access, equity, and system coordination.

Chapter 10 – Summary and Call to Action:

Summarises key findings and urges systemic reform to ensure PALM participants receive equitable, culturally safe, and accessible healthcare in Australia.

Chapter 2 – Experiences of PALM Participants Accessing Healthcare

Introduction

Health-related issues and access to healthcare services among PALM participants are critical areas of concern. Workers encounter occupational risks and difficulties, including financial constraints, Medicare ineligibility and cultural barriers that hinder their ability to seek timely or appropriate healthcare (35). Furthermore, while PALM participants are overall a younger population and must pass a medical examination to ensure they meet the health requirements for their Australian employment, they often face hazardous workplace conditions that increase the risk of injury and compromise long-term health outcomes (36). The precarious nature of seasonal employment may contribute to a culture of risk-taking, driven by financial necessity (37). This elevated risk is compounded by factors such as cultural and language barriers unmitigated through appropriate or insufficient support, safety training, protective equipment, and regulatory oversight in industries that employ migrant workers (38-40).

Alongside these workplace health concerns, existing health issues such as BBVs among PALM participants warrant attention. This study was initially scoped to examine hepatitis B and access to related care for PALM participants. However, as the research progressed, it became evident that most PALM participants possessed a limited awareness of their hepatitis B status in the context of their overall health. Rather, interviews with PALM participants highlighted numerous broader concerns regarding health experiences. Consequently, the study was expanded to include an exploration of broader health issues, including other BBVs, sexual health and health care access. This section presents findings from the arm of the research that explores the lived experiences of PALM participants, focusing on their interactions with the healthcare system and the challenges they face in addressing health issues.

Experiences of PALM participants

The motivation for participating in the PALM scheme was largely underpinned by deep-rooted family and community commitments, characterised by a strong sense of collectivity. Participants frequently mentioned their responsibilities to send money back home to build homes, fund their children's education, support parents, and contribute to building community structures such as churches. Several participants talked of their families (both direct and extended) and their community depending upon them for financial support. Others spoke of being motivated by the novelty of working in a different country, or to support their own education.
Participants presented a diverse range of perspectives and experiences shaped by their cultural backgrounds, healthcare in their home countries, and their work and lived experiences in Australia. A complex interplay of factors impacting health and health system navigation were described, revealing that these challenges extended beyond hepatitis B and other BBVs. Three distinct, yet overlapping themes were identified and are explored here: i) Access Issues, ii) Awareness and Understanding, and iii) 'Battling the System'

PALM participants in Australia lived experiences of health & navigating health systems

Figure 4: Key themes related to the experiences of PALM participants

Access Issues Related to Health

When PALM participants discussed their experience of accessing health care in Australia, some consistent challenges were reported, including transportation, financial constraints, and employment-related factors. Limited transport options often left PALM participants dependent on employers, with 60% of survey respondents relying on their employer to assist them in accessing health services, which we found to be both a barrier and an enabler, depending on the workplace:

> *“ Even if you had your own health insurance card, and you knew how to use it, how to do all the paperwork, the doctor’s phone number, then the next issue would be transport. ”*
> *[PALM participant, Interview #21]*

> *“ ...why am I not getting the right treatment at the time I got injured? ”*
> *[PALM participant, Interview #24]*

Independent transport improved access:

> *“ I have my own transport.... If I want to go to the hospital, I just go. ”*
> *[PALM participant, Interview #38]*

Financial barriers were significant, as PALM participants lack Medicare and rely on private insurance, which has limited coverage. Costs deterred care:

> *“ I tried to access health and they told me that I cannot afford because it’s really big money...so I made my mind not to go. ”*
> *[PALM participant, Interview #23]*

Some opted to return home for treatment or said that would be their preferred option:

> *“ If I’m really being sick and my medical bill is like 2,500 or something, I’ll just pay 900 bucks, go back home to get treated for free, I’ll come back...Because that plane flight is cheaper than the medical bill... Otherwise then we just work for nothing. We work for medical bill. ”*
> *[PALM participant, Interview #18]*

Self-treatment was common, using traditional remedies:

> *“ Yes, yes they tested for hepatitis. They tell me that it’s spread through urine...I think when I go back home, I have to drink medicine... like leaf, like tree...my granny knows it...Yeah, my uncle, he drinks it. ”*
> *[PALM participant, Interview #40]*

Or over-the-counter medication:

> *“ Because they might lose money...they drink Panadol, because Panadol helps the body. Just take a Panadol and go to work. ”*
> *[PALM participant, Interview #24]*

Fear of missing work led many to avoid doctors:

> *“ ...they won’t even tell the supervisor or they won’t tell their bosses. Because they want to work and save money...They’re too scared that their manager will say, “You need to go to the doctors or the hospital”. Because they always did tell us to go to the hospital. But we have fear of the cost. And if you go to the hospital, you go and pay the money, and miss a day of work, and we go pay the money there, then it’s expensive...I don’t have the Medicare. That’s why I force myself to get better myself naturally and continue working. ”*
> *[PALM participant, Interview #18]*

Casual contracts meant lost wages for missed work, with employer support varying:

> *“ If you’re sick and the next day if you’re not working it’s no pay. That’s why everyone if you get sick, you go to work. ”*
> *[PALM participant, Interview #16]*

Workplace power dynamics influenced help-seeking. Fear of employer retaliation was evident:

> *“ If they open too much, they are worried they can be sent home... if you say that your body’s hurting from your work, the doctor might tell your boss. ”*
> *[PALM participant, Interview #26]*

Some participants perceived their employer welfare officer’s presence at appointments as monitoring, even though it was intended as support.

> *“ I don’t know why they do not allow the people to see the doctor by themself...I feel uncomfortable...Sometimes you want to say something, and you hold it back because they’re there. ”*
> *[PALM participant, Interview #17]*

Despite challenges, many participants described positive experiences, noting that they often relied on the welfare officer as a key source of support and assistance.

> *“ ...that’s what the farm is saying. That whatever happens to us, we have to talk. We don’t need to hide anything. Otherwise, it’s going to make it worse...you can always contact someone... Because I don’t know, how do I go to the hospital? We have our boss helps us. All of these people that we work under, they also help us. ”*
> *[PALM participant, Interview #25]*

Awareness and Understanding

Many participants shared that they had limited knowledge about their hepatitis B status and its potential health impacts. Additionally, navigating the Australian healthcare system was described as complex, with participants expressing a desire for clearer guidance and support in accessing services, including private health insurance.

Under the PALM scheme, pre-departure medical exams will only include hepatitis B testing if an individual intends to work in specific high-risk environments such as hospitals, aged care or disability care facilities. However, several PALM participants describe being excluded from the meatworks because of a blood infection or specified hepatitis.

> *" ...they do the test to see if I can work in the meat factory... they said no....this is common for other workers...they say I have to go to the farm. Yes, my friends also got told they had hepatitis. "*
> *[PALM participant, Interview #40].*

This highlights a critical gap in understanding: while workers may receive information about restrictions, they are not provided with adequate information about the disease, their health status beyond PALM scheme requirements and the broader implications for their well-being. Our data indicates that participants were not adequately informed by the health provider undertaking the medical examination of the importance of these screening assessments or the potential consequences associated with their results. One participant who believed they had hepatitis detailed:

> *" We all do medical check...Everyone has the same sick ... hepatitis, yeah. When they give us the result, I asked "How can I remove this type of sick?" ... And they said, "Oh, the sick does not have any treatment or nothing. "*
> *[PALM participant, Interview #38]*

Hepatitis was not a priority for help-seeking, possibly due to its often-asymptomatic nature and lack of awareness. However, 93% of PALM participants who responded to our survey and have accessed health services in Australia said they had either a good or very good experience:

> *" But when I'm in hospital, it was really good. The facilities and the equipment they use to check me. "*
> *[PALM participant, Interview #39]*

Navigating the healthcare system was challenging, leading to confusion and avoidance:

> *" Oh, I don't know the process of doing the insurance card and all those things and...It's complicated for me, because that was my first time in Australia, I didn't know what to do. "*
> *[PALM participant, Interview #39]*

Language and cultural differences added to the difficulties:

> *" I didn't really understand English good...So that was hard to understand what the doctor was talking about. They did not mention a translator. I was able to understand just some. It's not feeling good at all. I didn't really understand those things they try to tell you. "*
> *[PALM participant, Interview #34]*

While some found healthcare staff helpful:

> *" ... they do their best so that I can understand them "*
> *[PALM participant, Interview #17]*

Others relied on family:

> *" ...the language is hard. And I don't know what it means. It's really hard for me... Because that's the only option for me. I ring my family in Australia to help translate. "*
> *[PALM participant, Interview #24]*

or the welfare officer:

> *" ... she knows me; I'm not good speaking English...it's hard. But sometimes I use my phone to translate. Yeah, and so [the welfare officer] helped. "*
> *[PALM participant, Interview #23]*

Participants supported each other in navigating the healthcare system. One participant with a high English proficiency accompanied peers to medical appointments:

> *" They help each other if we're not good at English much. We just try to help out. Sometimes, yes, I would translate, to help speaking for another Samoan friend. "*
> *[PALM participant, Interview #22]*

Battling the System

This theme highlights systemic barriers that hinder healthcare access, particularly PHI complexities and tax-related confusion.

Private Health Insurance Challenges

Private health insurance is a mandatory visa condition, with payments deducted from PALM participants' wages. However, workers lack choice in provider and have a limited understanding of how PHI works. Many were confused about claims processes, coverage scope, and upfront costs, which varied. Based on the survey data, 81% of respondents said they do not know how their private health insurance works, with 50% stating that their employer helped them because they don't know how to use it. Further, 41% said they would like to understand better how the Australian health system works, including private health insurance.

> *" They say insurance can't pay for it because infection is happening at home. But I start feeling the infection at the farm. Then they didn't want to pay for it. Then I have to pay with my own money. "*
> *[PALM participant, Interview #34]*

Some clinics were not listed in PHI networks and there was confusion with hospital staff regarding PHI processes for PALM participants, leading to out-of-pocket costs and being dishonestly told by the clinic staff:

> *" They just say "card empty". "*
> *[PALM participant, Interview #35 & #37]*

> *" When I went to hospital, I asked to see the doctor, then they say sometimes they don't use the insurance card for seasonal workers. And they asked me, "How are you going to pay for the bill?" Then I say, "I have my health insurance." Then they told me that sometimes we don't accept the health insurance card...And I said, okay. Then I have to pay in cash. I didn't see the doctor first before I paid...940 I think. Yeah...That's my savings. "*
> *[PALM participant, Interview #34]*

It was reported that employers also deducted additional health insurance payments, which workers were told could be reclaimed after returning home. However, this process was not fully understood by the participants:

> *" They say they will take the $74 and then they don't deduct the $18.50, they will just leave it. But that didn't happen. So they say that on December all workers, you don't have to pay the health insurance...so we signed the paper. But for two weeks we still paid first week of December, we still did that for the $18.50... So when I raised that and the lady told us, "oh that amount we going to pay it back to you when you leave". That's confusing for us too. It makes it hard because not everybody fully understands what's in the document... But they don't read it and just sign...For us, we just... All of the workers, if they bring the papers and we just sign, we don't have time to look at a paper and read what it says "*
> *[PALM participant, Interview #35]*

Several participants called for free hospital care, given their economic contributions:

> *" So we are paying for the tax. And at least we should have that little thingy that we can use and just tap-tap and we can see the doctor "*
> *[PALM participant, Interview #20]*

Financial Trade-offs & Taxation Issues

Many PALM participants prioritised sending money home over seeking healthcare, emphasising that Medicare access would remove this financial burden:

> *" If my family needed money, I would send it... then another day I need money for healthcare... 'Oh, I don't have money now.' If I had that Medicare card, I wouldn't worry. "*
> *[PALM participant, Interview #17]*

Discussion and Conclusion

The findings from this chapter align with broader research showing that temporary migrant workers frequently encounter intersecting barriers to healthcare access, including logistical, financial, and cultural constraints (41). For PALM participants, these barriers are compounded by precarious employment arrangements, limited autonomy in health decision-making, and a lack of culturally and linguistically appropriate support, consistent with patterns observed in other seasonal worker programs internationally (42).

Low awareness of hepatitis B and other BBVs among participants reflects a wider absence of coordinated prevention, screening, and follow-up care between sending and receiving countries. This gap persists despite Australia's endorsement of the World Health Organization (WHO) viral hepatitis elimination strategy (43), underscoring the disconnect between international health commitments and the inclusion of temporary migrant workers in national BBV responses (32).

The broader Australian healthcare system was often perceived as inaccessible and unfair. Private health insurance, while a visa requirement, was poorly understood and inconsistently accepted across services. Many workers were unaware of their policy entitlements or how to lodge claims, while others recounted experiences of being overcharged or misled. Employer-controlled processes and language barriers often added to feelings of disempowerment. These processes mirror documented challenges in navigating complex and exclusionary health coverage systems for non-citizens and other national evidence from the PALM scheme (7) where participants reported they don't understand how their private health insurance works, that some don't know they're insured, and hospitals/community services frequently see workers presenting unsure of their coverage. This underscores the need for standardised direct-billing, a simple insurance orientation in-language, and employer-independent navigation. These experiences highlight the structural conditions in which economic participation is prioritised over equitable access to healthcare, raising critical questions about Australia's adherence to human rights principles in the design and implementation of labour mobility schemes.

A central thread across all accounts was the participants' deep sense of familial and communal obligation, sending remittances and building futures back home, against a backdrop of structural disadvantage in the Australian health system. While some workers reported receiving support from welfare officers and employers, others described systemic failures that left them isolated, uninformed, and financially vulnerable.

Access to care was consistently challenged by physical distance, transportation issues, casual employment conditions, and a lack of Medicare eligibility. Participants described navigating these obstacles while fearing the financial and occupational repercussions of taking time off work, which often led them to avoid formal healthcare altogether. Instead, many self-treated with traditional remedies, Panadol, or simply endured illness, highlighting the untenable choice between protecting one's health and fulfilling one's role as a breadwinner.

Participants' understanding of their health, especially regarding hepatitis B, was often limited, compounded by language barriers with health providers, the absence of culturally and linguistically appropriate information, and confusion around private health insurance processes.

Participants raised ethical concerns about the disconnect between their economic contributions through taxation and insurance payments and their lack of access to affordable healthcare. Many expressed a strong desire for more transparency, fairness, and inclusion in the system, calling for better information, improved insurance processes, and, ultimately, access to Medicare or more affordable care.

In sum, this chapter has highlighted how healthcare access for PALM participants is shaped by systemic inequities embedded in migration, health, and labour policies. Their stories reflect a population striving to meet expectations of productivity, while navigating a health system that often fails to meet their needs.

Chapter 3 – A Research Study to Improve Hepatitis B and Sexual Health Outcomes for PALM Participants

Introduction

This chapter examines the experiences of both clinical service providers and employer welfare officers in supporting healthcare access for PALM participants. These two groups, though situated differently, offered overlapping and complementary insights into the persistent and complex barriers PALM participants face in accessing timely, appropriate, and culturally safe healthcare in Australia.

Experiences of Clinical Service Providers

Barriers to Healthcare Access and Provision

Healthcare providers described multiple and persistent barriers encountered by PALM participants in accessing healthcare services and for them to provide adequate person-centred care and support that addresses PALM participants' healthcare needs, particularly for BBVs and sexual health:

Table 1: *% of health providers that have faced barriers in providing testing for specific STIs and BBVs to PALM participants (Source: research project survey).*

BBV/STI	%
Syphilis	33%
Gonorrhoea	33%
Chlamydia	33%
Trichomoniasis	56%
Hepatitis B	67%
Hepatitis C virus	56%
HIV	33%

The absence of Medicare access leads to significant out-of-pocket expenses for medical consultations, diagnostic tests, and treatments. Over half (56%) of surveyed health providers identified this lack of eligibility as the primary barrier preventing PALM participants from accessing testing, treatment, and care for BBVs and STIs:

> *" As these workers are non-Medicare eligible, there have to be negotiations with each on a case-by-case with the health service to waive the fee where required and this may limit testing so as not to incur excess costs, or the costs of the testing are put back onto a health service that is already resource poor and in financial deficit. It also ends up that services that could otherwise be provided in a primary health care setting have to be done at a public hospital or in a specialist clinic. "*
> *[Clinician, survey response]*

> *" Although seasonal workers are required to hold private health insurance, it often does not adequately cover preventative care, chronic disease management, or sexual health services. "*
> *[Clinician, survey response]*

Language barriers were reported as a major impediment to effective healthcare access. Participants described difficulties obtaining informed consent, delivering health education, and ensuring medication adherence among workers:

> *" And then when they do present, the language barrier is difficult...We've relied on good role models who assist, and the patient appears to consent to that and there's some assistance there with translation. But the translation access and online resources makes having those conversations with the patients around symptomatic screening or symptomatic testing, I should say, really difficult. So, I would say my experience is it's difficult to do a thorough job in this area. "*
> *[Clinician, Interview #7]*

Health providers reported that transportation further compounded healthcare access problems, limiting workers' ability to attend healthcare appointments regularly:

> *"...a lot of them just have access to one rural hospital in their area. And that hospital doesn't have what they need to care for someone with hepatitis B a lot of the time, so they have to travel out to a bigger hospital to get that care."*
> *[Health educator, Interview #3]*

> *"In terms of sexual health...I've got a woman in her 40s from PNG, who's out here on that seasonal work visa...only working about 20 hours a week, so not much money, no transport, very poor English. And we've made a diagnosis of her when she was in hospital recently of HIV. She's got positive TB serology. She has no transport...and it's almost impossible...So our sexual health nurse is going out to where she's working and living."*
> *[Clinician, Interview #15]*

Additionally, cultural differences in health-seeking behaviours, including deference to authority figures and stigma associated with BBVs and STIs, were seen as obstacles to timely and appropriate care:

> *"... it's something that they don't like people to know about...It's not something that they will share and say, "Oh, I have hep B or whatever." Generally, if they know they have it, they won't say anything. It's almost like a shameful thing."*
> *[Employer welfare officer, Interview #1]*

> *"I would say there's still a lot of stigma and a lot of reticence around discussing these issues, or talking about using condoms for safer sex, or having sexual health screens, or having treatments. And as far as contact tracing goes, that's really complicated."*
> *[Clinician, Interview #15]*

Providers also highlighted their own limited knowledge of the PALM scheme, the PHI processes, and the healthcare systems in the Pacific Island nations, which further complicated service delivery and continuity of care, leading to ethical dilemmas centred on the continuity of care. Providers expressed concern about initiating treatment for conditions such as hepatitis B, knowing that workers might soon return to under-resourced health systems where follow-up care would be limited or unavailable:

> *"We may not start treatment as early as we'd like because it might be, I've got to go back to Kiribati for six months and I won't have access to treatment. Well, we can't start hep B treatment and then stop it. That would be dangerous."*
> *[Clinician, Interview #2]*

> *"So, it becomes an international issue around access to, equitable access, to treatment for all. So, when they go back to the islands, they've been on hep B treatment for six months in Australia. They're going really well. They're below detectable levels. They go back to the islands. They might still have a couple of months of treatment, but know that Mum is also positive, so now I'm going to share my treatment with Mum. I've been given six months' worth of treatment from Australia until I come back next time. But I run out three months early and mum's had three months of treatment, so they both go into a reaction. They have a flare, a hep B flare. Mum goes to hospital, mum dies."*
> *[Clinician, Interview #12]*

Altruism, Creativity, and Collaboration in Service Provision

In the absence of clear policy guidance and systemic support, healthcare providers often relied on individual altruism, creativity, and collaboration to bridge service gaps. Health providers described developing informal partnerships with welfare workers, adapting care models, and creating innovative outreach solutions to deliver essential services to workers:

> *" I have links with some of the welfare workers employed by different farming groups, so those welfare workers contact me directly. I've become a bit of a contact person as an inroad into the sexual health service to reduce that difficulty that some of the people were having in even making access, like making contact with our service...we just built a pathway between myself and the welfare worker. "*
> *[Nurse, Interview #28]*

> *" I know of some staff in EDs who are treating and making no record. There is definitely staff doing stuff off record so they don't have to charge them. "*
> *[Clinician, Interview #3]*

Experiences of Approved Employer Welfare Staff

Supporting Workers to Navigate the Healthcare System

Employer representatives, such as welfare officers, described an extensive and multifaceted role in supporting PALM participants' healthcare access. Their responsibilities included arranging medical appointments, facilitating transport, assisting with private health insurance claims, and providing informal health education. Many also acted as cultural mediators and advocates, helping workers understand healthcare processes and navigate unfamiliar systems.

Figure 2: *Employer representatives duties undertaken related to PALM participants and healthcare access (Source: research study survey).*

Duties undertaken as part of the role and their percentage:

86%	I provide health education to the workers
71%	I determine which health service the worker requires when they are unwell (e.g. GP or ED)
86%	I provide transport for the workers to attend appointments
71%	Advocacy for health care
100%	I am the contact person when a worker becomes unwell
86%	I book health care appointments for the workers
57%	I help with communication between the health professional and the worker when language or confidence is a barrier
71%	I attend appointments with the workers
71%	I process private health insurance claims on behalf of the worker
57%	Organising health promotion
57%	Counselling/mental health support

The welfare worker role emerged as complex and demanding, requiring a unique combination of administrative, advocacy, cultural competence, and interpersonal skills. Participants emphasised the importance of local system knowledge, tenacity in navigating insurance processes, and cultural sensitivity in supporting workers' diverse needs. Several welfare officers reflected on the limitations of their roles, recognising when specialist support was needed, particularly in areas such as sexual health education, cultural considerations demanded professional expertise. Out of the welfare officer survey respondents, 86% stated that they feel 'somewhat adequately' trained to undertake these duties, with 14% responding that they are 'definitely adequately' trained.

Participants frequently portrayed themselves as occupying a "piggy in the middle" position, balancing obligations to employers, workers, healthcare systems, and regulatory requirements. Many (71% of those surveyed) attended medical appointments with workers, however employer welfare officers reported tensions with healthcare providers who sometimes perceived them as controlling or gatekeeping access to services. Welfare officers expressed frustration that their advocacy roles were misunderstood, leading to exclusion from consultations despite their perceived role in facilitating communication and cultural mediation.

> *" We find there's a lot of resistance from service providers to allow us in the room because they don't understand, I guess our role. They see us as the employer, which yes, we are the employer, but I think what they don't seem to realise is that when you are in a role like mine or my team's, we're piggy in the middle. We're in between the worker, the employer, the government and everybody. We're not on anybody's side. They see us as the employer, and they think that we're trying to control the conversation...And then on top of that, there's also really limited translating services. It would be fine if you could access translating services and you knew that you could let the guys go in and there'd be a readily available translator. But for the Pacific Islands, there is almost next to nothing available to them. We've had appointments that have to be rescheduled. We've gotten to a point where we take a team leader with us, but obviously team leaders aren't trained to explain medical terminology. But it's better than the alternative, which is nothing. "*
> *[Employer welfare officer, Interview #10]*

Welfare Officers as Frontline Health Navigators: Addressing Complex and Sensitive Health Needs of PALM participants

Welfare officers consistently described the breadth and complexity of health issues faced by PALM workers, frequently placing themselves in the role of informal health navigators. While they commonly managed concerns such as workplace injuries, mental health challenges, skin infections, boils and diabetes, it was the domains of BBVs, STIs, and reproductive health that emerged as particularly sensitive and difficult to manage. Sexually transmissible infections were frequently cited as a major issue, as PALM participants lacked access to sexual health education and had limited understanding of prevention and symptoms:

> *" We struggle a lot because you've got adults that are coming over, that are not provided, I suppose, any sexual education... Unfortunately, I would say that, well, in my experience, 100% of them that have been tested have had an STI. We've never had anyone tested that hasn't had one... They're not taught about safe sex or anything like that. They're not taught about pregnancy prevention. We try as best we can, but our abilities are quite limited as well. "*
> *[Employer welfare officer, Interview #10]*

Out of the welfare officer survey respondents, 71% stated that STIs (including Syphilis, Gonorrhoea, Chlamydia and Trichomoniasis) were a moderate to serious concern amongst PALM participants. Testing was usually reactive rather than proactive, often only occurring when symptoms became severe or when partners had tested positive. Efforts to conduct broad-based STI testing were hindered by the inability to access services outside of business hours, which is when workers were available due to their working hours:

> *" The health service will only come between Monday to Friday 9:00 and 5:00 and have a guess where my guys are—at work...The limitation we have is the absolute refusal from anybody in the world to deal with these guys outside of business hours... If we pull them out of work for a day, they lose money. They're here for money. You are not going to get their consent to go and do an STI testing on a Tuesday. "*
> *[Employer welfare officer, Interview #10]*

Similarly, hepatitis B was described as a common but hidden health issue, detected incidentally during unrelated hospital visits. Reportedly, workers rarely disclosed a known hepatitis B diagnosis voluntarily, often due to shame or fear of being sent home. Where workers were diagnosed with hepatitis B, employers often stepped in to coordinate long-term monitoring and management:

> *" ...we've had quite a few people go through that have had bloods come back and they've said, 'Yeah, that's definitely hep B,' and we've got a couple that are getting long-term treatment. "*
> *[Employer welfare officer, Interview #1]*

Reproductive healthcare posed its own set of challenges, particularly as female PALM participants face significant cultural stigma and repercussions for becoming pregnant while abroad (8). Unplanned pregnancies were described as common. Some women chose to terminate pregnancies, knowing that they wouldn't be able to continue their employment in Australia under the PALM scheme, fear of ostracism from their communities if they were pregnant and the inability to pay for pregnancy and birth care due to PHI not covering these health services. One manager explained that supporting workers through terminations was a major part of her role, often involving transport, temporary financial support from the employer, booking and attending appointments and emotional care:

> *" The girls are scared. So, their response to that is they have worked out that there's abortions that are readily available in Australia. I would say that's probably one of the things we spend most of our time doing, is supporting girls through that. That's a challenge because it's a lot on our system. It's a lot for the girls. "*
> *[Employer welfare officer, Interview #10]*

> *" A woman who gets pregnant, she can't go back home because she'll get killed because she's pregnant to someone who she shouldn't be pregnant to, so she's stuck here. She can't work and she can't get care. "*
> *[Nurse, Interview #8]*

Access to contraception was inconsistent, and choices made in Australia were not always viable once workers returned to their home countries, where some forms of contraception are socially unacceptable or legally restricted:

> *" Whatever birth control they get here, if they wish to continue it, it has to be available in their home islands. Now, that's a challenge because you're only allowed it once you've given birth, if you are over a certain age. If you are young, basically you're not allowed it and the doctor will actually tell your pastor and will tell your village, and then you're a disgrace to your family's name. "*
> *[Employer welfare officer, Interview #10]*

Barriers Encountered by PALM participants

Employer representatives echoed the barriers identified by healthcare providers, including high costs of healthcare, confusing insurance entitlements, limited GP availability in regional settings, transportation challenges, and language and cultural barriers:

> *" Access is a big issue here. We don't have access to a lot of services here at all. We basically have the hospital and a few local doctors... you need to know two weeks ahead if you're going to be sick here to get a doctor's appointment. "*
> *[Employer welfare officer, Interview #1]*

Participants also noted that PALM participants frequently preferred assistance when attending healthcare appointments, seeking the reassurance and advocacy that welfare workers provided. However, some PALM participants, particularly after gaining familiarity with the healthcare system, preferred to access services independently.

Discussion and Conclusion

The experiences of clinical service providers and employer welfare officers presented in this chapter echo and further reveal the deep systemic, logistical, and cultural challenges that impede equitable healthcare access for PALM participants in Australia, consistent with broader evidence on temporary migrant worker health inequities (41).

Despite their distinct roles, both groups described overlapping barriers, ranging from Medicare ineligibility and cost-related access issues to transportation difficulties, language constraints, and the complexity of navigating healthcare systems. These issues were particularly pronounced in the context of BBVs, STIs, and reproductive health domains that demand not only clinical intervention but also trust, cultural sensitivity, and continuity of care.

Health professionals and welfare officers alike described a service environment that is reactive rather than proactive, where preventive care is often delayed or deprioritised, and workers may avoid care altogether due to stigma, confusion, or fear. While many providers demonstrated remarkable dedication, creativity, and ethical commitment in responding to these challenges, the burden of system navigation has largely fallen on individuals rather than being supported by policy or institutional frameworks. The chapter also underscores the critical but undervalued role of welfare staff, who routinely extend beyond their job descriptions to coordinate care, provide advocacy, and fill communication gaps. However, this reliance on informal systems and personal goodwill is neither sustainable nor sufficient.

The systemic, logistical, and cultural barriers identified by health providers and employer welfare officers for PALM participants resonate strongly with the challenges faced by 'key populations' globally, as highlighted by the WHO (44). Although PALM participants are not among the five specific 'key populations' defined by WHO, their experiences reflect a similar pattern of disproportionate vulnerability and structural impediments to healthcare access. The WHO guidelines emphasise that social, legal, structural and other contextual factors significantly obstruct access to health and other essential services for marginalised population groups.

Furthermore, the observation that care for PALM participants is often reactive, delayed, or avoided due to stigma, confusion, or fear, particularly concerning BBVs, STIs, and reproductive health, aligns with WHO's recognition that stigma and discrimination lead to delayed testing and missed diagnoses, poor retention in treatment programmes and poor treatment outcomes, and concealment of health status (44).

Chapter 4 – Access to Blood-borne Virus and Sexual Healthcare

Introduction

Pacific Australia Labour Mobility participants arrive in Australia with mandatory private health insurance and specific visa-related medical requirements. However, navigating the Australian healthcare system, particularly for non-Medicare eligible workers in regional areas, presents a complex landscape shaped by systemic barriers, employer-dependent support, and PALM participant health-related knowledge.

This chapter explores how PALM participants access healthcare during their stay in Australia, drawing on findings from interviews with PALM participants, employers, and healthcare providers. It outlines the structure and limitations of private health insurance, and the practical implications of this coverage. The chapter also explores how PALM participants engage with general practitioners, emergency departments, and local services, often relying heavily on employer facilitation for appointment booking, transport, and interpreting. Finally, the chapter examines how PALM participants receive health information, particularly related to BBVs, sexual and reproductive health, and how health literacy interventions are delivered in practice.

Private Health Insurance

As discussed in previous chapters, PALM scheme participants are responsible for ensuring their private health insurance policy remains valid for the duration of their stay. Stopping health insurance coverage is an automatic breach of visa conditions. To ensure PALM participants do not break visa conditions, we found through our interviews that insurance premiums are typically deducted by the employer automatically from workers' pay.

In addition to hospital-based services, NIB provides a range of health supports tailored for PALM participants, organised across six service domains: self-understanding, primary care navigation and access, everyday healthcare, guided health support, population health initiatives, and critical incident case management. These include translated health education materials, telehealth consultations, access to a PALM Support Nurse, virtual prescriptions and delivery, and thematic workshops on issues such as sexual and reproductive health, mental wellbeing, and respectful relationships. A dedicated nurse hotline, digital symptom checker, and support for physical and virtual primary care access are available to address geographic barriers to care.

Some local GPs and specialists, such as pathologists and radiologists, may be included in the NIB medical network (45). When this is the case, it allows the provider to send the claimable part of the bill directly to NIB rather than charging the full fee upfront. PALM participants may still need to pay a gap fee at the time, but they are not required to submit a manual claim. In our study, we saw examples of primary care providers who operated this way, with reported greater ease of access to GPs compared to other towns:

> *" Because we have a relationship with the Dr, he bulk bills the guys and then he sends the bill directly to the insurance company. So, the guys don't have to worry about any of the claims side of things. They just turn up, get seen, and leave. "*
> *[Employer welfare officer, Interview #4]*

Under the NIB insurance policy, GP and outpatient pathology testing are all covered to the relevant Medicare rate, if the Employer can supply item numbers for the pathology, NIB can provide the rates. Regarding STI treatment and contraceptive access, it would depend on the specific drug and whether it is PBS-listed, which would determine if it were covered by NIB.

However, this system is not functioning uniformly. It is advised on the NIB website that workers can check whether a GP is in the insurer's direct billing network and request they be added if not. In areas without participating providers, workers are required to pay the full cost. This was identified in our study as a major barrier in towns where no GPs were listed on the NIB network, which was often referred to as 'card empty' by the GP clinic staff to PALM participants. Interviews revealed that in many high-density PALM participant regions, no local providers were enrolled in NIB's billing network (which can be viewed on their website), creating significant access and affordability issues. It was reported that when workers faced unexpected costs, employers sometimes paid the bill to enable care and recouped the amount through regular deductions from workers' wages.

Although NIB offers a suite of targeted services, implementation is uneven, and our interview data suggests that there is a lack of awareness of these services amongst PALM workers, employer welfare staff and health services providers. Further, not all services are accessible in rural or regional areas, and primary care providers' inclusion in the NIB billing network varies widely. We also observed inconsistencies in how emergency departments and hospitals bill PALM participants: some charged upfront, others billed NIB directly, and some developed their own policies for non-Medicare eligible patients. This lack of consistency resulted in confusion, delays, high out-of-pocket costs, or PALM participants opting out of care altogether.

Accessing Health Services

PALM participants access healthcare through a range of pathways, often relying heavily on their employer for assistance with arranging appointments and transportation as described in previous chapters. The type of care sought, and the location of services depend largely on the worker's immediate health needs and their geographic placement during employment. For many, the local GP serves as the first point of contact for routine care such as minor illnesses, injuries, or ongoing health concerns. In the survey responses on 'where are PALM participants most likely to seek care?', employer welfare staff reported:

Figure 3: *Where do PALM participants seek care? Employer representative survey responses*

29%	14%	43%	14%
PALM workers try to avoid accessing health services	General Practitioner	Hospital Emergency Department	Other

Financial and geographic challenges frequently limit access to primary care. As noted earlier, not all GPs accept direct billing through NIB, leading many PALM participants to instead present at hospital emergency departments, believing they will receive free care. In one regional town, this pattern was particularly common, with workers consistently being refused appointments by local GP clinics. These experiences contributed to a growing perception that hospitals were more accessible. As a result, emergency departments became the preferred point of care, even for issues typically managed in a primary care setting:

> *" The clinic asked me for payment. I showed the card and they say, 'you need to pay.' I was confused. I left and went to hospital. "*
> *[PALM participant, Interview #35]*

In addition, GP shortages in regional and rural areas mean that workers frequently encounter long wait times or are unable to book appointments due to providers not accepting new patients. In such cases, workers may need to travel to larger towns or cities to find available services. At one employer, the welfare officer arranged a standing GP appointment every Friday morning at a clinic in a town approximately 150 km away to ensure consistent access to primary healthcare for their employees. This arrangement was necessary because there were no GPs available locally, as nearby clinics were either not accepting new patients or fully booked for weeks at a time. This regular booking provided a reliable option for non-urgent medical issues and allowed for the welfare officer to plan for her employees' health needs:

> *" There's no GPs that we can use close by. Most of them either don't take new patients or they're booked out. We have a standing appointment on a Friday morning. "*
> *[Employer welfare officer, Interview #27]*

The extent to which workers can access care is significantly shaped by the support provided by employers. While the welfare officer is not required to have a health background, they are tasked with supporting workers' access to healthcare, disseminating health information, and often performing informal triage to determine what type of health service a worker requires. In practice, this means workers frequently rely on employers to assess their needs, coordinate appointments, and provide or organise transport. This reliance, however, introduces variability and potential delays. If a welfare officer is unavailable, under-resourced, or less engaged, workers may experience delayed or inadequate access to necessary care. As a result, the quality and timeliness of healthcare access for PALM participants are inconsistent.

Across several interviews, PALM participants described significant barriers to accessing healthcare stemming from inadequate support by their employers. PALM participants encountered delays or dismissive responses when seeking medical attention through their employer, even in cases of ongoing or worsening symptoms. Some participants noted that requests to see a doctor were postponed repeatedly with promises of assistance that never eventuated. Others shared that without personal transport and in the absence of employer-provided support, they had no practical way to attend appointments:

> *" When I ask to go doctor, supervisor says we have a full day. Maybe next week when it's quiet. But I was already sick. "*
> *[PALM participant, Interview #36]*

Testing, Diagnosis and Treatment

Under the Migration Regulations 1994 – Required Medical Assessment Instrument (July 2024) (46), PALM participants applying for a temporary Subclass 403 visa and staying in Australia for more than six months (e.g. up to nine months as per the PALM scheme working placements on the short term visa) are required to complete specific health checks prior to visa approval. However, hepatitis B testing is not routinely required for PALM participants unless they fall into a limited set of categories defined in the legislation.

Health Examination Requirements for PALM participants

All PALM scheme participants are required to undergo the following tests:

- A medical examination
- A chest X-ray
- A serum creatinine/eGFR test

Additional tests, such as HIV or hepatitis B testing, are only required if the applicant:

- Intends to work or train as a doctor, dentist, nurse or paramedic
- Intends to give birth in Australia
- Intends to work in specific high-risk environments such as hospitals, aged care or disability care facilities

Therefore, most PALM participants are not required to undergo hepatitis B testing during their visa health check, regardless of their country of birth and the hepatitis B prevalence there. While all of the PALM sending countries (apart from Fiji) are considered high-prevalence countries for hepatitis B, subclass 403 applicants from these locations do not meet the conditions under which testing is mandated. See Table X below

Country	Hepatitis B Risk Classification	Hepatitis B Testing Required for Subclass 403 PALM Workers?	Reason
Vanuatu, Samoa, Tonga, Solomon Islands, Kiribati, Timor-Leste, Tuvalu, Papua New Guinea, Nauru	**High-risk**	**Not required**	**Temporary visa; not in a healthcare/ pregnancy category**
Fiji	**Low-risk (Schedule 5)**	**Not required**	**Low-risk country; not relevant for temporary subclass 403 assessment**

If a PALM Participant Is Tested and Diagnosed with Hepatitis B

In the rare event that a PALM scheme applicant does undergo hepatitis B testing and tests positive, this does not automatically result in visa refusal. The process is guided by the Department of Home Affairs' health assessment procedures.

Medical Officer of the Commonwealth (MOC) Review

If a hepatitis B diagnosis is recorded, the case is referred to a MOC. The MOC assesses whether the applicant:

- Meets the health requirement
- Meets the health requirement with a Health Undertaking
- Does not meet the health requirement (only in rare cases where treatment costs are expected to exceed the significant cost threshold and no waiver applies)

Health Undertaking Requirement

If the MOC deems it necessary, the applicant will be asked to sign a Health Undertaking, which includes:

- Booking an appointment with Bupa Medical Visa Services within 28 days of arrival in Australia
- Attending ongoing care with a public health clinic or GP

Visa Impact

If the MOC deems it necessary, a Health Undertaking will be issued to the applicant, stating:

- Visa approval is not prevented
- The PALM applicant is not required to hold a health waiver, as the expected costs of treatment (eg for tenofovir) are low and below the current significant cost threshold of $86,000

Once PALM participants arrive in Australia, there is no routine testing for BBVs such as hepatitis B and STIs. This was found to be a major barrier to effective diagnosis and management. Typically, STIs were tested for once a PALM participant would feel symptomatic:

> *“ STIs are a major issue as well. So we'll have people say, "I can't go to work. I can't pee properly. ”*
> *[Employer welfare officer, Interview #1]*

When PALM participants are proactive in seeking testing for hepatitis B, they are met with financial barriers:

> *“ So a lot of patients that came to me were saying, "Hey look, can I get tested for hepatitis B?" ... we had to talk to the health fund to actually pay for those four tests for them." I told them, "Look, if you want to do hepatitis B, you have to talk to the manager and organise for the test." The main hindrance is that they have to pay out of pocket, which is about $80. So once we say that to them... I think out of the 20 people that mentioned that they wanted to test for hepatitis B, eventually three people ended up taking the paperwork. They haven't done the blood test yet. ”*
> *[General practitioner, Interview #5]*

Access to Health Information

PALM participants access health information through several channels, both before they depart their home countries and during their time working in Australia. Before departing their home countries, PALM participants typically receive a pre-departure briefing organised by the labour-sending unit, which varies between countries (7). This information is given at a time when bulk information is given to the workers about everything they need to know when living in Australia. These briefings contain generalised information around maintaining good health in Australia, but do not have any specific focus on BBVs, sexual and reproductive health. When workers need health information while in Australia, they primarily receive this via their employers.

Table 4: *PALM participant survey responses to where they seek health information from in Australia*

Where do PALM participants seek health information from in Australia? (can respond to more than 1)	%
Employer	82%
Health professionals - a doctor or nurse	14%
The internet, such as Google	5%
Other seasonal workers	9%
Others	9%

In addition to employer support, health education sessions are provided on-site, ad-hoc by healthcare professionals or not-for-profit organisations. Health educators working with PALM participants provide tailored outreach, focused on improving understanding of BBVs, STIs, and reproductive health. These educators deliver sessions directly to workers, often at farms or accommodation sites, using in-language educators, interpreters and culturally appropriate materials to ensure the information is accessible and relevant. A key part of the work involves correcting common misconceptions, such as the belief that hepatitis B can be cured, and providing reassurance about testing and confidentiality:

> *“ They thought they could just take medicine and get rid of it. We had to explain that hepatitis B is something you manage, not cure. ”*
> *[Health educator, Interview #4]*

While the health educators report a strong and positive response from PALM participants, who are highly engaged and often eager to learn, the delivery of these services is constrained by limited funding, time, and resources, such as bilingual educators. The outreach is often opportunistic and ad hoc, dependent on external coordination with employers and local services. Educators noted that with greater resourcing, they could deliver more consistent and structured support:

> *“ We don't have the resources to be doing consistent work across all the farms. It's really opportunistic, and I think we could be doing so much more if we were funded better. ”*
> *[Health educator, Interview #4]*

Despite these challenges, workers express appreciation for the sessions, often asking for more time, follow-up visits, or additional information:

> *"The amount of people that wanted to talk to us after that session was phenomenal. They were all like, 'Can you come back? We've got questions."*
> *[Health educator, Interview #5]*

The education not only improves health knowledge but also builds confidence in navigating the healthcare system, especially around culturally sensitive issues such as sexual health and BBV-related care.

When PALM participants were surveyed about the most important ways for them to receive health information, the top-ranking response was *'I would like information given to me in my home country before I come to Australia'*, followed by *'I want more information from my employer when I am in Australia'*. PALM participants responded in the survey that they *'want someone to talk to me about health'* compared to receiving printed or online information.

Language Services

While the PALM Scheme requires workers to have a certain level of English proficiency before being eligible to work in Australia, this proficiency varies widely among workers. State health departments, such as Queensland Health, provide interpreter services in more than 130 languages, however, there are significant challenges in terms of availability and suitability for PALM workers from specific Pacific Island countries. In many cases, the availability of interpreters for specific languages is limited or non-existent:

> *"I've seen the process of them trying to get an interpreter, and it doesn't take two minutes. It takes ages and then they're in there and they're getting charged for a double appointment because they've been in there for 45 minutes already."*
> *[Clinician, Interview #6]*

NIB states they have interpreters, and they state on their website that their online nurses, as the first point of contact for health issues 'can also connect you with an interpreter or have a support person call the nurse on your behalf.' However, we found in our interviews that awareness of this service amongst PALM participants, health providers, and employer welfare workers was almost non-existent. A visual representation of this typical healthcare journey, informed by co-design workshops, is presented in Figure 8, Chapter 10.

Discussion and Conclusion

As discussed in previous chapters, Medicare access remains a significant challenge. The Commonwealth Government (DEWR) is currently trialling a Family Accompaniment Pilot, which allows up to 200 long-term PALM workers to bring their families to Australia and gain access to Medicare and other support services (e.g., Family Tax Benefit, Child Care Subsidy) during their stay (48). This development provides a promising test case for how access to core health services can transform the experience of PALM participants whilst living and working in Australia. Evaluating the pilot's impact on healthcare utilisation, financial security, and wellbeing, and exploring pathways to extend Medicare access to all PALM workers would be an equity-affirming next step.

Unlike Medicare-eligible populations, PALM participants depend on private health insurance. This dependence translates into uneven access, unanticipated out-of-pocket costs, and in some cases, complete avoidance of care, despite Australia's policy commitments to equity and universal health coverage (UHC) under the Sustainable Development Goals (49). As outlined in the *Tracking Universal Health Coverage: 2023 Global Monitoring Report* (50), equitable UHC requires that essential services be accessible to all, without financial hardship, and that coverage gaps for non-citizens and temporary migrants are addressed as part of national strategies. The persistent exclusion of PALM workers from Medicare and their reliance on fragmented private insurance arrangements illustrate a misalignment between these global commitments and domestic policy implementation.

The reliance on private insurance for a workforce concentrated in rural and regional locations exposes a fundamental mismatch between program design and service context. In many of these areas, even Medicare-eligible residents face long wait times, workforce shortages, and limited service availability (51). For PALM participants, these structural constraints are compounded by additional financial, administrative, and linguistic barriers, effectively placing them at the farthest end of the healthcare access continuum. This layered disadvantage echoes global evidence that temporary migrant workers are disproportionately excluded from essential health services, with downstream consequences for both individual wellbeing and population-level public health outcomes (52).

Employer engagement emerged as a key determinant of whether these systemic barriers were mitigated or exacerbated. While some employers ensured regular GP appointments, facilitated transport, and provided ongoing health information, such practices were inconsistent and highly dependent on individual workplaces. This variability highlights a policy-practice gap within the PALM scheme, where the framework for health and welfare obligations exists on paper but lacks mechanisms for accountability and standardisation.

Participants' calls for earlier, clearer, and culturally tailored health information, particularly pre-departure or at induction or both, which point to an underutilised opportunity for prevention and system navigation support. Similar recommendations have been made in the *Draft Fourth National Hepatitis B Strategy 2023–2030* (53) for migrant populations, yet implementation for PALM participants remains fragmented. Strengthening bilateral health coordination between Australia and sending countries would align with WHO guidance on protecting migrant workers' health through coherent, cross-border policy approaches (52).

Ultimately, the findings in this chapter highlight a structural tension: the PALM scheme is predicated on the economic productivity of a healthy workforce, yet its health access provisions are not fully aligned with principles of equity, universality, or Australia's human rights obligations. Addressing this requires moving beyond nominal coverage through private insurance towards integrated and enforceable health access mechanisms that ensure PALM participants are not excluded from the benefits of the health system to which they contribute.

Chapter 5 – Macro-level Barriers and Enablers for PALM Participants accessing Blood-borne Virus and Sexual Healthcare

Introduction

Understanding how PALM participants access healthcare in Australia requires a multi-layered perspective. To explore this complexity, the following chapters are organised using a macro–meso–micro framework which analyses how structural, organisational, and individual-level factors interact to shape health outcomes.

This chapter will examine macro-level factors, which encompass the broader systemic and policy environment. These high-level influences form the backdrop against which PALM participants attempt to access health services, creating overarching conditions that either support or hinder healthcare access for them.

Macro-level

Immigration policy, Medicare Ineligibility, Private Health Insurance and Out-of-pocket Costs

As private health insurers are the primary custodians of most healthcare utilisation data for PALM participants, the research team approached the preferred provider, NIB, to request de-identified data to support this study. While NIB was unwilling to share data, we engaged in email correspondence to clarify specific queries and confirm aspects of policy coverage and exclusions. To the best of our knowledge, information on private health insurance, including NIB's role as the preferred provider for the PALM scheme, is accurate, though it cannot be verified with absolute certainty. One clinician described the impact of this:

> *" Unfortunately, the waiting list on the public hospital for anyone is over six months. By that time, these seasonal workers actually end up going back to where they come from. Specialists charge anywhere from $500 to $600 per consultation and then the tests on top of that. But if we send them to the public hospital... the public hospital funds the majority of these tests. Although, like I said before, a pre-existing medical condition has to wait for 12 months before further tests are carried out. "*
> *[Clinician, Interview #9]*

In the survey responses from PALM participants, the top reason for not seeking healthcare was *'I am worried about the cost'*. Health providers ranked *'Medicare ineligibility for PALM participants'* as the greatest barrier to providing effective care, and employer welfare staff reported *'Out of pocket costs associated with health care'* as the top reason for PALM workers not wanting to access care. When employers were surveyed about the impact of out-of-pocket costs, the most common survey response was *'PALM participants typically avoid health care because they fear the costs'.* Some interviewees stated:

> *" The price of things scares them because they come here to work, and they come here to save and send money back home and spending this amount is going to limit that for them. "*
> *[Employer welfare officer, Interview #4]*

> *" We had a case a year or two ago...of a young woman from a very remote Vanuatuan island, who only spoke the local dialect. So, we didn't have a translator. She was pregnant. She had Syphilis. We had pushback from maternity saying, Well, it's not our business to treat her, she hasn't got a Medicare card. We thought, This woman's pregnant. And then it turns out that she's being sexually trafficked to the male bloody workers there. This woman had nowhere to go with a newborn baby. "*
> *[Clinician, Interview #15]*

While private health insurance is intended to offset healthcare costs, the reality is that many workers face out-of-pocket expenses. When employer welfare staff were surveyed on how common it is to see PALM participants receive out-of-pocket healthcare costs, 29% responded 'always', 14% responded 'very often', 29% responded 'often' and '29% responded 'sometimes'.

> *" ...the impacts for the worker are potentially catastrophic, because we had people talking about, 'we just can't afford to do this. If we rack up this bill, we're going to get sent home' So, it was really people making a choice between their health and accessing care, versus the money that they were here to earn. "*
> *[Clinician, Interview #9]*

PALM participants must often pay upfront for medical services and seek reimbursement later, a process that is financially burdensome, time-consuming, and often dependent on employer support. Private health insurance premiums are deducted from their wages before care is accessed, alongside other common deductions for flights, accommodation, and transport. With most earning minimum wages, these costs create significant financial barriers to accessing healthcare, including essential hepatitis B prevention, screening, and treatment.

Hepatitis B Invisibility: Fragmentation, Confusion, and Missed Opportunities

One of the key barriers for PALM participants in accessing appropriate healthcare for hepatitis B is the invisibility of their infection status. This invisibility stems from a lack of routine testing both in home country and in Australia, including through the visa process:

> *" .... so that's why it's kind of been interesting because no routine testing in home country, low vaccination rates, no routine testing here. People that can't access the healthcare system, high prevalence of Hepatitis. So probably our guess is there's a lot of unknown Hepatitis circulating."*
> *[Clinician, Interview #9]*

The information around pre-departure medical examinations and testing for hepatitis B was conflicting amongst our interviewees. One employer welfare officer reported that she had heard of potential PALM participants being denied eligibility for the program based on a hepatitis B diagnosis:

> *" ...from talking to a few of the doctors, they would actually fail their medicals based on that. And then they wouldn't be able to travel to Australia because you have to pass a medical. That's for Australian government standards. Our standard, we don't require the medical. That's for the home country LSU standards....Yeah. Their home governments have to approve it... "*
> *[Employer welfare officer, Interview #10]*

Whereas some health providers stated that PALM participants still arrive in Australia with significant health issues:

> *" And we found that the in-country medical that is done prior to coming. Most of the time, it's not worth a piece of paper it's written on. A lot of workers arrive with quite significant health issues. "*
> *[Health provider, Interview #14]*

Even during broader screening initiatives in Queensland, hepatitis B was left off the list of tests:

> *" They tested Gonorrhea, Syphilis, HIV... I think they chose not to test for Hepatitis B and C because they felt they couldn't do anything about it. And then, if they would have to vaccinate. So if you test someone for Hep B, the first thing is it requires three tests in order to distinguish whether or not someone has Hepatitis B or they're vaccinated, and then they require three immunizations in order to be vaccinated. I think that would've been quite problematic...from a resource perspective."*
> *[Clinician, Interview #9]*

In our survey, 20% of PALM participants said they had been tested for hepatitis B in their home country, with 80% stating they hadn't or were unsure. When asked if they had ever received a diagnosis of hepatitis B, 50% said no and 50% were unsure:

> *" Most of this information is limited because the seasonal workers don't know themselves about what testing they have had or what report has come. All they know is that they have had tests and that the outcome has been good or bad, but they do not know any specific information as to what they had testing from. "*
> *[GP, Interview #5]*

As a result of no routine testing, PALM participants may go undiagnosed and unsupported until they exhibit symptoms, if they actively request testing, or if a specific clinician or health service includes it in their assessment:

> *" When they come here to work, they come here to work, they want the money. So, he'd had two or three days off. Is there something going on? This is not usual I did the welfare check, and he just said just general malaise, didn't feel right, bit of stomach pain, bit of pain in the side, sometimes uncomfortable going to the toilet, but not always. He's like, 'No, no, I haven't got that, but I just don't feel well. Some days I just feel very tired.'...So we took him to see a doctor...He was already aware probably what his issue was. And yes, when he went in to see the doctor, he'd had it from birth. It was something that was passed on from his mother. Again, I'm saying this is actually quite common. "*
> *[Employer welfare officer, Interview #1]*

In turn, opportunities for early intervention, tracing contacts, or access to antiviral treatment could be delayed or missed altogether.

Another challenge clinicians face when considering hepatitis B testing for PALM participants is the lack of continuity of care across international borders. Hepatitis B can require long-term medical management, and clinicians may be concerned about initiating care that may be difficult to sustain once the worker returns to their home country. Given the temporary and often transient nature of seasonal employment, there are limited mechanisms for coordinating follow-up between Australian health services and healthcare systems in Pacific Island nations. However, the absence of a guaranteed treatment pathway should not deter testing.

Even when ongoing care cannot be assured, testing provides an opportunity to equip PALM participants with vital knowledge about their health, including how hepatitis B is transmitted and how it can be managed. Early diagnosis enables individuals to take steps to protect others, seek follow-up care in the future, and make informed decisions, benefits that extend well beyond the duration of their stay in Australia.

Commonwealth and State Public Health Hepatitis B Policy Inclusion of PALM Participants

A significant macro-level barrier to equitable hepatitis B care for PALM participants is their exclusion from Commonwealth and state-level BBV strategies (32). Despite originating from regions with a high prevalence of hepatitis B, our policy analysis found that PALM participants are not explicitly identified as a priority population in key national public health frameworks.

This policy omission has material consequences. Without targeted recognition, there is no structural mandate to ensure that PALM participants are linked into prevention, testing, vaccination, or treatment pathways. As a result, they remain excluded from population-level strategies designed to reduce the burden of hepatitis B and improve continuity of care. This lack of policy recognition also means that healthcare resources, such as funding for screening, vaccination programs, culturally appropriate health promotion, and workforce training, may not be allocated to address hepatitis B in this population, further entrenching service gaps.

However, there are signs of emerging recognition at the state level. Queensland Health has taken a notable step by including seasonal workers as a distinct population group in its Queensland Hepatitis B Plan 2030 (54). This inclusion marks a critical shift towards addressing the specific health needs of this workforce and embedding them into hepatitis B care strategies. It also provides a state-level policy precedent that could inform broader national efforts. Acknowledging this population in national strategies would help establish a health system that proactively identifies and responds to the structural inequities they face. Until then, PALM participants remain on the periphery of Australia's public health response, despite the clear epidemiological, ethical, and economic rationale for their inclusion.

Discussion and Conclusion

The findings of this chapter show that PALM participants' access to hepatitis B care is shaped by intersecting macro-level policy and financing barriers: Medicare ineligibility, exclusionary PHI policies, and fragmented governance between sending and receiving countries. These barriers are embedded in the structural design of Australia's migration and health financing systems. The reliance on PHI for a temporary migrant workforce concentrated in rural and regional areas reproduces global patterns of exclusion (52). The UCL–Lancet Commission on Migration and Health highlights how structural exclusions systematically deter migrant access to essential services, notably communicable disease prevention and management (55).

In Australia, Medicare remains the cornerstone of affordable, universal care for citizens, permanent residents, and most humanitarian entrants, covering the majority of primary, specialist, and hospital services (56). By contrast, PALM participants are excluded from Medicare and must rely on PHI to meet visa requirements. While this satisfies immigration compliance, it fails to guarantee equitable access to healthcare.

The evidence presented here underscores that PALM participants' healthcare access challenges are entrenched in macro-level policy settings that systematically disadvantage temporary migrant workers. The invisibility of PALM participants in national and state policy frameworks, further entrenches these inequities by omitting a high-risk, underserved population from targeted programs, resources, and accountability mechanisms. Queensland's recent inclusion of PALM participants in its Hepatitis B Action Plan is a step forward, but without national alignment and bilateral coordination with sending countries, opportunities for prevention, early detection, and continuity of care will remain underutilised. Addressing these gaps requires reform at the intersection of migration policy, health financing, and communicable disease strategy, shifting from a compliance-driven model to one that guarantees equitable, integrated, and portable health coverage for all workers, regardless of visa status.

Chapter 6 – Meso-level Barriers and Enablers for PALM Participants accessing Blood-borne Virus and Sexual Healthcare

Introduction

This chapter examines the meso-level health system factors shaping PALM participants' access to care. These are the settings and services that workers interact with on a day-to-day basis, workplaces, local clinics, hospitals, support services, and the operational decisions made within them that directly influence how, when, and whether healthcare is accessed. This chapter highlights how meso-level systems can either entrench inequities or, with the right investment, begin to address them.

Meso-level

Left Behind in the Regions: Access Challenges for PALM Participants

Australia faces persistent and well-documented challenges in delivering equitable healthcare to regional, rural, and remote communities. Residents in these areas frequently experience poorer health outcomes and reduced access to timely care when compared with metropolitan populations. These disparities are driven by a combination of factors, including limited healthcare infrastructure, shortages of general practitioners and specialist services, reduced availability of after-hours care, and greater geographic distances between health facilities and communities. The compounding effect of these structural issues makes healthcare access in regional Australia both inconsistent and, at times, inaccessible:

> *“And I think this is part of what the bean counters don't realise, is the stuff that we do in the regions is a lot more complicated, and a lot more time intensive. And we don't have all that allied health backup either. We don't have counsellors. We don't have dieticians. We don't have pharmacy assistance especially looking after HIV, et cetera. We're really flying bare bones of one full-time nurse and me two days a month...We have one Infectious Diseases physician who covers the whole area...”*
> *[Clinician, Interview #15]*

PALM participants are overwhelmingly located in regional areas to meet the seasonal labour needs of the agricultural industry and are often housed in group accommodation on the outskirts of towns or in rural locations, frequently far from health services and without access to private vehicles or public transportation. Their ability to access medical care is largely dependent on their employer's willingness or capacity to provide transport and facilitate appointments.

Interviewees also raised the issue of health service shortages in the towns where PALM participants are based. PALM participants and those supporting them described long wait times to see general practitioners, difficulty securing urgent appointments, and an absence of specialist services for key areas such as BBVs, sexual and reproductive health, and mental health and a lack of continuity of care due to the reliance on locum doctors. Local clinics typically only operate during business hours, leaving little opportunity for casual employees:

> *“Treatment for Hep B requires medications with specialist experience. So, they need to be schedule 100 providers. And I know we have none here. So, when we're talking about care pathways, it's difficult to go ahead and test someone and then embark on a care pathway that's very, very logistically challenging and all the while you don't know whether that person's going to get care, because they're not a permanent resident.”*
> *[Nurse, Interview #7]*

In the absence of accessible primary care, some PALM participants attend public hospital emergency departments for non-urgent concerns. However, confusion over PHI coverage, out-of-pocket costs, and fear of large medical bills often deters workers from presenting unless their condition is acute. For many, this results in delaying or forgoing necessary healthcare, even when symptoms may warrant attention:

> *“We utilise the emergency department...Not always for emergencies. Often, it'll be because I simply cannot get them into a doctor.”*
> *[Employer welfare officer, Interview #27]*

> *“You can't just get them into the GP, which means you're accessing the hospital services. The hospital services aren't particularly overjoyed when you come to them with something that they consider not an emergency.”*
> *[Employer welfare officer, Interview #10]*

These intersecting barriers, health workforce shortages, limited clinic availability, geographic isolation, transport dependency, and cost concerns, compound the difficulties PALM participants face in managing their health while living and working in regional Australia.

Under-supported Capacity for Culturally Responsive Care

One of the critical barriers to healthcare access for PALM participants is the under-supported capacity for culturally responsive care in regional areas. Health services delivering care in these areas are often not resourced or supported to meet the distinct cultural, linguistic, and social needs of this population. Regional health services have not received dedicated or proportionate investment to develop their capacity in delivering culturally safe care. This underinvestment is not a reflection of the commitment or capability of local health providers, but rather a result of systemic funding models that have failed to evolve alongside the changing demographics and service demands of these areas:

> *" We have a real lack of culturally appropriate services in the regional hospitals. Which is interesting because it's seasonal workers that are making up a big portion of the population in these areas. "*
> *[Clinician, Interview #2]*

Health services typically do not have access to translated health materials in Pacific languages, nor to professional interpreters or culturally appropriate models of care. Clinicians are not offered structured opportunities for training in Pacific Islander health or supported to understand the broader social and cultural contexts that may influence healthcare engagement. Despite the growing presence of this workforce, cultural safety is not embedded into routine service delivery, largely because regional health services have not been resourced or guided to do so.

This lack of structural support has significant implications. PALM participants may attend consultations where communication is limited or misunderstood, particularly for sensitive issues such as hepatitis B, STIs, or unplanned pregnancy. In some cases, workers may avoid seeking care altogether if past encounters were confusing, culturally unsafe, or perceived as judgmental. These missed connections erode trust in the health system, delay diagnosis and treatment, and contribute to worsening health outcomes over time.

These are meso-level health system barriers, shaped by macro-level policy and funding decisions that have failed to equip regional services with the capacity to deliver culturally responsive care to PALM participants. Improving cultural competency in these regions is not about expecting overstretched services to do more with less, it is about ensuring the funding and policy structures are in place to meet the needs of all populations they are expected to serve. Without dedicated support, regional services will remain constrained, and PALM participants will continue to face avoidable barriers to essential healthcare.

Localised Workarounds and Systemic Gaps: Reactive Models of Care in the Absence of Streamlined Policy

A significant service-level barrier to healthcare access for PALM participants is the reactive nature of service delivery within individual hospitals and health services. This challenge is further compounded by the absence of streamlined, standardised protocols for the provision of hepatitis B, sexual health services and healthcare in general to this population. This creates a fragmented and inconsistent approach to healthcare access, heavily dependent on the discretion and resourcefulness of local health services.

In the absence of formal funding or policy mechanisms, many regional health services are forced to devise creative, ad hoc solutions to ensure that PALM participants can access essential care. As revealed through our interviews, health services frequently absorb the costs of care for BBVs and STIs within their service budgets, often informally, so that PALM participants are not turned away due to insurance exclusions or the inability to pay. These decisions are made in real-time by frontline staff who recognise the health needs of this cohort and attempt to bridge the structural gaps left by broader system failures.

Our research found that in several regions, informal collaborations between health services, local employers, and community organisations were being used to facilitate BBV screenings, sexual health checks, and vaccinations. While these arrangements are not the normal process for delivering healthcare to PALM participants, they reflect a consistent pattern of local adaptation to meet the healthcare needs of PALM participants. The success of these arrangements, however, hinges on the goodwill of individuals and the financial flexibility of local health budgets, neither of which are guaranteed or sustainable:

> *" ...It's going to be really dependent on the individual hospital and health service as to whether they're billed for that. You go into hospital, have a CT, have a few investigations, you can easily do a couple of grand. Yeah. And look, and there's no provisions for that currently, it's all based on the goodwill of the local hospital to bear the cost. "*
> *[Clinician, Interview #9]*

The lack of centralised protocols and formal funding pathways for PALM participants has left regional Hospital and Health Services (HHSs) to independently determine how, or whether, to deliver accessible care to this cohort. This decentralised approach has led to significant variability in local procedures and financial requirements, often shaped by informal relationships, organisational capacity, or individual discretion. The result is a system where healthcare access is highly reactive and uneven, and contingent on location.

A clear illustration of this disparity is found in the contrasting approaches of two hospitals in different hospital and health jurisdictions in Queensland. At one hospital, an informal but functional arrangement enables PALM participants to access care without upfront payment. One employer representative explained:

> *"If they go to the hospital, and they provide their passport, and their insurance card, they actually direct bill it to the insurance company… So, there's no upfront payment. That's not a health system process. That's a hospital process."*
> *[Employer welfare officer, Interview #1]*

This approach, while effective locally, is entirely dependent on the goodwill and flexibility of individual staff and is not formally supported by state-level health system policy. It reflects a broader trend where the burden of system failure is offset by informal workarounds.

By contrast, one hospital in Queensland enforces a formal cost-recovery model for Medicare-ineligible patients. This policy is not a statewide mandate but a local implementation, formalised through a brochure outlining fees and procedures for Medicare-ineligible patients. Under this policy, PALM participants, who are subject to upfront fees for emergency, outpatient, and inpatient care. An employer representative noted:

> *"And this hospital, for example, they charge the workers. I've had workers who go there, and then they'll get a bill for $400."*
> *[Employer welfare officer, Interview #10]*

This system causes confusion and financial stress for workers:

> *"They just don't understand that they get charged. They just go there because they're sick. And then they're like, 'Why do I have to pay?'"*
> *[Employer welfare officer, Interview #10]*

This pattern of localised adaptation is also evident in the delivery of sexual health services. Interviews with clinicians from two sexual health clinics, revealed stark differences in how PALM participants are included or excluded from care. At one clinic, PALM participants are generally excluded from routine access due to funding eligibility criteria set by the state health system. As one clinician explained:

> *"We're a public sexual health clinic. So, we're really limited in who we see. So, we only see people who have Medicare cards, and we prioritise Aboriginal and Torres Strait Islander people, young people, men who have sex with men, and sex workers."*
> *[Clinician, Interview #9]*

When asked what happens if a PALM participant presents to the clinic, the response was:

> *"If a seasonal worker came in, we would probably redirect them. We'd say you're not eligible for our service, unless it was something really urgent. And that's because of the state health directive around who we're funded to see."*
> *[Clinician, Interview #9]*

In contrast, another sexual health clinic in the state has taken active steps to integrate PALM participants into its service model by formally designating them as a priority population within internal clinic policy. This shift, driven by staff advocacy, allows for tailored access pathways, including walk-in appointments, direct referrals from welfare officers, and flexible clinician coordination. Importantly, all care at this clinic is provided free of charge, regardless of Medicare eligibility. A clinician explained:

> *"We've added them as a priority group—if they need to come in, we make sure we can see them."*
> *[Nurse, Interview #28]*

This variability in processes has resulted in fragmented, inequitable, and largely reactive service delivery, driven more by local discretion than coordinated policy. In the absence of national frameworks, funding mechanisms, and protocols tailored to PALM participants, responsibility shifts to individual health services. These services are left to develop ad hoc responses without consistent guidance or dedicated resources, exposing broader systemic failures and a lack of structural accountability.

Compounding this is the lack of communication and coordination between Commonwealth government departments, such as those administering the PALM Scheme, and the state health services responsible for delivering care. Health providers reported that they are not informed when or how many PALM participants are in their region, meaning they cannot prepare for increased demand. As a result, hospitals and health services are unable to proactively plan or allocate resources.

No Work, No Pay: Employment Structures Undermining Health

The casual nature of PALM participants' employment creates significant barriers to accessing healthcare, particularly due to the opening hours of medical services. Health services, including GP appointments, sexual health and BBV screenings, are typically only available during standard business hours. As casual employees, PALM participants face a difficult choice: take time off work to attend medical appointments or prioritise income in the absence of paid sick leave. The structure of their employment effectively incentivises continued work over timely healthcare access.

This tension leads to delays in seeking care, especially for health issues that require ongoing monitoring or are not perceived as urgent, such as STIs and BBVs. The risk of lost wages makes it difficult for workers to justify medical appointments, even when symptoms are present. One employer welfare officer explained:

> *" So, they tend to leave things as long as they can. Some of them don't want to miss a day off work because for them, the whole reason they're here is the money. They need money to support their family, so they don't want to lose a day's work. That'll be the number one reason why they don't do it. "*
> *[Employer welfare officer, Interview #1]*

Delays in care are not uncommon, even when workers are symptomatic. Without access to sick leave, workers often minimise or tolerate symptoms for extended periods:

> *" People are suffering with STI symptoms for lengthy time, could be months, and just tolerating it, not understanding that something could be wrong. But I think maybe people do know something's wrong, they just carry on and cannot take sick leave, cannot take a day off to access healthcare. It is not a priority when you're sending several hundreds of dollars home to family. You don't take a day off because you've got some urinary symptoms or a changed discharge, you just don't. "*
> *[Clinician, Interview #28]*

For those who do attend appointments, time pressure and concern about lost wages remain constant. One employer representative noted:

> *" Every time that I've taken them to an appointment, they're like, 'I've got to get back. I've got to get back. How long are we going to be?' And I'm just like, 'I can't tell you. As soon as the appointment's done, if there's anything else that we need to do, we'll head back.' "*
> *[Employer welfare officer, Interview #4]*

Even when healthcare is available, the misalignment with workers' schedules pushes some towards after-hours alternatives like hospital emergency departments:

> *" I think then they turn into the emergency department as well because you're open 24/7, so they're not wanting to take time off work to come to the doctors during business hours, so you'll often find them after hours for all of the presentations. "*
> *[Clinician, Interview #6]*

Access to hepatitis B testing and follow-up is similarly constrained:

> *" It does impact our team in the sense that it's really difficult to encourage guys to particularly do repeat blood tests because, 'Yeah, but I feel better now. I don't need a blood test.' And they have to miss work because pathology is obviously only open business hours, so you do have encourage them to miss work. Again, they're losing money, so it's a bit of a challenge. "*
> *[Employer welfare officer, Interview #10]*

In some regions, providers attempted to bring services to the workers on-site, but even this required ongoing negotiation with employers around time and pay:

> *" Then there's also the employer releasing them from work to come and get tested. We had to have those discussions about the responsibility of the employer to provide health services to their employees, and then to not dock their pay, so that it was a part of a work activity. Because the whole reason that the employees were there was to work, and to make some money for their families. So, there were negotiations every time we turned up on site. And when we were asked and encouraged to actually do the testing at the accommodation venues. That they would drop them off early from work, we tried to resist that for as long as we could, because it meant that the moment they left the farm, they stopped being paid. "*
> *[Clinician, Interview #11]*

Discussion and Conclusion

The meso-level barriers identified in Chapter 6 illustrate the fragility of healthcare access for PALM participants in regional Australia. Health service delivery in these areas is already constrained by chronic workforce shortages, limited specialist availability, and high turnover, conditions that are repeatedly documented in Australian rural health research (51, 57) and consistent with international evidence on underserved populations (58). While the *National Rural and Remote Health Strategy* and the *Stronger Rural Health Strategy* aim to address these gaps through workforce incentives and training pathways, they have not been adapted to the realities of a growing temporary migrant labour force with distinct healthcare needs. This absence of targeted planning and funding leaves clinicians and services underprepared to respond to PALM participants' health requirements, adding to the workload of providers who are already managing high demand with inadequate resources. In this context, access to care for PALM participants often hinges on discretionary action, whether an employer is proactive in providing assistance to healthcare, whether a hospital informally absorbs costs, or whether a clinician chooses to advocate beyond standard protocols. Such reliance on individual goodwill rather than systemic provision creates variability, inequity, and additional strain on local clinicians, who must navigate policy and funding gaps while maintaining clinical standards and deliver equitable and ethical healthcare. Without clear policies, streamlined processes, and dedicated funding for PALM participants in rural areas, health services risk being pushed to the limits of their capacity, with resultant negative health consequences for PALM participants.

Good Practice Approach: Coordinated Sexual Health Outreach for PALM Workers in Regional North Queensland

In one regional town in North Queensland, a novel approach was developed to overcome the barriers created by Medicare ineligibility among PALM participants. Employers approached the local Public Health Unit (PHU) requesting assistance with STI screening due to rising demand from workers. In response, the PHU coordinated with TRUE's Health in My Language team, a local GP, and a private insurer to deliver an integrated outreach program. The initiative included in-language sexual health education sessions, followed immediately by same-day, on-site STI screening and treatment. To address Medicare ineligibility, partners pre-arranged billing and pathology workflows with the private insurer, ensuring that workers did not face up-front costs. Employers contributed by organising transport, logistics, and protected work time so employees would not lose wages.

Participation was exceptionally high, and the model successfully addressed key barriers such as transport, scheduling, language, and confidentiality. However, it also placed a significant short-term coordination burden on the PHU. This highlights the need to consider formalising such models of care, rather than relying on employer goodwill and reactive, ad-hoc arrangements.

A key structural barrier identified is the absence of paid sick leave for PALM participants for those with a casual employment classification. Australian and international research consistently shows that paid sick leave facilitates early healthcare access, reduces presenteeism, and limits the spread of communicable diseases (59, 60). Yet, under the current PALM Scheme regulatory framework (the Deed of Agreement, Approved Employer Guidelines, and Minimum Conditions of Employment (29)) there is no requirement for employers to provide paid sick leave. This leaves workers financially disincentivised from seeking timely care, contributing to delayed presentations and avoidable health deterioration. These delays not only impact individual health outcomes but also shift the burden onto local health services, which face more complex and costly interventions when conditions worsen.

Reform is both possible and necessary. The Department of Employment and Workplace Relations and the Fair Work Ombudsman (FWO) could amend the PALM Scheme's regulatory instruments to mandate a baseline allocation of paid sick leave for all PALM workers, regardless of employment type. This approach aligns with the International Labour Organization's guidance that migrant labour protections should be explicitly linked to public health goals (61).

Our study found that health providers are not informed when PALM cohorts arrive or how many workers are in their health service jurisdiction, limiting proactive planning and resourcing. Closing this information gap via routine data feeds on cohort size, arrival timing, origins and languages should sit alongside targeted investment in rural workforce capacity, interpreter services, and culturally responsive care pathways to strengthen system readiness. This directly aligns with evidence from Kanan & Putt (7), who describe a transparency deficit and note hospitals' requests for regular access to PALM participant numbers and language profiles to plan services. Formalising such data-sharing within migration and health planning would move care from ad hoc goodwill to a coordinated, equity-driven model for regional Australia.

Chapter 7 – Micro-level Barriers and Enablers for PALM Participants Accessing Blood-borne Virus and Sexual Healthcare

Introduction

At the micro level, individual relationships and interpersonal dynamics play a decisive role in shaping healthcare access for PALM participants. In the absence of comprehensive system-wide support, frontline clinicians and employers often act as the primary facilitators, or barriers, to care. These actors mediate PALM participants' experiences with the health system, either enabling access or impeding it. This section explores how goodwill, advocacy, and interpersonal dynamics directly affect access to care on the ground.

Micro-level

The Goodwill and Advocacy of Health Providers

For PALM participants, the goodwill and advocacy of health professionals are often the determining factors in whether care is received. In the absence of system-wide policies or standardised processes, access to sexual health and BBV services frequently relies on individual clinicians who are willing to step outside of formal structures to ensure that necessary care is provided.

Health service providers play a frontline role in navigating the gap between policy and patient needs. Their advocacy is especially vital when care isn't covered by their health insurance and PALM participants are unable to afford out-of-pocket costs. Without this discretionary support, workers may miss out on necessary care. Nurses and other clinicians also frequently advocate within their services regarding billing processes or negotiating with hospital departments to remove financial barriers that would otherwise exclude PALM participants from care. One such example involved a clinician facilitating an ultrasound for a PALM participant:

> *" We needed to get her a scan, and the only way to do that without sending her privately and risking a huge bill was to go through the hospital. So, I just advocated with our contacts there and got her in as an inpatient. That way she got the scan and didn't have to pay. But technically that's not how the system's supposed to work. "*
>
> *[Nurse, Interview #28]*

This behind-the-scenes negotiation highlights that clinicians must navigate around rigid structures to secure care for a group that is otherwise underserved by existing systems.

Clinician Goodwill and Informal Advocacy in a Regional Sexual Health Service

In one regional sexual health service, clinicians routinely work around systemic constraints to ensure PALM participants can access timely treatment. Staff often bypass standard billing procedures, guided by professional ethics and a strong sense of advocacy for vulnerable patients.

As one clinician explained:

> *" There's a lot of stuff that we do off the books. And that's a fact. Like you just do it because it's the right thing to do. If it's not going to be recorded anywhere, and they're not going to have to pay for it, we will do it. I mean, for some of our guys, if they need antibiotics, like if we need to give someone Doxy or Azithro or whatever, we just do it. We don't charge them... If they're Medicare ineligible, we usually just bypass that whole thing. We just treat. I don't think we've ever turned anyone away. If they're here, and they need it, we'll figure it out later. "*
>
> *[Clinician, Interview #28]*

These efforts highlight both the compassion of health professionals and the structural inadequacies they are forced to navigate. While informal advocacy ensures that PALM participants are not denied care, reliance on clinician goodwill is neither sustainable nor equitable. Health services should not have to bend the rules to deliver basic treatment. Clinicians deserve systems that support, rather than obstruct, their capacity to provide equitable care—and PALM participants deserve consistent access that does not depend on chance encounters with a willing provider.

Employers: A Critical Gatekeeper to Healthcare Access

As highlighted in previous chapters, the role of employers is a critical component and a strong determinant of access to healthcare for PALM participants. In workplaces where employers have established good relationships with healthcare providers, they often facilitate access to care for workers by helping them navigate the healthcare system or by directly supporting the financial aspect of healthcare costs. However, not all employers provide this level of support, which can create variability in access to care across different workplaces.

Employers who prioritise the importance of healthcare access for their employees can significantly improve their workers' health outcomes by ensuring timely care, ensuring that their employers understand their insurance coverage, and arranging appointments for essential screenings. Workers' trust in their employers also plays a major role; workers are more likely to seek help and care when they feel supported and when they know that their employers will assist them in navigating the healthcare system. On the other hand, the absence of being proactive and supportive can present a significant barrier. PALM participants who lack strong relationships with employers may find it difficult to access care, especially when they are unsure of what services they are entitled to or how to navigate the healthcare system.

In areas where health services or employers do not prioritise worker wellbeing, these workers are left to navigate an unfamiliar system on their own, often leading to delays in seeking care or complete avoidance of necessary medical attention. While employer welfare officers do an admirable job supporting workers in challenging circumstances, the absence of broader, systemic support can contribute to worsened health outcomes for PALM participants. In our research, we also experienced the role of employers as key gatekeepers firsthand. Employers who were proactive about the health and wellbeing of their workers enabled access to worksites and actively supported workers to participate in interviews. Conversely, employers who were less supportive of health initiatives were often unwilling to speak with us or denied access to workers altogether. This highlights how employer attitudes not only shape workers' access to care but can also influence the visibility and accountability of the system itself.

For PALM participants, an employer's actions, or inaction, can have direct implications for healthcare access. Several PALM participants described employers who were dismissive or actively obstructive when health issues arose. One worker recounted how they were not supported by their employer despite a serious health concern:

> *" They just say, 'you're okay, you're okay.' Even when one of us is very sick and needs to go to the hospital, they say, 'just sleep, just sleep.' "*
> *[PALM participant, Interview #38]*

Another worker shared:

> *" Sometimes they say no to go to the doctor, just take Panadol."*
> *[PALM participant, Interview #39]*

In these instances, the employer's dismissal of medical concerns harmed workers' willingness to report symptoms or seek care:

> *" So, I had to wait until my day off. And even when I got there, they told me I should've come earlier because it had gotten worse. But I didn't want to ask. "*
> *[PALM participant, Interview #35]*

In contrast, other workers described supportive employers who took their health seriously and actively facilitated care:

> *" They always take us to the doctor if we need. They help book the appointment and even explain things if we don't understand. "*
> *[PALM participant, Interview #21]*

These contrasting narratives, drawn directly from PALM participants, highlight how employer behaviour significantly shapes access to care. Whether by facilitating appointments, providing transport, or simply showing concern, supportive employers help reduce barriers to care. On the other hand, when employers are dismissive or punitive, workers may delay or avoid care, with implications for their health.

Fear and Trust

For many PALM participants, trust in the health system and their employers plays a pivotal role in shaping decisions around seeking healthcare. Equally, fear of job loss, deportation, or being "blacklisted" from future work opportunities can act as a powerful barrier. These dynamics emerge clearly in discussions about health issues such as hepattitis B or pregnancy. Workers may avoid care due to concern that a health condition could jeopardise their ability to remain in Australia or return for future work opportunities. As one employer explained regarding hepatitis B:

> *" ...the other reason they don't tell you is they have this fear that they will not be allowed to come back if they finished that contract, it's then on their file that they have this disease and that we are going to say, 'No, you can't come back to Australia.' "*
> *[Employer welfare officer, Interview #1]*

This fear of being blacklisted or recorded in a way that impacts future visa eligibility is often closely linked to broader fears of deportation:

> *" Well, number one is fear of deportation. Some of them won't access health services because they don't want people to find out things and they'll be deported. "*
> *[Employer welfare officer, Interview #10]*

This fear was echoed strongly in worker interviews, who described concealing illness out of concern they would be sent home or not invited back:

> *" When I was sick, I just went to work. Because I'm afraid maybe they send me back home. So, I said, 'No, I don't want to lose the job.' I just go to work, even I'm sick. "*
> *[PALM participant, Interview #19]*

This fear often intersects with the risk of losing income or employment:

> *" I think that's what they're afraid that they're going to lose their job and have no income. "*
> *[Employer welfare officer, Interview #4]*

In addition to fears about immigration and employment, workers' decisions to engage with healthcare can also be shaped by concerns about whether their personal information will be handled with care and confidentiality by the health system. Trust in health professionals and systems to maintain privacy and to support them without judgment or risk to their community standing is critical, especially for services involving reproductive health or sexual health. One clinician described how a breakdown in this trust affected a patient seeking a termination due to a translator not accurately translating the information to the individual seeking care:

> *" The client said, 'I just need you to know she was not translating appropriately. I could understand what was being said in English.' … it takes one experience like that and you're going to be pretty reluctant to go back to a health service….trust and fear are huge "*
> *[Nurse, Interview #28]*

Conversely, where trust is established and maintained, particularly between workers and employers, access to care can be significantly improved. One employer emphasised the importance of supporting workers even for reassurance, noting the long-term value of maintaining trust:

> *" By taking them to the doctor, nine times out of 10, we know what the doctor's going to tell them. We know what the doctor's going to give them, but it gives them reassurance that, 'I'm okay. I'm not going to die.' If you choose not to take them to the doctor, it can erode a lot of trust with you. And then that can lead to other issues down the track when you're trying to explain things and get them to trust you. Because ultimately, that's the biggest key, is they need to trust you. They need to trust that you've got their best interest at heart "*
> *[Employer welfare officer, Interview #10]*

This emphasis on empathy and respect, particularly when workers are far from home, in unfamiliar systems, was highlighted by another employer:

> *" …it's about building trust. Like I've said to you before, I've encouraged my team to treat people the way that they would like to be treated… I am really, really big with my team about making sure they remember that and think about how they feel and how they would feel, put themselves in our guys' shoes. "*
> *[Employer welfare officer, Interview #10]*

Trust and fear form a powerful and often invisible axis that shapes healthcare access for PALM participants. Workers' willingness to seek medical care hinges not only on the availability of services but also on whether they believe engaging with those services will be safe, and in terms of their future employment. Where trust exists, in employers and healthcare providers, healthcare access improves. But where fear dominates, whether of being sent home, "blacklisted", or having their confidentiality breached, workers may delay or avoid care.

Health-Seeking Behaviours: Social and Cultural Influences

Interviews with healthcare providers revealed a range of perceived influences on how PALM participants engage with sexual and reproductive health services. These observations included perceived gender differences, stigma surrounding STIs and BBVs, and varying levels of comfort in accessing healthcare. While these should not be generalised across the diverse PALM population, they offer insights into the kinds of social and behavioural dynamics that may shape access to care.

While not culturally specific, service providers frequently commented on gendered patterns in health-seeking behaviours. Men were often described as more reluctant to seek care unless symptoms were severe, while women were observed to be more proactive in accessing services:

> *" There's kind of a sense from the men that if you ignore it, it'll go away. And they're not really keen on even doing STI screens unless there's something very obviously wrong...we often find that the women are very proactive. They're a lot more comfortable coming in and talking about sex and sexual health. And it's actually the men that we kind of struggle to get in. "*
> *[Nurse, Interview #28]*

Some health providers reflected on how PALM participants' beliefs and hesitations around healthcare may be shaped by limited exposure to health education and religious or cultural views. These views were presented as impressions developed through service delivery, not definitive cultural analyses:

> *" Reticence around discussing these issues, or talking about using condoms for safer sex, or having sexual health screens, or treatments. And as far as contact tracing goes, that's really complicated. And often seasonal workers have partners back home either wives, husbands, whatever and are not travelling or working with their partner. So, it's often quite complicated and, again, often poor baseline knowledge around these health issues. "*
> *[Clinician, Interview #15]*

Observations/reflections on extra-marital relationships whilst living and working in Australia was raised by PALM participants, health providers, and employers alike and were often framed within the social realities of long-term separation. While not universal, these dynamics were described as contributing to hesitancy in seeking sexual health care, particularly due to stigma, shame, potential social repercussions in their home community, or fear of judgment from peers or within the worker community. As one provider explained:

> *" So, shame definitely, not knowing how to talk about any of this stuff potentially, but possibly having sex outside marriage so you shouldn't be having sex in the first place. The fear that confidentiality will be broken within the community of workers. So, a woman might be here working alongside sister-in-law, husbands at home. She's got symptoms, she's pregnant. Yeah, big shame. "*
> *[Nurse, Interview #28]*

Stigma and shame were highlighted as significant deterrents to care, particularly in relation to reproductive and sexual health. Providers shared examples of how these concerns manifested in clinical settings:

> *" Most of them aren't very upfront with it or know if they've got any hepatitis and.... It's very much a taboo, I feel. Not something that's talked about in the community there. "*
> *[Clinician, Interview #6]*

Providers also emphasised that engaging workers in-language and through trusted communicators can help overcome stigma and support access:

> *" I think another one is stigma in our community with sexually transmitted infections and diseases, which is why the education part and what we do is so important because we help to break down that stigma that's around it. And because we are speaking to them in their language, most of the time they feel like, 'Oh, because this person looks like us and speaking to us in our language that we can understand, it's more accessible for us to go and now seek out those treatment options. "*
> *[Health educator, Interview #3]*

In addition to insights from service providers, survey responses from PALM participants echoed similar themes. Many workers expressed a belief that sexual health checks were unnecessary unless symptoms were present or if they were in a monogamous relationship. Stigma and embarrassment also featured, with one respondent noting:

> *" Shame, I would feel embarrassed going to a doctor, fear that other people might talk about me from my own country. "*
> *[PALM participant, survey response]*

These observations suggest that PALM participants' health-seeking behaviours are shaped by a complex interplay of social, cultural, and gendered factors, including stigma, faith, and expectations around privacy and care. While further research is needed to explore these influences across the diverse PALM cohort, service providers consistently highlighted the importance of trust, confidentiality, and culturally responsive communication.

Understanding and Awareness Gaps of BBV and Sexual Health: The Hidden Burden of Hepatitis B

A key issue for access to hepatitis B healthcare among PALM participants, which we have already highlighted, is its invisibility. This is driven by a lack of routine testing, which is also reinforced by low levels of awareness and gaps in education around BBVs and sexual health. Survey responses from PALM participants revealed significant knowledge gaps. When asked, "Do you know what hepatitis B is?", only 17% of workers responded "Yes," while a substantial majority (83%) answered "No." When asked if they had been vaccinated for hepatitis B, 43% of respondents said they had received the vaccine in their home country, while 14% reported that they had not been vaccinated, and another 43% said they were unsure. When asked about hepatitis B testing, only 20% of participants said they had been tested in their home country.

In contrast, 40% said they had not been tested, and 40% were unsure. Similarly, when asked whether anyone in their family had hepatitis B, 60% said no and 40% were unsure.

Awareness of other STIs was also limited. When asked if they were aware of conditions such as Chlamydia, Gonorrhea, or Syphilis, 15% said they had heard of Chlamydia, 25% of Gonorrhea, and 20% of Syphilis, indicating minimal awareness of these infections. When asked if they had been tested or diagnosed with any STIs in Australia, 86% were unsure, and 14% preferred not to say. When asked whether they would like a sexual health screen, only 9% of participants said they would like to but had not yet had one. Most (86%) said they did not want a screen.

Workers' beliefs about hepatitis B and other BBVs were often shaped by misinformation, unclear messaging, or limited engagement with healthcare providers. One clinician shared:

> *" They [workers] talked about hepatitis B. They believed that there's a cure of hepatitis B, that they got tested in Pacific Islands for hepatitis B. And some doctors down there are actually treating patients for hepatitis B and promising them that they can cure it...So they're giving them something and then doing a repeat test and telling, 'Hey, look, you've got hepatitis B. We're treating you with this, and now we have done a follow-up test and look at it, there's no hepatitis B in your blood, so you got cured of it.' "*
> *[Clinician, Interview #5]*

Employer welfare officers also described foundational gaps in understanding STIs:

> *" They're very open about the fact that they have them because I don't think they quite understand them. When you say STI to them, you're speaking a foreign language. It is not a concept that they understand...I would actually say they consider them as a disease that they only have when they're in Australia. They don't have it back at home. "*
> *[Employer welfare officer, Interview #10]*

Yet, clinicians also reported difficulties obtaining clear sexual health histories from PALM participants:

> *" ... even though we were finding STIs, but no one was having sex. So, we didn't get clear histories that were accurate. "*
> *[Clinician, Interview #11]*

These intersecting factors, uncertainty about personal health status, lack of routine testing, testing inaccessibility, and confusion about the nature of BBVs, contribute to hepatitis B remaining largely invisible within the PALM cohort. While a lack of awareness appears to play a central role, it is important to acknowledge that this may also be reinforced by stigma, shame, and fear of disclosing one's status.

Discussion and Conclusion

The micro-level barriers identified in Chapter 7 underscore how individual-level factors can act as powerful gatekeepers to healthcare for PALM participants, even when services are theoretically available. Fear of job loss or reduced hours, limited understanding of the Australian health system, language barriers, and low health literacy about specific health conditions such as hepatitis B combine to create an environment where workers may delay or avoid seeking care. In Levesque et al.'s Access to Healthcare framework (62), these barriers directly undermine "approachability", "ability to engage" and "ability to seek," meaning that PALM participants may not perceive services as accessible or feel empowered to initiate contact.

The reliance on employers as intermediaries for navigating the health system can further compound this. While some employers facilitate access, others fail to. In effect, these micro-level dynamics can nullify the benefits of meso- or macro-level reforms; for example, increased service capacity or policy changes have limited impact if workers remain fearful of negative employment consequences from accessing care. International evidence underscores that factors such as cultural responsiveness, interpersonal trust, and perceived safety significantly influence migrants' care-seeking behaviour. For example, the WHO emphasises the value of intercultural mediators in fostering trust and improving access for migrant communities (52). Further, this pattern is consistent with Kanan & Putt's safety-and-wellbeing study of the PALM scheme (7), whereby stakeholders flagged having employers as the first point of contact as problematic given visa and employment power imbalances; many workers are reluctant to seek help on personal matters, and some labour-hire companies were singled out for poor welfare support. This triangulates our participants' accounts and strengthens the rationale for confidential, employer-independent access pathways with clear escalation routes beyond the workplace.

In the Australian context, these findings intersect with the PALM Scheme's regulatory design, which grants employers significant control over workers' day-to-day conditions but lacks explicit safeguards to protect health access at the workplace level. Without binding requirements for culturally appropriate health communication, confidential health pathways, and protection from employment repercussions, workers may continue to avoid care until conditions worsen, as seen in our findings.

Addressing these micro-level barriers will require embedding protections and supports directly into PALM Scheme governance instruments, alongside service-side strategies to build trust and capability in engaging with PALM participants. This includes training health providers in culturally safe communication, expanding interpreter access, and establishing employer-independent channels for healthcare navigation. Such measures align with international human rights and labour standards, which emphasise that migrant workers' health rights must be safeguarded at all levels of governance.

Ultimately, micro-level access barriers are not merely interpersonal challenges, they are structural vulnerabilities manifesting at the individual scale. Without deliberate interventions to address them, the health system will remain reliant on individual acts of negotiation and resilience, perpetuating inequities in access and outcomes for PALM participants.


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Chapter 8 – A Cost-benefit Analysis of Hepatitis B Virus Screening and Treatment Program in PALM Scheme Participants

Introduction

This economic evaluation was undertaken in direct response to the systemic gaps identified throughout this report. Most notably, the absence of routine hepatitis B screening, fragmented care pathways, and limited access to treatment for PALM scheme participants. As demonstrated in earlier chapters, hepatitis B remains largely invisible in this population due to a combination of factors: low awareness, inconsistent or absent testing pre-departure and in Australia, and structural barriers that limit access to preventive care and follow-up. While the qualitative and survey findings have clarified the drivers of the reduced access to hepatitis B-related care, economic modelling brings an additional layer by examining the feasibility and value-for-money of implementing a structured screening and treatment approach.

The economic modelling presented in this chapter assesses whether a proactive screening and treatment approach could improve health outcomes for PALM participants and whether it is a cost-effective intervention. The rationale for this model is grounded in both public health logic and ethical responsibility. Participants commonly reported being unaware of their hepatitis B status or unsure if they had ever been tested or vaccinated. Clinicians and service providers highlighted the difficulty of justifying testing when follow-up care is inaccessible, contributing to a cycle of delayed diagnosis and missed opportunities for early intervention.

While data about the costs and benefits of hepatitis B screening and treatment in other populations in Australia are available (63, 64), there are no reports on the economic modelling of hepatitis B management, such as screening and treatment of hepatitis B infection, compared to the current model (status quo) in the PALM scheme population. This represents a critical gap in evidence, given the high burden of hepatitis B in many PALM-sending countries and the potential long-term consequences of delayed diagnosis and treatment. The lack of targeted economic analysis means that decision-makers are currently unable to weigh the costs of proactive screening and early treatment against the downstream health system costs (and individual out-of-pocket costs for non-Medicare eligible people) associated with late diagnosis, such as liver cirrhosis, hepatocellular carcinoma, and premature mortality. In contrast, cost-effectiveness studies in migrant populations in the USA (65) and the Netherlands (66) have demonstrated that hepatitis B screening and linkage to care are clinically effective and economically justified. Conducting economic modelling specific to PALM participants provides valuable evidence to guide health policy, reduce inequities, improve health system efficiency and reduce out-of-pocket healthcare costs by enabling timely, cost-effective hepatitis B management. This would also align with Australia's national strategies for hepatitis B elimination and support regional health commitments to Pacific Island nations.

This analysis models the costs and benefits of implementing hepatitis B screening and treatment for PALM workers, illustrating what a proactive and standardised care pathway could look like. It shifts the approach from reactive, discretionary responses to one that prioritises early detection and consistent management. The findings provide a robust evidence base to inform investment decisions in the health of PALM participants and broader public health. They also reinforce the need for national coordination, cross-border health planning, and the development of sustainable care pathways, as outlined throughout this report.

Methods

Description of the Intervention

The analysis compared the costs and outcomes of two scenarios:

- Screening and treatment of hepatitis B infection
- Status quo (no treatment and no screening)

A decision tree, incorporating a Markov model (Figure 5) to indicate the different states of hepatitis B infection was developed to estimate the comparative costs and benefits of the current hepatitis B management in PALM scheme participants against proposed hepatitis B screening serology and CHB management strategies. The model was developed using TreeAge Healthcare Pro 2025 Software. The essential measure was the net benefit or cost from implementing hepatitis B screening and management programs compared to no screening and treatment.

As PALM participants do not form the list of mandatory hepatitis B screening under Australia's temporary visa requirement, it was assumed that no hepatitis B screening was performed. Thus, there was no way to determine the prevalence of CHB in the PALM participant population.

The hepatitis B screening and CHB treatment protocol used in this analysis were based on the consensus recommendation by the Gastroenterological Society of Australia (GESA), the peak body in gastrointestinal and liver health and disease in Australia (67). Serological screening for hepatitis B infection uses enzyme immunoassay techniques to detect hepatitis B surface antigen (HBsAg) and determine hepatitis B susceptibility. The triple panel qualitative serological tests used for diagnostic purposes include testing for: i) hepatitis B surface antigen (HBsAg), ii) hepatitis B core antibody (anti-HBc), and iii) hepatitis B surface antibody (anti-HBs) to determine infection, exposure and immunity respectively.

Two standard anti-viral therapies GESA recommends for treating hepatitis B infection are entecavir and tenofovir. Clinical trials suggest no significant difference in hepatitis B DNA suppression when using either antiviral (68). In this analysis, costs and hepatitis

B infection state transition probabilities of tenofovir use were applied. All costs were derived from Australia's Medicare Benefits Schedule (MBS) (https://www.mbsonline.gov.au/) and the Pharmaceutical Benefits Scheme (PBS) (https://www.pbs.gov.au).

Model Structure and Time Horizon

PALM participants who entered the decision tree were assumed to have one of three hepatitis B conditions: active hepatitis B infection, hepatitis B carrier, or uninfected. From there, individuals with hepatitis B (active or carrier) transition into one of six defined Markov health states: CHB, Hepatitis B surface antigen loss (sAgLoss), Compensated Cirrhosis (CC), Decompensated Cirrhosis (DC), Hepatocellular Carcinoma (HCC), and Liver Transplant (LT). A 20-year time horizon was chosen to ensure the model captures the full spectrum of health outcomes and cost implications associated with hepatitis B progression. The extended timeframe allows for a more comprehensive evaluation of differences between intervention strategies, particularly given the long natural history of hepatitis B. While some previous economic models have used shorter horizons, such as 10 years (69), these may underestimate the long-term benefits and downstream costs of early detection and management, especially in at-risk populations like seasonal migrant workers.

Patients could either remain in their current health state or transition to a more advanced state (e.g., from CHB to CC or HCC), reflecting disease progression. Liver transplant was modelled as an absorbing state (i.e., no further progression), with a proportion of patients progressing to this state from DC or HCC. Mortality risks were incorporated where applicable, particularly from DC and HCC, with all-cause mortality included across states based on age-standardised life tables.

The model compared two protocols. First, the current standard care, where PALM participants are not routinely screened for hepatitis B infection. Second, an intervention arm where hepatitis B screening is introduced, and those eligible for antiviral treatment are referred to a local GP or primary health clinic. Individuals with active hepatitis B infection but not meeting treatment thresholds are offered continuity of care and monitoring. For each arm, the model estimated the number of PALM participants progressing to CHB-related complications alongside associated costs and health outcomes over the 20-year timeframe.

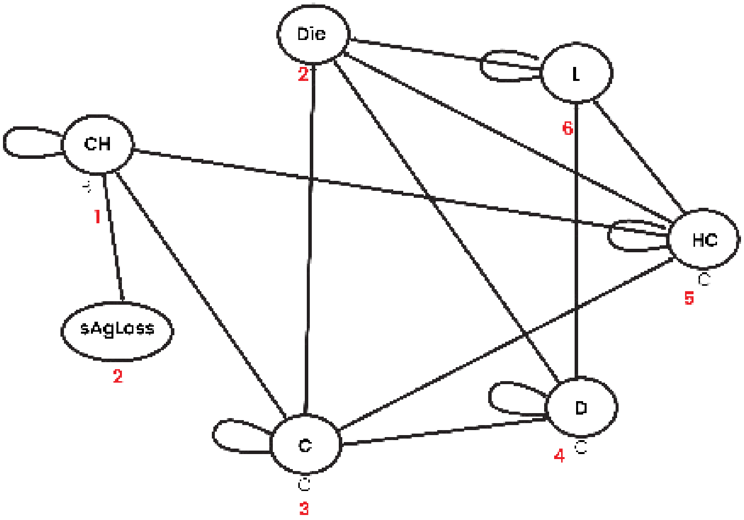


Figure 5: *Markov model. Note: Individuals being in one of the following states: Chronic Hepatitis B (CHB), Hepatitis B surface Antigen loss (sAgLoss), Compensated Cirrhosis (CC), Decompensated Cirrhosis (DC), Hepatocellular carcinoma (HCC), Liver transplant (LT).*

Appropriate transition probabilities derived from known probabilities were assigned to each scenario. Those not assigned screening and treatment were assumed to follow the transition probabilities of the natural history of hepatitis B infection. They could either remain in one of the five states (excluding death) of the Markov model (Figure 5) or move to one of the other possible five states unless they died before the end of the time horizon for the model. A cycle length of 1 year was deemed appropriate for this model.

Economic Evaluation

This economic evaluation followed best practice guidelines on Consolidated Health Economics Evaluation Reporting Standards (CHEERS) (70)

Study Perspective

The analysis was conducted from the perspective of the Australian health system/funders. All costs are presented in Australian dollars. The estimated total costs for individuals in the natural history progression, including treatment of hepatitis B infection (i.e. tenofovir) and resources used to screen for hepatitis B infection were derived from the MBS and PBS of Australia.

Comparators

In this analysis, two scenarios were modelled and compared: i) screening and treatment of hepatitis B infection, was compared to ii) the status quo, where there is no screening and treatment of hepatitis B infection in PALM participants.

Time Horizon

The analysis looked at the outcome over a 20-year time horizon.

Discount Rates

Costs and health outcomes were discounted at 5% according to the Australian guidelines (71).

Choice of Outcomes

The primary outcome of the model looked at the net costs and benefits of screening and treatment of hepatitis B infection. Utility scores between 1 (representing 'full health') and 0 (representing death) were obtained from the literature (69).

Estimating Resources and Cost

The costs of primary care visits, medical consultations, treatments, and investigations were taken from the MBS, and the costs of medication were adopted from the PBS. Prices were inflated to 2024 prices using seasonally adjusted Australian consumer price indices for health services (72). All costs of resources used were reported in Australian dollars.

Analytical Methods

A decision-analytic model was constructed using TreeAge Pro 2025. A cost-benefit analysis that compared a SCREEN/Rx (Treatment) strategy to a Usual Care (Status Quo) over a defined time horizon of 20 years.

The analysis reports mean costs, mean Quality-Adjusted Life Year (QALY)s, incremental costs, incremental QALYs, and net monetary benefit (NMB). Results are also presented using a cost-effectiveness scatterplot, which illustrates the distribution of incremental costs and QALYs across simulations, and a cost-effectiveness acceptability curve (CEAC), which shows the probability that the intervention is cost-effective across a range of willingness-to-pay thresholds.

Base Case Analysis

The constructed Markov model was analysed using Monte Carlo simulation to establish whether screening and treatment of hepatitis B infection was value for money when compared to the status quo. Known transition probabilities from beta distribution parameters, using the appropriate mean and standard deviation were used in the different states of hepatitis B infection. A Probabilistic Sensitivity Analysis (PSA) was performed using 1000 sample simulations.

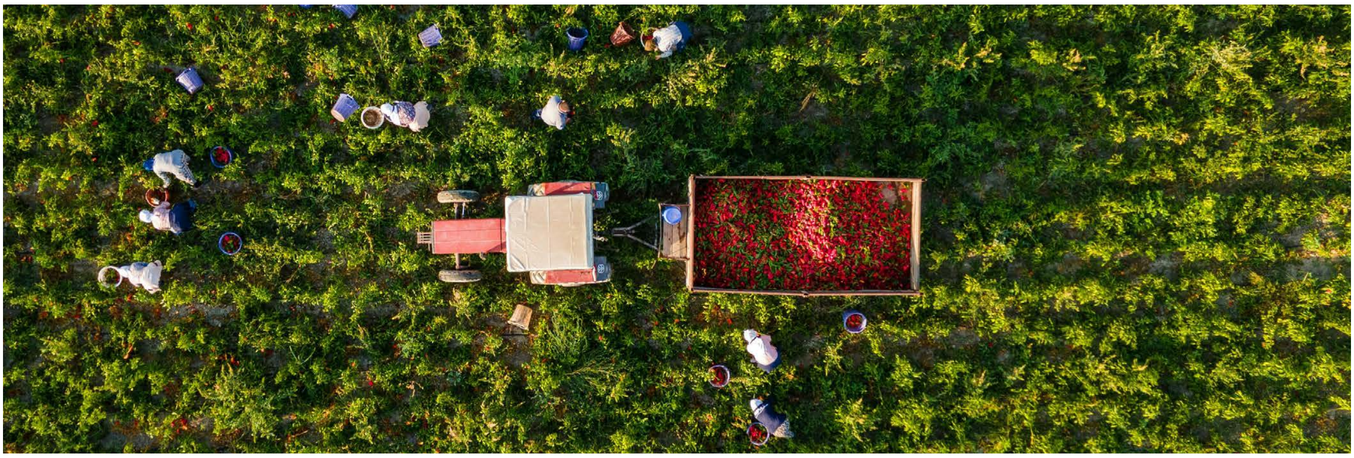
Results

The cost-benefit analysis demonstrated that implementing hepatitis B screening and treatment (SCREEN/Rx) for PALM participants yielded a substantially higher net monetary benefit (NMB) compared to Usual Care/Status Quo. At a willingness-to-pay (WTP) threshold of $50,000 per QALY. SCREEN/Rx generated an NMB of $514,660.22, while Usual Care yielded $415,683.47, resulting in a net economic advantage of approximately $99,000 in favour of SCREEN/Rx (Table 5).

In terms of cost-effectiveness (Table 5), the total cost per individual over the 20-year time horizon was $108,249.78 for SCREEN/Rx, slightly higher than $107,529.49 for Usual Care, reflecting an incremental cost of $720.29. However, this modest increase in cost was offset by a significant incremental gain of 1.99 QALYs per person. The resulting incremental cost-effectiveness ratio (ICER) was $361.24 per QALY gained, which is well below Australia's commonly accepted WTP threshold of $50,000 per QALY. This indicates that SCREEN/Rx provides excellent value for money.

Figure 5: *Monte Carlo C/E Rankings Report (CBA of Management of HEPATITIS B Infection)*

Category	Strategy	Cost	Incr. Cost	Benefit	Incr. Benefit	ICER (IC/IE)	NMB
ALL (no dominance)							
Undominated	USUAL/ STATUS QUO	107529.49		10.46			415683.47
Undominated	SCREEN/Rx	108249.78	720.29	12.46	1.99	361.24	514660.22



The cost-effectiveness scatterplot (Figure 6) presents the distribution of costs and benefits (measured in QALYs) from 1,000 Monte Carlo simulations for both strategies. The Usual Care/Status Quo simulations (red dots) exhibit a broader and more dispersed spread in total costs, ranging from approximately $70,000 to over $150,000. These simulations are largely clustered around 8 to 11 QALYs, indicating lower health benefits. In contrast, the SCREEN/Rx simulations (blue dots) are concentrated further to the right on the horizontal axis, representing higher health benefits, typically between 12 and 13.5 QALYs. While there is some overlap in costs between the two strategies, SCREEN/Rx consistently demonstrates greater effectiveness, underscoring its superior value in terms of QALYs gained.

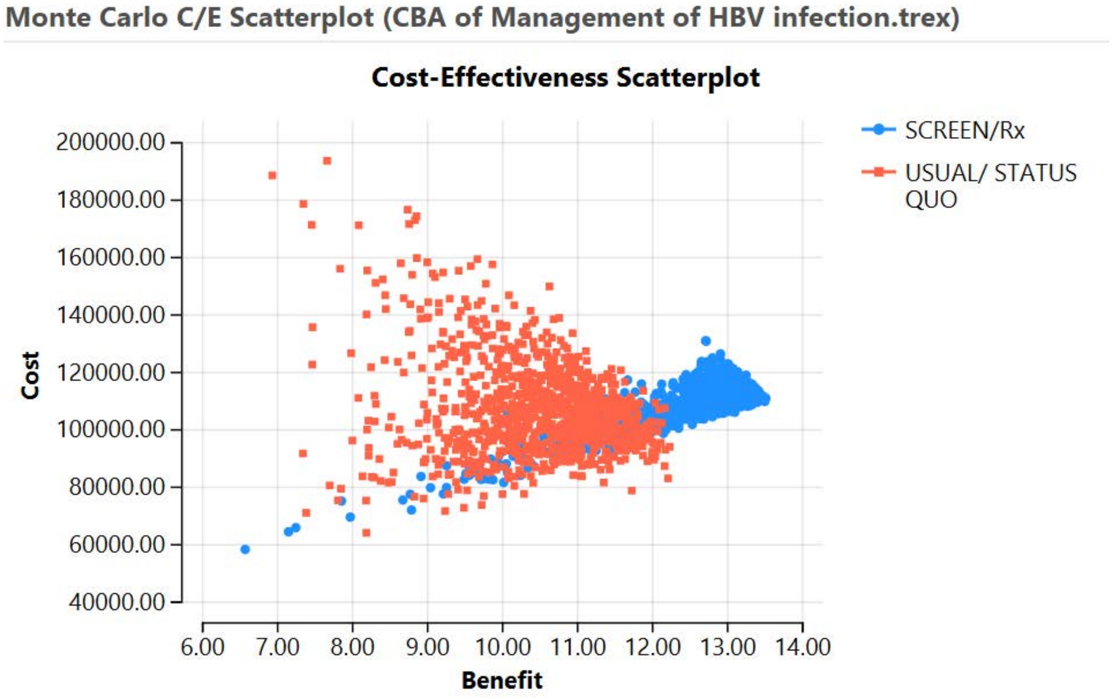


Figure 6: *Cost-effectiveness scatterplot*

The CEAC for SCREEN/Rx (Figure 7) illustrates the probability that the intervention is cost-effective across a range of WTP thresholds. At a relatively low WTP threshold of $10,000 per QALY, SCREEN/Rx is already cost-effective in approximately 85% of simulations. This probability increases steadily with higher WTP values and plateaus at just over 90% when the threshold reaches $50,000. These results indicate a high degree of confidence that SCREEN/Rx is a cost-effective strategy across plausible WTP scenarios used in Australian health economic evaluations.

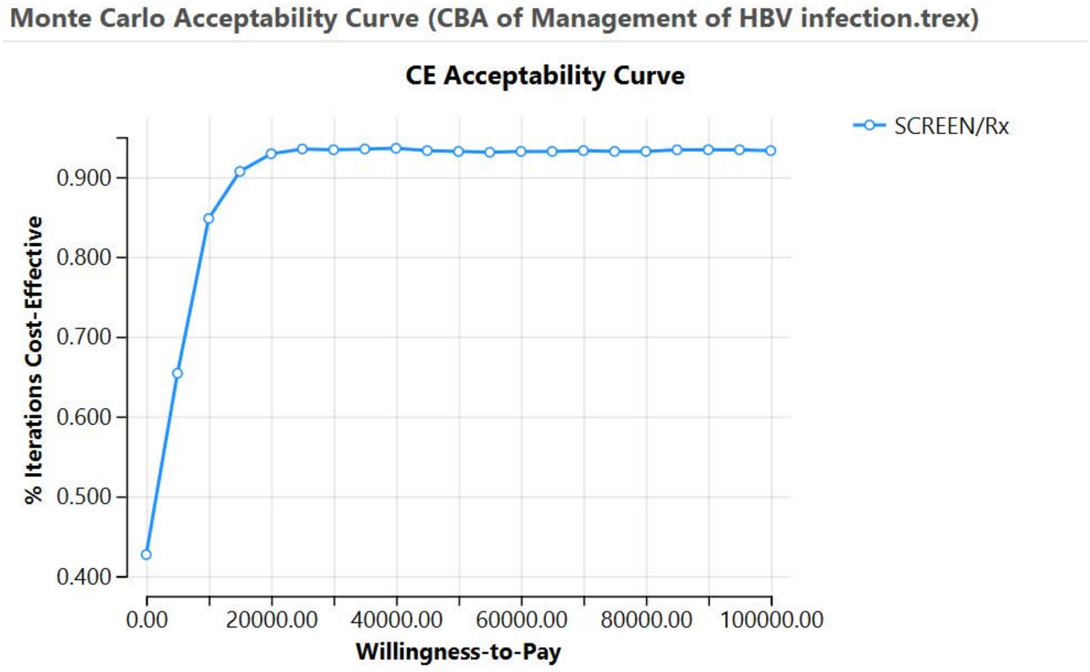


Figure 7: *Cost Effectiveness Acceptability Curve for SCREEN/Rx*

Discussion and Conclusion

A Monte Carlo probabilistic sensitivity analysis was conducted to evaluate the economic and health outcome implications of implementing a screening and treatment strategy (SCREEN/Rx) versus maintaining Usual Care (Status Quo) for the management of chronic hepatitis B infection in PALM participants. The results consistently favoured SCREEN/Rx as a cost-effective and economically attractive intervention.

Despite a modest increase in mean cost per person ($720.29), SCREEN/Rx delivered an additional 1.99 QALYs, resulting in an ICER of $361.24 per QALY gained. This figure is substantially lower than Australia's commonly cited WTP threshold of $50,000 per QALY, indicating that the intervention offers outstanding value for money. Moreover, the NMB for SCREEN/Rx exceeded that of Usual Care by approximately $99,000 per person, reinforcing its economic advantage.

The cost-effectiveness scatterplot illustrates this dominance, with SCREEN/Rx simulations clustering towards the right, indicating higher health benefits, while Usual Care simulations show wider variability and lower benefit concentrations. Although there is some overlap in cost ranges, the consistent rightward shift of SCREEN/Rx data points confirms its superior QALY performance.

The CEAC further substantiates these findings. SCREEN/Rx demonstrates a high probability of being cost-effective across a wide range of WTP thresholds. At a WTP of $10,000 per QALY, SCREEN/Rx is cost-effective in approximately 85% of simulations, rising above 90% as the WTP reaches $50,000. This plateau in probability reflects strong decision-making confidence in the intervention, even under varying budget constraints.

The high NMB and low ICER of SCREEN/Rx are likely attributable to earlier identification of CHB cases and prevention of downstream complications such as cirrhosis, hepatocellular carcinoma, and liver transplantation. By interrupting the disease progression early through diagnosis and timely medical management, SCREEN/Rx may reduce long-term clinical burden, health system costs, and associated mortality. Taken together, these findings strongly support the implementation of systematic hepatitis B screening and treatment among PALM scheme participants. Beyond being a cost-effective health intervention, SCREEN/Rx aligns with public health priorities to reduce hepatitis B transmission, promote early treatment, and improve health equity among the PALM participant population. The findings of this economic analysis provide clear evidence that implementing a standardised hepatitis B screening and treatment program for PALM participants is a cost-effective public health intervention. Early identification and care would significantly reduce the health system burden of advanced liver disease, while improving equity for a population that is currently excluded from routine prevention and care pathways.

This modelling reinforces the urgent need for a nationally coordinated response, one that embeds hepatitis B screening and follow-up into the PALM program as a core component. The Commonwealth Government should prioritise funding, policy alignment, and care infrastructure to support this shift. Doing so will not only advance Australia's hepatitis B elimination goals but also demonstrate a commitment to ethical, preventive, and regionally responsible health policy. Embedding this approach into routine care for PALM participants is both economically sound and ethically imperative, representing a shift from discretionary goodwill to systemic responsibility.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Chapter 9 – Recommendations and Conclusions

Recommendations from Health Providers and Employers

Across interviews with health professionals and employer welfare officers, a shared sense of urgency and frustration emerged regarding the systemic barriers faced by PALM participants in accessing equitable healthcare in Australia. Many respondents described "working around the system" to support PALM participants, despite a policy and funding environment that often left them unsupported.

Building on the barriers detailed in the previous chapters, this section presents direct insights and recommendations from health providers, employers and PALM participants about how to overcome them. Structured into ten thematic areas, this narrative draws from in-depth interviews and survey data, with a focus on actionable pathways to improve healthcare access for PALM participants.

1. Medicare Eligibility

A central recommendation was the need for policy reform at the federal level:

Respondents advocated for granting PALM participants direct access to Medicare, or for creating a dedicated healthcare access model that ensures they are not left without essential medical coverage during their time in Australia. Many described the current exclusion from Medicare as inequitable and unsustainable, particularly given the duration of stay and nature of their work.

In the survey responses, where health providers were asked to rank what would be the most important factors for providing effective care to PALM participants, having access to Medicare was ranked as the most important. Access to Medicare was considered especially vital for the effective management of chronic conditions like hepatitis B. Stakeholders emphasised that without Medicare, PALM participants face significant barriers to accessing routine testing, vaccinations and treatment:

> *" The thing that would change at this side for Medicare is that we would test them more often. We would provide education. We would vaccinate, which would then mean, when they go home, they're not going to end up with hep B, so they're not going to need access to treatment. It's health promotion. It's harm reduction. It's harm minimization. It's public health. The bigger solution is that there's equitable access to treatment everywhere for everyone. The smaller one is that we have Medicare provided for these workers so that we can test and treat what we can and educate where we can and vaccinate. "*
>
> *[Clinician, Interview #12]*

Some respondents referenced healthcare provisions for refugee populations as a useful precedent. They suggested that a similar model, whereby population groups without full residency status are granted subsidised care through Commonwealth mechanisms, could be adapted for PALM participants, given their long stays, economic contribution, and vulnerability to health risks.

2. Reforming Private Health Insurance: If Not Medicare, Then What?

If access to Medicare remains restricted, health providers stressed that PHI must be urgently reformed to meet the needs of PALM participants. Many described the current model as confusing, exclusionary, and inadequate, especially when it comes to managing chronic conditions like hepatitis B, sexual and reproductive healthcare. A central concern was that PHI policies do not cover pre-existing conditions, meaning even known diagnoses are effectively left untreated. As one respondent explained:

> *" So, the only way around this is if there is funding for the seasonal workers to bypass their 12-month pre-existing condition. If we are able to negotiate something with the health fund so that they have access to treatment of chronic medical conditions because hepatitis B will always be a pre-existing medical condition for them. "*
>
> *[Clinician, Interview #5]*

This gap in coverage is compounded by the out-of-pocket payment system, where workers must pay upfront and seek reimbursement later, a process many avoid due to cost or uncertainty. Therefore, recommendations to the billing processes, potentially around greater education for health providers were made.

Providers noted that reproductive health services were not included in PHI policies and recommended inclusion of pregnancy-related services into the insurance policy. Equity in access to healthcare was recommended. Others suggested that PHI is fundamentally ill-suited to address chronic, long-term, or recurring care needs in a seasonal workforce context and reform is needed. Finally, in the survey with health providers, *'having a better understanding of navigating private health insurance'* was ranked as the third most important factor that would help to provide effective healthcare to PALM participants. Approved employers ranked *'private health insurance having broader coverage for all conditions'* as the most important factor for improving access to health care for PALM participants.

Taken together, these perspectives suggest that relying on PHI as a substitute for Medicare is neither sustainable nor ethical, unless major reforms are undertaken. At minimum, PHI needs to:

- Cover chronic and pre-existing conditions (like hepatitis B)
- Eliminate or reduce upfront payment requirements
- Expand coverage to include reproductive health services
- Be transparent about costs, fees and coverage
- Be user-friendly for PALM participants and clinicians

In the absence of Medicare, health equity for PALM participants hinges on reforming the design, delivery, and enforcement of PHI.

3. Proactive Screening and Preventive Health Checks

A consistent recommendation from health providers was the urgent need for early and proactive healthcare engagement with PALM participants. Rather than waiting until medical issues become urgent, stakeholders stressed the importance of establishing routine of preventive care, including BBV and STI screening, general health checks, and immunisation assessments, ideally undertaken before departure or within the first few weeks of arrival.

This sentiment was echoed across clinical and public health respondents who underscored the importance of applying the same standards used with other marginalised groups, such as those experiencing homelessness or substance dependence:

> *" We do routine testing at homelessness services. We do routine testing at drug and alcohol services. And it feels like it's an appropriate setting that we could be doing routine testing. The problem is that the barriers that are there prevent us from providing best practice care to a cohort of people who require it. "*
> *[Clinician, Interview #11]*

The failure to embed these practices structurally into the PALM program was viewed by many as a missed opportunity for prevention of BBVs and STIs.

4. Culturally Appropriate and Ongoing Health Education

Running parallel to calls for early screening, providers placed equal emphasis on the need for ongoing, in-language, culturally appropriate health education. Health literacy was identified as a critical enabler of healthcare access, with many respondents expressing concern that current education efforts were inadequate. Some participants specifically highlighted the need for clearer communication about the Australian healthcare system, including what PALM participants are entitled to, what their insurance does or doesn't cover, and how to navigate care options once in Australia:

> *" ...as of now, people that come here have no idea about what this community provides or what their health fund covers. Some people tend to think that their health fund covers everything, and some people tend to think that they'll be out of pocket and the health fund covers nothing. So, the system needs to be more transparent. We need to educate them prior to coming into Australia about the nature of what we can provide here and what the barriers are so they can make informed choices around whether they want to come or not. "*
> *[Clinician, Interview #5]*

Other providers echoed this, emphasising the importance of visible, localised promotion of services once workers are in Australia:

> *" We should be promoting services that they can access while they're here, helping them. They're in a new country, a new town, they've got no idea...And that's where I think we get the best bang for buck to reduce the barriers is accurate education for them. "*
> *[Clinician, Interview #7]*

Embedding education into arrival processes was a recurring theme. Providers advocated for building it into the PALM scheme:

> *" One of the recommendations we made... upon arrival, there should be an introduction to sexual health services. "*
> *[Nurse, Interview #28]*

5. Community-Based and Outreach Healthcare Models

A strong theme across interviews was the need for locally delivered, accessible health services tailored to the realities of PALM participants' working and living conditions. Welfare officers ranked *'outreach services where health practitioners come to the workplace'* as the second most important factor for improving access to healthcare for PALM participants. Health providers consistently advocated for walk-in clinics, mobile health units, and outreach models based near worksites or accommodation hubs in areas with high concentrations of PALM participants. These services were envisioned as comprehensive one-stop clinics offering routine STI and BBV testing, contraception, pregnancy care, chronic disease screening, and general health assessments. One provider described in detail the viability and efficiency of such a model:

> *“I did up a costing for what it would cost on a [walk-in] clinic like that because you need a medical prescriber, someone who can initiate treatment. We’re authorised sexual health nurses, we can do the treatment, but we do need a medical officer on site. You can be collecting all your pathology, it goes through Local Hospital A or Local Hospital B. There are ways to do it. And it’s actually not that expensive. You can be doing contraception, pregnancy tests, the works. It would be a bustling operation and the follow-up is tricky, but you’re back there every week and there’s an opportunity for follow up the week later.”*
> *[Nurse, Interview #28]*

Others echoed the importance of bringing care directly to workers rather than requiring them to navigate unfamiliar health systems or travel long distances during limited free time. A mobile GP visit to the worksite was seen as impactful:

> *“Even if they could have a GP service that would go and see them and then you don’t have to leave the work site, you can go for your liver appointment, come back.”*
> *[Clinician, Interview #6]*

These perspectives highlight a practical, community-led approach to care; one that is mobile, relationship-based, and embedded in the places where workers live and work. Rather than forcing PALM participants to reach distant or inaccessible health services, providers called for the system to come to them, meeting people where they are.

6. Funding and Workforce Support

Throughout the interviews, a consistent concern emerged around the chronic underfunding of services, particularly in rural and regional areas where PALM participants are concentrated. Providers described a system in which services were expected to stretch existing resources or “work around” the gaps, rather than being meaningfully supported to deliver the care needed. As one respondent put it:

> *“...they need to actually think about how to fund it across everywhere else instead of just expecting people to cope.”*
> *[Nurse, Interview #7]*

There were strong calls for public investment in sexual health services, including structural funding that covers essential diagnostics:

> *“Make changes to publicly funded sexual health services so that pathology is covered.”*
> *[Nurse, Interview #12]*

Participants emphasised the need for new workforce roles to enhance culturally safe care and reduce pressure on clinicians. Suggestions included dedicated healthcare workers or liaison officers who could support communication, understanding, and follow-up care. In the survey responses from clinicians, having a Pacific Island health worker or liaison officer was ranked the second most important factor that would help them to deliver effective healthcare to PALM participants:

> *“I think that’s always going to be a resource limitation, particularly in rural areas where you’re already resource-limited there. It would be good to have someone like a healthcare worker who could actually do a little of the background stuff for us. I think that would make a big difference, particularly someone who’s aware of the cultural norms. I think having a liaison officer would be a really big thing.”*
> *[Clinician, Interview #6]*

Others echoed this need for increased funding, not only to enhance testing and service capacity, but to give stretched services the staff and time they need to deliver consistent care:

> *“Yeah, I suppose, more money, more staff, more time. More money, you’ve got access to more testing and follow-up. Yeah, I suppose it all stems in the whole budget thing, doesn’t it?”*
> *[Clinician, Interview #8]*

Finally, one respondent broadened the lens beyond Australia, noting the value of investing in health promotion and workforce development in the Pacific region itself, to support health equity upstream:

> *“I’d also like to see some time money invested in the Pacific Islands. I think that’s a huge part of it that we forget about. We’ve really invested in Australia, which we absolutely need to be and that needs to be the priority, but I also think we need to look at bigger scale, and we need to start with the kids that are there now.”*
> *[Welfare Officer, Interview #10]*

7. Sexual and Reproductive Health Access and Informed Choice

Sexual and reproductive health was identified by several interviewees as a key area where PALM participants require more support, clearer pathways, and culturally appropriate services. Stigma and shame were highlighted as significant deterrents to care, hence the importance of safe and confidential health care access:

> *" So, shame definitely, not knowing how to talk about any of this stuff potentially, but possibly having sex outside marriage so you shouldn't be having sex in the first place. The fear that confidentiality will be broken within the community of workers. "*
> *[Nurse, Interview #28]*

8. Time Off for Medical Appointments and Workplace Support

Even when health services are available, PALM participants are not always able to access them due to structural barriers in the workplace. Providers highlighted the need for employers to explicitly support time off for medical appointments:

> *" I think one of the other big things is the farm is allowing them...everyone else in Australia gets time off to go for medical appointments. "*
> *[Clinician, Interview #6]*

9. Cultural Safety and Training for the Australian Health Workforce

Providers expressed a strong need for increased cultural safety training within the Australian health system, with a particular focus on sexual and reproductive health:

> *" ...we do need a level of cultural training around that as well to know how to ask questions. There's a big gap between maybe western understanding of consent and violence and a Pacific Island person's understanding. So yeah, there's cultural knowledge that needs to increase, and this is going to be a significant part of Australia's workforce. "*
> *[Nurse, Interview #28]*

Cultural training was framed as necessary not just for clinical staff but also for service planners and administrators. A systemic approach to cultural competency, akin to First Nations health training was suggested:

> *" But I think if the federal government really wants to actually take this seriously, they probably need to address that better. We've learned after 30, 40 years that First Nations cultural training is still essential and adaptive. We are always looking at new iterations of that and there's always something new that becomes compulsory. "*
> *[Nurse, Interview #7]*

10. International Collaboration and Pacific Region Investment

Some respondents reflected on the need for health investment beyond Australia's borders. Given the high rates of hepatitis B and other health issues in the Pacific, there was a call for Australia to support health system strengthening in sending countries:

> *" For example, providing vaccinations for people with their hep B, I mean, it's cheap as bloody chips. And it really wouldn't be a huge investment to support some of these countries in getting their own testing and treatment strategies up to speed. Which is obviously then going to, I mean, it's a bit of a delayed loop, but it's eventually going to turn around to fewer infections in people coming, and also a better, less public health risk with people being here. "*
> *[Nurse, Interview #11]*

Suggestions for Improving Healthcare Access: Voices from PALM Participants

Through interviews with PALM scheme participants, a set of consistent themes emerged around how healthcare access could be improved whilst living and working in regional Australia. These insights reflect the participants' lived experiences and offer practical, culturally grounded recommendations for change.

1. Orientation and Health Education on Arrival

Most PALM participants arrive in Australia with limited or no knowledge of the healthcare system. Several participants reflected on the confusion they faced early on, particularly during their first illness or medical need. PALM participants wanted basic information such as how to find a doctor and what insurance covers:

> *" We need to be told about the health system in our first week. "*
> *[PALM participant, Interview #20]*

> *" It would be good if someone explained the insurance properly, like a session at the start. "*
> *[PALM participant, Interview #34]*

2. Health Insurance Understanding and Cost Transparency

As previously highlighted in this report, health insurance remains a source of stress and confusion amongst PALM participants. Although all workers are provided with private insurance, few understood how to use it. Many feared they would have to pay large fees or be denied care, and some experienced delays in treatment because they didn't know how to navigate claims or billing. Suggestions focused on greater clarity and support in understanding what is covered and how to access reimbursements:

> *" If they could make it easier to claim back the money. "*
> *[PALM participant, Interview #25]*

> *" We have the insurance card, but we don't really know what it's for or how to use it. "*
> *[PALM participant, Interview #22]*

3. Language and Communication Barriers

PALM participants offered suggestions to improve communication and understanding within the healthcare system. Many recommended the use of interpreters, bilingual staff, or translated materials to help them communicate symptoms accurately and understand medical instructions. These changes were seen not only as tools for improving access but also as ways to reduce stress and increase confidence in seeking care.

> *" It's hard to talk to the doctor when you don't know the words. "*
> *[PALM participant, Interview #23]*

4. Balancing Support and Autonomy in Healthcare Access

PALM participants identified a range of preferences when it comes to employer involvement in healthcare access. Some workers emphasised the value of supervisors or team leaders who actively assist with booking appointments, organising transport, or guiding them through the health system. These participants recommended having a dedicated contact person at the worksite who can support health-related matters. At the same time, other participants expressed a desire for greater independence and privacy when accessing healthcare. Some voiced that while logistical support was helpful, they preferred to manage their health needs without relying on employers or having to share their medical information:

> *" We don't want our boss to know everything about our sickness. "*
> *[PALM participant, Interview #40]*

These perspectives highlight the importance of enabling autonomy and providing multiple access pathways that respect individual preferences.

5. Transport and Accessibility

PALM participants shared ideas for improving access to healthcare in regional settings where transport is limited. Many recommended that employers organise scheduled trips to town for medical appointments or arrange designated drivers for health-related travel. Others proposed the use of mobile clinics that could visit farms or worksites directly, making healthcare more accessible without the need for workers to leave during work hours:

> *“If the clinic could come here sometimes, that would help.”*
> *[PALM participant, Interview #35]*

6. Cultural Safety and Privacy in Care

PALM participants suggested that cultural safety and confidentiality in healthcare must be strengthened. Many emphasised the value of being able to choose same-gender providers, particularly for sensitive issues such as sexual or reproductive health. Others recommended that healthcare staff receive training to better understand cultural beliefs and norms, improving communication and trust. Ensuring private pathways to care, without relying on employers or housemates for interpretation or coordination, was also seen as essential:

> *“Some girls feel shame talking to male doctors.”*
> *[PALM participant, Interview #26]*

> *“It would help if nurses understood our culture.”*
> *[PALM participant, Interview #25]*

These recommendations reflect a broader call for culturally safe care that respects the dignity, privacy, and autonomy of PALM participants. Participants saw these approaches as essential for making healthcare more approachable and responsive to their needs.

Summary of Feedback

While health providers, employers and PALM participants offered insights from different perspectives, their suggestions converged around a shared goal of building a system that is accessible, culturally safe, practical, and responsive to the needs of PALM participants.

PALM participants called for early and clear orientation about healthcare, greater support in understanding insurance, improved transport options, and access to interpreters and culturally respectful care. They emphasised the importance of having choices, between independent access and employer-supported pathways, and expressed the need for privacy, respect, and gender-sensitive services.

Health providers and employers echoed many of these ideas and further advocated for structural reforms, including Medicare access or significant private health insurance reform, routine STI and BBV screening and prevention, and funding for outreach services tailored to the regional contexts where PALM participants live and work. They also called for workforce investment, including cultural liaison roles and interpreter services, and greater education both within the health sector and for PALM participants.

Together, these recommendations start to form a roadmap for change. They demonstrate that solutions are not only possible but already visible in practice. Many stakeholders are already “working around the system” to do what they can. What is now needed is a coordinated, resourced, and systemic response that brings these ideas to scale.

Chapter 10 – Co-design of Recommendations and Project Conclusions

Co-design of Recommendations

As the final phase of this project, four co-design workshops were held to test, refine, and validate the draft recommendations emerging from earlier phases of the research. These workshops brought together PALM participants, employers, health professionals, and other industry stakeholders to engage in collaborative dialogue and critical review of the findings.

Participants were presented with key themes and preliminary recommendations developed from the survey and interview data. PALM participants were invited to reflect on whether these aligned with their lived experiences, identify any gaps or assumptions, and suggest more effective or culturally relevant alternatives. This approach allowed for critical validation of the study's emerging recommendations, ensuring they were firmly grounded in the realities of both PALM participants and the frontline experiences of health providers and employers.

Two of the workshops were held with PALM participants using a culturally adapted story-sharing method. A visual storyboard was developed, depicting the typical journey of a PALM participant "Mary" (see figure 8) navigating healthcare in regional Australia after becoming unwell with symptoms of hepatitis B. The storyboard was based on research findings from previous phases of the project and illustrated key challenges, including uncertainty about private health insurance, fear of medical costs, limited transport options, fear of loss of income, and cultural and language barriers. Mary's story reflected common experiences raised in earlier interviews and helped workshop participants connect with the issues and offer solutions in a relatable way. Participants were guided through each stage of Mary's journey and asked to comment on what would improve the situation. This method helped draw out grounded, experience-based recommendations in a safe and engaging format that was relatable to all PALM co-design workshop participants.

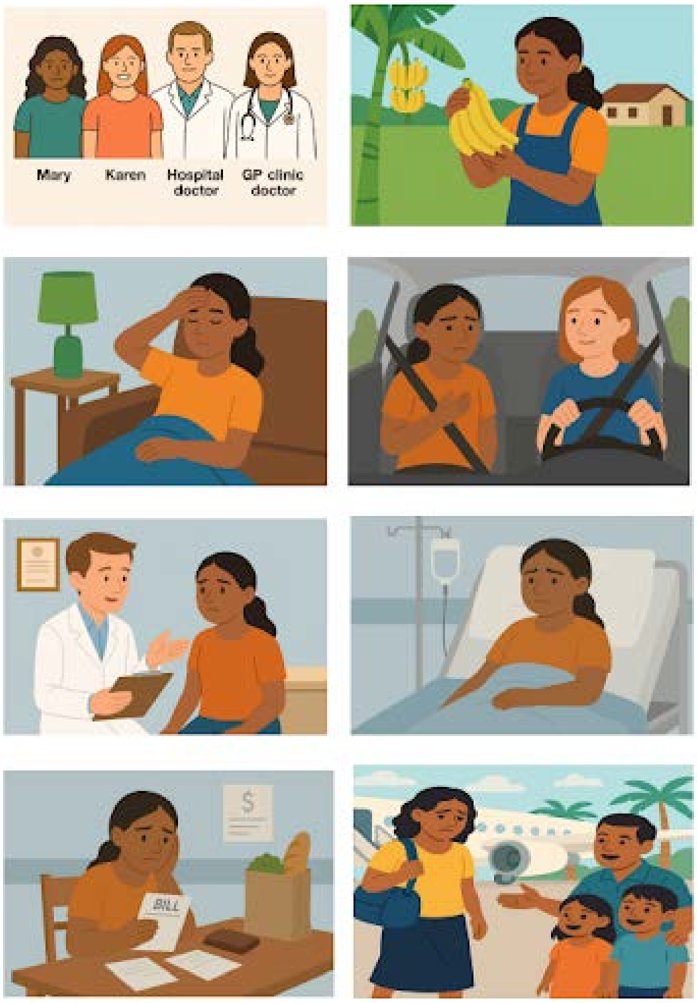

Figure 8: *Storyboard used for co-design workshops with PALM participants*

The remaining two workshops were conducted with employers, health providers, and the project steering committee, which is made up of key industry stakeholders. These sessions, which were held via Zoom and in person, used structured small-group tasks, where participants were provided with a specific barrier and asked to co-develop recommendations for overcoming it. These ideas were then shared and refined collectively. Importantly, stakeholders were also presented with the co-developed recommendations from PALM participants to ensure alignment with population-identified needs and to embed PALM participants' priorities into broader service and policy responses. The following section presents the final outcomes of these co-design workshops.

PALM Participant Co-design Workshop Results

By engaging directly with a narrative that mirrored their own journeys or those of other colleagues and friends, participants were able to identify specific pain points in the current system and propose practical changes.

At each point in the care journey presented in the storyboard, researchers guided participants through structured prompts to test key hypotheses: What is working? ("OK") What is not working? ("Fail") And what could be improved? ("Ideas"). These questions helped elicit critical reflections and co-developed recommendations. Several key themes emerged from the workshops, consistent with earlier findings from the interviews and surveys:

1. Trust and Confidentiality: Supporting Multiple Pathways to Help

Participants held mixed views about who they would want to seek help from when needing to access health care. Some valued the support of team leaders or close friends in navigating healthcare, while others expressed discomfort or mistrust, especially when it came to sensitive health issues. This suggests that PALM participants want multiple trusted access pathways, including independent and confidential options, not only employer-mediated routes.

2. Financial Protection and Equitable Health Coverage

Financial stress and confusion around healthcare costs emerged as a central theme, exacerbated by limited upfront information and poor understanding of PHI. Participants recommended clear, multilingual education on Australia's health system, both before departure and again upon arrival. There were strong calls to eliminate up-front healthcare payments. Suggestions included employer-covered health costs, reimbursement options, or informal peer lending when no other support was available. A clear recommendation was around systemic reforms, including Medicare access. These suggestions were tied to a broader call for equity and fairness in public systems and a call to action from the Australian Government. The findings highlighted the sense of being priced out of Australia's healthcare system, with workshop participants warning that without reform, PALM participants would continue to experience exclusion and hardship. Many had witnessed this reality among fellow colleagues and friends in the PALM scheme, where they were faced with illness, reduced work hours, medical bills and were unable to work and access healthcare, so they returned to their home country.

3. Accessing Healthcare During Work Hours Without Financial Penalty

PALM participants consistently raised the need for healthcare access during work hours without risking a loss of income. As casual workers, many felt forced to delay treatment or self-manage symptoms to avoid missing paid shifts. To address this, participants recommended that the PALM scheme introduce paid sick leave entitlements consistent with broader Australian employment protections and outreach models of care.

4. Culturally Safe Care

Participants called for healthcare that respected both cultural context and gender preferences. Key recommendations included access to translated health materials, and the option to use interpreters or translation tools. Some recommended Pasifika liaison officers, though others expressed concerns about confidentiality if these roles were filled by someone connected to their home community. These recommendations reinforce the earlier theme of trust, suggesting that cultural safety is not just about background, but about relationship, respect and confidentiality.

Health Providers, Employers, and Key Stakeholders Co-design Workshop Results

1. Extend Public Entitlements and Reform Health Financing

Participants across all stakeholder groups strongly advocated for systemic reforms to how healthcare is funded and accessed by PALM participants. This included:

- Extending Medicare Access: Many supported expanding the current family accompaniment visa Medicare pilot to include all PALM participants, backed by cost modelling and public health arguments (e.g., parity with access to HIV care).
- Cost-Sharing Models: There were calls for state, federal, and PHI collaboration to manage healthcare costs, especially for pre-existing conditions, pathology, specialist care, and pregnancy.

2. Improve Private Health Insurance Navigation and Coverage

There was a shared concern about the limitations of PHI and the complexity workers face in using it and recommendations to overcome this include:

- Better PHI Orientation: Workshop participants recommended enhanced pre-departure and on-arrival education about PHI entitlements and usage.
- Waive Waiting Periods: For chronic health conditions such as hepatitis B, and reproductive and maternity health services
- Clarify Coverage: Clear communication and tools to explain exactly what is covered by PHI.

3. Embed Routine Screening and Preventive Care

Workshop participants agreed and recommended that hepatitis B and STI screening should be standardised, either pre-departure or on arrival, with clear consideration of stigma, logistics, and equity:

- Routine Screening on Arrival: Especially for BBVs, with shared funding responsibilities between states, PHI, and the Commonwealth.
- Prevention as Public Health: Routine vaccinations, contraception access, and health checks should be incorporated into standard PALM participant onboarding.
- Point-of-Care Testing Models: Trialled and expanded to support early diagnosis and care continuity.

4. Increase Accessibility Through After-Hours and Onsite Care

Time off work, casual employment conditions and limited availability of services during standard hours were noted barriers. Stakeholders proposed:

- After-Hours Clinics: Government-funded after-hours service provision to reduce the need for workers to take time off from employment.
- Onsite Clinics and Nurse-Led Models: Especially in large worksites.
- Employer-Funded Transport or Shuttle Buses: In rural areas where health services are distant.

5. Strengthen Navigation and System Coordination

Many recommendations focused on better integrating service navigation across jurisdictions:

- PALM-Focused Health Hub or Call Centre: With interpreters and regional information.
- Streamline Interagency Coordination: Between DFAT, DEWR, DHA, PHI providers, state health systems, and the home country governments.
- Dedicated Liaison or Navigator Roles: Who are trained, trusted, and culturally competent.

6. Ensure Culturally Appropriate and Trusted Care

There was consensus that culturally safe care must be expanded and normalised:

- Translation and Interpreting Services: Embedded at key care points, including appointments and insurance navigation.
- Cultural Competency Training: Mandatory for health service staff in regions with high PALM participant presence.
- Choice and Trust: Workers must be given options for who they trust—team leaders, welfare officers, or independent providers.

7. Improve Data, Planning, and Equity Across Regions

Participants highlighted inconsistency in service delivery across Queensland and called for:

- PALM-Specific Categories in QH Policy: Rather than treating PALM participants as generic overseas visitors.
- Advanced Notice and Planning Support: So regional health services know when and where workers are arriving.

8. Build Continuity of Care Between Australia and Home Countries

A lack of communication and shared medical records between countries undermines care continuity. The following recommendations to address this were made:

- Health Passports: A possible tool to support continuity of care by tracking vaccination, screening, and treatment.
- Formal Referral Pathways: Especially for chronic diseases like hepatitis B.
- Cross-National Collaboration: Between Australian health systems and Pacific country Ministries of Health.

Summary of Co-design Workshops

The co-design workshops provided a powerful final phase of this project, drawing together PALM participants, health providers, employers, and sector stakeholders to test, refine, and validate the recommendations emerging from earlier research phases. Together, these voices produced a unified set of solutions aimed at addressing the complex and intersecting barriers PALM participants face in accessing healthcare in Australia. This aligns with participatory health systems research literature, which emphasises that policy and service reforms are more effective and sustainable when shaped through inclusive, multi-stakeholder processes (73).

What emerged from these sessions was not only strong alignment between PALM participants and service system stakeholders, but also a shared commitment to pragmatic, culturally appropriate, and scalable systemic reform. Across all groups, there was broad consensus on the need for more inclusive public health entitlements, echoing global calls to extend universal health coverage to migrant workers as part of the Sustainable Development Goals (SDG 3.8) (49) and the WHO *Global Action Plan for Promoting the Health of Refugees and Migrants* (58). Where Medicare access was not possible, participants stressed the importance of improved navigation and education around PHI, reflecting evidence that shows that the complexity of health insurance systems, coupled with low insurance literacy, can lead to suboptimal healthcare choices and ultimately, health outcomes (74).

Stakeholders also identified essential workplace-based reforms, including sick leave entitlements, expanded access to care during and outside work hours, and greater investment in culturally safe and confidential pathways to healthcare. These recommendations align with the International Labour Standards that labour protections, including paid leave and occupational health measures, are central to safeguarding migrant workers' health and reducing the spread of communicable diseases (75).

Trust, fairness, and access were the common threads that ran through all workshop discussions. PALM participants emphasised the need for multiple, culturally safe entry points to care, ranging from supportive team leaders to independent and confidential services, reflecting international evidence that relational trust and perceived safety are critical determinants of care-seeking among migrants (52). Employers and health providers echoed these calls, alongside advocating for system-level reforms such as Medicare access or improved PHI frameworks, alongside government-backed support models to reduce financial and service gaps.

Importantly, the workshops reinforced that meaningful improvement requires structural change through funding models that recognise PALM participants' contributions to the Australian taxation system; planning frameworks that anticipate their arrival; and cross-jurisdictional systems that ensure continuity of care. Such approaches are consistent with the WHO *Health Systems Framework*, which calls for coordinated action across governance, financing, and service delivery to reduce inequities for underserved populations (76). Stakeholders also recognised the vital role of cultural competency, service coordination, and local solutions such as onsite clinics in workplaces, Pasifika liaison officers, and outreach services in operationalising these structural shifts. A practical workforce lever could be dedicated Pacific cultural liaison roles within Hospital and Health Services. The Logan Hospital position (77) demonstrates a workable model; placing similar roles in regions with high PALM concentrations would anchor culturally safe navigation, interpreter coordination, and trusted referral pathways (rather than employer-mediated access).

By embedding participant designed priorities into PALM Scheme policy, health system planning, and cross-border cooperation, the reforms proposed through these co-design workshops offer a clear, evidence-informed pathway to closing the equity gap for PALM participants and ensuring that their health rights are upheld.

Key Recommendations

This project set out to investigate the barriers and enablers to healthcare access for PALM scheme participants in regional Queensland, with a specific focus on BBVs, particularly hepatitis B and sexual health. Across multiple phases, including interviews, surveys, and co-design workshops, the project gathered evidence from PALM participants, health providers, employers, and key stakeholders. These findings paint a consistent and urgent picture of health inequity.

This project generated a set of 15 refined recommendations across individual, organisational, and systemic levels. **Recommendations can be found in Appendix 1.**

As these recommendations are taken forward, it is essential that PALM participants are not only considered as beneficiaries of public health initiatives but as active contributors to their design, implementation, and evaluation. The next phase of work should involve PALM participants, (where appropriate), in shaping how these recommendations are translated into practice. This reflects the broader need to continue shifting public health efforts away from top-down models and toward approaches that recognise the agency, assets, and lived expertise within the PALM participant population.

Conclusion Statement – A Call to Action

This report concludes with a clear and urgent message: Australia's current approach to supporting the health of PALM participants is not only inadequate, but also unjust. Despite their critical role in our economy, PALM participants are too often excluded from the health protections afforded to other residents. They face avoidable illness, disrupted treatment, stigma, and financial vulnerability in a system that was not designed to meet their needs. Without targeted reform, Australia will also continue to fall short of its commitment to the 2030 hepatitis elimination goals, as inequitable access to testing, treatment, and prevention leaves significant gaps in the national response.

Yet, this is also a moment of opportunity. This report offers a roadmap that is backed by evidence, community input, and consensus across sectors, for a system that is more ethical and inclusive. Implementing these recommendations will not only improve health outcomes for PALM participants, but it will strengthen Australia's reputation as a fair and rights-based migration partner.

Now is the time for leadership. We call on government agencies, employers, health services, and Pacific country partners to take collective action to:

- Embed equity and fairness into the PALM scheme program design.
- Remove financial and systemic barriers to healthcare.
- Centre cultural safety, continuity of care, and trust in service delivery.
- Create accountability mechanisms to ensure long-term reform.

In doing so, Australia can move from fragmented responses to a better coordinated, just, and sustainable model of care, one that honours the contributions of PALM participants, upholds their rights, and secures their health and wellbeing for the long term.

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Appendix 1: Recommendations

#	Recommendations	Intended outcome(s)	Resources required	Who is responsible/ needs to be involved?	The cost of inaction	What potential barriers might arise from the recommendations, and how can they be addressed?	Long/ short/ medium term
1	Extend Medicare eligibility to all PALM participants for the duration of their stay in Australia.	All PALM participants have access to universal health care. Reduced out-of-pocket healthcare costs and financial stress for PALM participants. Improved health and human rights for PALM participants. Increased access to timely health services (including hepatitis B and STI testing and treatment and regular hepatitis B monitoring and vaccination). Reduced mortality and morbidity. Reduced risk of transmission of communicable diseases, impacting positively on population health. Greater equity for PALM participants as contributors to the Australian taxation system.	Budget allocation at the federal level for Medicare access. Legislative and policy reform to amend Medicare eligibility criteria. System integration support to implement Medicare eligibility within the relevant Commonwealth Government departments.	Australian Government – Department of Health and Aged Care (DoHAC), Department of Employment and Workplace Relations (DEWR), Department of Foreign Affairs and Trade (DFAT), Department of Home Affairs (DHA). Queensland Health (similar to the access provided to non-Medicare eligible asylum seekers). Medicare and Services Australia	Reduced access to necessary health care. Increased healthcare costs experienced by PALM participants and/or health services. Financial hardship and medical avoidance due to unaffordable care. Continued health inequities and poorer health outcomes for PALM participants. Increased risk of population health consequences from the burden of untreated communicable diseases such as hepatitis B and STIs, including an increased risk of community transmission. Mortality resulting from advanced chronic hepatitis B. Erosion of Australia's reputation in ethical labour practices and human rights compliance.	Barrier: Political resistance to expanding Medicare access to non-permanent residents due to low public visibility, perceived fiscal burden, and limited political gain from addressing the needs of non-permanent workers. Mitigation: Build a public health and economic case supported by modelling of cost-effectiveness and cost savings to inform evidenced-based policymaking. Barrier: Concerns about Medicare system capacity. Mitigation: Explore pilot schemes or capped enrolment periods tied to employment duration and employer contributions prior to expansion. Barrier: Complexity in administering eligibility. Mitigation: Use existing PALM program enrolment data to auto-enrol workers and ensure administrative efficiency.	Medium

#	Recommendations	Intended outcome(s)	Resources required	Who is responsible/ needs to be involved?	The cost of inaction	What potential barriers might arise from the recommendations, and how can they be addressed?	Long/ short/ medium term
2	Waive waiting periods for pre-existing health conditions and pregnancy-related care (including ante, peri and post-natal). Remove out-of-pocket expenses for PALM participants. without increase on premiums.	Improved access to health services for PALM participants. Reduced risk of community transmission of communicable diseases. Reduced out-of-pocket costs and health-related financial stress. Improved health and human rights for PALM participants.	Review and renegotiation of PHI policy terms with the PALM scheme. The financial cost for PHI to include all pre-existing health conditions and pregnancy and antenatal care.	Department of Employment and Workplace Relations (DEWR). Private health insurance provider (NIB as preferred provider). Department of Health and Aged Care (for oversight).	Reduced access to necessary health care. Poorer health outcomes for PALM participants, specifically people with chronic health conditions (such as Chronic Hepatitis B) and pregnant women. Continued violation of human rights. Financial consequences, potentially to PALM participants and/or health services of the cost of healthcare. Potential reputational damage for the Australian Government. Negative impact on the PALM scheme and availability of workers.	Barrier: Limited political will to implement health equity reforms for PALM participants, due to low public visibility, perceived fiscal burden, and limited political gain from addressing the needs of non-permanent workers. Mitigation: Support evidenced informed policymaking with cost modelling, human rights framing and cross portfolio leadership. Barrier: Resistance from PHI providers to expanding coverage or waiving exclusions. Mitigation: Leverage government procurement power and competitive tender processes to require PALM-compliant coverage as an eligibility requirement for insurers under government-endorsed PALM arrangements. Barrier: Increased insurance costs passed on to employers or workers. Mitigation: Explore cost-sharing models or subsidies involving the Australian Government, employers, and private insurers to fund enhanced coverage without shifting financial burden onto PALM participants. Barrier: A lack of transparency from PHI. Mitigation: Commonwealth government-mandated, enforceable measures set in policy to improve PHI accountability and transparency.	Medium

#	Recommendations	Intended outcome(s)	Resources required	Who is responsible/ needs to be involved?	The cost of inaction	What potential barriers might arise from the recommendations, and how can they be addressed?	Long/ short/ medium term
3	Reform of the PALM Scheme's regulatory instruments, namely the Deed of Agreement, the Approved Employer Guidelines, and the Minimum Conditions of Employment, to set the rules for employers to provide a minimum allocation of paid sick leave days for all PALM participants, regardless of casual or permanent contract. Embed compliance mechanisms through Fair Work Australia, supporting implementation and ensuring protections are upheld as standard practice across the scheme. Compliance oversight from Fair Work Australia: working with employers to implement and operationalise these protections as standard practice across the PALM Scheme.	Access to sick leave for all PALM participants to ensure PALM participants can seek timely medical care without risking financial hardship or job insecurity. Improve health and safety outcomes on worksites by reducing presenteeism. Align employment conditions in the PALM Scheme with fair work standards and human rights principles. Increased access to healthcare for PALM participants and improved overall health outcomes.	Legislative and policy amendments to key PALM regulatory documents. Development of compliance and enforcement frameworks led by Fair Work Australia. Training and communication resources for employers and PALM participants. Financial costs to employers to provide sick leave.	Department of Employment and Workplace Relations (DEWR) – policy reform and regulatory oversight. Fair Work Australia – enforcement, compliance, and employer engagement. Approved Employers – implementation and operationalisation of new entitlements.	Reduced access to necessary health care and poorer health outcomes for PALM participants. Continued violation of human rights. Loss of productivity due to untreated health conditions. Ongoing delays in healthcare access due to loss of income concerns. Greater risk of disease progression, emergency care, and workplace incidents. Continued exploitation of PALM participants under casual employment conditions. Breach of Australia's international commitments to fair work and migrant labour protections.	Barrier: Employer resistance due to perceived increase in financial and/or administrative burden. Mitigation: Evidence of long-term benefits of productive workplace due to healthy workers and clear government guidance, potential financial incentives, or sector-wide cost-sharing models. Barrier: Inconsistent implementation. Mitigation: Strengthen Fair Work Australia's capacity to audit and enforce compliance. Barrier: Lack of awareness or understanding among PALM participants. Mitigation: Ensure clear, multilingual education about sick leave rights is provided pre-departure and on arrival.	Medium

#	Recommendations	Intended outcome(s)	Resources required	Who is responsible/ needs to be involved?	The cost of inaction	What potential barriers might arise from the recommendations, and how can they be addressed?	Long/ short/ medium term
4	Fund and expand after-hours primary care services in regions with high numbers of PALM workers, including clinics operating in the evenings and on weekends. Introduce mobile or outreach services (e.g., nurse-led or GP services) to visit worker accommodation outside of standard business hours. Review existing telehealth access to ensure after-hours access with translation support for PALM participants. Review the availability/location of 'Urgent Care Centres' funded by Commonwealth as an option to support PALM participants in regional and remote communities.	All PALM participants have access to timely healthcare regardless of geographical location. Improved continuity of care and early intervention for acute and chronic conditions such as CHB. Reduced pressure on emergency departments. Improved health equity for PALM participants by aligning service access with their employment conditions. Improved health outcomes for PALM participants. Broader public benefits from early intervention of conditions such as BBVs and STIs.	Funding to extend clinic hours or establish after-hours clinics in regional/rural areas. Investment in mobile outreach units (staff, vehicles, equipment). Regional coordination mechanisms for scheduling and delivering services. Technology infrastructure for after-hours telehealth, including free interpreters.	State Health Department – service delivery. Primary Health Networks (PHNs) – identifying service gaps and coordinating local responses. Approved Employers – supporting access logistics. Healthcare providers – staffing and implementing after-hours models. Private health insurance – provision of telehealth data.	Reduced and delayed access to necessary health care. Poorer health outcomes for PALM participants. Continued reliance on emergency departments for avoidable care. Increased healthcare costs from late-stage interventions. Erosion of trust in the health system among PALM participants. Continued violation of human rights.	Barrier: A lack of recognition of PALM participants as priority population and evidence of benefits of universal healthcare. Mitigation: Include PALM participants as priority population groups in state and national public health policies. Barrier: Health care workforce shortages in regional areas. Mitigation: Address through incentives, training, and remote care models (e.g., telehealth). Barrier: Funding constraints. Mitigation: Advocate for state-federal co-funding agreements and inclusion of PALM participants in regional health equity funding streams. Barrier: Coordination challenges. Mitigation: Assign regional coordination roles to PHNs or local health districts and engage employers early in planning. Barrier: Resistance to data provision by PHI. Mitigation: Accountability from Commonwealth government to provide transparency of data (to ensure data driven decisions).	Medium - long

#	Recommendations	Intended outcome(s)	Resources required	Who is responsible/ needs to be involved?	The cost of inaction	What potential barriers might arise from the recommendations, and how can they be addressed?	Long/ short/ medium term
5	Introduce free, routine hepatitis B and STI testing for all PALM participants, conducted either pre-departure or on arrival in Australia. Offer free hepatitis B catch-up vaccination to all participants who are non-immune, unvaccinated or unsure of their vaccination status. Ensure culturally appropriate information and consent processes are in place to support testing and vaccination. Establish clear referral pathways for follow-up care in Australia, particularly for those who test positive for a chronic condition such as hepatitis B. Integrate these measures into standard PALM program health protocols, DHA visa processes (if undertaken offshore) to support early detection, prevention, and continuity of care.	Early detection of hepatitis B and STIs, enabling timely treatment, reducing long-term health complications, and limiting transmission within the community. Improved prevention of hepatitis B. Enhanced health literacy and informed decision-making among PALM participants. Strengthened continuity of care via clear and coordinated referral pathways for PALM participants. Institutionalised health safeguards. Enhanced understanding of epidemiology and disease burden.	State healthcare human resources – clinicians, interpreters, administrative staff. Healthcare financial resources – for testing, hepatitis B vaccinations and STI screening and follow up care.	Australian Government agencies – DFAT (embedding protocols), DEWR (update PALM policies for preventative care), DHA (if testing or vaccination is done offshore), and DoHAC (national public health guidance). State health department for service delivery. Approved employers and labour hire companies to provide assistance to follow up health care in Australia. Private health insurance to develop regional service delivery models, employ culturally appropriate staff, and ensure follow-up pathways at no cost to PALM participants. Pacific Island Ministries of health to provide pre-departure education and support continuity of care for returning PALM participants. PALM participants co-designing programs to ensure acceptability and cultural safety.	Poorer Health Outcomes for PALM Participants Delayed or missed diagnoses of chronic hepatitis B or STIs may lead to: Liver failure, cancer, infertility, or ongoing infection. Avoidable morbidity and mortality in a young, otherwise healthy workforce. Loss of income and inability to work, increasing vulnerability and hardship. Increased Community Transmission of STIs and BBVs. Without early detection and treatment, PALM participants may unknowingly transmit infections to others, including: • Fellow workers in communal living settings. • Local Australian communities (e.g., sexual partners). • Partners and families in home countries upon return. Continued Violation of Human Rights Failing to provide preventive care and equitable access to healthcare contravenes Australia's international obligations under human rights and migrant worker protections. Risks of reinforcing structural racism and health inequities in temporary migrant systems.	Barrier: Jurisdictional fragmentation with multiple agencies (DFAT, DEWR, DHA, DOH, State Health) with shared responsibilities, leading to unclear accountability for implementation. Mitigation: Develop a national PALM health coordination framework. Appoint a lead coordinating agency (e.g., Department of Health and Aged Care) to oversee integration into PALM program protocols. Establish interagency agreements to support role clarity and resource alignment. Barrier: Lack of funding or political will. Costs associated with pre-departure/on-arrival testing, vaccination, and follow-up may be perceived as too high. Mitigation: Present cost-benefit analyses (presented in this project report) showing long-term savings through early detection and prevention. Highlight public health risks of inaction. Advocate through alliances with peak health bodies and regional partners. Barrier: PHI limitations and waiting periods. Current PHI packages may not cover preventive services or may impose waiting periods. Mitigation: Advocate for Medicare, if not, PHI reform, including waived waiting periods for BBVs/STIs. Consider supplementing PHI with targeted government funding for preventive services. Barrier: Stigma and confidentiality concerns. PALM participants may fear judgment, discrimination, or disclosure of results, especially in group settings or through employer channels. Mitigation: Provide private and culturally safe care pathways. Ensure confidential testing and results management. Engage trusted community health workers to support care navigation. Barrier: Logistical Constraints (e.g. transport, time off). Accessing screening or vaccination may be difficult due to remote locations, work hours, or transport issues.	Medium - long

#	Recommendations	Intended outcome(s)	Resources required	Who is responsible/ needs to be involved?	The cost of inaction	What potential barriers might arise from the recommendations, and how can they be addressed?	Long/ short/ medium term
					Increased system costs over time from treating advanced-stage liver disease, cancer, or undiagnosed STIs is far more expensive than prevention and early intervention. Missed opportunities for public health control increases the long-term burden on the Australian health systems. Damage to Australia's global reputation. Ongoing media and civil society attention due to the treatment of PALM participants may impact diplomatic relationships with Pacific nations and the credibility of Australia's regional labour mobility and human rights commitments.	Mitigation: If undertaken onshore, provide on-site testing and mobile clinics. Align testing with visa processing or arrival briefings. Barrier: Reluctance to test for hepatitis B due to lack of treatment availability on home country or fear of consequences Mitigation: Pair testing with immediate tangible benefit (vaccination if non-immune; linkage to specialist care if positive). Provide stigma free counselling and peer support in participants' languages to minimise risk of ongoing transmission. Barrier: Concern that a positive test result will affect visa status or employment. Mitigation: Non-discrimination clauses in PALM contracts; independent oversight and grievance mechanisms; transparent communication in workers' languages to build trust. Barrier: Low health literacy or misunderstanding of purpose. Some PALM participants may not understand the importance of screening or fear testing procedures. Mitigation: - Use co-deigned, translated materials and visual aids.Offer verbal education sessions on arrival and pre-departure.Involve peer educators or former PALM participants in delivery. Barrier: Data and Referral Gaps. Poor record-keeping and lack of cross-border referral pathways can hinder continuity of care. Mitigation: Introduce PALM health passports or electronic health summaries. Create formal referral mechanisms to home country health systems (e.g., Ministry of Health partnerships). Barrier: If policies or processes are instituted placing restrictions on PALM visas due to a positive hepatitis B diagnosis. Mitigation: Policy development that is in line with public health and human rights standards and ensures that potential PALM participants are not discriminated against based on a positive hepatitis B diagnosis.	

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6	Dedicated PALM model of care outreach. Promote pharmacy extended scope of practice amongst PALM participants. Support partnerships between employers and local health services to coordinate transport-linked care, such as mobile clinics or coordinated appointment schedules. Utilise new technology such as Point of Care testing (for hepatitis B, STIs etc) to screen PALM participants and ensure timely linkage to appropriate support and health services.	Improved access to healthcare for PALM participants. More timely access to primary and specialist care, reducing the risk of delayed treatment and improving overall health outcomes.	Resources involved in outreach model, as per	Approved Employers – logistics coordination and funding support. State Health Departments and PHNs – partnership with local providers and mobile services. Local Government / community transport services – participation in subsidised or shared access initiatives. Researchers and NGOs (such as Ethnic Communities Council of Queensland, who is currently conducting rapid testing as part of research) Hepatitis Australia and Hepatitis Queensland.	Missed or delayed healthcare access for preventable and treatable conditions, leading to poorer health outcomes. Increased health risks for workers and long-term costs to health services. Greater inequity for PALM participants due to predominantly living in regional and rural areas Employer productivity losses due to unmanaged illness or emergency situations.	Barrier: Limited local transport infrastructure. Mitigation: Support mobile clinics or regional service outreach as complementary strategies. Barrier: Hepatitis B Point of Care Testing has not yet been approved by TGA. Mitigation: Use it within the framework of a research project.	Short - medium

#	Recommendations	Intended outcome(s)	Resources required	Who is responsible/ needs to be involved?	The cost of inaction	What potential barriers might arise from the recommendations, and how can they be addressed?	Long/ short/ medium term
7	Fund dedicated bilingual health education in medium and high-density PALM participant areas so that all PALM participants have access to culturally safe and accessible health information. Ensure the availability of qualified interpreters or culturally appropriate translation tools during healthcare appointments, insurance interactions, and orientation processes. Support the recruitment and training of culturally competent liaison officers, including Pasifika community navigators, where appropriate and trusted by PALM participants. Deliver mandatory cultural awareness training for healthcare workers and wellbeing officers who support PALM participants.	PALM participants have choices of modality for translation. Improved understanding of health entitlements, services, and care instructions. More equitable and confident healthcare engagement, including for sensitive or complex conditions. Increased cultural safety, reducing fear, shame, and	Investment in bilingual health educators and materials Interpreter service funding or access to remote interpreters. Funding for cultural liaison officer roles, with ongoing training and community support. Development and delivery of cultural awareness training programs for healthcare staff in regions with high PALM participants.	State health department – lead implementation in service delivery areas and embed cultural awareness modules in training pathways. Hepatitis Queensland provide BBV/STI training for a wide range of workers and could support liaison officers. DEWR – mandate culturally appropriate resources at orientation and during employment. Approved Employers – support interpreter access, distribute translated materials, and fund/host liaison staff where appropriate.	Culturally unsafe healthcare. Reduced and delayed access to healthcare. Ongoing inequity in access to and outcomes from healthcare for PALM participants. Misdiagnoses, treatment non-compliance, and preventable complications due to misunderstandings. Continued fear and avoidance of care, particularly for reproductive or sexual health issues. Erosion of trust in health services.	Barrier: Confidentiality concerns with liaison officers from the same community. Mitigation: Offer multiple access options (e.g., external support workers) and ensure strict training in privacy and ethical conduct and consequences applied if breeched. Barrier: Lack of interpreter access in rural areas. Mitigation: Expand telehealth interpreter models and co-design translation app. Barrier: Low engagement with cultural training. Mitigation: Mandate it within workplace obligations similar to First Nations cultural awareness. Barrier: Funding gaps. Mitigation: Evidenced based decisions demonstrating benefits of culturally appropriate healthcare and ensure equitable healthcare funding.	Short-medium

#	Recommendations	Intended outcome(s)	Resources required	Who is responsible/ needs to be involved?	The cost of inaction	What potential barriers might arise from the recommendations, and how can they be addressed?	Long/ short/ medium term
8	Develop a standardised, statewide policy framework for PALM participants' healthcare access, including billing, service eligibility, and referral protocols, to ensure consistency across all health services. Embed PALM-specific service guidance into Queensland Health policy and operational documents, distinguishing PALM participants from generic overseas visitors and recognising their unique health access needs. Develop health equity plans for temporary visa holders such as PALM participants, including mechanisms to invest in equity. Establish a central PALM health coordination point (e.g. through Queensland Health or PHNs) to provide real-time advice and navigation support to local hospitals, GPs, and workers.	Consistent and equitable service delivery for PALM participants across all regions. Reduced ad hoc decision-making by individual services that creates confusion or denial of care. Increased clarity for PALM workers, employers, and health staff about eligibility and access pathways. More proactive, integrated care planning for PALM cohorts arriving in different regions. Greater access to healthcare and improved health outcomes for PALM participants. Ensuring that temporary visa holders are visible, counted, and supported.	Policy development and consultation by state health department. Staff training on new protocols across public hospitals and community health services. IT and administrative updates to booking, billing, and referral systems to include PALM-specific flags or categories. Resourcing a central contact hub or navigator role to support implementation and troubleshooting.	Queensland Health and relevant state health departments – lead policy development and implementation. Could also be done with DoHaC to make Australia-wide reforms implemented in each state and territory. Hospital and Health Services – apply new protocols, train staff, and ensure service compliance. DEWR – ensure alignment with PALM Scheme requirements. PHNs – coordinate across primary care settings. Approved Employers – inform workers and support transitions into local health systems.	Continued inequity and service exclusion for PALM participants across regions. Inefficient and inconsistent use of public resources through reactive service decisions. Ongoing confusion for both PALM participants and providers.	Barrier: Resistance to policy change at local levels. Mitigation: Engage local health leaders early in policy design and demonstrate the benefits of consistent service policy alignment. Barrier: Administrative burden on health services. Mitigation: Provide templates, streamlined implementation tools, and centralised training. Barrier: Confusion over PALM participant identification. Mitigation: Introduce a consistent intake flag or referral code linked to visa/work arrangements.	Medium

#	Recommendations	Intended outcome(s)	Resources required	Who is responsible/ needs to be involved?	The cost of inaction	What potential barriers might arise from the recommendations, and how can they be addressed?	Long/ short/ medium term
9	Service mapping of Hepatitis B health services in PALM participating countries. Develop formal cross-national referral pathways for PALM participants diagnosed with hepatitis B. Introduce a portable "health passport" or digital medical summary documenting diagnosis, test results, and treatment plans that can be shared with clinicians in participants' home countries. Establish partnerships between the Australian Government and Ministries of Health in Pacific Island countries to strengthen care transitions and support hepatitis B management post-return.	Improved continuity of care for PALM participants with chronic conditions such as hepatitis B. Reduced risk of treatment interruption and associated health complications. Strengthened cross-border coordination and communication between healthcare systems. Universal access to hepatitis B testing, diagnosis, monitoring and treatment.	Resources for mapping exercise. Bilateral agreements and memoranda of understanding between Australia and Pacific health ministries. Development of standardised clinical referral templates or digital records. Staff and system capacity for information sharing and coordination. Training for clinicians in both settings on referral and follow-up protocols. Cost sharing or Medicare for testing, diagnosis and treatment of hepatitis B.	DoHAC DFAT and DEWR (as PALM program leads). Ministries of Health in PALM sending countries. State health departments. Health providers in Australia and PALM sending countries. Commonwealth to fund peak bodies (ASHM) for delivery of education to clinicians.	Unknown diagnosis of Hep B and increased risk of transmission in community in Australia and home countries. Interruptions to clinical management of hepatitis B, leading to increased risk of liver disease and complications. Increased burden of morbidity and mortality associated by untreated Hepatitis B. Individual financial impacts of being sick and paying for healthcare. Health system costs of providing tertiary versus primary healthcare. The ethical predicament faced by clinicians due to a lack of clarity around process for testing, diagnosis and treatment of Hepatitis B for PALM participants.	Barrier: Lack of interoperable health information systems between countries. Mitigation: Use simplified PDF (or similar) clinical summaries until digital exchange is feasible. Barrier: Privacy and consent concerns. Mitigation: Embed clear, multilingual informed consent processes and data-sharing agreements. Barrier: Lack of coordinated international policy mechanisms. Mitigation: Leverage existing health diplomacy channels and regional partnerships through DFAT, WHO, or SPC (Pacific Community). Barrier: Lack of resources for service mapping. Mitigation: Committed funding from the Commonwealth Government	Long

#	Recommendations	Intended outcome(s)	Resources required	Who is responsible/ needs to be involved?	The cost of inaction	What potential barriers might arise from the recommendations, and how can they be addressed?	Long/ short/ medium term
10	Resource Pacific-led and diaspora health organisations to act as trusted health intermediaries and deliver in-language culturally grounded education on BBVs, sexual and reproductive health across the entire migration pathway from 'sending countries', to Australia and on return to the Pacific. Implement and evaluate a structured BBV and sexual health education program at multiple PALM journey points (pre-departure, on-arrival, and during employment) using first-language, visual, and peer-led tools. Develop and fund ongoing in-language health messaging using digital formats that reinforce key topics and provide access to trusted sources of information.	Increased health literacy among PALM participants on key BBV and sexual health topics. Earlier uptake of testing, monitoring, treatment, and prevention services. Reduced misinformation, stigma, and unsafe sexual health behaviours. Empowerment of PALM participants to make informed decisions about their health and relationships.	Funding for co-design, translation, and culturally appropriate educational materials. Partnerships with Pacific community organisations, peer educators, and public health and sexual health units. Digital delivery tools (e.g. mobile-friendly content platforms). Health promotion staff with relevant cultural and language competencies.	Department of Employment and Workplace Relations. PALM Scheme employers. State and local health services including BBV/STI units. Pacific-led and diaspora health organisations such as TRUE, alongside NGOs such as Hepatitis Australia, Hepatitis Queensland and Ethnic Communities Council of Queensland.	Ongoing spread of preventable infections such as hepatitis B and STIs. Continued stigma and silence around BBVs and reproductive health. Missed opportunities for early intervention and harm prevention. Undermined PALM participant wellbeing and reproductive autonomy. Poorer BBV and sexual health outcomes for PALM participants. Higher health system costs of providing tertiary vs preventative healthcare.	Barrier: Cultural taboos or discomfort discussing sexual health. Mitigation: Use bilingual educators (such as TRUE), trusted community leaders, and culturally appropriate methods to normalise conversations. Hepatitis Queensland has developed a range of BBV/STI training packages and resources for workers and consumers and could adapt something for PALM participants or people supporting them. Barrier: Language barriers and low health literacy. Mitigation: Use co-designed visual materials, first-language audio/video content, and avoid technical terms. Barrier: Employer hesitancy to allocate time for education Mitigation: Integrate short modules into induction or routine briefings and highlight the occupational health and productivity benefits. Barrier: Resources for Pacific-led and diaspora health organisations. Mitigation: Show demonstrated benefits of BBV and sexual health literacy of organisations such as TRUE, alongside cost savings of preventative vs tertiary and public health with increased disease.	Short-medium

#	Recommendations	Intended outcome(s)	Resources required	Who is responsible/ needs to be involved?	The cost of inaction	What potential barriers might arise from the recommendations, and how can they be addressed?	Long/ short/ medium term
11	Ensure PALM participants diagnosed with hepatitis B through the immigration process receive accurate, confidential health education delivered in-language without fear of visa or employment consequences. Establish confidential linkage and navigation pathways to free or low-cost hepatitis B clinical services in Australia (e.g. liver function testing, viral load, ultrasound, GP review, specialist referral if required). Provide catch-up hepatitis B vaccination for all PALM participants who are non-immune, unvaccinated or unsure of their vaccination status, with culturally appropriate consent processes.	Improved understanding of hepatitis B status among PALM participants. Timely access to monitoring, treatment, and preventive care. Reduced stigma and misinformation around hepatitis B. Increased vaccine uptake among non-immune PALM participants. Reduced transmission. Reduced morbidity and mortality associated with undiagnosed hepatitis B.	Medical personnel time for providing health education and navigation of Hepatitis B health services. Health educators with cultural and language skills. Cost of testing, diagnosis, monitoring, vaccinations and ongoing treatment. Public health service coordination such as hepatitis nurses, public health and sexual health units. Confidential referral pathways and interpreter support. Educational resources tailored to Pacific Islander populations. The cost of interpreters.	DHA and health screening providers (offshore). DEWR for oversight. State health departments. Hepatitis B and BBV public and sexual health teams. Community health services, and organisations (such as Hepatitis Queensland), and GPs. Approved employers and wellbeing officers.	Continued high prevalence of hepatitis B in PICTs populations. Health system and individual costs of tertiary vs preventative healthcare. Undiagnosed or unmanaged chronic hepatitis B, leading to worse health outcomes such as liver disease and cancer. Increased transmission risk to others. Ongoing fear, stigma, and misinformation about hepatitis B. Missed opportunities for treatment, vaccination, and education.	Barrier: Fear of losing job or visa if hepatitis B is diagnosed in PALM participant. Mitigation: Assure confidentiality and legal protection against visa or work-related penalties for hepatitis B status. Barrier: Lack of trust in the health system or in information provided Mitigation: Use trusted health workers, interpreters, and bilingual educators. Barrier: Inconsistent access to services across regions Mitigation: Develop standardised care protocols and referral pathways across all PALM-receiving areas. Barrier: Changing governments, systems, policies and processes. Mitigation: Evidence of benefits of increasing access to testing diagnosis, health education, vaccination and ongoing treatment of CHB. Barrier: Continued care in home country such as hepatitis B treatment can't be interrupted Mitigation: As per recommendations #9.	Medium and ongoing

#	Recommendations	Intended outcome(s)	Resources required	Who is responsible/ needs to be involved?	The cost of inaction	What potential barriers might arise from the recommendations, and how can they be addressed?	Long/ short/ medium term
12	Provision of resources and training to support wellbeing officers so that they are more knowledgeable and better equipped to deliver locally contextual health system information and navigation for PALM participants to access health services in their geographical location that is relevant to their health condition. Provide simplified models of healthcare access and delivery for PALM participants such as Medicare. Offer PALM participants the choice of who they receive navigation support from, e.g. welfare officer, team leader, Pasifika liaison officer or empower PALM participants to access care independently through multilingual tools and health system education.	Welfare officers feel empowered and confident to support PALM participants' access to healthcare. PALM participants have improved Australian health system literacy and agency. Increased confidence and competence among PALM participants to independently navigate health systems. More timely and appropriate healthcare access and improved outcomes. Strengthened trust and autonomy through flexible, person-centred models of support.	Localised health system navigation training and region-specific tools for welfare officers and team leaders. Multilingual education materials about Medicare/ PHI use and service access, developed in collaboration with workers. Policy reform and system-level support for simpler healthcare access models (e.g. Medicare eligibility). Potential financial costs associated with Medicare. Investment in trusted liaison or support roles when requested by PALM participants.	DEWR as scheme oversight. DFAT (change of visa to Medicare eligible). DoHAC for Medicare provision. Approved Employers. PHNs and local health services. Multicultural and community health organisations. PHI to refine and provide transparency for PALM participants and employers navigating care. Not inconsistent policies.	Continued reliance on inaccurate or inconsistent health information. Reduced access to necessary health care. Delayed care, poorer health outcomes, and preventable disease progression. Financial consequences of cost of healthcare and poorer health. Continued violation of human rights. Reduced PALM participant confidence and increased inequity across geographic regions.	Barrier: Inconsistent training and resourcing of employer welfare officers. Mitigation: National coordination and funding to support a standardised training package with local flexibility. Barrier: Resistance to Medicare access reforms. Mitigation: Present strong equity, cost-benefit, and public health cases for simplifying coverage for temporary visa holders. Could use evidence from evaluation of family accompaniment visa. Barrier: Concerns about trust in navigators (e.g. Pasifika liaison officer tied to home community) Mitigation: Offer flexible access models and protect confidentiality through training and protocols.	Short-medium
13	Establish an independent PALM Health Advisory Panel to oversee health-related reforms. Ensure the panel includes diverse representation from PALM participants, health experts, employers, and Pacific community leaders, key non-government stakeholders, and relevant government agencies (state and Commonwealth). Empower the panel to review progress, flag emerging issues, and advise on policy and operational improvements.	Strengthened cross-sector coordination and accountability in delivering health services to PALM participants. Institutionalised mechanisms for community and stakeholder input. Timely identification and response to health system gaps, improving access and equity.	Secretarial and administrative support (e.g., part-time coordination officer). Budget for panel meetings, remuneration of community members, and operational costs. Clear terms of reference, governance structure, and reporting mechanisms.	Commonwealth Government - DEWR, DoHAC, and DFAT. State/Territory Health Departments. PALM scheme employer representatives. Key peak body and not-for-profit representatives. Pasifika community representatives in Australia.	Continued fragmentation and inefficiencies in healthcare delivery for PALM participants. Missed opportunities to address systemic issues proactively. Reduced trust in the program and further marginalisation of vulnerable people.	Barrier: Jurisdictional complexity and reluctance to share authority. Mitigation: Clear governance mandate and ministerial endorsement. Barrier: Lack of diverse and authentic representation. Mitigation: Transparent selection process and community co-design of the panel structure. Barrier: Risk of tokenism or limited influence. Mitigation: Accountability mechanisms such as formal powers to review policy, monitor implementation, and publish findings.	Medium

#	Recommendations	Intended outcome(s)	Resources required	Who is responsible/ needs to be involved?	The cost of inaction	What potential barriers might arise from the recommendations, and how can they be addressed?	Long/ short/ medium term
14	Invest in independent, participatory research to monitor, evaluate, and strengthen health, equity, partnerships, and policy settings across the PALM scheme.	Continuous, evidence-based improvement of health outcomes and service access for PALM participants. Stronger accountability mechanisms across stakeholders (government, employers, health providers). Integration of PALM participants' voices into ongoing policy and health system reform. Improved public transparency and trust in the PALM scheme.	Dedicated federal and/or state funding for ongoing research. Independent research partnerships with academic and community-based organisations. Collection of/ or access to anonymised PALM administrative health-related data.	Commonwealth Government departments (funding) – DEWR, DFAT, DoHAC. State health departments (health service use data). Independent academic research institutions. Private Health Insurance (data provision).	Missed opportunities for learning and systems improvement. Continued inequities and poor health outcomes for PALM participants. Inefficient policy interventions unsupported by real-world data. Erosion of public trust in Australia's commitment to ethical labour and public health practices.	Barrier: Political or institutional reluctance to fund research. Mitigation: Demonstrate how participatory PALM-focused research aligns with: Australia's National Health and Medical Research Council (NHMRC) priorities, including health equity, prevention of communicable diseases (e.g. hepatitis B, STIs), and strengthening health systems for vulnerable populations; Australia's National Hepatitis B Strategy 2023–2030, which commits to reaching priority populations, including CALD and migrant communities; The Australian Government's Pacific Engagement Strategy, which prioritises sustainable development, health system strengthening, and equitable labour mobility, and The National Preventive Health Strategy 2021–2030, which supports structural reform to address health inequities and promotes community-led data and responses.. Further, present the impact of previous research and cost–benefit modelling (as in this project's economic analysis) to show that strategic research investments prevent higher downstream costs. Engage public health peak bodies (e.g. PHAA, ASHM) to strengthen advocacy and policy translation. Barrier: Lack of disaggregated health data due to most state health departments not collecting visa or migration status. Mitigation: Advocate for the inclusion of visa category field in state and national health data systems. Work with health departments to ensure these data are collected for health access improvement. Barrier: Limited capacity to manage participatory approaches. Mitigation: Partner with Pacific-led organisations and utilise inclusive methodologies.	Medium-long (ongoing)

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15	Ensure PALM participants are involved in all next steps of healthcare and policy development (where appropriate), shifting from top-down models to ones that recognise their agency, assets, and community expertise and contribution to Australian society and economy.	Empowered PALM participants with ownership of care pathways. Culturally relevant, effective, and acceptable policies and health programs or interventions. Strengthened community trust, uptake of services, and improved health outcomes.	Funding for sustained community engagement and consultation mechanisms. Development of culturally safe, linguistically appropriate co-design processes and outputs.	Commonwealth Government - DEWR, DFAT and DHA, alongside state health departments to embed participation into PALM policy cycles. Pasifika community health organisations to facilitate local engagement. Approved Employers – to enable worker participation without penalty. PALM participants – as co-designers and community leaders. Independent academic research institutions with co-design experts.	Ineffective programs due to lack of cultural resonance. Continued disempowerment and invisibility of PALM participants in decision-making. Poor service uptake, health literacy, and outcomes. Damage to Australia's reputation for human rights commitment.	Barrier: Tokenistic engagement. Mitigation: Develop clear participatory frameworks with indicators for meaningful involvement. Barrier: Logistical constraints (e.g., time, transport, literacy). Mitigation: Use accessible formats, schedule during non-work hours, compensate PALM participants for their time, and involve trusted peer facilitators. Barrier: Employer reluctance. Mitigation: Emphasise benefits of engagement for workforce wellbeing and reputation; consider policy requirements for participation.	Short – medium (ongoing)

CONTACT US

Phone: +61 132786

Email: PALMhealth@cqu.edu.au

Website: www.cqu.edu.au

Address: 554/700 Yaamba Rd, Norman Gardens QLD 4701, Australia