Seasonal Labour, Systemic Injustice:

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

2025

Summary Report

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Background

PALM Scheme

Australia's labour migration policies have shifted significantly over the past decades to address persistent workforce shortages in agriculture and regional industries. Informal reliance on Pacific Island workers began in the 1960s–70s, evolving in the 1990s into formal schemes that marked a shift from permanent migration to temporary "guest-worker" arrangements with restricted access to welfare, healthcare, and education. In 2008, the Seasonal Worker Program (SWP) was established, allowing workers from nine Pacific Island nations and Timor-Leste to work in agriculture for up to nine months. In 2018, the Pacific Labour Scheme (PLS) expanded opportunities to meat processing and other regional industries, further aligning Pacific labour supply with Australia's economic needs.

In 2021, the SWP and PLS were consolidated into the Pacific Australia Labour Mobility (PALM) Scheme, administered under the Temporary Work (International Relations) visa (subclass 403). The PALM scheme enables both short-term (up to nine months) and long-term (up to four years) placements, managed jointly by the Department of Foreign Affairs and Trade and the Department of Employment and Workplace Relations with support from the Pacific Labour Facility. As of January 2025, over 30,000 PALM participants are employed across 494 Approved Employers, with Queensland hosting 35% of workers. Vanuatu (20%), Fiji (17%), and Timor-Leste (16%) are the largest sending countries. Agriculture (54%) and meat processing (38%) dominate employment, with smaller roles in healthcare (4%) and accommodation (2%). While the scheme is vital to Australia's regional workforce, concerns remain around housing, wellbeing, and vulnerability to exploitation.

Rationale for Study

The Pacific region has some of the world's highest rates of blood borne viruses (BBVs) and sexually transmitted infections (STIs). Chronic hepatitis B (CHB) prevalence ranges from 4.4% in Samoa to 9.7% in Timor-Leste. In Australia, more than 200,000 people live with CHB, with up to 100,000 unaware of their infection. More than 70% of new CHB cases in Australia are attributable to migration, and 4.6% of people with CHB in Australia were born in Oceania (excluding Australia). Untreated CHB can progress to cirrhosis, liver failure, or liver cancer, with up to 25% of cases resulting in death. Yet these outcomes are largely preventable through regular monitoring, antiviral therapy, GP visits, pathology testing, liver imaging, and specialist care. Without access to these services, PALM participants face avoidable harm and may also act as a reservoir for ongoing transmission, creating a wider public health risk.

While the PALM scheme has addressed critical labour shortages in regional industries, it also exposes systemic inequities in healthcare access for participating workers. Unlike Australian residents, citizens, and many other visa holders, PALM participants are excluded from Medicare. This creates significant disadvantage, particularly for those with chronic conditions such as CHB, which is highly prevalent in their home countries. Denying access to essential health services raises human rights concerns, as the right to health is recognised under international law and should apply regardless of immigration status.

Study Overview

Design

This report presents a summary of the key findings from 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 professionals, and employers
2. Surveys with PALM participants, employers, health professionals, and key industry stakeholders
3. Cost-benefit analysis of a CHB intervention and the current model of care
4. Co-designed workshops with PALM participants, employers, health professionals, and key industry stakeholders to test and refine policy and service-level recommendations

Research Questions

1. What are the experiences of PALM participants accessing healthcare 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 costs of CHB screening, treatments and other early medical interventions for PALM participants offset the costs of responding to serious avoidable sequelae?

For a comprehensive discussion of findings and recommendations, please refer to the full report.

Key Findings (Phases 1 and 2)

Experiences of PALM Participants

"If I'm really being sick and my medical 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]

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

Figure 1: *Key themes related to the experiences of PALM participants*

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'. (See Figure 1above)

Findings highlight that PALM participants face multiple, intersecting barriers to healthcare, including logistical, financial, and cultural challenges, compounded by precarious employment and limited autonomy in health decision-making. Low awareness of hepatitis B and other blood-borne viruses reflects the absence of coordinated prevention, screening, and follow-up care between sending and receiving countries, despite Australia's commitment to eliminating viral hepatitis by 2030.

The Australian health system was widely perceived as inaccessible and unfair. Private health insurance (a visa requirement), was poorly understood, inconsistently accepted, and often left PALM participants overcharged or uncertain about entitlements. Employer-controlled processes and language barriers reinforced disempowerment. These experiences point to the need for standardised direct billing, simple in-language insurance orientation, and independent navigation support.

PALM participants described structural inequities where economic participation is prioritised over equitable healthcare. Access was further constrained by distance, transport, insecure employment, and lack of Medicare eligibility, leading many to avoid formal care, self-treat, or endure illness. Despite contributing through taxation and insurance, participants felt excluded and called for transparency, fairness, and Medicare access or more affordable alternatives.

Experiences of Health Providers and Employers

Experiences of Health Providers

Health providers consistently identified the absence of Medicare access as the most significant barrier to healthcare for PALM participants. They reported high out-of-pocket costs, case-by-case negotiations with under-resourced services, and reliance on public hospitals for conditions that could otherwise be managed in primary care. Private health insurance, though mandatory, was poorly understood, inconsistently accepted, and often failed to cover preventative or chronic disease management.

"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." [Healthcare provider]

Language barriers created further challenges, with difficulties in gaining informed consent, ensuring medication adherence, and providing health education. Limited access to professional interpreters forced reliance on peers or ad hoc methods, making comprehensive care difficult. Transport issues compounded access, particularly in rural areas, with some clinicians conducting outreach visits to farms or worker accommodation.

"*When they do present, the language barrier is difficult... it's really difficult to do a thorough job in this area."* [Healthcare provider]

Cultural stigma around BBVs and STIs further restricted timely diagnosis and treatment, with providers noting reluctance to disclose conditions or seek care. Ethical dilemmas also arose when initiating treatments such as hepatitis B therapy, given the limited continuity of care once PALM participants returned to under-resourced Pacific health systems.

"*We may not start treatment as early as we'd like because... we can't start hep B treatment and then stop it. That would be dangerous..."*[Healthcare provider]

In the absence of clear policy support, many providers relied on altruism and informal collaboration, building ad hoc referral pathways or waiving fees to ensure care. While these adaptive strategies demonstrate clinicians' commitment, they also highlight systemic inequities that place PALM participants at risk and undermine equitable healthcare access.

Experiences of Employer Welfare Staff

Employer representatives, particularly welfare officers, play a central role in supporting PALM participants' healthcare access. Their duties span from booking appointments, arranging transport, processing insurance claims, providing informal health education, and acting as cultural mediators. Many also serve as first points of contact when their workers become unwell, helping them navigate complex and unfamiliar health systems. Survey data from our study show that 100% of welfare officers act as health contacts, 86% arrange appointments and transport, and 71% assist with insurance and advocacy. This role is demanding, requiring administrative, advocacy, and cultural competence skills.

Many officers described being "piggy in the middle," balancing the expectations of employers, PALM participants, and health services. While they often attended medical appointments to facilitate communication, healthcare workers sometimes perceived them as controlling or gatekeeping. Limited access to translation services further reinforced their involvement:

"We find there's a lot of resistance from service providers to allow us in the rooms...They see us as the employer...but we're really in between the worker, the employer, the government and everybody." [Employer representative]

Sexual and reproductive health emerged as particularly sensitive and highlighted vexed issues. Welfare officers reported high levels of STIs and limited sexual health knowledge among PALM participants, with testing usually reactive rather than preventative. They also highlighted stigma around hepatitis B and pregnancy, noting unplanned pregnancies as a recurring challenge:

"I would say that one of the things we spend most of our time doing is supporting girls through abortions. That's a challenge because it's a lot for the girls, and a lot on our system." [Employer representative].

Both clinicians and welfare officers identified overlapping barriers that hinder PALM participants' access to healthcare, including Medicare ineligibility, high costs, transport difficulties, language constraints, and the complexity of navigating an unfamiliar system. These challenges are especially acute in areas such as BBVs, STIs, and reproductive health, where stigma, cultural sensitivity, and continuity of care are essential. It was reported that PALM participants often avoided care altogether due to the fear of costs, confusion regarding the health system including private health insurance, or stigma. While health providers and welfare officers showed significant commitment and creativity in addressing these gaps, responsibility for navigating the system has fallen heavily on individuals rather than being supported by formal policy or institutional mechanisms.

Welfare officers in particular play a critical but undervalued role, extending beyond their formal duties to coordinate care, advocate for their workers, and bridge communication barriers. However, this reliance on informal goodwill is unsustainable and insufficient to meet the scale of need.

Macro-, Meso-, and Micro-Level Barriers and Enablers to Healthcare Access

Healthcare access challenges for PALM participants occur across multiple, interconnected levels. At the macro level, structural and policy settings create systemic inequities, such as Medicare ineligibility and reliance on inadequate private health insurance. At the meso level, gaps in service delivery and workplace conditions restrict access to timely, culturally appropriate care. At the micro level, individual vulnerabilities, including language barriers, low health literacy, and reliance on employer or provider goodwill, further compound these challenges.

Table 1: *Barriers to healthcare access for PALM participants in Australia*

Level	Barriers
Macro	Immigration policy restrictions, ineligibility for Medicare, reliance on private health insurance with limited coverage, high out-of-pocket costs, CHB as an "invisible" issue in health policy for PALM participants.
Meso	Limited access to healthcare services in regional areas, lack of culturally responsive and in-language care, reactive rather than preventive models of care, "No work, no pay" conditions limit ability to seek care.
Micro	Dependence on goodwill and advocacy of health providers and employer welfare officers, fear of job loss or reduced hours if health needs disclosed, limited understanding of the Australian health system, language barriers and low health literacy

Key Findings (Phase 3)

Cost-Benefit Analysis of Hepatitis B Virus Screening and Treatment Program in PALM Scheme Participants

The economic evaluation responds directly to the systemic gaps identified throughout this summary report, most notably the lack of routine CHB screening, fragmented care pathways, and limited treatment access for PALM participants. CHB remains largely invisible in this population due to low awareness, inconsistent or absent testing before and after arrival in Australia, and structural barriers to preventive care and follow-up. While qualitative and survey findings have clarified the drivers of reduced access, economic modelling adds value by testing the feasibility and cost-effectiveness of structured screening and treatment. This analysis examined whether proactive hepatitis B management could improve health outcomes for PALM participants while also being economically justified. Further details can be found in full report.

The analysis compared the costs and outcomes of two scenarios:

1. Screening and treatment of Hepatitis B infection
2. Status quo (no treatment and no screening)

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 2).

In terms of cost-effectiveness (Table 2), 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.

Table 2: *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

Project Recommendations (Phase 4)

From Health Providers and Employers

1. Medicare Eligibility - A central recommendation was the need for policy reform at the federal level.

2. Reforming Private Health Insurance: If Not Medicare, Then What? - If access to Medicare remains restricted, PHI must be urgently reformed to meet the needs of PALM participants.

3. Proactive Screening and Preventive Health Checks - There is an urgent need for early and proactive healthcare engagement with PALM participants.

4. Culturally appropriate and ongoing health education – Health providers and employers emphasised the need for ongoing, in-language, culturally appropriate health education.

5. Community-Based and Outreach Healthcare Models - Health providers and employers highlighted the need for locally delivered, accessible health services tailored to the realities of PALM participants' working and living conditions.

6. Funding and Workforce Support - A consistent concern emerged around the chronic underfunding of services, particularly in regional areas where PALM participants are concentrated.

7. Sexual and Reproductive Health Access and Informed Choice - Sexual and reproductive health was identified as a key area where PALM participants require more support, clearer pathways, and culturally appropriate services.

8. Time Off for Medical Appointments and Workplace Support – Health providers highlighted the need for employers to explicitly support time off for medical appointments.

9. Cultural Safety and Training for the Australian Health Workforce – Health providers expressed a strong need for increased cultural safety training within the Australian health system, with a particular focus on sexual and reproductive health.

10. International Collaboration and Pacific Region Investment - The need for health investment beyond Australia's borders was highlighted by stakeholders within a human rights context and mutuality of responsibility.

From PALM Participants

1. Orientation and Health Education on Arrival - Most PALM participants arrive in Australia with limited or no knowledge of the healthcare system. PALM participants wanted basic information such as how to find a doctor and what insurance covers.

2. Health Insurance Understanding and Cost Transparency - Health insurance remains a source of stress and confusion amongst PALM participants. Suggestions focused on greater clarity and support in understanding what is covered and how to access reimbursements.

3. Language and Communication Barriers - PALM participants recommended the use of interpreters, bilingual staff, or translated materials to help them communicate symptoms accurately and understand medical instructions.

4. Balancing Support and Autonomy in Healthcare Access - PALM participants identified a range of preferences when it comes to employer involvement in healthcare access. These perspectives highlight the importance of enabling autonomy and providing multiple access pathways that respect individual preferences.

5. Transport and Accessibility – Some PALM participants 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.

6. Cultural Safety and Privacy in Care - PALM participants suggested that cultural safety and confidentiality in healthcare must be strengthened. Ensuring private pathways to care, without relying on employers or housemates for interpretation or coordination, was also seen as essential.

Conclusion

Conclusion Statement – A Call to Action

This research 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 research 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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