Australian Government
Australian Institute of Health and Welfare

Use of hospitals and homelessness services by refugees and humanitarian entrants

Web report | Last updated: **26 Jul 2024** | Topic: Culturally and linguistically diverse Australians

About

Refugees and humanitarian entrants have different health outcomes, health service use, and causes of death compared with other permanent migrants and the rest of the Australian population. Understanding their health and homelessness service use can inform policies and services for these diverse populations.

This web report presents data on the hospitalisations, emergency department presentations and homelessness service use by humanitarian entrants who arrived in Australia from 2000 to 2020.

Cat. no: PHE 345

Findings from this report:

- Humanitarian entrants were hospitalised with COVID-19 over 5 times more than other permanent migrants
- Humanitarian entrants were almost twice as likely to be hospitalised or attend an ED as other permanent migrants
- In 2020–21, 9.2% of humanitarian entrants were aged over 60, compared with 22% of the general Australian population
- A higher proportion of the humanitarian population were SHS clients (13%) than other permanent migrants (2.0%)

Summary

Key findings

Cohort demographics

A small proportion of people are aged over 60 in the migrant cohorts; as of December 2020, only 9.2% of humanitarian entrants and 6.8% of other permanent migrants were aged over 60 in 2020–21, compared with 22% of the general Australian population, excluding Western Australia and the Northern Territory (ABS 2021). Further details about the data sources and who is included in the data, are in the Technical notes.

Hospital services

Humanitarian entrants were almost twice as likely to be hospitalised or attend an emergency department (ED) as other permanent migrants in the period 2016–17 to 2020–21 (243 hospitalisations and 293 ED presentations per 1,000 people in humanitarian entrants, compared with 135 hospitalisations and 149 ED presentations per 1,000 people in other permanent migrants).

Most common reasons for hospitalisations and emergency department presentations

Childbirth was the most common reason for hospitalisation in humanitarian entrants (8%) and other permanent migrants (12%) in 2020–21. Pain-related reasons, including pain in the throat or chest and pain in the abdomen were common reasons for ED presentations in both cohorts, consistent with top reasons for ED admissions in the general Australian population (AIHW 2021).

Emergency department presentations

In 2020–21, the rate of ED presentations in humanitarian entrants (289 per 1,000 people) was higher than for other permanent migrants (246 per 1,000). However, the proportion of total ED presentations that were classified as lower urgency care was lower in humanitarian entrants (32%) compared with other permanent migrants (42%) in 2020–21.

Across the period 2016–17 to 2020–21, a higher proportion of humanitarian entrants (28.5% in 2020–21) arrived to an ED via ambulance than other permanent migrants (15.6% in 2020–21). In 2020–21, 29% of humanitarian entrants arrived at an ED by ambulance; this was similar to the general Australian population (27%) (AIHW 2021) but higher when compared with of other permanent migrants (16%).

Injuries

In 2020–21, injuries amongst humanitarian entrants resulted in 53.6 ED presentations per 1,000 people and 16.8 hospitalisations per 100,000 people. Falls, contact with objects and transport accidents were the three most common reasons for injury-related hospitalisations amongst humanitarian entrants. Assaults caused a higher rate of injury-related hospitalisations among humanitarian entrants (1.9 per 1,000 people) than other permanent migrants (0.3 per 1,000 people). In comparison, the published rate of injury-related hospitalisations due to assault in the general Australian population is 0.9 per 1,000 people (AIHW 2024).

Of all injury-related hospitalisations in humanitarian entrants, 7.4% were due to injuries that occurred whilst working, compared with 9.0% of injury-related hospitalisations in other permanent migrants. This difference may potentially be related to lower employment rates in humanitarian entrants (43%), compared with other permanent migrants (81% of skilled migrants and 62% of family migrants) (ABS 2023).

Homelessness services

One in eight (13%) of the total humanitarian entrant population were specialist homelessness services (SHS) clients at any point in the period, between 1 July 2011 to 30 June 2021, compared with 1 in 50 of the other permanent migrant populations. Almost three in five (58%) humanitarian entrant SHS clients were female, compared with almost 3 in 4 (73%) other permanent migrant SHS clients, and 22% of humanitarian SHS clients were under the age of 18 when they first received services, compared with 14% of other permanent migrant SHS clients.

For humanitarian entrants, accommodation was the main reason for seeking assistance from a SHS (40%) followed by Interpersonal issues (24%); with family and domestic violence the most common main (interpersonal) reason (18%).

The most common services needed by humanitarian entrant SHS clients were accommodation services (86% - which include short-term or emergency, medium-term or transitional, and long-term housing) and general services (87% - which include advice and information, material aid, meals and living skills). In almost 1 in 6 support periods (16%), humanitarian entrant clients needed a domestic violence service and in almost 1 in 7 (14%) needed immigration or cultural services. A 'support period' is the period of time a client receive services from a SHS agency. A client may have multiple support periods if they receive SHS services on multiple occasions.

For more detailed data including for other permanent migrants, refer to the Data tables.

Sections in this report

Profile of study cohort

Explore demographic information about the humanitarian entrant cohort and the comparison cohort of other permanent migrants.

Use of hospital services

Explore hospitalisations and emergency department presentations in the migrant cohorts, including for injury, lower urgency care, potentially preventable hospitalisations and hospitalisations for birth

COVID-19 outcomes

Explore COVID-19 hospitalisations and COVID-19 deaths in the migrant cohorts.

Use of homelessness services

Explore the use of homelessness services by the migrant cohorts, including profile of people accessing services, reasons for accessing services and service needs.

Data

Explore extensive data from this project in downloadable data tables, including outcomes by state and territory.

References

Australian Bureau of Statistics (ABS) (2023) *Permanent migrants in Australia* - external site opens in new window, ABS website, accessed 06 June 2024.

AIHW (2021) *Emergency department care 2020–21: Australian hospital statistics*, AIHW website, accessed 05 June 2024.

AIHW (2024) *Injury in Australia: Assault and Homicide*, AIHW website, accessed 20 June 2024.

Backgound

Refugees and humanitarian entrants' health outcomes in Australia can be severely impacted by their experiences and health challenges prior to arriving in Australia. They are a subset of a group of people from culturally and linguistically diverse backgrounds, who have been identified as a population of interest across the health sector, including in several key Australian Government strategies such as the National Women's Health Strategy 2020–2030 (Department of Health and Aged Care 2019a), National Men's Health Strategy 2020–2030 (Department of Health and Aged Care 2019b) and National Action Plan for the Health of Children and Young People 2020–2030 (Department of Health and Aged Care 2019c).

While data are routinely collected on the health and welfare outcomes of the general Australian population, there is no demographic information to identify the refugee and humanitarian population in national health and welfare data sets. As a result, there is limited information on refugees and humanitarian entrants' health status and outcomes and changes over time.

This report builds on AIHW's earlier report Health of refugees and humanitarian entrants in Australia which examined the health service use, medication dispensing patterns, health status and mortality of refugees and humanitarian entrants. This second report examines data on refugees and humanitarian entrants who arrived in Australia from 2000 to 2020 and their hospital admissions and emergency department presentations between 2016–2017 and 2020–2021, and use of specialist homelessness services between 2011–12 and 2020–2021. Hospital admission and emergency department analyses in humanitarian entrants and other permanent migrants does not include data from hospitals in Western Australia or the Northern Territory due to these analyses using pre-existing linkage infrastructure (which does not contain hospital data for these jurisdictions) to create the Refugee health linked data set.

For details of the data sources, who is included in the data, the linkage strategy, and data gaps, please see Profile of the study cohort and the Technical notes.

References

Department of Health and Aged Care (2019a) *National Women's Health Strategy* - external site opens in new window 2020–2030, Australian Government, accessed 19 June 2024.

Department of Health and Aged Care (2019b) *National Men's Health Strategy* - external site opens in new window 2020–2030, Australian Government, accessed 19 June 2024.

Department of Health and Aged Care (2019c) *National Action Plan for the Health of Children and Young People 2020–2030* - external site opens in new window, Australian Government, accessed 19 June 2024.

Profile of study cohort

Outcomes are reported for refugees and humanitarian entrants and for people who have migrated to Australia under other permanent migration visas (family, skilled and other) as a comparison. Where possible comparisons are made to published data in the general Australian population to provide context. These comparisons should be cautiously interpreted as differences in methodology and data sources may contribute to differences. Please see Technical notes for further information.

For the purposes of this project, *humanitarian entrants* refers to those who have been resettled in Australia under the offshore component of Australia's Humanitarian Program. The term *humanitarian entrants* is used in the report to refer to refugees and humanitarian entrants.

Refugees and humanitarian entrants

The Department of Home Affairs administers the Australian Government's Refugee and Humanitarian Program which resettles humanitarian entrants in Australia. Consistent with the approach adopted by the United Nations High Commissioner for Refugees (UNHCR), under the Humanitarian Program, Australia prioritises those cohorts who have the greatest resettlement need, including:

- people outside their home country, assessed as refugees by the UNHCR and referred to Australia for resettlement
- applicants proposed by a close family member in Australia
- vulnerable cohorts within refugee populations, including women and children, ethnic minorities, LGBTQI+ and other identified minority groups. (Home Affairs 2023).

For details about how the cohorts were defined from the Settlement Database, please see the Technical notes. For details of settlement services in Australia, please refer to information on settling in Australia provided in our previous report. For details of the data sources, who is included in the data, the linkage strategy, and data gaps, please see the Technical notes.

Demographic profile

In 2020–21, the humanitarian entrant population was 210,310 people (50.4% female and 49.6% male), and the other permanent migrant population was 2,794,284 people (52.8% female and 47.2% male). The sex ratio was consistent between 2016–17 and 2020–21.

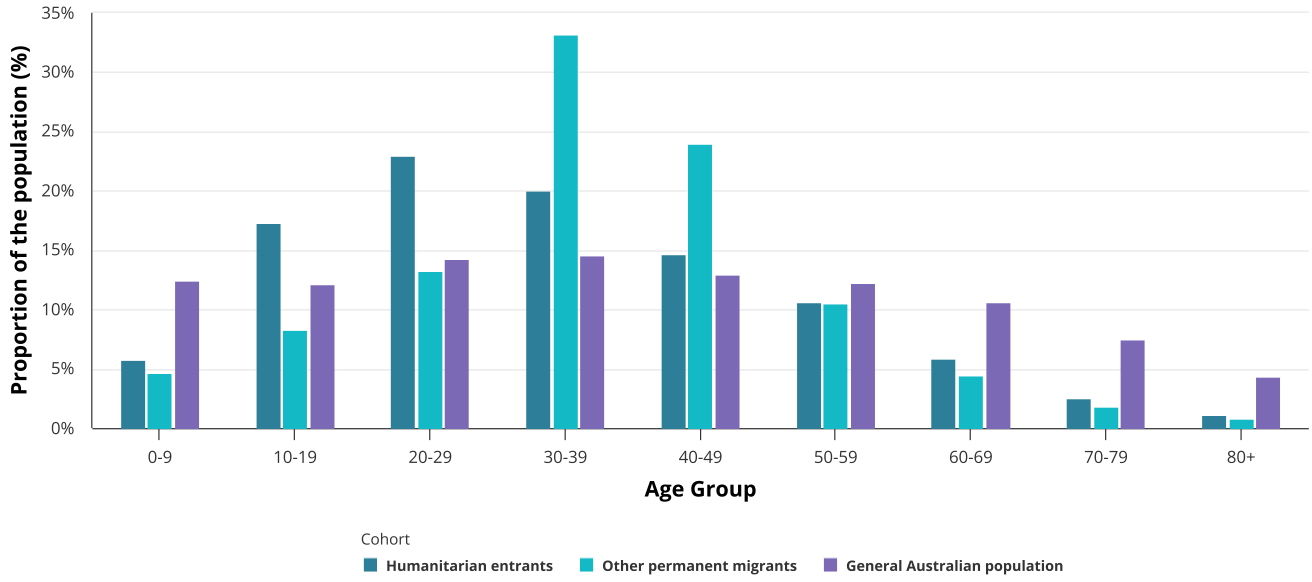
As these analyses include humanitarian entrants and other permanent migrants who arrived in Australia from the year 2000, the age profile of both populations is relatively young (Figure 1). In 2020–21, the humanitarian entrant population (median age 31.8) was younger than other permanent migrants (median age 37.4) and the general Australian population (median age 39.3) (ABS 2021).

The age structure of the populations is consistent across the last 5 financial years, 2016–17 and 2020–21.

For humanitarian entrants, the most populous age group is 20 to 29, with more than 1 in 5 of the cohort in this age group. The other permanent migrant comparison group is slightly older, with almost 1 in 3 of the cohort in the 30 to 39 year age group. There are very few people in the older age groups, with only 9.2% of humanitarian entrants and 6.8% of other permanent migrants aged over 60 in 2020–21, compared with 22% of the general Australian population, excluding Western Australia and the Northern Territory as of December 2020 (ABS 2021). For details of the data sources, who is included in the data, the linkage strategy, and data gaps, please see the Technical notes.

Figure 1: Cohorts, by age group, 2020–21

This column charts shows the age distribution of humanitarian entrants, other permanent migrants, and the general Australian population. Humanitarian entrants are generally younger, peaking at 20-29 years old. Other permanent migrants are older, peaking at 30-39 years. The general Australian population has a flatter age structure with a larger proportion in the older age groups.



Sources:
Refugee health linked data set
Australian Bureau of Statistic (ABS) National, state and territory population December 2020 (ABS 2021)

Notes:

1. The cohorts shown here do not include people living in WA or the NT.
2. The general Australian population is from the Australian Bureau of Statistics (ABS) estimated residential population (ERP) at 31 December 2020 (ABS 2021).

A larger proportion of the migrant populations lived in New South Wales and Victoria (Table 1).

Table 1: Proportion of the population in each state and territory, by cohort, 2020–21

State or Territory	Humanitarian entrants	Other permanent migrants	General Australian population
NSW	32.2	33.6	31.8
Vic	33.1	27.9	25.9
Qld	13.3	15.1	20.2
SA	8.9	5.6	6.9
WA	8.9	13.4	10.4
Tas	1.9	1.0	2.1
NT	0.6	0.9	1.0
ACT	1.2	2.4	1.7
Total population (people)	210,310	2,794,284	25,694,393

Sources: Refugee health linked data set, Australian Bureau of Statistic (ABS) National, state and territory population December 2020 (ABS 2021)

Notes:

1. State is as recorded on the Medicare Consumer Directory on 31 December 2020.
2. State of the general Australian population is from the Australian Bureau of Statistics (ABS) estimated residential population (ERP) at 31 December 2020 (ABS 2021).
3. Proportion of the population living in WA and NT are provided to demonstrate to demonstrate the proportion living in these jurisdictions. These jurisdictions are excluded from hospitals and ED analysis but included in analysis of specialist homelessness services and deaths.

References

Australian Bureau of Statistic (ABS) (2021) *National, state and territory population* - external site opens in new window, Australian Bureau of Statistics website, accessed 5 June 2023.

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Use of hospital services

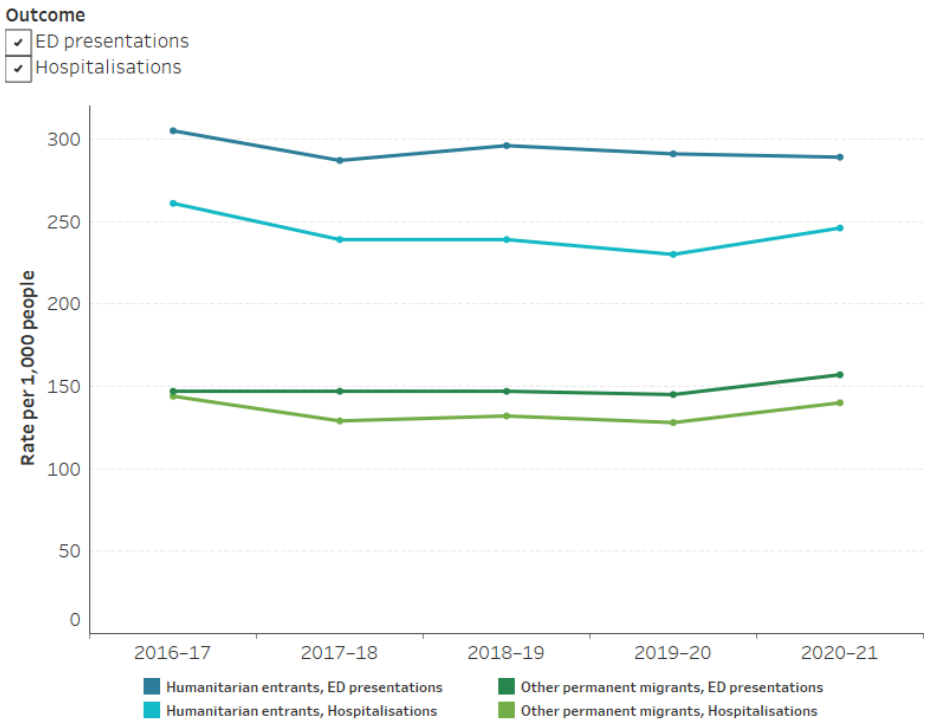
Use of hospital services

Between 1 July 2016 and 30 June 2021, there were 231,000 hospitalisations and 279,000 emergency department (ED) presentations for humanitarian entrants, or an average of 243 hospitalisations per 1,000 people and 294 ED presentations per 1,000 people annually.

Humanitarian entrants were almost twice as likely to be hospitalised or attend an ED as other permanent migrants in the period 2016–17 to 2020–21 (Figure 2).

Figure 2: Hospitalisations and ED presentations by financial year by cohort, 2016–17 to 2020–21

This line graph shows the rate of emergency department presentations and hospitalisations in humanitarian entrants and other permanent migrants in the years 2016–17 to 2020–21. ED presentations and hospitalisations are higher in humanitarian entrants across all financial years.



Source: Refugee health linked data set
https://www.aihw.gov.au/

Notes:

1. Hospitalisations are counts of admitted patient care separations with an admission date in the financial year.
2. This analysis excludes people who lived in WA or NT or had hospitalisations in WA or NT.
3. This analysis is sourced from the Refugee health linked data set, direct comparisons to rates in the Australian population are not possible as this data source is limited to permanent migrants.

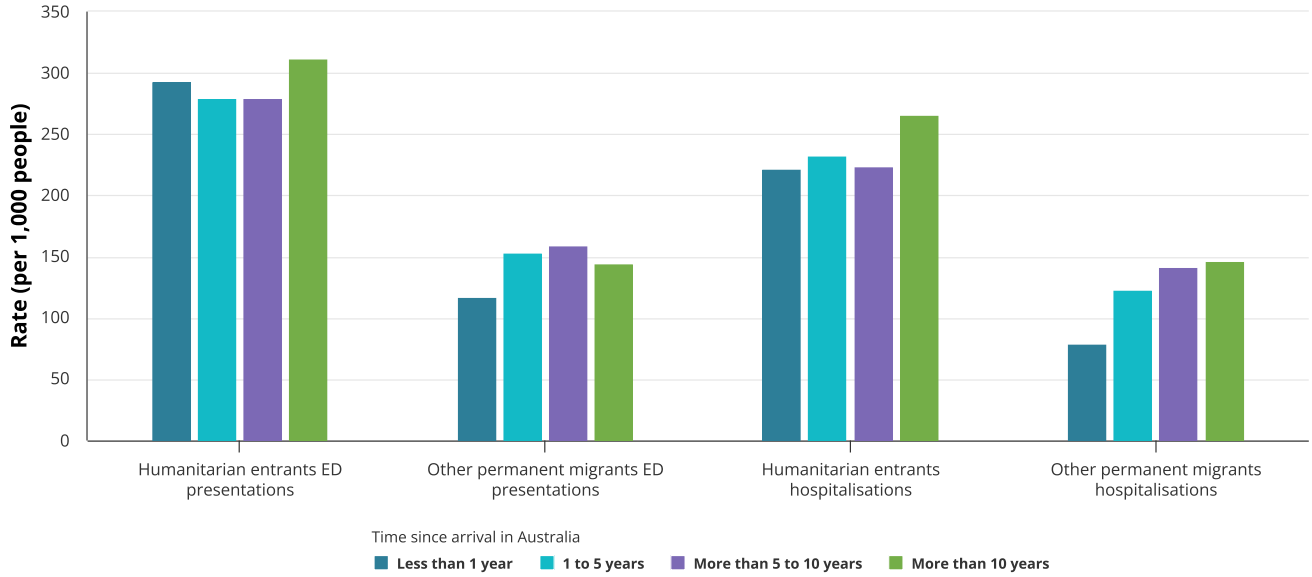
From 1 July 2016 to 30 June 2021:

- Rates of hospitalisations were highest in people who had been in Australia more than 10 years for both humanitarian entrants and other permanent migrants (Figure 3).
- Rates of ED presentations were highest in people who had been in Australia more than 10 years for humanitarian entrants and highest for people who had been in Australia more than 5 to 10 years for other permanent migrants (Figure 3).

These findings may relate to different age structures of each migrant cohort and would benefit from further investigation.

Figure 3: Hospitalisations and ED presentations, by time since arrival in Australia, by cohort, 2016–17 to 2020–21

Column chart of hospitalisations and emergency department presentations in humanitarian entrants and other permanent migrants by time since arrival in Australia. Humanitarian entrants had higher rates of both ED presentations and hospitalisations in those who arrived in Australia more than 10 year ago. Other permanent migrants had lowest rates of ED presentations and hospitalisation in people who had been in Australia less than a year.



Source: Refugee health linked data set

Notes:

1. Hospitalisations are counts of admitted patient care separations.
2. Time since arrival is calculated as the time between admission date (for hospitalisations) or presentation date (for ED presentations) and the arrival date in the Settlement Database.
3. This analysis excludes people who lived in WA or NT or had hospitalisations in WA or NT.

Use of hospital services

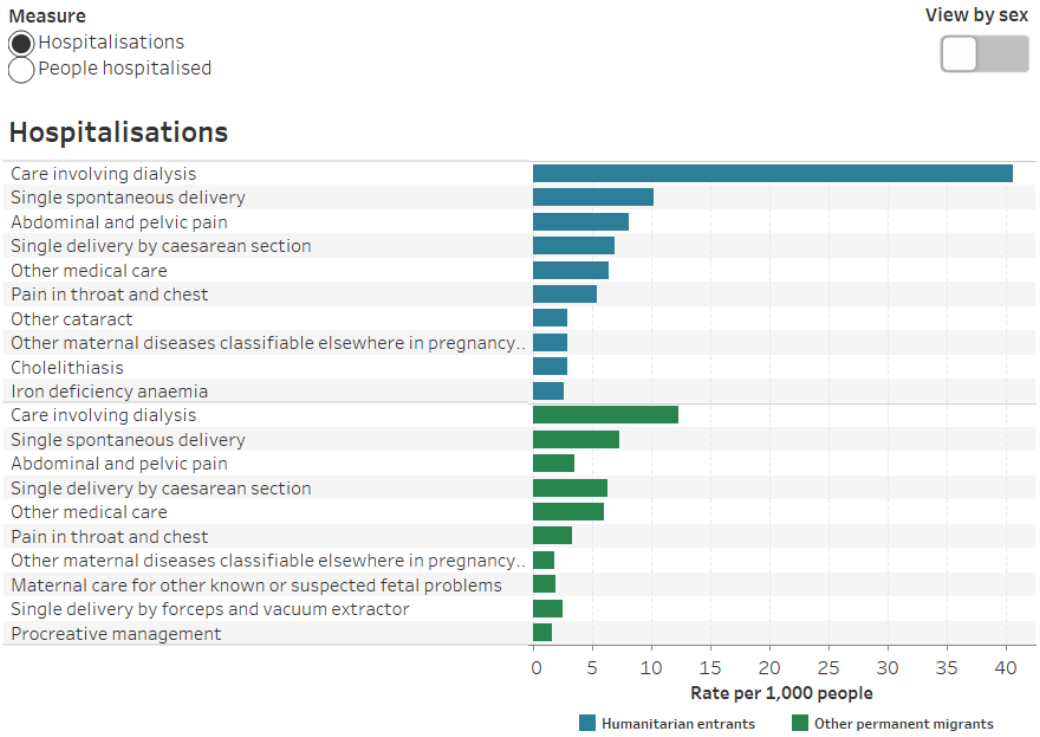
In 2020–21, humanitarian entrants were most commonly hospitalised for:

1. Unassisted vaginal birth of a single baby (single spontaneous delivery) (10 people hospitalised per 1,000 people, specifically 20 females hospitalised per 1,000 females)
2. Abdominal and pelvic pain (7.3 people hospitalised per 1,000 people)
3. Birth of a single baby via caesarean section (single delivery by caesarean section) (6.9 people hospitalised per 1,000 people, specifically 14 females per 1,000 females) (Figure 4).

In 2020–21, the highest number of hospitalisations (episodes of care) for both humanitarian entrants and other permanent migrants was for care involving dialysis. However, as most people undergoing dialysis attend three sessions per week (ANZDATA 2021), the total number of hospitalisations for dialysis relate to a relatively small number of people (103 humanitarian entrants in 2020–21) (Figure 5). Further details of the most common reasons for hospitalisation, including disaggregation by gender are in Data tables and Figure 4.

Figure 4: Top 10 most common principal diagnoses by number of hospitalisations and number of people with a hospitalisation, by cohort, by sex, 2020–21

Bar chart showing the top reasons for hospitalisations at the three character ICD-10-AM level. Reasons are similar for humanitarian entrants and other permanent migrants, with the top reason by number of hospitalisations dialysis and the top reason by number of people hospitalised single spontaneous delivery (unassisted birth).



Source: Refugee health linked data set
https://www.aihw.gov.au/

Notes:

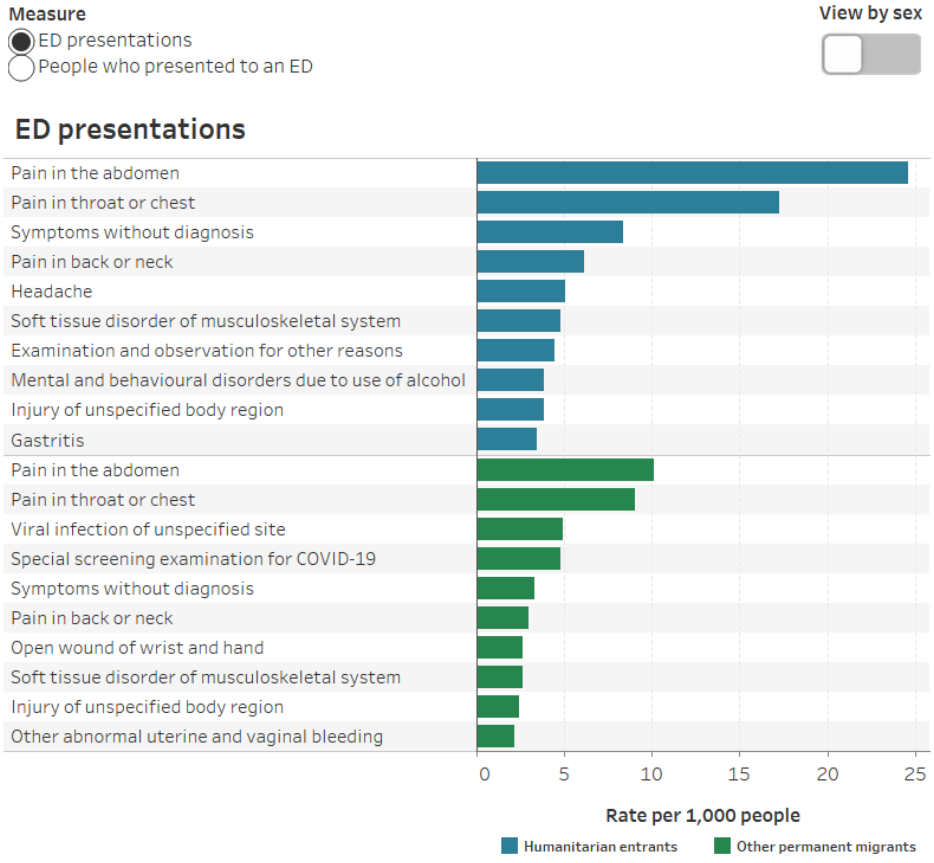
1. Primary diagnosis is the first listed diagnosis on the hospitalisation record.
2. Rate of hospitalisations is the number of hospitalisations per 1,000 people. Rate of people hospitalised is the number of people who were hospitalised in that financial year for the specified reason, this will only count each person once in each diagnosis category- even if they are hospitalised on multiple occasions in a financial year for the same specific principal diagnosis.
3. Principal diagnosis is based on the ICD-10-AM (11th Edition). Group labels have been edited for length and clarity, see Technical notes for further details on the classification system.
4. This analysis excludes people who lived in WA or NT or had hospitalisations in WA or NT.

In 2020–21, the two leading causes of ED presentations for humanitarian entrants and other permanent migrants were pain in the abdomen, and pain in the throat or chest (Figure 5).

In the same time period, the fourth most common reason for ED presentations in other permanent migrants was special screening examination for COVID-19 but it was not in the top 20 reasons for humanitarian entrants.

Figure 5: Top 10 most common principal diagnoses by number of emergency department presentation and number of people with an emergency department presentation, by cohort, by sex 2020–21

Bar chart showing the top reasons for ED presentations at the three character ICD-10-AM level. Reasons are similar for humanitarian entrants and other permanent migrants, with the top reason by number of presentations pain in the abdomen and the top reason by number of people who presented also pain in the abdomen.



Source: Refugee health linked data set
https://www.aihw.gov.au/

Notes:

1. Primary diagnosis is as described in the ED ICD-10-AM principal diagnosis short list (11th edition).
2. Rate of ED presentations is the number of ED presentations per 1,000 people. Rate of people who presented to an ED is the number of people who presented to the ED in that financial year for the specified reason, this will only count each person once in each diagnosis category- even if they attend an ED on multiple occasions in a financial year for the same specific principal diagnosis.
3. Principal diagnosis is based on the primary diagnosis information coded to the ED ICD-10-AM (11th edition) principal diagnosis short list. Group labels have been edited for length and clarity, see Technical notes for further details on the classification system.
4. This does not include emergency department presentations which occurred in WA or NT or in people living in WA or NT.

There are different reasons for hospitalisations and ED presentations by age (AIHW 2023). Variations in the top reasons for hospitalisations and ED presentations between these migrant cohorts and data reported for the general population may be due to the age structure of the populations and include:

- less hospitalisations for cancer and chronic health conditions
- headache featuring in the top 20 for humanitarian entrants and other permanent migrants but not in the top 20 for the general Australian population (AIHW 2023).

For more detailed data, including the top 20 reasons for ED presentations and hospitalisations and hospitalisations by ICD-10-AM chapters from 2016–17 to 2020–21, refer to the Data tables.

References

ANZDATA (Australia and New Zealand Dialysis and Transplant Registry) (2021) *ANZDATA 44th Annual Report 2021*- external site opens in new window - external site opens in new window, ANZDATA website, accessed 05 June 2024.

AIHW (2023) Australia's hospitals at a glance , AIHW, Australian Government, accessed 07 May 2024.

AIHW (2021) *Emergency department care 2020–21: Australian hospital statistics*, AIHW website, accessed 05 June 2024.

Use of hospital services

On this page:

Time of emergency department presentations

The timing of humanitarian entrants presenting to emergency departments was consistent across the last 5 financial years, 2016–17 to 2020–21. In 2020–21 humanitarian entrants were most likely to present to emergency departments (ED) between the hours of 10 am and 10 pm, with Monday the day of the week with the highest proportion of presentations (15.1%) (Figure 6). Monday was also the day with a higher proportion of ED presentations for the general Australian population in 2020–21. Compared with the general Australia population, humanitarian entrants had slightly higher proportions of ED presentations from 10 pm to 3:59 am and lower proportions from 6 am to 10 am (AIHW 2021).

Further data on time of ED presentations including for other permanent migrants, and further financial years in the Data tables.

Figure 6. Proportion of emergency department presentations on each weekday by time of day, in humanitarian entrants, 2020–21

Heat map showing the proportion of ED presentations that occur at time of day and day of the week, darker colours from 10 am to 9:59 pm show more ED presentations within these hours. The pattern is consistent across all days of the week.

Time of presentations	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total
Midnight to 1:59 am	6.7	5.6	5.9	6.0	5.5	6.0	6.8	6.1
2 am to 3:59 am	4.9	4.0	3.9	3.9	3.9	3.8	4.4	4.1
4 am to 5:59 am	3.9	2.9	2.9	2.6	2.8	2.6	3.4	3.0
6 am to 7:59 am	3.7	3.2	2.6	2.9	3.1	2.9	3.5	3.1
8 am to 9:59 am	6.1	6.7	6.5	6.1	6.1	6.7	6.1	6.3
10 am to 11:59 am	10.0	11.3	10.9	11.6	11.9	11.0	10.8	11.1
Midday to 1:59 pm	11.4	12.2	12.7	12.1	11.5	12.2	11.3	11.9
2 pm to 3:59 pm	11.4	11.3	11.1	11.1	11.9	11.3	11.4	11.3
4 pm to 5:59 pm	10.5	12.7	11.7	12.3	11.4	11.9	10.2	11.5
6 pm to 7:59 pm	10.4	11.3	11.8	11.9	11.8	12.2	11.4	11.6
8 pm to 9:59 pm	11.3	10.3	11.0	10.7	11.2	10.4	10.5	10.8
10 pm to 11:59 pm	9.7	8.3	8.8	8.8	9.0	9.0	10.0	9.1
Total	13.9	15.1	14.1	14.3	14.2	14.5	13.9	

Proportion of ED presentations within the weekday
0.0 15.1

Source: Refugee health linked data set
https://www.aihw.gov.au/

Notes:

1. This does not include emergency department presentations which occurred in WA or NT or for people living in WA or NT in 2020–21.

Mode of arrival to emergency departments

The mode of arrival relates to how a patient arrives at the ED, whether by ambulance which includes air ambulance and helicopter rescue), or another form of transport.

Between 2016–17 and 2020–21, a higher proportion of humanitarian entrants arrived to an ED via ambulance compared with other permanent migrants and the general Australian population. (AIHW 2021) (Table 2).

Table 2: Proportion of ED presentations with an arrival mode of ambulance (which includes air ambulance or helicopter rescue), by cohort

Financial year	Humanitarian entrants	Other permanent migrants	General Australian population
2016–17	24.9%	13.6%	25.4%
2020–21	28.5%	15.6%	27.4%

Source: Refugee health linked data set for humanitarian entrants and other permanent migrants, AIHW Australian hospital statistics for general Australian population.

Note:

1. This analysis excludes people who lived in WA or NT or had ED presentations in WA or NT.

Emergency department presentations for lower urgency care

Around 1 in 3 ED presentations in humanitarian entrants (32%) were classified as lower urgency care in 2020–21.

What is lower urgency care?

Lower urgency ED presentations are defined as presentations at formal public hospital EDs where the person:

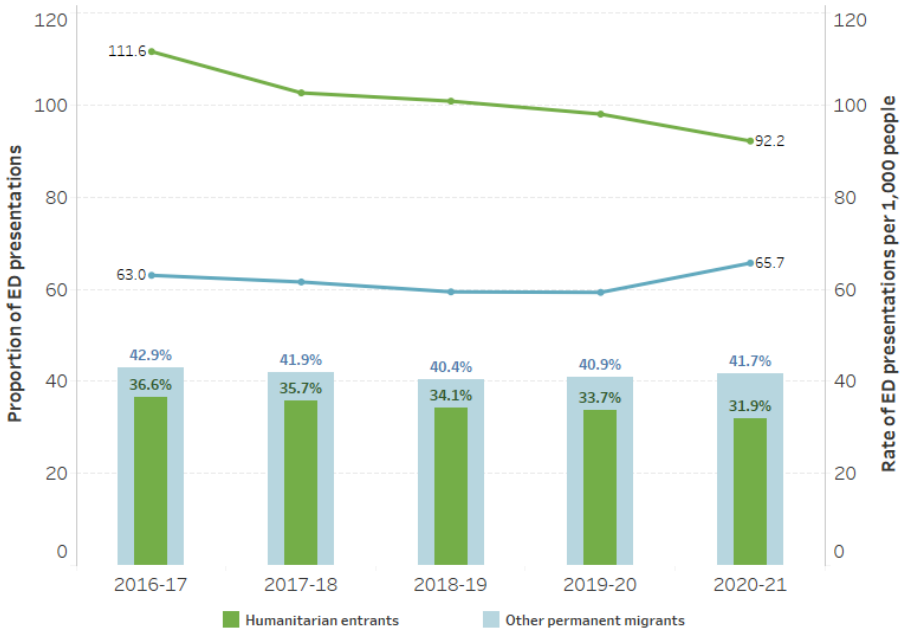
- had a Type of visit to the ED of Emergency presentation, and
- had a triage category of *semi-urgent* (triage category 4: should be seen within 60 minutes) or *non-urgent care* (category 5: should be seen within 120 minutes), and
- did not arrive by ambulance, or police or correctional vehicle, and
- was not admitted to the hospital, was not referred to another hospital, and did not die.

Humanitarian entrants had higher rates of lower urgency ED presentations per 1,000 people (92 presentations per 1,000 people) but had a lower proportion of the total ED presentations that were classified as lower urgency (32%) than other permanent migrants (66 presentations per 1,000 people and 42%, respectively) (Figure 7).

For humanitarian entrants the rate of lower urgency ED presentations decreased from 112 per 1,000 people in 2016–17 to 92 per 1,000 people in 2020–21. This pattern was not seen in other permanent migrants (see Figure 7 and the Data tables for more detail).

Figure 7: Proportion of total ED presentations that were classified as lower urgency and crude rate of lower urgency ED presentations per 1,000 people, by cohort, 2016–17 to 2020–21

The graph shows the proportion of ED presentations that were classified as lower urgency care in a column graph, and the rate of lower urgency care ED presentations per 1,000 people in a line graph, from 2016–17 to 2020–21. The proportion is consistently lower and the rate is consistently higher in humanitarian entrants compared with other permanent migrants.



Source: Refugee health linked data set
https://www.aihw.gov.au/

Notes:

1. This does not include emergency department presentations which occurred in WA or NT or for people living in WA or NT.

Between 2016–17 and 2020–21, among humanitarian entrants, of ED presentations classified as lower urgency varied by age group:

- Close to a quarter (26%) of all lower urgency ED presentations (25,006 presentations) were for people aged under 20, compared with only 16.9% of all ED presentations
- Children under 10 represented 8.6% (8,193 presentations) of all lower urgency ED presentations, compared with 4.4% of total ED presentations, and had the highest presentation rate (129 per 1,000 people)
- Conversely, people aged 60 and over accounted for 5.4% of lower urgency ED presentations (5,131 presentations, at a rate of 66 per 1,000 people), compared with 11.2% of total ED presentations.

The patterns seen for lower urgency ED presentations in humanitarian entrants reflect the patterns seen for the general Australian population (AIHW 2024). In 2020–21, the overall proportion of ED presentations that were classified as lower urgency was lower in the humanitarian entrant population than the general Australian population (32% compared with 36% respectively). Both cohorts also had younger age groups with higher rates of lower urgency ED presentations and lower rates in older age groups.

References

AIHW (2021) *Emergency department care 2020–21: Australian hospital statistics*, AIHW website, accessed 05 June 2024.

AIHW (2024) *Use of emergency departments for lower urgency care*, AIHW, Australian Government, accessed 05 June 2024.

Use of hospital services

On this page:

In 2020–21, injuries amongst humanitarian entrants resulted in:

11,275 ED presentations

53.6 presentations per 1,000 population

3,521 hospitalisations

16.8 hospitalisations per 1,000 population

Injury diagnoses

An injury is identified by having a primary diagnosis code in the ICD-10-AM chapter 19 *Injury, poisoning and certain other consequences of external cause.* These analyses focus on the first instance of injury, see Technical notes for further details. These injuries were grouped into subchapters (Table 3).

Table 3: Counts of the hospitalisations and ED presentations among humanitarian entrants, by injury subchapter, 2020–21

ICD-10-AM subchapter	Principal diagnosis	Hospitalisations	ED presentations
S00–S19	Injuries to head & neck	773	1,806
S20–S39	Injuries to thorax, abdomen, back, spine & pelvis	425	512
S40–S99	Injuries to upper and lower limbs	1,444	5,748
T00–T19	Injuries to multi- or unspecified region; foreign body effects	51	1,450
T20–T35	Burns and frostbite	61	303
T36–T65	Poisoning and toxic effects	220	524
T66–T79	Other and unspecified effects of external causes	79	n.p.
T80–T88	Complications of medical and surgical care	468	492

Source: Refugee health linked data set

Notes:

1. Sources: AIHW National Hospital Morbidity Database (NHMD) and AIHW National Non-admitted Patient Emergency Department Care (NNAPEDC) Database.
2. This does not include hospitalisations which occurred in WA or NT or for people living in WA or NT.
3. Small counts for burns and frost bite mean these figures cannot be further disaggregated.

In 2020–21, injuries to upper and lower limbs were the leading cause of hospitalisations and ED presentations, among humanitarian entrants and other permanent migrants. Further data are provided in Data tables.

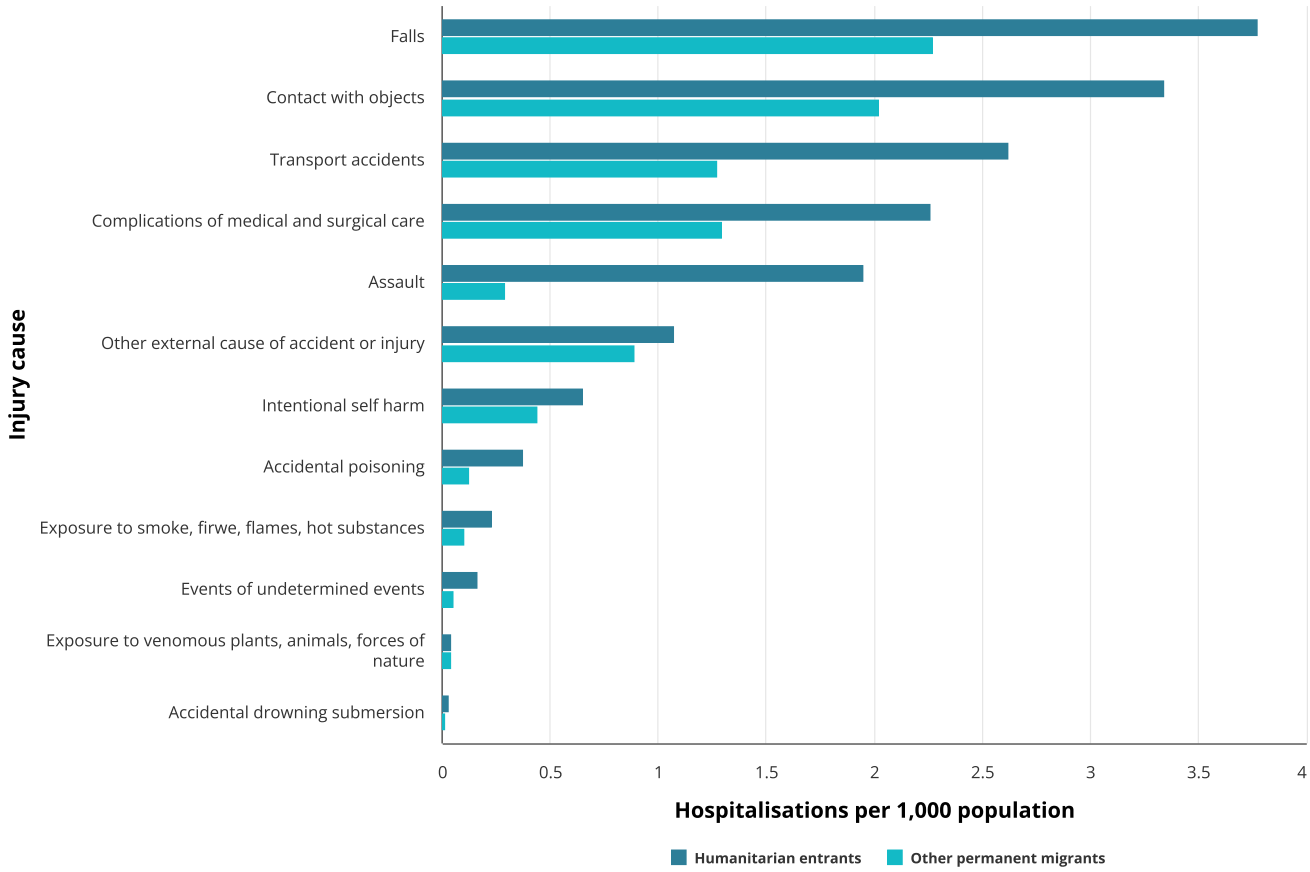
Main causes of injury-related hospitalisations

The two leading causes of injury-related hospitalisation in 2020–21 for both humanitarian entrants and other permanent migrants were falls (22%, 792 cases and 25%, 6,355 cases, respectively) and contact with objects (20%, 702 cases and 22%, 5,653 cases, respectively).

The rate of injury-related hospitalisations that were a result of assaults in 2020–21 was 6.6 times higher in humanitarian entrants (1.9 per 1,000 people, 409 cases) compared with other permanent migrants (0.3 per 1,000 people, 819 cases). This compares with the published rate of injury hospitalisations due to assault in the general Australian population in 2020–21 of 0.9 per 1,000 people (22,981 cases) (AIHW 2024). Additional detail on the demographics and locations of assault related injury hospitalisations is beyond the scope of these analyses and further investigations in this area would be valuable; see Data gaps, limitations and opportunities for further information.

Figure 8. Crude rates (per 100,000) of hospitalisations for injuries among humanitarian entrants and other permanent migrants, by cause of injury, 2020–21

Bar chart of hospitalisations for injury in humanitarian entrants and other permanent migrants by injury cause. Falls was the leading cause for both cohorts. The rate of hospitalisations for injury due to assault was much higher in humanitarian entrants than other permanent migrants.



Source: Refugee health linked data set

Notes:

1. This does not include hospitalisations which occurred in WA or NT or for people living in WA or NT.
2. Injury cause is determined by the first recorded external cause code in the hospitalisation record.

External cause data are not available for emergency department presentations. For more detail, see Technical notes.

Activity while injured

Of the total number of hospitalisations for injury among humanitarian entrants, those injuries occurred while working in 7.4% of cases (10.7 per 10,000 people). This compares with 9.0% of hospitalisations for injury (7.0 per 10,000 people) among other permanent migrants. In 2021, there were lower employment rates in humanitarian entrants, with 43% employed, compared to other permanent migrants where 81% of skilled migrants and 62% of family migrants were employed (ABS 2023). This may contribute to the difference in hospitalisations due to injuries which occur at work.

References

Australian Bureau of Statistics (ABS) (2023) *Permanent migrants in Australia* - external site opens in new window, ABS website, accessed 06 June 2024.

AIHW (2024) *Injury in Australia: Assault and Homicide*, AIHW website, accessed 20 June 2024.

Use of hospital services

In 2020–21, around 1 in 14 hospitalisations (7.2%) in humanitarian entrants were for conditions classified as potentially preventable. This was compared with 1 in 21 hospitalisations (4.8%) in other permanent migrants.

Compared with published data the rate of potentially preventable hospitalisations (PPH) in humanitarian entrants in 2020–21 was lower than the overall rate in the general Australian population (AIHW 2022).

Potentially preventable hospitalisations

Hospital separations for the selected conditions are considered to be 'potentially preventable hospitalisations' as they are amenable in some circumstances to primary and community care interventions. These conditions reflect the National Healthcare Agreement: Performance Indicator 18-Selected potentially preventable hospitalisations, 2022 - external site opens in new window and are categorised as:

- acute (conditions that usually come on suddenly, and may not be preventable, but may not result in hospitalisation if timely and adequate care had been received in the community)
- vaccine-preventable (hospitalisations due to conditions that can be prevented by vaccination)
- chronic (conditions that are persistent and long-lasting but may be preventable through lifestyle change, and can also be managed in the community to prevent worsening of symptoms or hospitalisation).

Potentially preventable hospitalisations (PPH) can tell us about the effectiveness of health care in the community, as higher rates may suggest a lack of timely, accessible, and adequate primary care. However, higher rates of PPH may be due to a range of reasons and some PPH may not be avoidable. Rather, PPH are a useful tool to identify and investigate variation between different groups of people to better understand health inequalities. See Technical notes for more detail.

When examining the proportion of PPH with at least one diagnosis in the cause category, in 2020–21, in comparison with other permanent migrants, humanitarian entrants had a higher proportion of PPH that were classified as vaccine preventable, a lower proportion of PPH classified as chronic, and a similar proportion of PPH classified as acute (Table 4).

The numbers of PPH for vaccine-preventable conditions were lower in the 2020–21 financial year amongst both humanitarian entrants and other permanent migrants compared to earlier years. This is due to drops in the rates of pneumonia and influenza-related hospitalisations during this period which may have been influenced by the coinciding public health measures instigated in response to the COVID-19 pandemic (AIHW 2024).

Table 4: Potentially preventable hospitalisations by conditions, by cohort, 2020–21

Potentially preventable hospitalisation cause	Humanitarian entrants (% of all potentially preventable hospitalisations)	Other permanent migrants (% of all potentially preventable hospitalisations)
Vaccine-preventable conditions	**20.4**	**14.8**
Pneumonia and Influenza (vaccine-preventable)	0.5	0.4
Other vaccine-preventable conditions	19.9	14.4
Chronic conditions	**38.5**	**41.5**
Asthma	3.8	5.1
Congestive heart failure	4.0	2.8
Diabetes complications	7.6	5.0
Chronic Obstructive Pulmonary Disease	2.7	1.4
Angina	3.4	4.3
Iron deficiency anaemia	13.3	18.4
Other chronic conditions	3.7	4.5
Acute conditions	**42.8**	**44.3**
Ear, nose or throat infections	4.9	6.3
Urinary tract infections	13.1	14.8
Dental conditions	10.7	8.0
Convulsions and epilepsy	8.6	5.3

Other acute conditions	5.5	9.9

Source: Refugee health linked data set

Notes:

1. Denominator is the total number of potentially preventable hospitalisations.
2. This does not include hospitalisations which occurred in WA or NT or for people living in WA or NT.
3. Hospitalisations are grouped into the categories presented in this table as per the description of the indicator National Healthcare Agreement: PI 18–Selected potentially preventable hospitalisations, 2021 (METEOR identifier: 725793 - external site opens in new window). Not all hospitalisations with the described diagnosis are considered potentially preventable, only those which meet the criteria outlined in the indicator description.
4. Other chronic conditions includes bronchiectasis, hypertension, nutritional deficiencies and rheumatic heart disease.
5. Othe acute conditions includes pneumonia (not vaccine-preventable), perforated/bleeding ulcer, cellulitis, pelvic inflammatory disease, eclampsia and gangrene.
6. The total number of hospitalisations in each category may not equal the total within a group or the total overall as one potentially preventable hospitalisations can encompass more than one potentially preventable condition.
7. COVID-19 is not included in the definition of potentially preventable hospitalisation.
8. This analysis includes all ages unless otherwise prescribed in the indicator description.

The most common cause of PPH in humanitarian entrants in 2020–21 was other vaccine-preventable conditions, followed by iron deficiency/anaemia and urinary tract infections. These were also the top three causes of PPH in other permanent migrants, with iron deficiency anaemia being the most common. This differs from the general Australian population where dental conditions are the most common cause of PPH, followed by urinary tract infections (AIHW 2022).

Other vaccine-preventable conditions include chicken pox (varicella), diphtheria, haemophilus meningitis, hepatitis B, German measles (rubella), measles, mumps, polio, rotavirus, tetanus and whooping cough (pertussis) but does not include COVID-19.

The COVID-19 pandemic impacted health service access, use and delivery, especially in New South Wales, Victoria and the Australian Capital Territory which had extensive lockdowns restricting services throughout this period (AIHW 2024). This may have impacted access to primary health care and admitted patient care activity, and by extension impacted PPHs. For more detail on the impact of COVID-19 on health care service utilisation see Australia's Heath 2024: COVID-19.

References

Australian Institute of Health and Welfare (AIHW) (2022) *Admitted patient care 2020–21 8 Safety and quality of health systems*, AIHW website, Australian Government, accessed 05 June 2024.

AIHW (2024) *Australia's health 2024: Topic summaries: COVID-19*, AIHW, Australian Government, accessed 05 July 2024.

Use of hospital services

Method of birth

During 2020–21, of the total female humanitarian entrants hospitalised for birth:

- 52% had a non-instrumental vaginal birth (compared with 57% in the 2016–17 financial year)
- 9.1% had a vaginal birth assisted by vacuum or forceps (compared with 8.8% in the 2016–17 financial year)
- 35% had a caesarean section birth (compared with 30% in the 2016–17 financial year)
- Humanitarian entrants were slightly less likely to have a caesarean birth or forceps and vacuum extractor assisted birth than other permanent migrants, regardless of age
- 3.8% gave birth requiring other forms of assistance or had multiple births using a combination of birth methods (compared with 4.2% in 2016–17 financial year)
- A lower proportion of women were aged 35 years and over when giving birth in humanitarian entrants (20%), compared with other permanent migrants (32%).

The proportion of women who were humanitarian entrants and had a non-instrumental vaginal birth has decreased over time, and the proportion of this group who had a caesarean section birth has increased. Vaginal births assisted by vacuum or forceps have remained relatively stable. These patterns are consistent with the experiences of other permanent migrants and the Australian data more broadly (AIHW 2023).

For AIHW published data on the method of birth in the general Australian population, refer to the web report Australia's mothers and babies. Due to differences in data sources and methods it is not valid to make direct comparisons with the data presented in this report.

Method of birth

Method of birth refers to how the baby was born, which may be vaginally or by caesarean section. When compared with non-instrumental vaginal births, instrumental vaginal births (vacuum or forceps) and caesarean section births can carry additional risks for mothers and babies, such as infection and physical trauma. Although each method carries risks, they are chosen by women and their healthcare providers to minimise complications and increase the likelihood of positive pregnancy outcomes (Victorian Department of Health and Human Services 2017). See the Technical notes for information on how method of birth was defined in this report.

Data for methods of birth for humanitarian entrants and other permanent migrants, including by age, are available in the data tables.

References

AIHW (2023) *Australia's mothers and babies*, AIHW, Australian Government, accessed 05 June 2024.

Victorian Department of Health and Human Services (2017) *Caesarean section* - external site opens in new window, Victorian Department of Health and Human Services, Victorian Government, accessed 05 June 2024.

COVID-19 outcomes

On this page:

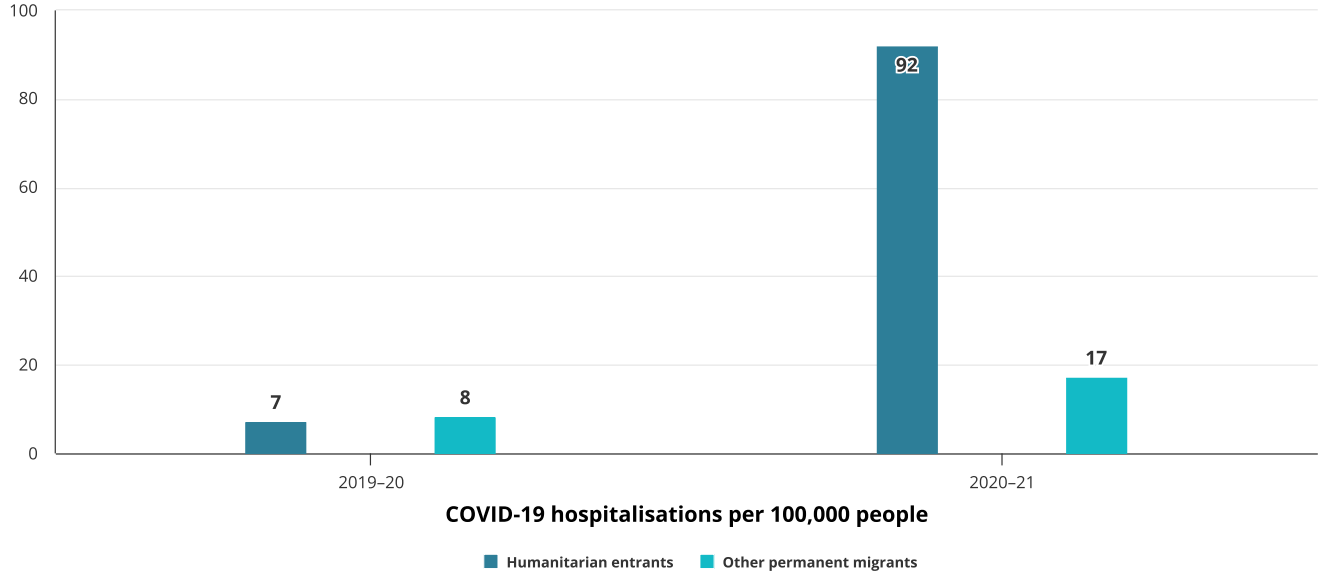
COVID-19 hospitalisations

Between 1 July 2019 and 30 June 2021, there were 209 hospitalisations for humanitarian entrants who had a COVID-19 ICD-10-AM diagnosis code.

The rate of COVID-19 hospitalisations for humanitarian entrants was similar to that for other permanent migrants in 2019–20 (Figure 9). However, in 2020–21, the rate of hospitalisations for humanitarian entrants with a COVID-19 diagnosis code was over 5 times as high as other permanent migrants.

Figure 9: Rate of COVID-19 hospitalisations by cohort, 2019–20 to 2020–21

This bar chart shows COVID-19 hospitalisations per 100,000 people for humanitarian entrants and other permanent migrants. The cohorts had similar rates of COVID-19 hospitalisations in 2019–20, however humanitarian entrants had much higher rates than other permanent migrants in to 2020–21.



Source: Refugee health linked data set

Notes:

1. This does not include hospitalisations which occurred in WA or NT or for people living in WA or NT.

Please refer to the Data tables for more detailed data, and the Technical notes for more details about the ICD-10-AM codes.

COVID-19 deaths

Between 1 July 2019 and 30 June 2022, 53 humanitarian entrants died due to COVID-19 where it directly caused conditions leading to death (listed as the underlying cause of death on the death certificate).

In 2021 for deaths due to COVID-19, the crude death rate for humanitarian entrants was 19.5 per 100,000 people. The crude death rate for other permanent migrants was 0.6 per 100,000 people and 5.2 per 100,000 people for the general Australian population (ABS 2024) (Table 5).

Table 5: COVID-19 deaths and crude rates by cohort, 2020 and 2021

Cohort	COVID-19 deaths in 2020	Rate of COVID-19 deaths in 2020 (per 100,000 people)	COVID-19 deaths in 2021	Rate of COVID-19 deaths in 2021 (per 100,000 people)
Humanitarian entrants	7	3.0	46	19.5
Other permanent migrants	13	0.2	19	0.6
Australian population	906	3.5	1,355	5.2

Source: Refugee health linked data set, Australian Bureau of Statistics, COVID-19 Mortality in Australia: *Deaths registered until 31 January 2024 27/02/2024*

This observation continues after adjusting for age using Standardised Mortality Ratios (SMRs) to control for differences in age structures. The rate of deaths due to COVID-19 in 2021 was 8.5 (CI: 6.0 to 11.0) times as high in humanitarian entrants as the general Australian population. While the rate of deaths due to COVID-19 in other permanent migrants was lower than the general Australian population, 0.3 times as high (CI: 0.1 to 0.4). Unlike crude rates, these SMRs cannot be used to compare COVID-19 mortality rates between other groups or across time. This is because each SMR is a measure that provides a comparison that is specific to the populations involved. See the Technical notes for further detail.

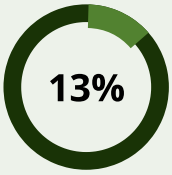
References

Australian Bureau of Statistics (ABS) (2024), COVID-19 Mortality in Australia: Deaths registered until 31 January 2024 - external site opens in new window, ABS website, accessed 06 June 2024.

Use of homelessness services

On this page:

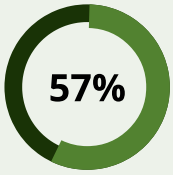
Between 1 July 2011 and 30 June 2021



13% of humanitarian entrants were SHS clients.

Almost 3 in 5

humanitarian entrant SHS clients were female (58%).



57% of of humanitarian entrant clients were assisted by SHS agencies on more than one occasion.

Between 1 July 2011 and 30 June 2021, a total of 104,163 specialist homelessness services (SHS) periods of support were provided to 29,518 humanitarian entrant clients. The data presented in this chapter were collected as part of the Specialist Homelessness Services Collection.

Specialist Homelessness Services Collection

A specialist homelessness service (SHS) is an organisation that receives government funding under the National Housing and Homelessness Agreement - external site opens in new window (NHHA). A SHS provides accommodation or accommodation-related services and/or assistance and support services to people experiencing homelessness or at risk of homelessness. Under the NHHA, these agencies are required to participate in the Specialist Homelessness Services Collection (SHSC). Nationally 1,698 agencies delivered specialist homelessness services to almost 278,300 clients during 2020–21, in all states and territories (AIHW 2022).

All SHSC agencies report standardised data about the clients they support each month to the AIHW, as specified by the SHS National Minimum Dataset (NMDS - external site opens in new window). Data are collected about the characteristics and circumstances of clients when they first present to an agency. Additional data on the assistance received by clients and their circumstances are collected at the end of the month in which the client receives services, and again when contact with the client has ceased.

A SHS support period is the period of time a client receive services from a SHS agency. A client may have multiple support periods if they receive SHS services on multiple occasions.

More information on the Specialist Homelessness Services Collection is available on the AIHW website. The AIHW produces several reports using SHS data.

Migrants use of Specialist Homelessness Services

One in eight (13%) of the total humanitarian entrant population were SHS clients at any point between 1 July 2011 to 30 June 2021 (Table 6). The proportion of male humanitarian entrants who were SHS clients was 11%, compared with 15% of female humanitarian entrants. This is consistent with the whole SHS population where more females receive support than males (AIHW 2024).

A higher proportion of the humanitarian population were SHS clients than other permanent migrants overall, and for males and females (Table 6).

Table 6: Humanitarian entrant and other permanent migrant SHS clients, total population and proportion of the population who were SHS clients, by sex, 2010–11 to 2020–21

Cohort	Sex	SHS clients (number)	Total population (number)	Proportion of population who were SHS clients
Humanitarian entrants	Persons	29,518	234,957	12.6
Humanitarian entrants	Male	12,293	117,264	10.5
Humanitarian entrants	Female	17,225	117,693	14.6
Other permanent migrants	Persons	65,950	3,291,149	2.0
Other permanent migrants	Male	17,497	1,556,343	1.1
Other permanent migrants	Female	48,453	1,734,806	2.8

Source: Refugee health linked data set

Notes:

1. The number of SHS clients is the count of unique clients who accessed a SHS client at any point between 1 July 2011 and 30 June 2021.
2. The total population is the total count of people who were in the respective cohort at any point from 1 July 2011 to 30 June 2021.

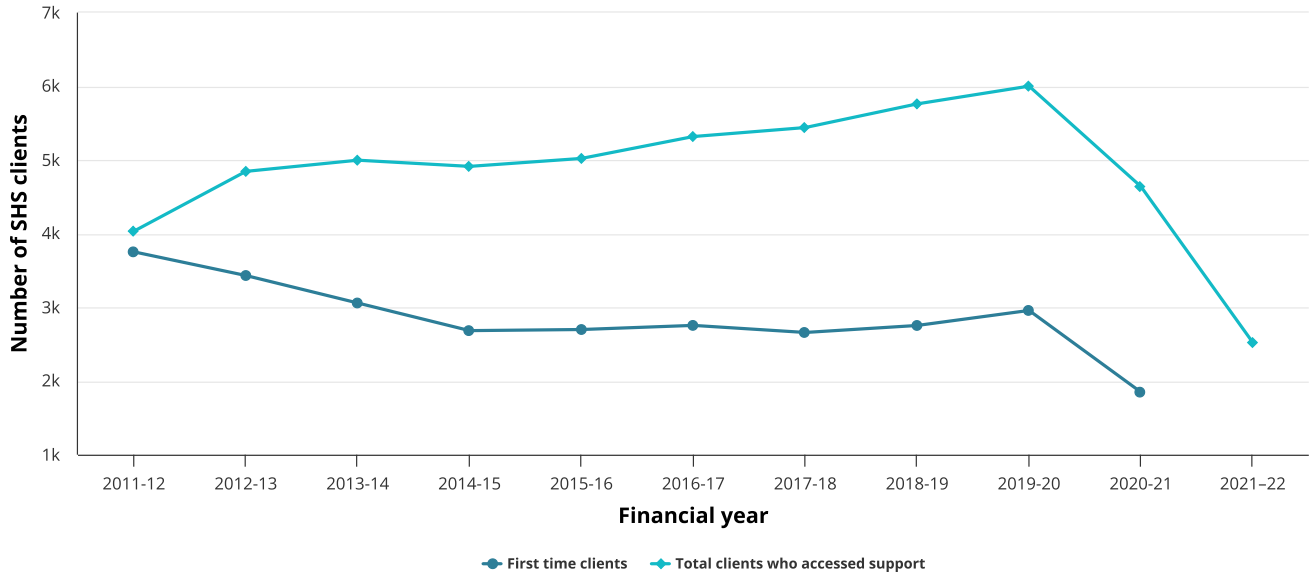
SHS use in humanitarian entrants by financial year

Over the reporting period, 1 July 2011 to 30 June 2021, the number of humanitarian entrant SHS clients receiving support increased from 2011–12 to a peak in 2019–20 (Figure 10). The number of clients decreased in the 2020–21 and 2021–22 financial years and may have been impacted by several state and territory policy changes in response to the COVID-19 pandemic. See Specialist Homelessness Services: monthly data report for details on the impact of these policies on SHS support.

Humanitarian entrant SHS clients presenting to homelessness services for the first-time decreased from 3,753 in 2011–12 to 1,849 in 2020–21 (Figure 10). The decrease in first time clients in 2020–21 may reflect the decrease in visas granted as part of the offshore humanitarian program during the COVID-19 pandemic (Department on Home Affairs, 2021).

Figure 10: Specialist homelessness services clients, humanitarian entrants, by financial year, 2011–12 to 2021–22

Line chart of humanitarian entrant specialist homelessness services clients in each financial year.



Source: Refugee health linked data set

Notes:

1. First time clients is the count of unique clients who accessed a SHS for the first time beginning in that financial year.
2. Total clients is the count of unique clients who had a support period which began in that financial year.
3. The data presented does not include people who first used specialist homelessness services in 2021–22 but includes support periods in 2021–22 for people who had previously been SHS clients since 31 Jul 2011.

Number of support periods per client

From 1 July 2011 to 30 June 2022, there were 104,163 support periods provided to 29,518 clients who were humanitarian entrants. More than half (57%) of humanitarian entrant clients were repeat clients, and 43% received support on one occasion (Table 7).

Female humanitarian entrants were more likely to be repeat clients than male humanitarian entrants (61% of females compared with 52% of males).

Table 7: Specialist Homelessness Services clients by number of support periods, 2011–12 to 2021–22

Number of support periods for client	Proportion of humanitarian entrant SHS clients	Proportion of other permanent migrant SHS clients
1 support period	42.6	45.9
2 support periods	19.8	19.7
3 support periods	10.7	10.7
4 support periods	6.5	6.5
5 or more support periods	20.4	17.2

Source: Refugee health linked data set

Notes:

1. Denominator is the total SHS clients who received support at any period between 2011–12 to 2021–22
2. The number of support periods does not necessarily reflect the level of support as length of support periods may vary greatly meaning some clients may have many brief support periods and some may have a smaller number but that last a longer period.

References

Australian Institute of Health and Welfare (2022) *Specialist homelessness services annual report 2020–21*, AIHW, Australian Government, accessed 05 June 2024.

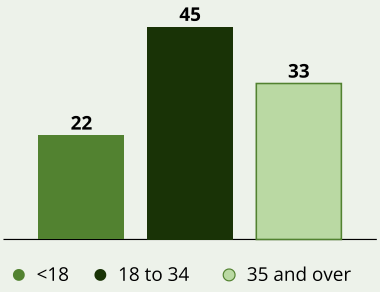
Australian Institute of Health and Welfare (2024) *Specialist homelessness services annual report 2022–23*, AIHW, Australian Government, accessed 13 May 2024.

Department of Home Affairs (2021) *Australia's Offshore Humanitarian Program 2020–21* - external site opens in new window, Department of Home Affairs, Australian Government, accessed 05 June 2024.

Use of homelessness services

On this page:

Between 1 July 2011 and 30 June 2021



22% of humanitarian entrant SHS clients were under the age of 18 when first accessing SHS

More than 1 in 4

humanitarian entrants were living as one parent with child/ren when they first accessed homelessness services

1 in 4 humanitarian entrant SHS clients have experienced mental health issues

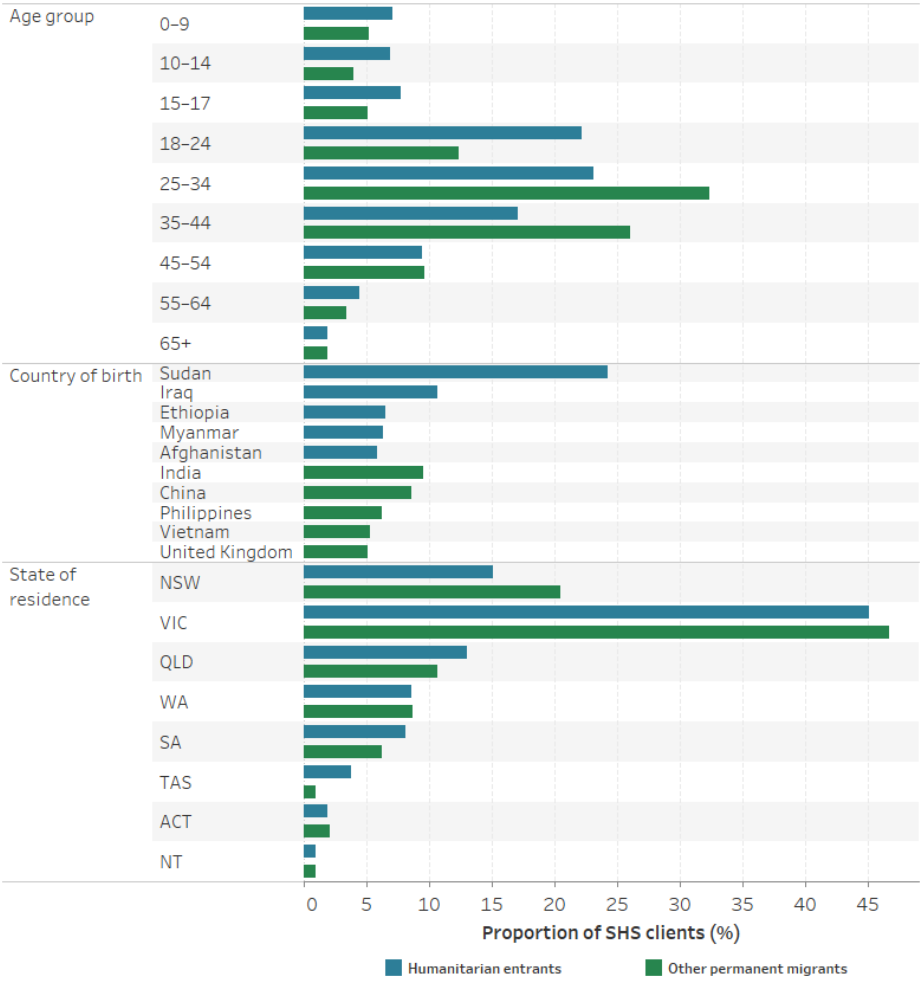
Demographics

Of the total humanitarian entrants who used a Specialist Homelessness Service (SHS) between 2011–12 and 2020–21:

- The most common age group was 25 to 34 year olds (23%)
- 22% were under the age of 18
- 45% of clients had an address registered in Victoria on the Medicare Consumer Directory. This is consistent with the overall SHS data which also has high rates of SHS clients in Victoria (AIHW 2024).
- There was a higher proportion of females than males in all age groups except 0 to 9 and 10 to 14, where the proportion of males was 52% for both age groups in humanitarian entrants and 51% for both age groups in other permanent migrants
- Sudan was the most common country of birth (24%) recorded (Figure 11).

Figure 11: Demographic of SHS clients when they first access SHS services, by cohort 2011–12 to 2020–21

Bar graph showing the distribution of various demographic characteristics amongst SHS clients when they first present for support, with humanitarian entrants and other permanent migrants cohorts shown. Other permanent migrants SHS clients were generally older and from different countries of birth than humanitarian entrants.



Source: Refugee health linked data set
https://www.aihw.gov.au/

Notes:

1. Age calculated at the 31st of December of the financial year in which SHS was first provided to the client.
2. State of residence as recorded on the Medicare Consumer Directory on the 31st December of the financial year in which SHS was first provided to the client.
3. Country of birth as stated in the Department of Home Affairs' Settlement Database.
4. Migrants with a birth place listed as Sudan in the Settlement Database may include migrants whose birth place is in the area which is now the country of South Sudan which gained independence in 2011. Therefore a birth place of Sudan may include South Sudanese migrants.
5. Differences between states may not reflect demand or service availability but may reflect differences in humanitarian entrant populations, and state and territory policies and service provision models.
6. Victoria has the largest number of SHS services and high rates of SHS clients (AIHW 2024).

Further data on the demographics of humanitarian entrants and other permanent migrants can be viewed in the Data tables.

Living arrangement and presenting unit type

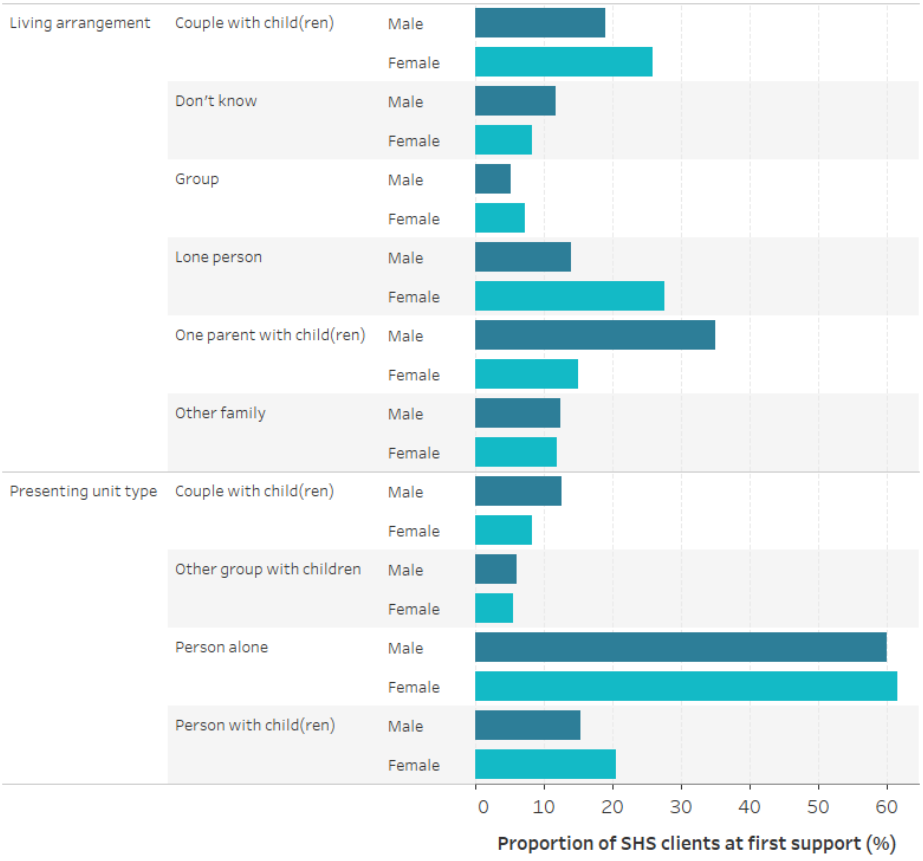
The living arrangement of a client describes who a client is usually living with when they present to a SHS. Presenting unit type indicates how a client presents to a SHS agency.

Between 2011–12 to 2021–22, among humanitarian entrant SHS clients first accessing the SHS:

- the most common living arrangement was one parent with child/children (27%)
- 61% of humanitarian entrants presented alone
- there were differences in living arrangement and presenting unit type reported for men and women (Figure 12).

Figure 12: Living arrangement and presenting unit type for humanitarian entrant SHS clients, by sex, 2011–12 to 2020–21

Bar graph showing the proportion of humanitarian entrant specialist homelessness services clients by living arrangement and presenting unit type at first support by sex. Females had a higher proportion living as a lone person, males had a higher proportion living as one parent with children. Both sexes most often presented alone.



Source: Refugee health linked data set
https://www.aihw.gov.au/

Notes:

1. Living arrangement and presenting unit type are reported when first attending for receiving SHS support.
2. Children may be reported as presenting alone to a SHS agency for several reasons, see the Technical notes for further details.

Comparisons with other permanent migrants can be explored in the Data tables.

Socioeconomic characteristics of humanitarian entrant SHS clients

The ability to sustain adequate housing can be impacted by various socioeconomic factors including, but not limited to employment, education and income.

Among humanitarian entrant SHS clients when first receiving SHS:

- A high proportion were either not in the labour force (34%) or unemployed (42%) (Table 8a).
- Females were more likely to not be in the labour force (39% of females compared with 27% of males). Males were more likely to be unemployed (36% of females compared with 51% of males)
- Government income support was the most common main source of income (70%) (Table 8b) with the most common payment type being different for males and females - JobSeeker (formerly NewStart -44% of males) and parenting support (30% of females).
- More than 1 in 4 (27%) were currently students of any kind compared with almost 1 in 6 (16%) other permanent migrants (Table 8c).

Table 8a: Labour force status for clients when first receiving SHS services, by cohort (clients 15 years and older)

Labour force status	Proportion of humanitarian entrant SHS clients (%)	Proportion of other permanent migrant SHS clients (%)
Not stated	13.9	22.8

Employed	7.8	18.6
Not in labour force	34.1	26.4
Unemployed	41.9	30.1

Source: Refugee health linked data set

Table 8b: Main source of income for clients when first receiving SHS services, by cohort (clients 15 years and older)

Main source of income	Proportion of humanitarian entrant SHS clients (%)	Proportion of other permanent migrant SHS clients (%)
Newstart allowance	25.4	13.6
Parenting payment	16.8	10.8
Youth allowance	8.9	3.2
Other government benefit	9.2	8.0
Nil income	7.7	20.4
Employee income	4.5	15.7
Not stated	13.0	25.7

Source: Refugee health linked data set

Table 8c: Student status for clients when first receiving SHS services, by cohort

Student status	Proportion of humanitarian entrant SHS clients (%)	Proportion of other permanent migrant SHS clients (%)
Yes, preschool, primary or high school.	15.1	9.1
Yes, university student	2.8	2.1
Yes, vocational education and training	5.1	3.1
Yes, other, or not stated	3.8	2.1
No	55.6	58.6
Not stated	17.6	25.0

Source: Refugee health linked data set

Note: Definitions of the responses in the above tables and how these responses are collected can be explored via the SHS data definitions on the AIHW website.

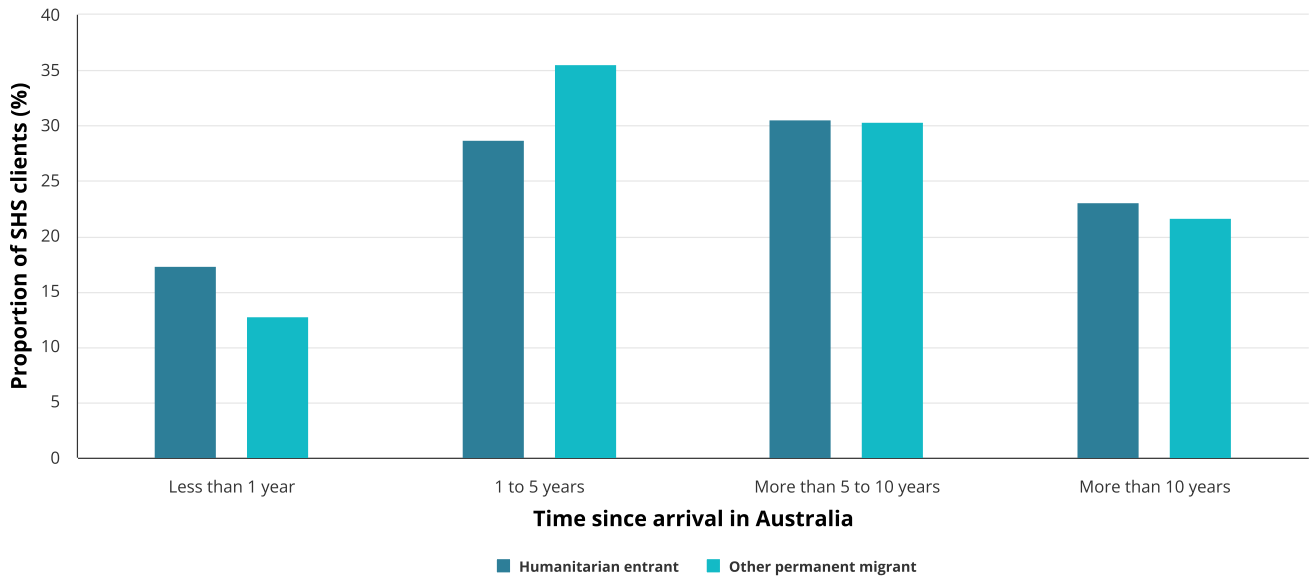
Further data on the socioeconomic characteristics of humanitarian entrants and other permanent migrants when they first access SHS can be explored in the Data tables.

Time since arrival when first accessing SHS

A higher proportion of humanitarian entrant SHS clients first accessed SHS within 1 year of arrival in Australia (17%) than other permanent migrant SHS clients (13%) (Figure 13).

Figure 13: Proportion of SHS clients by time since arrival when first accessing specialist homelessness services, by cohort, 2011–12 to 2020–22

Column chart of proportion of SHS clients by how long since they arrived in Australia when they first accessed specialist homelessness support. Humanitarian entrant and other permanent migrant where least likely to access report within 1 year of arrival in Australia.



Source: Refugee health linked data set

Notes:

1. Time since arrival in Australia is calculated from the time between the arrival date recorded in the Settlement Database and the episode start date of the first SHS support for that client
2. The denominator is the total number of unique SHS clients who accessed support at any point between 2011–12 and 2020–21.

Referral source

No formal referral source was recorded for 31% of humanitarian entrant clients when first accessing SHS support. Of the humanitarian entrant SHS clients who did have a formal referral recorded:

- The top three referral sources were other agencies (18%), specialist homelessness agency/outreach worker (17%) and family or friends (13%)
- Immigration department or refugee support services were identified as the fourth most common referral source for 8.4% of humanitarian entrants.

For other permanent migrants, the most common referral source was the police (21%). In comparison, the police was a referral source for 6.7% of humanitarian entrants.

For detailed breakdown of referral sources see Data tables.

Clients with a mental health issue

Of humanitarian entrant clients who accessed SHS between 2011–12 and 2021–22:

- 1 in 4 (25%) were identified as ever having a mental health issue, compared with almost 1 in 3 (30%) other permanent migrant SHS clients- lower than all SHS clients (31%) (AIHW 2024).
- Females (27%) were more likely than males (21%) to be identified as having a mental health issue.

See Box 1 for how mental health issues were identified in the SHSC.

People with mental health issues are especially vulnerable to experiencing homelessness (Nilsson et al 2019). Mental health issues that increase psychological distress and impair decision-making in everyday life can contribute to employment issues, social support breakdown, and financial hardship (Johnstone et al. 2016, Kaleveld et al. 2018). These issues can lead to challenges with securing or maintaining housing (Brackertz et al. 2018). Also, people from culturally and linguistically diverse backgrounds experiencing mental health conditions may face additional challenges and vulnerabilities in accessing health services owing to shame, stigma and misunderstanding (Khatri and Assefa 2022) which may increase the risk of challenges with securing or maintaining housing.

Box 1: Identifying clients with a mental health issue in the Specialist Homelessness Services Collection (SHSC)

A client is identified as having a mental health issue if they were 10 years or older and in at least one support period within the reporting period:

a. They reported 'mental health issues' as a reason for seeking assistance or the main reason for seeking assistance.
b. At some stage during their support period, was assessed as having a need for psychological services, psychiatric services or mental health services.
c. They were formally referred to the agency by a mental health service.
d. They indicated at the beginning of a support period that they were receiving services or assistance for their mental health issues or had in the last 12 months.
e. They had been in a psychiatric hospital or unit in the last 12 months.
f. They had a dwelling type of psychiatric hospital or unit.

References

Brackertz N, Wilkinson A and Davison J (2018) *Housing, homelessness and mental health: towards systems change* - external site opens in new window, report to the Australian Government National Mental Health Commission, Australian Housing and Urban Research Institute Limited, accessed 05 June 2024.

Johnstone M, Parsell C, Jetten J, Dingle G and Walter Z (2016) *Breaking the cycle of homelessness: Housing stability and social support as predictors of long-term well-being* - external site opens in new window Housing Studies, 31(4):410-426, doi: 10.1080/02673037.2015.1092504.

Kaleveld L, Seivwright A, Box E, Callis Z and Flatau P (2018) *Homelessness in Western Australia: A review of the research and statistical evidence* - external site opens in new window, Government of Western Australia, Department of Communities.

Khatri RB and Assefa Y (2022) Access to health services among culturally and linguistically diverse populations in the Australian universal health care system: issues and challenges - external site opens in new window, *BMC Public Health,* 22:880, doi:10.1186/s12889-022-13256-z.

Nilsson SF, Nordentoft M and Hjorthøj C (2019*) Individual-Level Predictors for Becoming Homeless and Exiting Homelessness: a Systematic Review and Meta-analysis* - external site opens in new window *Journal of Urban Health,* 96(5):741-750, doi: 10.1007/s11524-019-00377-x.

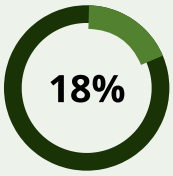
Australian Institute of Health and Welfare (2024) *Specialist homelessness services annual report 2022–23,* AIHW, Australian Government, accessed 13 May 2024.

Use of homelessness services

On this page:

Between 1 July 2011 and 30 June 2021

Short term accommodation was provided or referred in 74% of the support periods for humanitarian entrants where it was identified as a need.



For more than 18% of support periods, domestic violence was identified as the main reason for accessing support.

1 in 3 humanitarian entrant SHS clients

were homeless when they first received specialist homelessness services

Service needs identified and whether provided or referred

Specialist Homelessness Service (SHS) provide a range of services to clients including the direct provision of accommodation, such as a bed in a shelter, to more specialised services such as counselling and legal support. These services are generally either provided to the client directly by the agency or the client is referred to another service. The need for particular services and whether they are provided or referred are collected as part of the SHS collection. The data presented below is based on individual support periods between 1 July 2011 to 30 June 2022. The approach used in this report differs from most other reports using SHS data, therefore comparisons with other reports are not valid.

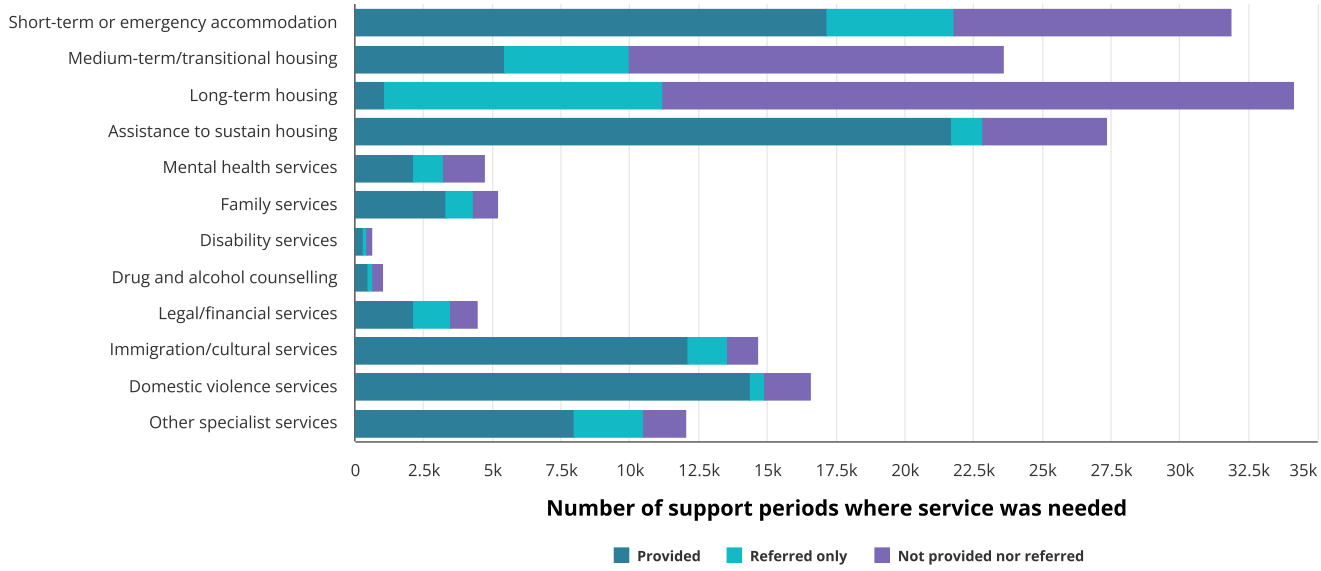
General services were identified as a need at presentation for 87% of support periods provided to humanitarian entrants. General services include advice and information, material aid, meals and living skills. Where general services were identified as needed in humanitarian entrants they were provided in 98% of support periods, referred only in 1% of support periods, and neither provided or referred in 1.4% of support periods.

The need for more specialised services in humanitarian entrant SHS clients varied by service type (Figure 14).

- Accommodation services were commonly identified as a need including short-term or emergency accommodation in 31% of support periods, medium-term or transitional housing in 23% of support periods, and long-term housing in 33% of support periods.
- In 14% of support periods, immigration and cultural services were needed, of which these services were provided or referred on 93% of occasions. These include interpreter services, assistance with immigration services, culturally specific services, and assistance to connect culturally.
- In 16% of support periods, domestic violence services were needed, of which these services were provided or referred on 90% of occasions.

Figure 14: SHS support periods provided to humanitarian entrants by need for services and whether provided, referred only or neither provided nor referred, 2011–12 to 2021–22

Stacked bar chart showing the number of support periods where service was needed by service group. Within the bars the percent of the services needed that where provided, referred only or neither provided nor referred is shown. Long-term housing was the most needed support but only provided in 3.2% of support periods.



Source: Refugee health linked data set

Notes:

1. Services can be both provided and referred.
2. The total length of the bar is the total number of support period where the services was recorded as needed.
3. Totals percentage may not equal 100% due to rounding.

For further detail of the service and assistance types included in the service groups shown in Figure 14, see the Data table CLIENTS.24 in the Specialist homelessness services annual report 2022–23 data tables and the SHS data definitions on the AIHW website.

Reasons for accessing specialist homelessness services

SHS clients can identify a number of reasons for seeking assistance, reflecting the range of situations that contribute to housing instability. SHS agencies also record all reasons and a single main reason for clients seeking assistance for each support period (Table 9). Data presented here relate to every support period for humanitarian entrant and other permanent migrant SHS clients which differs from other reports, therefore, comparisons with other published data are not valid.

Accommodation issues (including housing crisis, inadequate or inappropriate dwelling conditions or that previous accommodation had ended) was the most common main reason group for seeking assistance among humanitarian entrants.

Family and domestic violence was the main reason 17.8% of the time, the highest for any specific reason. More than 1 in 7 support periods had lack of family and/or community support identified as a contributing reason for requiring SHS support.

Table 9: Reasons for humanitarian entrants accessing SHS support by proportion of total support periods, 2011–12 to 2021–22

Reason group	Proportion of support periods identified as main reason	Proportion of support periods identified as any reason
Accommodation	40	67
Financial	22	69
Health	1.6	14
Interpersonal relationships	24	45
Not stated	3.1	3.2
Other	10	32

Source: Refugee health linked data set

Reasons are presented at higher level groupings. For more detailed breakdown of the reasons for humanitarian entrants accessing specialist homelessness services and for the reasons in other permanent migrants see Data tables.

Reasons for ending support

More than half of support periods provided to humanitarian entrants (53%) ended because the clients' immediate needs were met or case management goals were achieved.

Additionally, almost 1 in 8 support periods (12%) ended because the client no longer requested assistance; that is, a client may have decided that they no longer required assistance or they may have moved from the state/territory or region.

Housing situation

Three aspects of a client's housing situation are considered in their housing circumstances: dwelling type, housing tenure and the conditions of occupancy. See Technical notes for details on how each of the categories of housing situation are derived. These data are presented at the client level.

1 in 3 humanitarian entrant SHS clients (33%) were homeless when they first received specialist homelessness services. Of those who were homeless, half were living in a house, townhouse or flat as a couch surfer or with no tenure. Of those that were at risk of homelessness, 82% were living in private or other housing as a renter, rent free or owner.

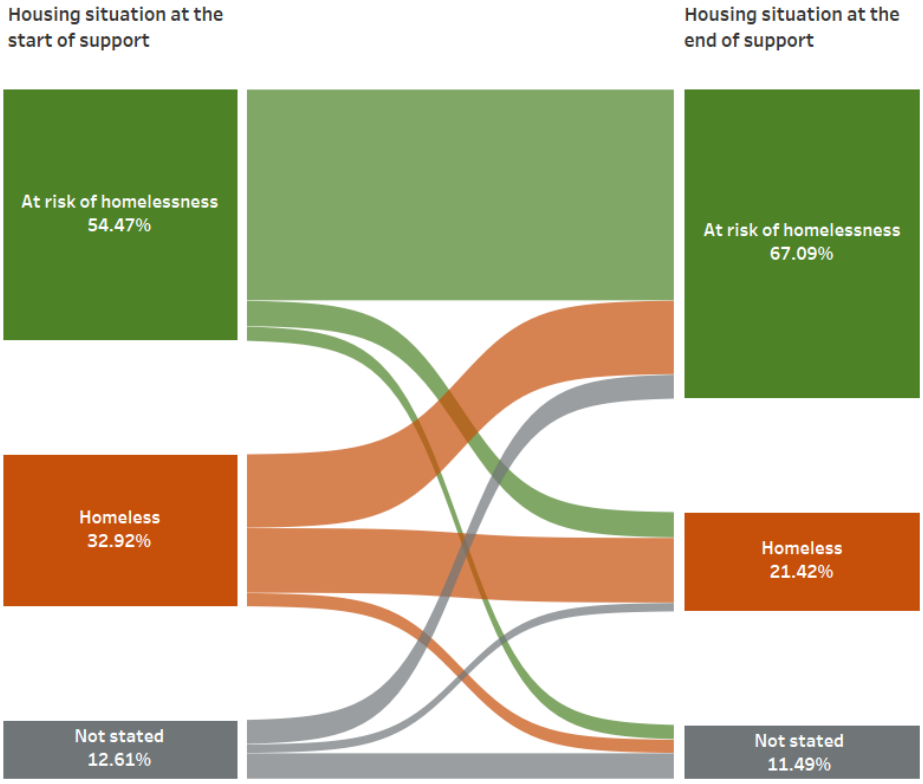
For further detail on the housing situation of humanitarian entrants when they first receive support, and comparisons to other permanent migrants, refer to the Data tables.

Homelessness status at the beginning and end of support

Outcomes presented here describe the change in clients' housing situation between the start and end of support (figure 15). There is an improvement in the proportion of humanitarian entrant clients who are homeless from 33% of clients at the beginning of support to 21% of clients at the end of support. Data are limited to clients who ceased receiving support during the reporting period, meaning that their support periods had closed and they did not have ongoing support at the end of the year 2021–22 financial year. By the end of 2021–22 financial year, 24,500 (97%) of humanitarian clients were no longer accessing SHS support.

Figure 15: Homelessness status at beginning and at end of support for humanitarian entrant SHS clients with closed support, 2011–12 to 2021–22

Diagram showing the proportion of humanitarian entrants who were homeless at the start and end SHS support, and the number which moved between classifications form the start to the end of support.



Source: Refugee health linked data set
https://www.aihw.gov.au/

Notes:

1. Occupancy, tenure and dwelling type information are combined to determine housing situation, which is then further aggregated to homelessness status.
2. All clients are classified as either homeless or at risk of homelessness depending on the housing situation recorded at the start and end of support.
3. Client are classified as homeless if they are living in no shelter or improvised dwelling, short-term temporary accommodation or couch surfing or with no tenure in a house, townhouse or flat.
4. Clients are classified as at risk of homelessness if they are living in public or community housing (renter or rent free), private or other housing (renter, rent-free or owner) or institutional settings.

What's next?

This project has demonstrated linking the Settlements Database to administrative datasets can provide valuable new insights into the experiences of humanitarian entrants, but there is more work that can be done.

The hospitalisations for injury show humanitarian entrants are being admitted for injuries cause by assault at higher rates than other permanent migrants. The Specialist Homelessness Services data indicates experiences of domestic violence may be a significant issue in this community and future work could include more detailed exploration of humanitarian entrants' experiences with violence.

These analyses will assist service providers in understanding ways in which their services to humanitarian entrants can be adapted to better address the needs of this vulnerable group including working with a broader network of providers such as the police, ambulance services, primary health care settings and medium-to-long-term accommodation service providers.

Australian Government
Australian Institute of
Health and Welfare

Technical notes

Technical notes

Data for permanent migrants who arrived in Australia on a permanent visa since 1 January 2000 to December 2022 was obtained from the Department of Home Affairs' Settlement Database. The Settlement Database provides statistical data on permanent arrivals to Australia. It brings together data from various sources to assist government and community agencies involved in the planning and provision of services to migrants.

The data set used for these analyses was created by the AIHW Data Linkage Unit by linking Settlement Database cohort information to health and welfare data sets held by the AIHW. The final linked data asset contains the following data:

- Settlement Database (SDB) January 2000 to December 2022
- Medicare Consumer Directory (MCD) January 2000 to December 2022
- Pharmaceutical Benefits Scheme (PBS) July 2002 to March 2023
- Medicare Benefits Schedule (MBS) January 2000 to March 2023
- National Death Index (NDI) January 2000 to December 2022
- National Hospital Morbidity Database (NHMD) July 2010 to June 2021
- National Non-Admitted Patient Emergency Department Care Database (NNAPEDCD) July 2010 to June 2021
- Specialist Homelessness Services Collection (SHSC) July 2011 to June 2021*
- Client files (July 2011–June 2021)
- Content data (July 2011–June 2022)

**Any new clients presenting after 30 June 2021 were not included in the linkage map used for this project and consequently, these clients will not be included in the client and support period content data files. If clients who first present before 30 June 2021 have support periods in June 2021– June 2022 these will be present in the data.*

See sections below for further details of the sources of data used to create the linked data asset that were analysed for this report.

Data suppression

The data presented in this report adheres to strict rules of suppression to ensure the confidentiality of people presented in the data. The dataset rules of each database included in the linked data asset have been strictly adhered to, ensuring the confidentiality and privacy rules of all data providers are upheld.

Technical notes

Linkage process

Cohort data from SDB was first linked to the MCD deterministically. Where cohort records agreed with MCD records exactly on first and last names as well as sex and birthdate, and where each set of values for these fields yielded a single one-to-one match, then these matches were accepted.

Probabilistic linkage was then undertaken on the remaining cohort records to identify probability matches based on similarities in characteristics such as surname, given name(s) and day, month, and year of birth. Sample-based clerical review and post-linkage refinement were also undertaken to further ensure linkage quality. Of the accepted links, 95.5% were a result of unique deterministic links and the remaining resulting from probabilistic linkage.

Linkage results

The final number of accepted links between the cohort and MCD was 3,591,246, an overall linkage rate of 86.6%. Further investigation of unlinked records showed that most unlinked records were records from people on temporary visas on which the visa holder is not immediately eligible for Medicare (see visa information below). These individuals are not in scope of these analyses until they become Medicare eligible. Excluding these records, the linkage rate of in scope records was 97.8%.

There was no notable variation in linkage rates by age or sex.

Technical notes

The SDB contains migrants who entered Australia in or after 2000 on a permanent visa or a visa which is a pathway to a permanent visa.

Each record in the SDB has an associated visa subclass which identifies the specific visa granted. Visa subclasses were assigned to visa streams to identify whether the record was a permanent humanitarian entrant or another permanent migrant (skilled, family and other). See Table 1.1 for the visa subclass groupings for permanent humanitarian entrants and other permanent migrants used in these analyses.

Table 1.1: Visa Subclass Groupings

Visa Stream	Visa Subclasses
Humanitarian	200, 201, 202, 203, 204, 205, 208, 209, 210, 211, 212, 213, 215, 216, 217, 815, 817, 851
Family	100, 101, 102, 103, 104, 110, 114, 115, 116, 117, 118, 143, 173, 300, 209, 310, 445, 801, 802, 804, 806, 808, 812, 814, 820, 826, 831, 835, 836, 837, 838, 859, 864, 884
Skilled	105, 106, 119, 120, 121, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 134, 135, 136, 137, 138, 139, 160, 161, 162, 163, 164, 165, 175, 176, 186, 187, 188, 189, 190, 475, 476, 485, 487, 489, 491, 494, 495, 496, 805, 816, 818, 840, 841, 842, 843, 844, 845, 846, 855, 856, 857, 858, 861, 862, 863, 880, 881, 882, 885, 886, 887, 888, 890, 891, 892, 893
Other	850, 866

The humanitarian entrant cohort for these analyses includes only those granted offshore humanitarian visas and excludes those were granted protection visas onshore.

The SDB is limited to permanent migrants who arrived on or after the year 2000, therefore the migration cohorts do not include any permanent migrants who arrived before 2000. This should be considered when interpreting the outcomes presented in this report.

There are several temporary visas that are included in the SDB. These are temporary visas with a clear pathway to permanent visas, for example people who arrive on a temporary partner visa while waiting for the permanent partner visa to be assessed. Medicare eligibility on these temporary visas varies depending on the visa subclass: some are Medicare eligible on the temporary visa, some are eligible if they have applied for a permanent visa, and some are not eligible until they are granted a permanent visa. These visa holders are only included in the cohort if they link to a record on the MCD.

Identifying presence in the reporting period

The reporting period for hospitalisation and emergency department presentation outcomes in these analyses is the 2016–17 to 2020–21 financial years. For homelessness data the reporting period is 2011–12 to 2021–22 financial years.

Whether a person was within the cohort in the reporting period was identified using the persons date of birth from the MCD, arrival year from the SDB and date of death from the NDI. Only month and year were provided for the date of birth, the day of the month was set to the first.

There is no information in the data to identify people who leave the country, and this may lead to an underestimation in rates due to people being included in the denominator despite not being in the country to access services.

For the hospitalisation and emergency department analyses, any events that occur prior to the person's arrival date have been excluded from the numerator as these people will not be included in the denominator until the arrival date. The arrival date recorded in the SDB was the most recent date of arrival in Australia after the visa being granted for offshore visas and prior to the visa being granted for onshore visas. Therefore, exclusion of pre-arrival date events will only affect those who were previously in Australia on a temporary visa and exited the country before arriving on a permanent visa or a visa that lead to a permanent visa.

The SHS analyses includes all support periods recorded in the SHS in the reporting period.

Identifying state of residence

The state of residence used in these analyses was derived from the state recorded on the MCD on the 31st of December of the financial year. If the state was missing in a given financial year the most recently recorded state was used.

Country of birth

The country of birth was as recorded on the SDB. This variable is not standardised to the Standard Australian Classification of Countries. Where a previously used name was recorded it was replaced with the most current name for the country (e.g. Burma to Myanmar, Zaire to the Democratic republic of Congo). Migrants with a birthplace listed as Sudan in the SDB may include migrants whose birth place is in the area that is now the country of South Sudan which gained independence in 2011. Therefore a birth place of Sudan may include South Sudanese migrants.

Technical notes

Comparisons to other permanent migrants throughout this report are based on analyses of the same linked data asset as for humanitarian entrants. This enables direct comparisons as the same data sources and methods are used. Additionally, other permanent migrants are a valuable comparator group for humanitarian entrants as this group has a broadly similar age structure and similar lack of familiarity with the Australian health care system due to migrating from other countries. However, there are differences between these groups which may impact health service use including differences in the support provided from the government to access health services, particularly within the first five years of arrival.

Where possible, to provide context, comparisons are made to published data relating to the general Australian population. Comparisons are limited to where the context in the Australian population may provide additional understanding of the outcomes for humanitarian entrants. These comparisons should be cautiously interpreted as differences in methodology and data sources may contribute to differences in outcomes.

Direct comparisons based on specific measures (e.g. a rate being X times higher than the Australian population) should be interpreted with caution as the older age structure of the general Australian population will impact the absolute numbers.

Technical notes

Data Specifications

The hospital data supplied for the linked dataset used in this project was derived from the National Hospital Morbidity Database (NHMD). Data are reported for the last 5 financial years from the most recent year of data available for hospitalisations outcomes, 2016–17 to 2020–21. Small changes may have occurred since the time that data were extracted for linkage.

The emergency department data supplied for the linked dataset used in this project was derived from the National Non-admitted Patient Emergency Department Care Database (NNAPEDCD). Data are reported for the last 5 financial years from the most recent year of data available for hospitalisations outcomes, 2016–17 to 2020–21.

The hospitalisation and emergency department data does not include data from Western Australia (WA) or Northern Territory (NT). The analysis was restricted to people who lived in all states/territories except NT and WA and attended hospital in the states/territories for which data are available.

National Hospital Morbidity Database (NHMD)

The NHMD is a compilation of episode-level records from admitted patient morbidity data collection systems in Australian public and private hospitals.

The counting unit in the NHMD is a separation, referred to as a hospitalisation in this report. Separation is the term used to refer to the episode of admitted patient care, which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation).

Although hospital separations data are a valuable source of information about admitted patient care, they have limitations as indicators of ill health. Sick people who are not admitted to hospital are not counted and those who have more than 1 separation in a reference year are counted on each occasion. Therefore, these data count episodes of care, not patients.

The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments. However, patients in these settings may be admitted subsequently, with the care provided to them as admitted patients being included in the NHMD.

National Non-admitted Patient Emergency Department Care Database (NNAPEDCD)

The NNAPEDCD provides information on the care provided (including waiting times for care) for non-admitted patients registered for care in public hospital emergency departments that have:

- a purposely designed and equipped area with designated assessment, treatment, and resuscitation areas.
- the ability to provide resuscitation, stabilisation, and initial management of all emergencies.
- the availability of medical staff in the hospital 24 hours a day.
- designated emergency department nursing staff 24 hours per day 7 days per week, and a designated emergency department nursing unit manager.

Emergency departments (including ‘accident and emergency’ or ‘urgent care centres’) that do not meet the criteria above are not in scope for the NNAPEDCD, but data may have been provided for some of these by some states and territories.

Diagnosis information in Hospitals and Emergency department data

Diagnosis data for hospital separations is presented using the 11th edition of the International statistical classification of diseases and related health problems, 10th revision, Australian modification (ICD-10-AM). Mapping was undertaken to update the recorded principal diagnosis from the 9th edition used for 2016–17 data and the 10th edition used for 2017–18 and 2018–19 data to ensure all data presented aligns with the ICD-10-AM 11th edition coding.

Diagnosis information for emergency department presentations were reported using the Emergency Department ICD-10-AM principal diagnosis shortlist. The 10th edition was used for data in 2018–19 and the 11th edition for data in 2019–20 and 2021–22. 2018–19. Diagnosis information prior to this used different classifications and is not presented in this report.

In tables and figures presenting information on diagnoses and external causes, the codes and abbreviated descriptions of the ICD-10-AM classification or ED shortlist are used. Edits have been made to the descriptions where necessary for length and clarity. Full descriptions of the categories and included diagnosis are available in ICD-10-AM and ED ICD-10-AM version 11 shortlist publications on the Independent Health and Aged Care Pricing Authority website - IHACPA - external site opens in new window.

Analysis methods

For all analysis of hospitalisations data records were excluded where the care type was *newborn with unqualified days only* (7.3), *organ procurement - posthumous* (9), or *hospital boarder* (10).

Hospitalisation analysis denominators

The denominators for migrant groups were derived from the linkage of the SDB to the MCD. The SDB was linked to the MCD to identify the humanitarian entrants and other permanent migrants recorded on the MCD in the study period (see section Identifying presence in the reporting period). From this, the number of people in the study cohort within a financial year can be derived and person time then calculated for the denominator. If a person is in the cohort for the full financial year they contribute 1 to the denominator. The contribution to the denominator for people in the cohort for less than the full financial year is calculated from the month they entered or left the cohort. For example, a person who arrived in December of the financial year is only present for 7 of the 12 months in that financial year so their contribution to the denominator is 0.58 (7/12). Similarly, if a person dies in August, two months into the financial year, they will only contribute 0.17 (2/12) to the denominator. The sum of all person time within the financial year is the hospital analysis denominator for that financial year.

Age groups for the hospital analysis denominator are calculated using the age at 31 December of the financial year.

Emergency department presentations

Time of presentation analysis

The time and weekday of presentation is based on the day of week and presentation time variables recorded in the NAPCEDCD. Presentation time is the time of first recorded contact with an emergency department staff member, which may be at the start of clerical registration or of the triage process.

Arrival mode analysis

The arrival model is the mode of transport by which the person arrives at the emergency department as recorded in the NNAPEDCD. The other category includes people arriving by private transport, public transport and by walking.

Lower urgency care

In this data release, National Healthcare Agreement (NHA) indicator, Rate of GP style emergency department presentations, is referred to as ED presentations for lower urgency care. It is based on the NHA specifications 'PI 19: Selected potentially avoidable GP-type presentations to emergency departments'. - external site opens in new window

ED presentations for lower urgency care are defined as presentations to public hospital emergency departments with a Type of visit of Emergency presentation where the patient:

- was allocated a Triage category of 4 (Semi-urgent: within 60 minutes) or 5 (Non-urgent: within 120 minutes) and
- did not arrive by ambulance, or police or correctional vehicle and
- was not admitted to the hospital, not referred to another hospital, or did not die.

Presentations without a mode of arrival or episode end status excluded in this ED presentations for lower urgency care measure.

Injury analysis

Hospitalisations for injury

This report counts and describes injury incidents that result in a hospital admission or an emergency department presentation. A person may have more than one incident of injury resulting in hospitalisation in a financial year and each case of hospitalisation will be counted separately in this report; this is because we are counting incidents of injury resulting in hospitalisation, rather than the number of people who were hospitalised, in a given financial year.

Each record in the NHMD refers to a single episode of care in a hospital. Some injury incidents result in more than one episode of care and, hence, more than one record.

This can occur in 2 main ways:

- a person is admitted to one hospital, then transferred to another or has a change in care type (for example, from acute to rehabilitation) within the same hospital
- a person has an episode of care in hospital, is discharged home (or to another place of residence) and is later admitted for further treatment for the same injury, to the same hospital or another.

The NHMD does not allow for the identification of multiple episodes of care belonging to the same instance of injury. This means there is the potential for overcounting injury events if we are simply counting the number of injury episodes of care. To minimise this, the mode of admission is taken into account. Episodes of care with a mode of admission of transferred from another hospital (1) are excluded from injury case counts. This is because transfers are likely to have been preceded by an episode of care that already met the case selection criteria. Similarly, episodes of care where the mode of admission is statistical admission – episode type change (2) and the care type is not listed as acute (1, 7.1, 7.2), are also excluded as they are likely to have been preceded by an acute episode of care that already met the case selection criteria. Additional, records where *Care involving use of rehabilitation procedures (Z50)* has been coded in any additional diagnosis field, are excluded from this analysis to prevent counting of hospitalisations for rehabilitation.

This process largely corrects for overestimation of cases due to transfers (both internal and external) but does not correct for overestimation due to re-admissions.

The external cause classification (Chapter 20 of ICD-10-AM) consists of 3-character category codes in the range of U50–Y98 (including place of occurrence and activity when injured). The NHMD is structured so that the first listed external cause for a record relates to the first listed injury diagnosis. The first reported external cause is taken to be the nominal external cause for this analysis. The categorisation of external causes using ICD-10-AM codes are detailed in Appendix tables to Technical notes for Injury in Australia.

This analysis includes counts of injury in the category *Complications of surgical and medical care (T80 – T88).* This is excluded from standard AIHW injury reporting.

Emergency department presentations for injury

All emergency department presentations with a primary diagnosis ICD-10-AM codes in the range S00–T88 using 'Chapter 19 Injury, poisoning and certain other consequences of external causes', are included in this analysis.

Due to differences in state/territory data collection, no nationally comparable external cause data are available for NNAPEDCD records.

Potentially preventable hospitalisations

Hospital separations for selected conditions are considered to be 'potentially preventable hospitalisations' as they are amenable in some circumstances to primary and community care interventions. These conditions reflect the National Healthcare Agreement: Performance Indicator 18-Selected potentially preventable hospitalisations, 2022 - external site opens in new window and are categorised as being:

- acute (conditions that usually come on suddenly, and may not be preventable, but may not result in hospitalisation if timely and adequate care had been received in the community)
- vaccine-preventable (hospitalisations due to conditions that can be prevented by vaccination)
- chronic (conditions that are persistent and long-lasting but may be preventable through lifestyle change, and can also be managed in the community to prevent worsening of symptoms or hospitalisation).

Primary and community health care – including care from a general practitioner or community health nurse – can effectively manage and treat these health conditions (for example, by administering vaccines or prescribing lifestyle changes). Primary and community health care can be an opportunity for early intervention, which can help to reduce the risk of a person developing a disease, their symptoms worsening, or complications developing, to the point that they need hospitalisation.

Potentially preventable hospitalisations (PPH) can tell us about the effectiveness of health care in the community, as higher rates may suggest a lack of timely, accessible, and adequate primary care.

However, there are many other reasons why an area or group of people may have higher rates of PPH. These may include:

- higher rates of disease
- lifestyle factors and other risks
- a genuine need for hospital services.

Some PPH may not be avoidable, such as those for patients with complex illness, or patients having procedures as follow-up to primary care.

This means that it is important not to assume that higher rates of PPH always indicate a less effective primary care system. Rather, PPH are a useful tool for identifying and investigating variation between different groups of people to better understand health inequalities. PPH can help guide research about how different groups use and respond to health services, including barriers they may face and areas of unmet demand.

For more information on how PPH are defined and what conditions are included see the What are potentially preventable hospitalisations? Section of the AIHW's Potentially preventable hospitalisations in Australia by small geographic areas, 2020–21 to 2021–22 web report.

Hospitalisations for birth

Method of birth was derived from the primary diagnosis of the hospitalisations as classified in the ICD-10-AM (Table 2). Codes from O80–O84 are assigned when delivery is completed within the episode of care (for classification purposes delivery is not complete until after expulsion of the placenta, excluding any retained portion(s), expelled or requiring removal post delivery).

Table 2: ICD-10-AM codes for method of birth analysis

Method of birth in this report	ICD-10-AM codes
Non-instrumental vaginal birth	*O80 Single spontaneous delivery* *O84.0 Multiple delivery, all spontaneous*
Vaginal birth assisted by vacuum or forceps	*O81 Single delivery by forceps and vacuum extractor* *O84.1 Multiple delivery, all by forceps and vacuum extractor*
Caesarean section birth	*O82 Single delivery by caesarean section* *O84.2 Multiple delivery, all caesarean*
Other forms of assistance or combination of delivery methods for multiple births	*O83 Other assisted single delivery* *O84.8Multiple delivery, combination of methods* *O84.9 Multiple delivery, unspecified*

Source: International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) - external site opens in new window

This classification differs from other AIHW reports which source data from the National Perinatal Data collection (NPDC). Births in this report only include those that occur in hospitals which are in scope for the NHMD. This will not include births that occur in birth centres, in the community or free births.

These analyses do not include information on the outcome of birth.

Technical notes

Hospitalisations for COVID-19 were identified by hospitalisations with the ICD-10-AM diagnosis code U07.1, *Emergency use of U07.1 [COVID-19, virus identified],* or U07.2, *Emergency use of U07.2 [COVID-19, virus not identified]* listed as a diagnosis code for the separation.

Deaths due to COVID-19 were identified by the ICD-10-AM code of U07.1, U07.2, or U10.9 as the underlying cause of death.

Standardised mortality ratio

Standardised mortality ratio (SMR) is a widely recognised measure used to account for differences in age structures when comparing death rates between populations. This method of standardisation can be used when analysing relatively rare events (i.e. where number of deaths is less than 25 for the analysed time period). The SMR has been used in the analysis of deaths due to COVID-19. It is used to control for the fact that the migrant populations have a younger age profile than the Australian population, and rates of COVID-19 deaths vary by age in both the study populations and the Australian population. The SMRs control for these differences, enabling comparisons of counts of COVID-19 deaths between the migrant groups and Australia without the confounding effect of differences in age. The SMR is calculated as the observed number of events (deaths due to COVID-19) in the study population divided by the number of events that would be expected if the study population had the same age and sex specific rates as the as the comparison population.

In the analysis of deaths due to COVID-19, 95% confidence intervals (CIs) are provided for each SMR to indicate the level of uncertainty around these estimates. Estimates produced using low numbers can be sensitive to small changes and will therefore have wide CIs. 95% CIs are provided within this report as they may account for the variation in absolute numbers of deaths due to COVID-19 (related to the small sample size). It is important to note that there are other sources of uncertainty, such as linkage error, that are not captured by the provided CIs.

Use of CIs is the simplest way to test for significant differences between migrant groups and Australian comparison groups. For the purpose of this report, differences are deemed to be statistically significant if CIs do not overlap with 1.0 in the case of an SMR.

Technical notes

The Specialist Homelessness Servies (SHS) data supplied for the linked dataset used in this project was derived from the Specialist Homelessness Service Collection (SHSC). Data are reported for the period 1 July 2011 to 30 June 2022. The extraction of data from the SHSC used existing linkage maps that included clients up until 30 June 2021. Due to this, data for the 2021–22 financial year only includes existing clients and will not include data for clients who first access SHS in this financial year. Small changes may have occurred since the time that data were extracted for linkage.

Data Specifications

For definitions of terms relating to SHSC data used in this report see the AIHW homelessness topic page glossary.

The SHSC includes data for clients who receive services from specialist homelessness service agencies funded under the National Housing and Homelessness Agreement (NHHA). Nationally 1,698 agencies delivered specialist homelessness services to almost 278,300 clients during 2020–21, in all states and territories (AIHW 2022).

A specialist homelessness service is an organisation that receives government funding to deliver accommodation related and/or personal services to people who are homeless or at risk of homelessness. Under the NHHA, these agencies are required to participate in the SHSC.

Other organisations not directly funded by governments also provide a wide range of support services to people in need; these organisations are not required to provide data to the SHSC. Also, NHHA funded agencies may provide support beyond the NHHA directly funded support packages; this support is also excluded from the SHSC.

The SHSC is a service-based collection, not a demand-based collection. Due to this, any changes should be interpreted as changes to the number of clients serviced by the specialist homelessness agencies, and not be interpreted as changes in the demand for service.

The SHSC is a support period based collection and client level information is derived from information collected at the support period level. A support period is the period of time a client receives services from a SHS agency. A support period starts on the day the client first receives a service and ends when:

- the relationship between the client and the agency ends, or
- the client has reached their maximum amount of support the agency can offer, or
- a client has not received any services from the agency for a whole calendar month and there is no ongoing relationship.

The end of the support period is the day the client last received services from the agency.

Analysis methods

Homelessness services analysis denominators

The SDB records that linked to the MCD will be used to define the denominator for the migrant cohorts. This denominator will be used to derive the proportion of the humanitarian entrant and other permanent migrant population who used a homelessness service in the reported period. All other measures for the homelessness services analysis will be reported as the proportion of the total population (study cohort) who used a homelessness service in the reporting period.

Data for SHS at client level

The data presented in the section ‘Profile of humanitarian entrants accessing homelessness services’ is presented at the client level, derived from the information provided at the first support period for each client, except the data provided mental health issues ever identified which is derived from information provided across all support periods provided to the client.

Age at first presentation

The age of a SHSC client when they first received support was calculated at the 31st of December of the financial year in which their first support period began.

Children presenting alone

Children may be reported as presenting alone to a SHS agency for several reasons:

- It is possible that a child physically presented with an adult to an agency, but only the child required and received SHSC services. In this case, the child is reported as 'presenting alone' as the accompanying adult does not have an SHSC support period that can be linked to the child client.
- A child may have presented with an adult to a SHS agency and both received services, but the agency worker may not have properly linked the child to the accompanying parent/guardian when opening a support period for the child; hence the child is reported as presenting alone.
- Service was sought by and provided to the child only (without an accompanying adult) and therefore the child is the only client and is reported as presenting alone.

SHS service level data

Data presented on reasons for seeking assistance and need for services is presented at the support period level with all instances of support (support periods) counted separately in these analyses. A client who presents for the main reason of family and domestic violence on ten separate occasions will be counted in the data 10 times. Similarly, a client who is identified as needing assistance sustaining housing on 5 separate occasions will be counted in the needs analysis 5 times. Due to this the data presented reflects the service provision to the whole humanitarian entrant population as a whole and not the relative requirements and profiles of individual clients.

Homelessness status and housing situation derivations

Occupancy, tenure and dwelling type information are combined to determine housing situation, which is then further aggregated to homelessness status. Clients are considered to be homeless if they are living in any of the following housing situations:

- No shelter or improvised dwelling: includes where dwelling type is no dwelling/street/park/in the open, motor vehicle, improvised building/dwelling, caravan, cabin, boat or tent; or tenure type is renting or living rent-free in a caravan park.
- Short-term temporary accommodation: dwelling type is boarding/rooming house, emergency accommodation, hotel/motel/bed and breakfast; or tenure type is renting or living rent-free in boarding/rooming house, renting or living rent-free in emergency accommodation or transitional housing.
- House, townhouse or flat (couch surfing or with no tenure): tenure type is no tenure; or conditions of occupancy is couch surfing.

Clients are considered to be at risk of homelessness if they are living in any of the following housing situations:

- Public or community housing (renter or rent free): dwelling type is house/townhouse/flat and tenure type is renter or rent-free public housing, renter or rent-free-community housing.
- Private or other housing (renter, rent-free or owner): dwelling type is house/townhouse/flat and tenure type is renter-private housing, life tenure scheme, owner–shared equity or rent/buy scheme, owner-being purchased/with mortgage, owner-fully owned, rent-free-private/other housing.
- Institutional settings: dwelling type is hospital, psychiatric hospital, disability support, rehabilitation, boarding school, adult correctional facility, youth/juvenile justice detention centre or immigration detention centre.

References

Australian Institute of Health and Welfare (2022) *Specialist homelessness services annual report 2020–21*, AIHW, Australian Government, accessed 05 June 2024.

Technical notes

It is important to note the health and housing situation of any population is measured by many factors beyond those analysed in this report.

Although hospital separations data are a valuable source of information about admitted patient care, they have limitations as indicators of ill health. Sick people who are not admitted to hospital are not counted and those who have more than 1 separation in a reference year are counted on each occasion. Therefore, these data count episodes of care, not patients. Furthermore, these analyses exclude people who lived in WA or NT or had hospitalisations in WA or NT as the linkage infrastructure used to create the Refugee health Linked this data set does not currently include linkage to WA and NT hospitals data.

Data were not available to examine health and homelessness service usage at smaller geographic areas, which would have assisted in service planning. Similarly, data were not available to investigate health and homelessness service usage among priority subgroups within the humanitarian entrant populations, such as people with disability and/or people who identify as lesbian, gay, bisexual, trans/transgender, intersex, queer, and other sexuality (including asexual), gender, and bodily diverse (LGBTIQ+).

There is also a gap in data availability in relation to the use of supports to assist people to access these health and homelessness services. For example, there is no information available about the cultural appropriateness of services and the use of interpreter or translation services when accessing these services.

External causes of injury and activity undertaken when injured is only available for hospitalisations. Therefore, this more detailed information is only available for more severe injuries which require hospitalisations. Investigating more detailed information on injury causes in emergency department presentations would be valuable in providing insights into targeting injury prevention information and policies for this population.

Further analysis to understand the drivers of the high rates of potentially preventable hospitalisations for other vaccine preventable conditions in this population could also be insightful.

The data presented on the impact of COVID-19 in this population is limited to counts of hospitalisations and deaths. The indications from these data would be valuable to investigate further including analyses of immunisation and antiviral uptake for these populations by smaller areas of geography, to enable targeted public health initiatives.

These analyses indicate that in humanitarian entrants, assault was a leading cause of injury hospitalisations, women and one parent families presenting to SHS, and the need for domestic violence services. Given these findings, an investigation of child welfare data in this population could be a future area of investigation.

Australian Government
Australian Institute of Health and Welfare

Data

Data tables: Hospital, ED and COVID-19 outcomes

Data

Data tables S1.1 to S2.2: Hospitalisation, Emergency Department and COVID-19 outcomes
XLSX 399Kb

Data table: Homelessness outcomes

Data

Data tables S3.1 to S3.17: Homelessness outcomes
XLSX 211Kb

Data tables: Hospital and ED outcomes by state and territory

Data

Data tables S4.1 to S4.7: Hospital and ED outcomes by state and territory
XLSX 203Kb

Related material

Resources

Health of refugees and humanitarian entrants in Australia

Resource

The web report from stage 1 of this project.

Refugee and humanitarian entrant health

Resource

Information page for background on the project.

Related topics

- Culturally and linguistically diverse Australians
- Homelessness services
- Hospitals