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An issue of access: Delivering equitable health care for newly arrived refugee children in Australia

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Abstract: Newly arrived refugees and asylum seekers are faced with many difficulties in accessing effective health care when settling in Australia. Cultural, language and financial constraints, lack of awareness of available services, and lack of health provider understanding of the complex health concerns of refugees can all contribute to limiting access to health care. Understanding the complexities of a new health care system under these circumstances and finding a regular health provider may be difficult. In some cases there may be a fundamental distrust of government services. The different levels of health entitlements by visa category and (for some) detention on arrival in Australia may further complicate the provision and use of health services for providers and patients. Children are particularly at risk of suboptimal health care due to the impact of these factors combined with the effect of resettlement stresses on parents' ability to care for their children. Unaccompanied and separated children, and those in detention experience additional challenges in accessing care. This article aims to increase awareness among health professionals caring for refugee children of the challenges faced by this group in accessing and receiving effective health care in Australia. Particular consideration is given to the issues of equity, rights of asylum seekers, communication and cultural sensitivities in health care provision, and addressing barriers to health care. The aim of the paper is to alert practitioners to the complex issues surrounding the delivery of health care to refugee children and provide realistic recommendations to guide practice.

Key words: Asylum seekers; children; eligibility; health care access; human rights; refugees.

Refugees and those with refugee-like backgrounds are at risk of poor health before and after arrival in Australia.[1,2] Prior to arrival refugees may not have had access to appropriate health care and may have experienced exposure to many traumatic events, losses, separations or threats.[3] In situations of political and social instability where populations are exposed to human rights violations and organized violence, children and adolescents are at heightened risk of psychosocial deprivation and exposure to trauma[4] and therefore, require special attention when addressing health needs.[1,2]

Access to appropriate health assessment after arrival in a new country is often limited by cultural, language or financial constraints and the low priority given to health in the immediate resettlement period.[2,5] A lack of awareness of services available and poor understanding of the rights to health care and how to access a regular health provider also exist. This may be compounded by lack of awareness amongst health providers of refugee health issues.[6,7] In addition there may exist a fundamental distrust of government services following previous adverse experiences, such as imprisonment or torture.[1,2,8] Given these limitations, the need for sensitive service provision and advocacy for refugee children and their families is essential.

Complicating basic health provision for new arrivals in Australia is confusion surrounding health entitlements by visa category. In general, refugees arriving under the 'off-shore Humanitarian Program' are settled with the help of agencies and resources coordinated by the Integrated Humanitarian Settlement Strategy (IHSS) funded by the Department of Immigration and Multicultural & Indigenous Affairs (DIMIA). Information regarding health services, housing assistance and social support (through Centrelink) are provided.[9] However a number of categories of refugees and asylum seekers have been created, some of which have limited access to service entitlements (Table 1). Only 'off-shore Humanitarian Entrants' are entitled to most forms of assistance. Other refugees and those from refugee-like backgrounds fall within categories with low eligibility to services, including health. Those arriving without authority, including children, are held in detention centres while their claims are processed. If their application is successful they are released from detention and granted a three year Temporary Protection Visa (TPV), which gives them the right to work, access to Medicare, and some other benefits[10] but not the comprehensive support arrangements available to those holding Permanent Protection Visas. The 'unauthorised' manner of entry of some asylum seekers has become the primary factor in the way they are treated by the state, although under International Law no refugee applicant is 'illegal', and all should be entitled to equivalent services.[11] Five-year TPVs with similar restrictions are also provided to some categories of off-shore refugees, if they have transited a country for a certain period of time where there was provision to make a refugee application to UNHCR or to the host country.

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Table 1 Summary of health entitlements for Australian immigrants

	Off shore Humanitarian Program refugees	Refugees with temporary protection visas	On shore asylum seekers and other bridging visa holders	Asylum seekers awaiting review of negative DIMIA decision
Work rights	Right to work	Right to work, any income earned reduces welfare allowance 'dollar for dollar' with no allowance for travel and other work expenses	May be given work permission if follow correct procedures re 45-day rule[68]	Variable – some retain right through Refugee Review Tribunal (RRT) process[69]
Job seeking assistance	Access to all employment programs	Not eligible except for most basic services	Not eligible	Not eligible
English language classes (adult migrant English programme)	Free tuition: eligible for advanced English for migrants programme	Not eligible	Not eligible	Not eligible
Family reunion	Eligible to apply to sponsor family members	Not eligible	Not eligible	Not eligible
Income support	Eligible to apply for full range of social security benefits	Eligible for restricted entitlements: Special benefit through Centrelink (paid at Newstart rates but subject to stringent income tests, no rent assistance, maternity and family allowance or family tax payment)[68]	Not eligible (Australian Red Cross Asylum Seeker Assistance Scheme provides financial assistance to a proportion of eligible asylum seekers)[68]	Not eligible
Health assessment and early intervention programme (DIMIA)	Eligible[9]	Eligible[10]	Not eligible	Not eligible
Medicare	Eligible	Eligible (blue 'interim'å Medicare card)	Only if given permission to work. If asylum application made 45 days or more after arrival, no Medicare access	Variable – some retain access through RRT stage
Health care card	Eligible (usual criteria apply)	Eligible (usual criteria apply)	Ineligible	Ineligible
Residency	Granted permanent residency on determination of refugee status	Granted temporary protection only (currently reviewed every 3 years)	Not eligible	Not eligible
Settlement services	Eligible for assistance with orientation, accommodation, household formation.	Not eligible	Not eligible	Not eligible
Tertiary education	Eligible for HECS	Must pay full up-front fees	Full up-front fees	Full up-front fees
Torture and trauma counselling	Eligible	Eligible for limited amount only	May be eligible (non-DIMIA funded services)	May be eligible (non-DIMIA funded services)
Travel	May return if they travel overseas	No right to return	No right to return	No right to return

DIMIA, Department of Immigration and Multicultural & Indigenous Affairs; HECS, higher education contribution scheme; RRT, Refugee Review Tribunal.

Despite the 8–10 000 community-based asylum seekers currently residing in Australia[12] and the 8500 TPVs that have been issued since 1989, there has been diminishing emphasis placed on humanitarian obligations and human rights, including those related to health.[12,13] While families await assessment of their asylum application – a process that may take many years – health professionals may nonetheless be called upon to provide health care for children and their families. Indeed they are in an important position to act as advocates, especially for refugee children, who are physically and psychologically less able than adults to provide for their own needs or to protect themselves. Additionally, their parents are undergoing considerable stress related to the uncertainty of life circumstances and immigration status. Practitioners need to be aware of these issues to ensure access to health care is targeted accordingly.

Children comprise about 40% of newly arrived refugees under the Humanitarian Program.[14] A large number of children with 'refugee-like' experiences also enter Australia as asylum seekers or through the mainstream Family Migration Program.[14] Familiarity with health care access issues faced by this population is necessary if they are to receive appropriate and comprehensive care and if practitioners are to identify those who are likely to need further services.

This paper aims to increase awareness among health professionals caring for refugee children of the additional challenges faced by this group in accessing and receiving effective health care in Australia. Particular consideration is given to the issues of equity, rights of asylum seekers, communication and cultural sensitivities in health care provision, and addressing barriers to health care. The aim of the paper is to alert practitioners to the complex issues surrounding the delivery of health care to refugee children and provide realistic recommendations for reducing barriers to health care.

HEALTH AND HUMAN RIGHTS – THE RIGHTS OF THE CHILD

Refugee children share certain universal rights with others in the community, have additional rights as children, and particular rights as refugees. The right to health care is espoused through the 1951 United Nations Convention relating to the Status of Refugees, of which Australia is a signatory. This entitles refugees to access national health services on the same grounds as nationals of the resettlement country.[11] However in Australia, visa categories limiting health care eligibility together with reduced access for those in immigration detention result in diminished delivery of this right to care.[15]

Humanitarian entrants to Australia are recognized and protected by the Refugee Convention referred to above, gain permanent residency and have standard access to health care. However, asylum seekers, living in the community waiting to have their claims for refugee status assessed, have substantially restricted rights when accessing health care (Table 1). In order to ensure appropriate health outcomes, the Convention relating to the Status of Refugees should be applied in Australia to all newly arrived children and their families of refugee-like backgrounds, regardless of their immigration status, including asylum seekers or those on other bridging visas.

In relation to the United Nations Convention on the Rights of the Child[16] immigrant and refugee children, whether in detention or in the community have certain rights.[15] This Convention states that children should enjoy 'the highest attainable standard of health and access to facilities for the treatment of illness . . .' and that Parties to the Convention on the Rights of the Child shall 'ensure the provision of necessary medical assistance and health care to all children . . .'[16] It supports the rights of all children with respect to *protection* (from maltreatment, neglect and all forms of exploitation); *provision* (of food, health care, social security); and *participation* (in decisions affecting their lives).[16] When Australia ratified the Convention on the Rights of the Child, it entered into an agreement in applying these principles to refugee children. Support for the health-related rights of the child is paramount in being able to provide appropriate access to comprehensive health care. The current situation of asylum seekers in detention and those based in the community who are as yet ineligible for certain services contributes to the denial of these rights.[17]

HEALTH SERVICE USE, ACCESS AND ELIGIBILITY

The vast majority of health care for children of refugee background occurs within the mainstream health system[2] in which there are particular barriers to accessing effective health care.

First, recent humanitarian entrants and those who are yet to find employment may have severe financial constraints. Any service not fully covered by Medicare will pose a problem, such as allied health providers, dentists, and private specialists including paediatricians.[2] Evidence suggests that newly arrived refugees are unwilling to seek even urgent medical treatment because they cannot afford to pay.[18] Consideration needs to be given to minimizing costs to refugee families, possibly by identifying practitioners willing to provide affordable care. Local refugee health networks are one avenue of identifying suitable practitioners.

Second, refugees are known to under utilize health services. Lack of familiarity with the health system and reduced ability to negotiate and advocate for themselves creates barriers to access.[19] Transportation problems and excessive waiting times experienced by parents have been identified as major barriers to care for their children.[20] Similarly, lack of appropriate health information, education materials or knowledge about community health resources also creates barriers to care.

Third, health professionals may lack knowledge regarding their patient's rights to health care (and other entitlements) given the complexity of the entitlement restrictions under various visa categories. This can result in a loss of confidence and trust between patient and practitioner.[20] Professionals may also lack the skills needed to detect and manage unfamiliar conditions among refugee children.[21] Examples may include infections rarely encountered in Australia (e.g. parasitic infestations, tuberculosis), or genitourinary conditions in girls resulting from female genital mutilation.

As referred to above, in Australia there are specific gaps in health care availability due to legislation. Two examples are that: (i) approximately one third of asylum seeker children, youths and adults living in the community are not eligible for Medicare[1,22] and (ii) non-permanent residents, which incudes asylum seekers and those refugees holding TPVs are not eligible for certain Commonwealth-funded items such as hearing aids or prostheses. Their health is also put at risk through lack of access to key resettlement services such as English language tuition, Migrant Resource Centres, public housing and employment assistance.[2]

Health care in immigration detention is the responsibility of the centre management provider. However, cases that cannot be dealt with adequately are referred to private practitioners and/or State Health Services. It has been suggested by the United Nations Regional Advisor that human rights concerns relating to detention include restricted access to health care workers for those in detention.[23] In view of refugee children's already

vulnerable situation, there is likely to be increased need for regular access to primary care services and specialist health services for this group.

The health needs of those asylum seekers without Medicare eligibility living in the community in particular, has prompted the development of a number of services and loose networks, often staffed by volunteers, which aim to provide health care services to this population. Examples include care provided by the Asylum Seekers Centre in Sydney, the Refugee Claimants Support Centre in Brisbane, the Refugee and Asylum Seeker Network in Melbourne and networks of volunteer general practitioners and other health professionals in all Australian States and Territories.

Improving awareness amongst paediatricians and other health professionals of the variation in eligibility and access to health care for refugees and asylum seekers remains important for effective advocacy, sensitive care and referral to affordable and appropriate services.

UNDERSTANDING CULTURAL DIFFERENCE AND PROVISION OF CULTURALLY SENSITIVE CARE

Communication issues between newly arrived refugees or asylum seekers and providers remains one of the most notable barriers to accessing appropriate care. A degree of cultural competence is essential in providing optimal care to this group. Cultural competence is defined as the level of knowledge-based skills required to provide effective clinical care to patients from a particular ethnic or racial group.[24] Apart from the language discordance between practitioner and patient, communication may be affected by differences in cultural approaches to communication, views about the causes of illness and the way illness should be managed, the relationship between service providers and patient, and views about gender roles, customs and practices.[25]

Cultural barriers to care exist as a result of the perceptions of illness and disease and their causes, which vary by culture. Exploring the belief systems regarding health and illness is necessary as sickness is often thought to arise from sources other than physical causes.[26] Failure of the practitioner to use terms of respect and to fully elicit parents' concerns may result in negative perceptions and decreased satisfaction with care.[20] Practitioners may glean much information about the cause of an ailment by seeking the patient's perception of illness.[27] Practitioners need not agree with the patient's health beliefs but an awareness of them will enable better communication.[28]

Refugees will rarely raise certain sensitive health issues. Sexual abuse, domestic violence, alcohol or substance abuse and mental health issues may be associated with stigma and patients may be unfamiliar discussing these conditions in their communities.[4] Unaccompanied or separated children are at increased risk of neglect, sexual abuse and other abuses.[29] Such sensitive issues may need repeated consultations to elicit the relevant information.

In addressing culturally diverse groups, practitioners should also consider different approaches for each encounter. The demeanour of some patients may be misinterpreted by practitioners as a lack of engagement. For example, in some cultures it is considered improper to maintain eye contact with authority figures.[30] In terms of what is culturally acceptable to a patient and their family in the context of health care, a useful rule is to simply ask the patient. This not only shows respect but gives the person or family a sense of greater control.

WORKING WITH INTERPRETERS

Refugees, particularly those holding TPVs, are very likely to have a greater reliance on bilingual health care providers and interpreters for communication during health care visits.[31,32] Interpreters not only perform the important role of conveying information between provider and client, but can also act as client advocates. Interpreters can serve as a cultural bridge between providers and patients[33] providing insight into the cultural significance of what is being conveyed both verbally and non-verbally. Research indicates a more effective rapport may be established between health professionals and patients when assisted by interpreters; this improves attendance and the patient's sense of being understood.[34]

The use of children, other family members, friends, fellow patients or bilingual employees as interpreters should generally be avoided. It is not appropriate to induce children to discuss private issues. Children may not be sufficiently mature to understand the depth of what is being translated. Use of children in this role also alters the power balance within the family.[35] Relying on personal limited foreign language skills or untrained interpreters can also result in inaccurate interpretation and subsequent poor understanding of the issues at hand.[36]

Additionally, there are some particular issues inherent to using interpreters/bicultural workers. Occasionally, in small communities an interpreter may be known to the child or family, or even be associated with a traumatic experience in the country of origin. Many refugees come from countries where they have been persecuted due to belonging to a religious or ethnic minority group. In such cases, use of interpreters from the majority population from the same country may result in further feelings of victimization. Interpreter gender may also be an issue for some patients and the patient or family may be unable to work with them as a result.[37] Interpreters should be socially, ethically and politically acceptable to the patient and family. At all times the offer of an interpreter should be made, and the patient's wishes respected. In certain circumstances, a telephone interpreter may be preferable or the only option available.

Children present additional issues when working with interpreters as they may have difficulties explaining their symptoms. Working via an interpreter or their parents can in itself risk miscommunication or misdiagnosis.[21] Furthermore adults accompanying the child may be distant relatives or friends rather than parents, and as a result the child may be less forthcoming.

Guidelines for working with interpreters have been developed.[8] Table 2 highlights the main points to consider when engaging an interpreter, as well as practical advice on how to work with them. Suggestions are presented to help interpreters work effectively in the health care setting.[38] Free telephone interpreter services exist (plus a small number of on-site services) for use by private medical practitioners. The Telephone Interpreter Service Doctors Priority Line is a 24-hour service available by telephoning 1300 131450. In general, heightened awareness and facilitation of use of this service is needed especially among private procedural specialists such as surgeons and dentists.

DISTRUST OF GOVERNMENT SERVICES AND PERCEIVED DISCRIMINATION

Challenges in accessing health services may be further compounded by limited trust of health providers by some refugees.

Table 2 Practical guidelines for engaging interpreters

Before the interview
Choose a trained interpreter wherever possible (if not, work with staff or a community member who is not a member of the family)
Ask if the client prefers a male or female interpreter
Plan consultations in advance to ensure a longer consultation time and so an interpreter can be present
Book the same interpreter for repeat appointments with the client as this promotes rapport, trust and continuity of care
Negotiate briefly with the interpreter to form a team approach
(The Translating and Interpreter Service (TIS) is a nation wide service which provides interpreters for Medicare related services)
During the interview
Ask the interpreter for a 'cultural interpretation' which would include the patient's
• expectations of the visit
• views about causes and management of illness
• views about symptoms, tests or treatments
Use short simple statements. Minimise jargon
When conversing, watch the client not the interpreter, encourage questions and speak in first person
Visual aids, audio and videotapes should be encouraged with children
If communicating through a telephone interpreter, a hands free speaker phone should be used
When prescribing medications, have the interpreter write down the dose and course in the patient's own language
Ensure the client is comfortable with the interpreter.
After the interview
Where the client is literate, offer relevant translated material
Ensure the interpreter leaves with the client
The interpreter may also provide guidance on follow up instructions such as pharmaceuticals and investigations.

Mistrust may arise from previous experiences with health providers or institutions of authority, and a fear that recognition of certain health problems may affect residency status or the capacity for family reunion.[39,40] To ensure trust is restored and maintained health providers should reassure new refugee patients that their health assessment will not negatively influence their refugee status. Health providers should convey the strong message that information they receive is treated with confidentiality and independence.

Parents may distrust authority figures such as doctors, particularly if they are government employees, due to past experiences related to human rights with government authorities.[41,42] Asylum seekers and their children, who have experienced detention, are known to experience particularly high levels of distrust and lack of confidence with health providers.[43] Distrust may also contribute to non-attendance and non-compliance with treatment.[44] Parent's experiences of distrust are often causes of stress and anxiety for children. Providers need to be aware and sensitive of the distrust that parents may be experiencing to enable a holistic approach in caring for the family group.

Perceptions of racism and discrimination can also have an impact on health service access. Evidence suggests that patients from different ethnic backgrounds to the dominant one may be disinclined to utilize services that they perceive to be prejudiced against them.[45] If trust is not established early, then finding ongoing primary care with a suitable provider will prove difficult. The concepts of medical confidentiality and informed consent should be explained early in the consultative process.

COMPOUNDING HEALTH EFFECTS OF DETENTION AND LIMITED ACCESS TO HEALTH CARE IN THE COMMUNITY

Article 37 of the Convention on the Rights of the Child states that holding children in detention shall be used as a measure of last resort and only for the shortest possible time.[46] The Human Rights & Equal Opportunity Commission (HREOC) expressed concern about Australia's compliance with Convention obligations, and so conducted its own inquiry into newly arrived children in detention in Australia. Detrimental effects of detention were found to be extensive in Australia,[15] as well as in several other countries.[47,48] The report of the HREOC National Inquiry into Children in Immigration Detention was tabled in Parliament on 13 May 2004. Similarly the United Nations Working Group on Arbitrary Detention (WGAD) expressed concerns about 'the psychological impact' of detention, its 'automatic and indiscriminate character, its potentially indefinite duration and the absence of judicial control of the legality of detention'.[49]

Children are particularly vulnerable to psychological trauma resulting from long periods of insecure residency, exposure to harsh treatment, confinement, deprivation and exposure to unstimulating environments.[50] Such experiences create additional vulnerability in children and adolescents due to their incomplete biopsychosocial development, dependency, inability to understand certain life events[51] their underdevelopment of coping skills[52] and their experiences of past separation. Detention has been found to undermine parental capabilities with children experiencing suboptimal parenting as a consequence of the stresses of their confinement[40,53] and creating further difficulties when families are finally resettled.[54]

Being unaccompanied or separated from family members, whether in detention or in the community creates further stresses for children.[55] Unaccompanied minors, mostly adolescents, lack social support groups, relatives and other natural mentors. Additionally, fear of being returned to their country of origin whilst awaiting refugee determination status may be psychologically damaging.[40] Many unaccompanied adolescents hold TPVs, making them vulnerable to repatriation and impairing their capacity to feel settled and secure. Preliminary research amongst TPV holders indicates that the uncertainties and social deprivations experienced by TPV holders are associated with increased levels of psychological disability.[13] Decreased health service utilization has also been reported as a result of uncertainty and fear associated with TPV status.[56] Unaccompanied and separated children in particular should be provided with appropriate protection and care due to the greater risk of psychological and health problems than their accompanied peers.[57] Providers should be aware of the specific experiences of children who have previously been in detention.

Improved health provider awareness will enable sensitive care and appropriate referral to child psychiatrists and psychologists.

WHY HEALTH PROVIDERS NEED TO BE ADVOCATES FOR REFUGEE CHILDREN

Elevated rates of post-traumatic, affective and other psychosocial disturbances have been repeatedly documented amongst children exposed to extreme trauma.[52,58,59] Evidence suggests that some post-traumatic stress reactions persist.[60–62] These experiences are compounded by difficulties in attaining safety, and problems of social isolation, poverty, hostility and racism.[63] Moreover it has been suggested that adults underestimate symptoms of trauma experience in their children[64,65] especially those related to mental health. In addition the effects of torture and trauma may be difficult to diagnose in young children.[66] Such findings suggest the need for health professionals to assume an even greater advocacy role for dealing with these vulnerable patients.

ENCOURAGING PROTECTIVE FACTORS

Individual resilience, adherence to cultural values, opportunities to pursue education and other age-appropriate activities, consistency and quality of family support, parental physical and psychological well-being, and availability of supportive and predictable social structures have all been shown to protect health outcomes for children, and as such should be encouraged.[67] Consequently children's needs must not be addressed in isolation. It is necessary to strengthen the capabilities of refugee families to meet their own needs and improve the situation of carers and their environment, thereby contributing to the health of their children.

A refugee child's health is related to any mental health difficulties experienced by other family members prior to and following immigration.[58] As noted above, family functioning and mental health status must be considered in health consultations as these impact heavily on the child.

Practitioners should be aware of the importance of continuity of care and of a team approach involving community organizations and specific agencies (e.g. torture and trauma services) when addressing the needs of refugee children. One strategy to better address the health and access needs of this target group has been the development of specialised health services that focus specifically on refugees, including torture and trauma counselling services in each Australian jurisdiction.

CONCLUSION

There are clearly barriers to achieving optimal health and health care access for children from refugee-like backgrounds in the current policy environment for refugees and asylum seekers. Children in detention, unaccompanied or separated children, those in the process of seeking asylum and those having previously experienced trauma are at particular risk of sub optimal health. Refugee children are a small, marginalized group that can be easily overlooked. It is important for paediatricians and other health professionals to be aware of the health needs of such children, and of national and local policy and other factors that may impede their access to health care. Informed professionals can fulfil a significant role of advocacy and care for this vulnerable group.

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