Models of Child Health Appraised

Entitlements to healthcare for migrant children in Australia and relationship to migration status.

The Centre for Community Child Health

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The *Models of Child Health Appraised: Entitlements to healthcare for migrant children in Australia and the relationship to migration status* report was undertaken by the Centre for Community Child Health.

The Centre for Community Child Health is a research group of the Murdoch Childrens Research Institute and a department of The Royal Children's Hospital, Melbourne.

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Glossary

The following definitions were developed for the European Union Horizon 2020 project; "Models of Health Care Appraised (A Study of Primary Healthcare in 30 European Countries)". These definitions form the basis of the European Country Agent Questions and are reproduced verbatim below. These are not necessarily the definitions used in Australian immigration or legal documents. For the definitions of key terms used in the Australian immigrant health context, see the Royal Australasian College of Physicians *Policy on refugee and Asylum Seeker Health*.

Migrant
We define a migrant as "a person who changes his or her country of usual residence[a].

Child
We define a child as "every human being below the age of 18 years"[b].

Children of destitute EU citizens (not relevant in Australia)
EU citizens, who make use of the right to free movement[c], but lack resources, health coverage, valid identification papers or have not registered with the authorities for varies reasons, are not automatically granted the same entitlements as undocumented third-country nationals. The category of destitute EU citizens encompasses groups such as beggars, homeless and minority groups such as Roma people, who has EU citizenship, but fall outside EU social security regulations, and whose rights are largely determined by national legislation[d].

Children in asylum seeking families
Children of asylum seekers constitute children of persons who are in the process of applying for refugee status under the 1951 Geneva Refugee Convention. Persons under Dublin regulation are asylum seekers[e].

Children of undocumented migrants
Children in this category are also referred to as "irregular migrants" or "unregistered migrants". This group of children is a large, varied and highly vulnerable group in Europe[f]. They include children:

- Who live without a residence permit;
- Who have overstayed visas or were refused immigration applications as a family and who has not left the territory of the destination country subsequent to receipt of an expulsion order;
- Who have entered a country irregularly either alone or as a family.
- Who are passing through or residing temporarily in a country without seeking asylum

[a] Definition adopted from United Nations: ttp://unstats.un.org/unsd/publication/SeriesM/seriesm_58rev1e.pdf
[b] Definition adopted from Article 1 of the Convention on the Rights of the Child (CRC): http://www.ohchr.org/en/professionalinterest/pages/crc.aspx
[c] According to EU directive 2004/38/CE on Free Movement EU citizens can reside legally up to three months in another EU country as long as they have a valid ID-card or passport. Economically non-active persons (e.g. unemployed, students, retired, etc.) have the right to reside for longer than this period if they: *"have sufficient resources for themselves and their family members not to become a burden on the social assistance system of the host Member State during their period of residence and have comprehensive sickness insurance cover in the host Member State"* (Art. 7b) http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2004:158:0077:0123:en:PDF
[d] Extracted from UNICEF report from Sweden –available here, but only in Swedish: https://unicef.se/rapporter-och-publikationer/vilka-rattigheter-har-barn-som-ar-eu-medborgare-och-lever-i-utsatthet-i-sverige
[e] See glossary given by Health for Undocumented Migrants and Asylum Seekers (HUMA): http://www.episouth.org/doc/r_documents/Rapport_huma-network.pdf
[f] This section is largely based on Platform for International Cooperation on Undocumented Migrants' (PICUM) definition as given here: http://picum.org/picum.org/uploads/publication/Children%20First%20and%20Foremost.pdf

Unaccompanied children
Unaccompanied children are defined as children: *"who have been separated from both parents and other relatives and are not being cared for by any adult who, by law or custom, is responsible for doing so"*[g].

Emergency care, Primary care, Secondary care[h]
Emergency care includes life-saving measures as well as medical treatment necessary to prevent serious damage to a person's health. Primary care includes essential treatments of relatively common minor illnesses provided on an outpatient or community basis (such as services by general practitioners). Secondary care comprises inpatient and outpatient care and medical treatment provided by specialists.

Screenings and prevention programmes
Screening procedures in this questionnaire refer to preventive child health examinations offered to all children within the preventive healthcare in a country and aimed at assessing the child's physical, psychological, and social development and well-being.

Health examination/assessment
Health examinations in this questionnaire are defined as targeted intervention offered to new migrants only, to identify communicable disorders and unmet needs of medical care.

[g] We adapt this definition from the Committee on the Rights of the Child, General Comment no. 6: http://www2.ohchr.org/english/bodies/crc/docs/GC6.pdf
[h] This section is based on the European Union Agency for Fundamental Rights' (FRA) definitions of emergency, primary and secondary care as given here: http://www.compas.ox.ac.uk/media/PR-2011-FRIM_Healthcare.pdf

Abbreviations

ACIR	Australian Childhood Immunisation Register
ASID	Australasian Society for Infectious Diseases
BVE	Bridging Visa E
DIBP	Department of Immigration and Border Protection (Australian government)
EU	European Union
GP	General Practitioner
HCC	Health Care Card
IGOC	Immigration Guardianship of Children Act 1946
IHMS	International Health and Medical Services
IMA	Illegal Maritime Arrival
IME	Immigration Medical Examination
MOCHA	Models of Child Health Appraised
NIP	National Immunisation Program
PBS	Pharmaceutical Benefits Scheme
RHA	Refugee Health Assessment
RHCA	Reciprocal Health Care Agreement
RHeaNA	Refugee Health Network of Australia
SHEV	Safe Haven Enterprise Visa (a type of temporary protection visa)
SRSS	Status Resolution Support Services
TPV	Temporary Protection Visa
UHM	Unaccompanied Humanitarian Minor (arriving via the Humanitarian Programme)
UAM	Unaccompanied Minor (arriving as an asylum seeker)
UNC	Unlawful Non-Citizens

1. Executive Summary

Migration to Australia

This report is the response from Australia to a series of questions regarding the primary healthcare of migrant children posed through the European Union Horizon 2020 project; "Models of Health Care Appraised (A Study of Primary Healthcare in 30 European Countries)". The regulations and policies governing this area are highly variable across Australia's states and territories, subject to change and often difficult to interpret. We have focused therefore predominantly on national laws and policies, noting that accuracy may vary over time.

Children migrate to Australia through a variety of different pathways. They may enter as permanent migrants (via Australia's skilled, family, humanitarian or other migration steams) or as temporary migrants (as the children of workers, students, tourists or other entrants). Children also seek asylum in Australia, arriving by airplane or boat. Whilst most children come to Australia with family or relatives, some children come to Australia alone, as an unaccompanied minor (i.e. as a refugee or asylum seeker, on an orphan relative visa, or in an undocumented kinship care arrangement).

There are a number of international conventions that govern the rights of these children, many of which Australia is a signatory. These include, but are not limited to, the Convention on the Rights of the Child and the Refugee Convention and Protocol.[8-10] Once within Australian borders, these children are also under the jurisdiction of Australian Commonwealth (federal) and state laws and immigration law/policies. These laws and policies have a direct impact on the type of visa a child may be granted. Visa type then determines the essential life circumstances of migrant children. This includes whether a child can live in the community or whether they are subject to immigration detention; the work rights of their parents and the healthcare available to them - including whether they can access Australia's universal healthcare system (Medicare).

Healthcare entitlements of migrants to Australia

Australia has a mixed health care system consisting of the public universal health care system (Medicare) and privately provided healthcare subsided through private health insurance. The Pharmaceutical Benefits Scheme (PBS) provides subsidised medications. Low income earners are eligible for a Health Care Card (HCC) which reduces the cost of PBS medicines, medical appointments and other government and private health care services.

The healthcare entitlements of migrants and their children is highly complex and varies depending on type of migration (permanent, temporary, asylum seeker) and visa type (or lack thereof). For asylum seekers, healthcare entitlements also vary with living circumstances (immigration held detention, immigration community detention, living in the community on Bridging Visa or Temporary Protection Visa) which are in turn are determined by variables such as means of entry into Australia (boat versus airplane) and time period of entry into Australia.

Permanent migrants have the same healthcare entitlements as Australian citizens. Children who are permanent migrants can access Medicare and the PBS. Most permanent migrants are not eligible for a HCC initially (there is a two year waiting period).[11] Humanitarian entrants are exempt from this waiting period and are immediately eligible for a HCC.[11]

Temporary residents have different healthcare entitlements compared with Australian citizens. Healthcare for children in this category varies depending on factors such as the family's private health insurance arrangements; the family's ability to privately pay for services; whether the child comes from a

country which has a Reciprocal Health Care Agreement[i] with Australia; or whether the child has a Temporary Protection Visa.

Asylum seekers have varying entitlements to healthcare depending upon their visa status and their living circumstances:

- *Onshore Immigration Detention:* Healthcare in immigration detention on mainland Australia is contracted by the Australian government to a private provider, International Health and Medical Services (IHMS).[12] IHMS provides (a) on-site care for people in held detention, and (b) contracted community-based care for people in community detention - through IHMS-approved general practitioners and pharmacies.[12, 13] People in detention (held/community) have no Medicare, PBS or HCC. Emergency and acute healthcare is provided by local hospitals.[12, 14, 15] Hospitals are reimbursed for costs by IHMS. Whilst there have been no children in held detention on *mainland* Australia since April 2016, large numbers of asylum seeker children have been detained in recent years.
- *Offshore Immigration Detention (in Nauru and Papua New Guinea):* Healthcare in offshore held detention facilities is provided by IHMS. Emergency and acute healthcare that cannot be provided onsite is provided by local hospitals.[16] There is evidence to suggest that the standard of healthcare in offshore detention centres and in Nauru and PNG are below the standards of healthcare provided in Australian hospitals.[16, 17] As of June 30 2016, there were 49 are children in offshore immigration detention (all in Nauru).[18]
- *Asylum seeker boat arrivals granted a Bridging Visa*: This type of temporary visa allows people to stay in Australia legally while their visa application is being determined (these individuals are eligible for temporary protection visas only).[4] As of 30 June 2016, there were 28,163 asylum seekers living in Australia on a Bridging Visa E of whom 4,073 were children.[18] Medicare access for this group is conditional on having a valid bridging visa. Pharmaceuticals are provided through the PBS and the gap cost is covered by State Resolution Support Services[j]. People on this type of visa do not have access to a HCC[13].
- *Asylum Seekers who arrive by airplane:* These children and families enter Australia on a substantive visa, then make a subsequent claim for protection. They may be granted a bridging visa while their claim is being determined (if they are found to have a valid claim for protection, they are eligible for a permanent protection visa). This group has variable access to Medicare and face significant barriers to pharmaceutical access if they do not have Medicare (no PBS, no HCC).
- *Asylum seekers on Temporary Protection Visas:* As a result of this legislation passed in December 2014,[k] asylum seekers who arrive in Australia by boat and are found to have a valid claim are no longer eligible for a permanent protection visa.[19] They may only be granted either a Temporary Protection Visa (TPV, 3 years duration) or Safe Haven Enterprise Visas (SHEV, 5 years duration)[l].[20-23] Asylum seekers who are successful in obtaining these visas have been found to be refugees. Individuals on a TPV may reapply for a TPV; individuals on a SHEV who meet the conditions of the visa may be eligible to apply for one of several types of permanent visa.[24, 25] Asylum seekers on a TPV/SHEV have access to Medicare, the PBS, and HCCs (without the 2-year waiting period).[4, 11]

See Figure 1 for an overview of the migration pathways into Australia and related healthcare entitlements.

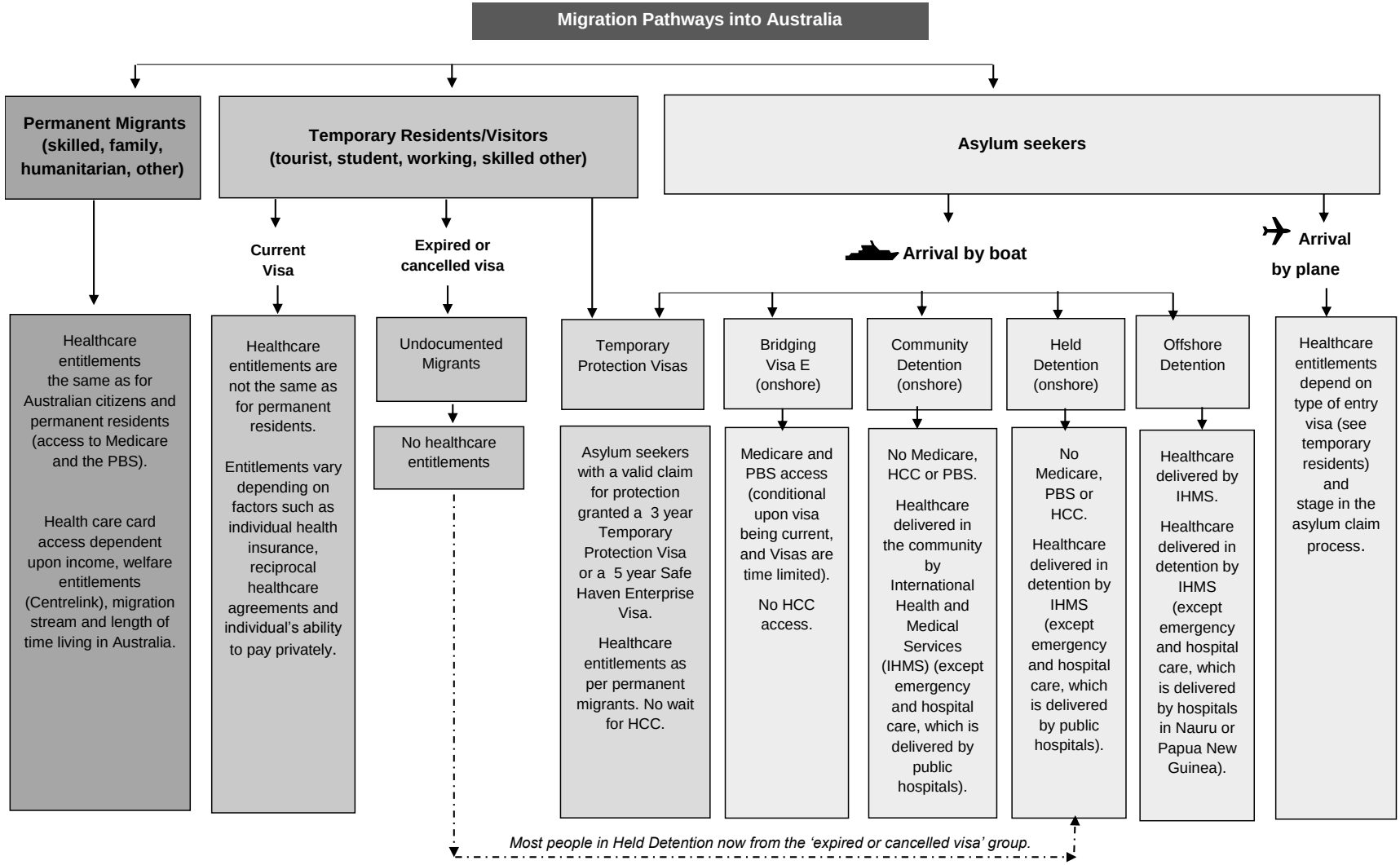
[i] Reciprocal Health Care Agreements: this allows access some subsidised health services for essential medical treatment. This is only for people visiting from overseas from countries with which Australia has a Reciprocal Health Care Agreement (New Zealand, the United Kingdom, Ireland, Malta, Italy, Sweden, the Netherlands, Finland, Norway, Belgium and Slovenia) See: https://www.humanservices.gov.au/customer/enablers/health-care-visitors-australia)

[j] Asylum seekers in the community are supported through the Commonwealth-funded Status Resolution Support Services program; contracted to agency providers within the states and territories. There are different levels of support, depending on vulnerability, and individuals who are working lose access to SRSS.

[k] *Migration and Maritime Power Legislation Amendment (Resolving the Asylum Legacy Caseload) Act 2014.*

[l] TPV; subclass 785 XD. SHEV; subclass 790

Figure 1: Migration pathways into Australia and related healthcare entitlements



Healthcare entitlements of migrants to Australia continued

Unaccompanied minors: In general, unaccompanied minors living in the community have specialised support services, but not specialised health entitlements. Unaccompanied humanitarian minors (arriving via the Humanitarian Programme) have the same healthcare entitlements as Australian-born children. Unaccompanied minors who are asylum seekers (UAM) in held and community detention - like other individuals in detention - receive healthcare from IHMS. UAM in community detention receive SRSS support. UAM are placed in community detention (not on a Bridging Visa E) in recognition of their vulnerability and support needs.

Destitute European Union (EU) migrants: As Australia is not a part of the EU, there is no specific legislation pertaining to destitute EU migrants. The report considers the case of New Zealanders living in Australia as a potentially equivalent group. Overall, New Zealanders with valid visas have the same healthcare entitlements and fee-paying structure as Australian residents (with exceptions). HCC and other social welfare entitlements are more complex and may not be the same as for Australian residents.

Undocumented migrants: There are no known laws/regulations pertaining to healthcare provision for undocumented children. Undocumented migrants are referred to as "Unlawful Non-Citizens", in comparison with valid visa holders who are 'lawful non-citizens'. As unlawful non-citizens, undocumented migrants do not meet the eligibility criteria for Medicare, the PBS or a HCC.[26-28]

Table 1: Levels of equality regarding entitlements to healthcare for migrant children compared to national children

Colour code:

Entitlements equal to nationals regarding coverage and cost and included in same healthcare system
Entitlements equal to nationals regarding coverage and cost but enrolled in parallel healthcare system
Entitlements restricted compared to nationals/No legal entitlements
Unclear legal provision

	Equality Dimension
Permanent migrants	
Temporary migrants	Entitlements vary. Not usually the same as nationals.
Asylum seekers on bridging visas	Medicare and PBS access conditional upon visa being current, and visas are time limited.
Asylum seekers in immigration detention	IHMS coverage. The quality of care may not always equivalent to the national health system.
Destitute EU citizens	No equivalent group in Australia.
Undocumented Migrants	No health entitlements.

2. Introduction

Children migrate to Australia through a variety of different pathways. They may enter as permanent migrants (via Australia's skilled, family, humanitarian or other migration steams) or as temporary migrants (as the children of workers, students, tourists or other entrants). Children also seek asylum in Australia, arriving by airplane or boat. Whilst most children come to Australia with family or relatives, some children come to Australia alone, as an unaccompanied minor (i.e. as a refugee or asylum seeker, on an orphan relative visa, or in an undocumented kinship care arrangement).

There are a number of international conventions that govern the rights of these children, many of which Australia is a signatory. These include, but are not limited to, the Convention on the Rights of the Child and the Refugee Convention and Protocol.[8-10] Once within Australian borders, these children are also under the jurisdiction of Australian Commonwealth (federal) and state laws. These laws and policies have a direct impact on the type of visa a child may be granted. Visa type (or a lack thereof) then determines the essential life circumstances of migrant children. This includes whether a child can live in the community or whether they are subject to immigration detention; the work rights of their parents and the healthcare available to them - including whether they can access Australia's universal healthcare system.

In this report we discuss the healthcare entitlements of migrant children in Australia. The report is arranged to respond (from an Australian perspective) to a series of questions regarding the primary health care of migrant children posed through the European Union Horizon 2020 project; "Models of Child Health Appraised (MOCHA) - A Study of Primary Healthcare in 30 European Countries" (see Appendix 1). Participation in this project is made possible through the National Health and Medical Research Council (NHMRC) European Union Collaborative Research Grant, which facilitates collaboration on EU Horizon 2020 grants.

The questions posed through MOCHA relate to the healthcare entitlements of migrant children of differing administrative status. The regulations and policies governing this area in Australia are highly variable across states and territories, subject to change and often difficult to interpret. We have therefore focused predominantly on national policies as it was outside the scope of this project to undertake a complete review of each state and territory (although we have included some examples); noting nevertheless that accuracy may still vary over time.

In order to illustrate the variation in healthcare entitlements within the complex Australian system, this report will:

(a) Discuss the national legal entitlements to healthcare for migrant children;
(b) Outline the complexity of the Australian system and variation within and between states and territories, primarily using examples primarily from Victoria and New South Wales (the states with the largest populations of people seeking asylum).

To provide context the report will provide a summary of Australian healthcare and migrant systems including:

(a) An outline of the basic healthcare structures;
(b) An overview of the different migration pathways; and
(c) An overview of migrants who are unaccompanied minors.

3. Methods

In Australia there is no one repository containing the required information necessary to respond to the specified questions designed for EU nations by MOCHA (see Appendix 1). Within the short time frame available, the following methods were utilised to seek and collate the necessary information.

a) Expert advice was sought from clinicians working in child immigrant health. These clinicians provided:
   - expert opinion on child health care for migrant children;
   - direction on important documents to review;
   - advice on further people/organisations to seek information; and
   - review of the report drafts.

   Interviews were completed with clinicians from the Royal Children's Hospital, Melbourne and the Department of Community Child Health, Sydney Children's Hospitals Network (Randwick campus), Sydney, New South Wales, Australia.

   Advice was also sought from local policymakers.

b) In order to quickly gather the most relevant grey literature, a snowball strategy approach was used which was iterative in nature. "Snowballing" is a research strategy that involves asking people who have been interviewed to identify other people who may fit the research criteria.[37] The same principle was applied to locating documents and resources, to inform this report. The starting point for this strategy was the information suggested by experts as well as the key document produced by the Royal Australasian College of Physicians, the *Policy on refugee and Asylum Seeker Health*. Many websites were accessed as part of this strategy. The sites that provided the most valuable information included:
   - Department of Immigration and Border Protection. See www.border.gov.au
   - Royal Children's Hospital, Immigrant Health Service. See www.rch.org.au/immigranthealth/
   - Australian Government. Federal Register of Legislation. See www.legislation.gov.au
   - Australian Government. Department of Human Services. See www.humanservices.gov.au
   - Parliament of Australia. Parliamentary Library. See www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library

4. Healthcare in Australia

Australia has universal healthcare (Medicare). Medicare is funded via a 'levy' on taxable income, which is reduced or not applicable to low-income earners. Funding is distributed through the Commonwealth and State governments to provide primary, secondary and tertiary healthcare services. Medicare provides free or subsidised medical and hospital services, including all primary healthcare services and optometry, as well as specialist and some allied health services.[m] [n] [38] Medicare does not cover ambulance costs, most dental services, physiotherapy, spectacles, podiatry, chiropractic services, or private hospital accommodation. Dental care is available through a Commonwealth funded schedule for children aged 2-17 years, and through Commonwealth-State partnership agreements for adult public dental services.[39] Hearing services are available through Commonwealth funded services, and Australia has a new National Disability Insurance Scheme which is in the process of being implemented. In some states and territories, state-funded community health services (often including medical and allied health services) are also available. These are generally targeted to lower income individuals/families and vulnerable population groups.

The Australian healthcare system has a significant private healthcare component, including private hospital and medical practitioners. Private hospital, dental and allied healthcare can be accessed through direct payment; alternatively cover is provided through the purchase of private health insurance and usually incurs a gap payment (i.e. consumer out-of-pocket expense).[40]

4.1 Access to healthcare

There are several healthcare schemes which determine access to care and the cost of services for consumers of the Australian healthcare system:

(a) Medicare: The *Health Insurance Act 1973 Section 3: Interpretation* outlines the citizenship and visa requirements of an 'Australian resident' required to access to Medicare.[41] To be eligible for Medicare (have a Medicare card), a person must:

- be an Australian or New Zealand citizen who is lawfully present in Australia, and who meets residency requirements (including Norfolk Island from July 2016); OR
- have a permanent visa and meet residency requirements; OR
- have applied for a permanent visa (excluding a parent visa), and reside in Australia; AND have permission to work in Australia, OR have a proven relationship to an Australian citizen, permanent resident, or New Zealand citizen who resides in Australia; OR
- hold a resident return visa and reside in Australia; OR
- be a resident of a Reciprocal Health Care Agreement (RCHA) country who is visiting Australia; OR
- be covered by a Ministerial order (i.e. fall in the category of 'special provisions for non-citizens', such as that used for people seeking asylum).[o] [4, 28, 42]

(b) Pharmaceutical Benefits Scheme (PBS): the PBS provides government subsidised medications to Australian residents *who have a Medicare card.*[27]

[m] Some healthcare practitioners accept Medicare payment alone, whilst others require additional payment from the patient.
[n] "Allied Health" is a term used to describe a multitude of health disciplines (excluding medicine and nursing) which may include, but are not limited to, clinical psychology, counsellors, nutrition, physiotherapy, occupation therapy, speech pathology, social work, audiology, podiatry, orthotics/prosthetics, dietetics, etc. See http://www.health.gov.au/internet/publications/publishing.nsf/Content/work-review-australian-government-health-workforce-programs-toc~chapter-8-developing-dental-allied-health-workforce~chapter-8-allied-health-workforce
[o] The Health Minister, under the *Health Insurance Act*, may permit non-citizens to access Medicare through a limited order. See Royal Australasian College of Physicians. Policy on refugee and Asylum Seeker Health. May 2015. Sydney; Australia [cited 2016 March 22]. Available from: https://www.racp.edu.au/docs/default-source/default-document-library/policy-on-refugee-and-asylum-seeker-health.pdf

(c) **Health Care Cards (HCC):** HCC are available for low income earners, and reduce the cost of PBS medicines, medical appointments and other government and private services (e.g. water bills, education fees).[43, 44] HCC eligibility is based on eligibility for particular Centrelink payments; Centrelink is the Australian welfare system that provides services and payments to people on a low income or no income, and/or at times of major change.[45] In general, only permanent residents/citizens are eligible for HCC (the exception to this are refugees on a Temporary Protection Visa or Safe Haven Enterprise Visa – see Section 8.5). People seeking asylum are not eligible for HCC.

4.2 Healthcare delivery

Healthcare delivery in Australia varies between the states and territories. Although primary healthcare services (General Practitioner services, Medicare, PBS, HCC) are Commonwealth entitlements, healthcare delivery is generally determined at a state level. Table 2 outlines the division of the health system in Australia and where possible, provides information on language services available to migrant children and families. This table uses the categories of healthcare services described in the MOCHA questions (see Appendix 1), with the additional category of tertiary healthcare, which is relevant in the Australian context.[46]

Table 2 provides a summary of the different forms of healthcare in Australia and the associated funding sources.

Table 2: Summary of healthcare in Australia

Overview	Cost
Primary Care	
• General Practitioners (GPs): GPs provide primary care and referrals to specialist services as needed. GPs in private practice are eligible for free Commonwealth translation services.	• GP services may be no cost to the patient (through billing Medicare directly) or include an out of pocket cost (Medicare billing plus co-payment).
• Allied health: includes clinical psychology, counsellors, nutrition, optometry, physiotherapy, etc. No allied health translation service funding, which is a barrier for patients with low English proficiency.	• Funding sources for allied health services vary between states. There are some Medicare entitlements for children and adults with chronic mental or physical disease and some subsidies through private health insurance. Optometry assessment is provided through Medicare.
• Maternal and child health services: Regular health checks provided by publicly funded nurses at key ages and stages for children from birth to school age. Includes support and assessment for child development, and parenting. Immunisation provided by some services. State funded translation services.	• No cost to consumer.
• Dental health: There are a limited number of state subsidised public dental health services including preschool and school dental services. Commonwealth-funded schedule for children aged 2-17 years, and Commonwealth-State partnership agreements for adult public dental services.[39]	• Dental services may be provided through Commonwealth funded schemes (e.g. for children) or through private dental services. Private dental services are funded through private health insurance schemes and/or direct cost (i.e. out of pocket expenses to consumers).
• Hearing services: audiology and hearing aids provided through Commonwealth-funded program.	• No cost for children (up to age 26), but variable costs to adults.[47]
• Mental health services (e.g. mental health nursing, child and adolescent mental health services, Headspace[p] services). Variable access to translation services.	• Low cost or no cost to the consumer.
Secondary Care	
• Specialist medical services (public/private practices).	• Require GP referral in order to access Medicare subsidy.
• Better Access Initiative (Medicare funding for specified mental health services for people with a clinically-diagnosed mental disorder) [48]. No translation service funding, which is a barrier for patients with low English proficiency.	• Medicare.

[p] Headspace: provides early intervention mental health and wellbeing services for individuals aged 12-25 years. The key areas headspace covers include mental health, physical health, work and study support and alcohol and other drug services. See www.headspace.org.au

Overview	Cost
Tertiary Care	
• Public Hospitals: may be long wait times; include sub-specialty services. Translation services available.	• No cost to the consumer. Public hospitals are funded by both Commonwealth and state/territory governments.
• Private Hospitals. Choice of doctor, private accommodation, shorter wait times. Translation service access variable.	• The cost of private hospital care is covered by the patient through private health insurance and/or private payment. Some services at private hospitals are covered by Medicare, such as pathology and medical practitioner services (a co-payment from the patient is usually required for medical practitioner services).
Emergency Care	
• Public Hospitals (translation services available).	• No cost to consumer.
• Private Hospitals (translation service access variable).	• Private payment or private insurance usually required.
• Ambulance services.	• Medicare does not fund ambulance services. State variation in funding for service availability.[35 49]
Medications	
• Medication dispensed by private retail pharmacies in the community and by hospital pharmacies. Private pharmacies are eligible for free Commonwealth translation services; translation services are available in hospitals.	• Government subsidised medication via the Pharmaceutical Benefits Scheme (PBS) and reduced further through access to a Health Care Card (which facilitates low cost medicine access).
Immunisation	
• Provided by a range of health care providers depending on the state/territory, including GPs (main location of delivery in Australia), some Maternal & Child Health (MCH) Services and healthcare workers. [50]	• No cost to the consumer for vaccines on the National Immunisation Program Schedule.
Preventative Health	
• Preventative health is provided across the healthcare system including the areas above, as well as by specific programs and initiatives (eg BreastScreen, Quit – anti-smoking)	• Most preventive services are free to the consumer and funded by a range of organisations including various levels of government as well as health insurance, not-for-profit organisations, etc.
Translation and interpreting services	
• Translating and interpreting services are not available for allied health services but are available for public and private GPs, hospitals, pharmacists and private specialists as above.	• Commonwealth funded translating and interpreting services for private GPs, private specialists, and pharmacists. State funded services for hospitals, and community health services, MCH, or occasionally, funded by the patient.

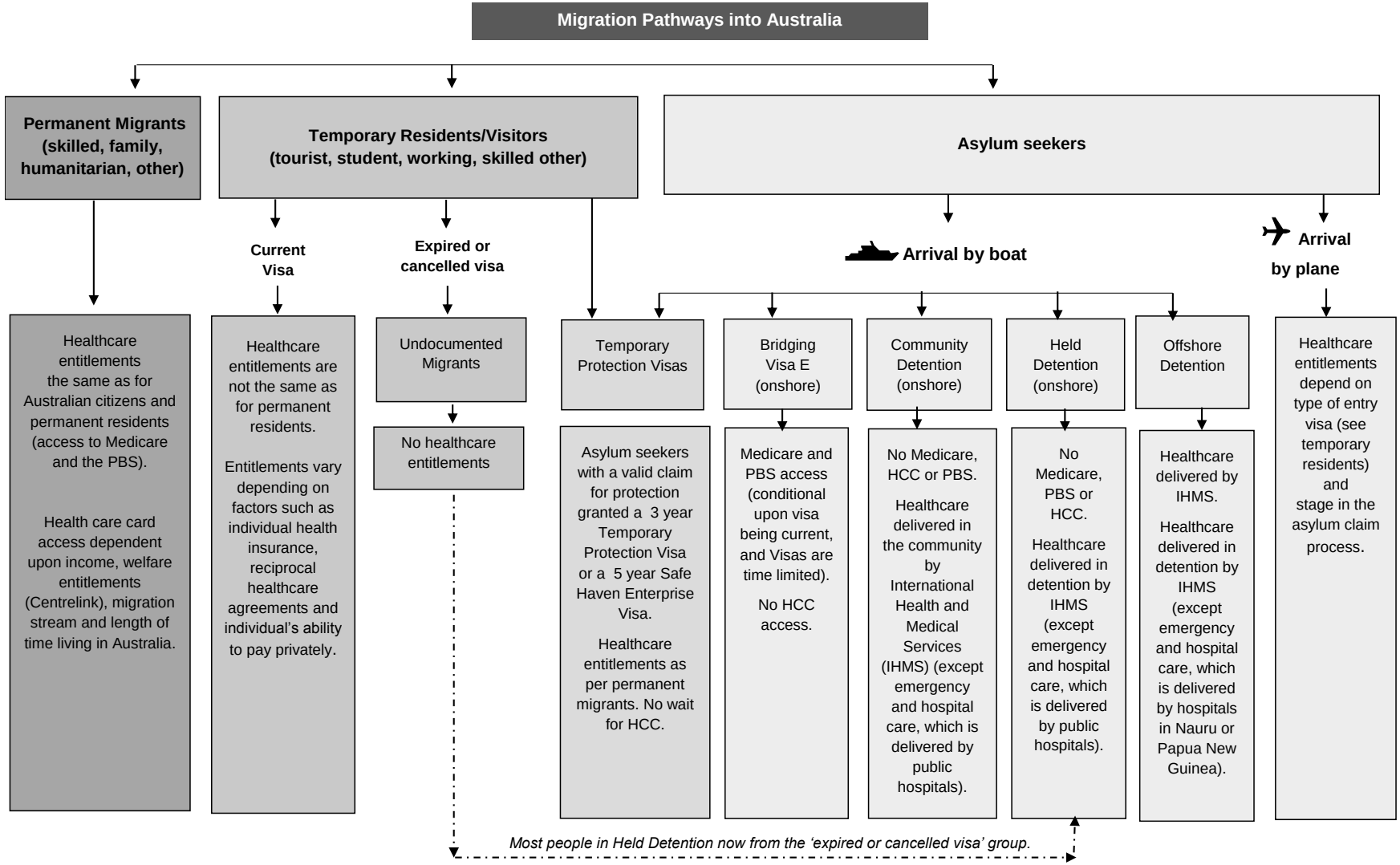
5. Migration in Australia

People migrate to Australia through three major pathways:

- Permanent migrants (skilled, family, humanitarian or other streams)
- Temporary migrants (workers, students, tourists or other visas)
- Asylum seekers - arriving by airplane (usually with a valid visa and travel documents) or boat (without valid visa or travel documents).

Figure 1 summarizes these migration pathways and the different healthcare entitlements for each group. Each migration pathway is then discussed in more detail.

Fiure 1: Migration pathways into Australia and related healthcare entitlements



6. Permanent migrants

Permanent migration into Australia occurs through the skilled stream, family stream, humanitarian stream and special eligibility stream, through the following programs:

- **The Migration Programme** predominantly includes skilled migrants, and immediate family members of permanent residents.[51, 52] Whilst numbers may fluctuate, a total of 189,097 people entered Australia through the Migration Programme stream in 2014-2015 (two thirds as skilled migrants, one third via the family stream and small numbers (0.1%) through the special eligibility stream).[q 53]

- **The Humanitarian Programme** is available for refugees and humanitarian entrants to Australia. Australia accepts approximately 13,750 refugee and humanitarian entrants annually[r]. This will increase to 16,250 places in 2017-2018 and 18,750 places in 2018-2019.[52, 54-56] In 2015, there was an additional allocation of 12,000 humanitarian places (in addition to existing places) for Syrian/Iraqi refugees in response to the Syrian crisis.[57] The Humanitarian Program has offshore and onshore components:

    - Offshore Humanitarian Programme: The majority of people who come to Australia via the Humanitarian Programme come via the offshore stream. They are supported by Humanitarian Settlement Services, which is provided through the Department of Social Services.[58]

    - Onshore Humanitarian Programme: Individuals who arrive in Australia *by airplane* and are found to have a valid claim for protection are eligible for a permanent protection visa. They then become permanent migrants to Australia under the Onshore Humanitarian Programme. In 2015-2016, there were 1,732 protection visa grants to non-illegal maritime arrivals via the Onshore Humanitarian Programme (2015-2016 cohort as at 30 April 2016).[59] This group are not eligible for Humanitarian Settlement Services.[54, 58]

Individuals who come to Australia via these Migration and Humanitarian Programmes are permanent visa holders and have the same healthcare entitlements as Australian citizens. This includes access to Medicare and the Pharmaceutical Benefits Scheme (PBS). [4] Most permanent migrants are not eligible for a Health Care Card (HCC) initially (there is a two year waiting period, with some exceptions).[11] Humanitarian entrants are exempt from this waiting period and are immediately eligible for a HCC.[11]

[q] Note: the 2015-2016 Budget announced there would be "*at least 3,485 places will be provided for Child category migrants outside the managed Migration Programme*'". However, the *sum total* family stream places will not change. (see Spinks, H. Commonwealth of Australia. Parliament of Australia. Migration and Humanitarian programs: Budget Review 2015–16 Index [Internet]. [cited 2016 May 23]. Available from: http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/BudgetReview201516/Migration)

[r] Note: this is for 2013-2014 and 2014-2015, however numbers fluctuate.

7. Temporary residents and visitors

Temporary visas include a visitor's visa or a temporary resident visa. Visitor visas are primarily for people coming to Australia for vacations, tourism, recreation, visiting family/friends and some short-term business activities. Temporary resident visas are typically for people coming to Australia as students, on a working holiday, as skilled temporary residents and for some other groups[s]. Whilst numbers fluctuate, there are large numbers of temporary migrants to Australia. For example, in 2013–14 over 4.7 million visitor and temporary resident visas were granted.[20]

In general, healthcare entitlements for temporary residents are not the same as for permanent residents. Visitors and temporary residents do not usually have access to Medicare and the PBS, unless they are residents of a country with Reciprocal Healthcare Agreement [t] (RHCA).[20] Temporary residents are not typically eligible for a HCC.[60]

The healthcare available for temporary migrants/visitors varies depending on considerations such as:

- The individual's health insurance arrangements (some temporary visas require proof of health insurance)[61];
- Whether the visa holder has come from a country which has a RCHA with Australia;
- An individual's ability to pay privately for services;
- Whether the individual has a Temporary Protection Visa.

An in depth discussion of the variations in healthcare entitlements for temporary migrants and visitors is out of scope for this report, with the following exceptions:

(a) Temporary Protection Visas (may granted to asylum seekers), and
(b) Cancelled or expired temporary resident visas (see below)

Cancelled or expired temporary visas

There are a significant number of people living illegally in Australia, outside immigration detention. This group is referred to as "Unlawful Non-Citizens" (UNCs) - in comparison with valid visa holders who are 'lawful non-citizens'. UNC include individuals who have had a temporary visa that has expired or been cancelled (also referred to as undocumented migrants) or permanent residents (without citizenship) who may have their visa cancelled based on character grounds. The Department of Immigration and Border Protection (DIBP) reported that as of June 30th 2014, there were 62,100 people in Australia who had a temporary visa which had expired or been cancelled, of whom 1,230 were aged 0-10 years, and 1,600 were aged 11-20 years[20].

[s] Other temporary residents: this category according to Migration Trends 2013-2014, includes "*a range of visas allowing people to come to Australia for social, cultural, international relations, training and research purposes, and those undertaking highly specialised short-stay work*". See Australian Government. Department of Immigration and Border Protection. Australia's Migration Trends 2013-2014. Commonwealth of Australia, 2014 [Internet]. Available from: https://www.border.gov.au/ReportsandPublications/Documents/statistics/migration-trends13-14.pdf#search=migration%20trends

[t] Reciprocal Health Care Agreements: this allows access some subsidised health services for essential medical treatment. This is only for people visiting from overseas from countries with which Australia has a Reciprocal Health Care Agreement (New Zealand, the United Kingdom, Ireland, Malta, Italy, Sweden, the Netherlands, Finland, Norway, Belgium and Slovenia) See Australian Government. Department of Health. About the PBS [Internet]. [updated 2016 January 1; cited 2016 April 13]. Available from: http://www.pbs.gov.au/info/about-the-pbs#Who_is_eligible_for_the_PBS and Australian Government. Department of Human Services. Health care for visitors to Australia [Internet]. [updated 2016 January 25; cited 2016 May 18]. Available from: https://www.humanservices.gov.au/customer/enablers/health-care-visitors-australia)

8. Asylum seekers

8.1 Background

An asylum seeker is someone who has applied for refugee status and who is awaiting a decision on this application.[62] Asylum seekers in Australia can broadly be divided by:[62]

(1) **Their means of arrival -** this determines whether they are (or have been) subject to mandatory detention:

- **Airplane arrivals:** People arriving by airplane by definition have an entry visa (e.g. a valid student or travel visa) and seek asylum after arrival in Australia. They are generally not subject to immigration detention, unless they do not clear immigration on arrive under circumstances such as if their visas are cancelled or expired.[4] There are limited data on the numbers of airplane arrivals; in 2012-2013, approximated 8,000 asylum seekers entered Australia by air.[4, 63]

- **Boat arrivals** without a visa (subject to mandatory detention): People may also arrive in Australia by sea without a visa, and seek asylum. Termed 'Illegal Maritime Arrivals' (IMAs), these individuals (including children) are subject to mandatory immigration detention.[63] The detention of these individuals - until they receive a visa or are removed from Australia - is prescribed under the *Migration Act 1958 Section 189.*[64, 65] Notably, the Act does not place a time limit on the duration of detention, and indefinite immigration detention is possible under Australian law (*Migration Act 1958: Section 196).*[12, 66]

  As a results of these laws, the there is no legislation preventing children being held in immigration detention in the future. According to *Migration Amendment (Detention Arrangements) Act 2005*, the detention of minors is considered a "last resort". This amendment to the *Migration Act 1958* states that "*The Parliament affirms as a principle that a minor shall only be detained as a measure of last resort*"[67]. Despite this amendment, significant numbers of children have - until very recently - been subject to prolonged[u] mandatory immigration detention (see Section 8.3).[68]

  The number of people entering Australia as IMA has fluctuated significantly, depending upon global forced migration, regional population flows, and the prevailing immigration policies and laws. For example, between 2000-2008 a total of 8,904 asylum seekers arrived by boat, and between 2009-2013, there were 51,637 asylum seekers arriving as IMA.[4, 69] There have been significant decreases in the number of people arriving in Australia by boat since September 2013.[18 70 4,]This is thought to be associated with changes in immigration policies such as increased maritime surveillance, the use of offshore processing and proposed offshore settlement; and changes to visa entry conditions in transit countries.[4, 62, 70]

  Between 2008-2013, the majority of asylum seekers arriving by boat (88-100%) were subsequently determined as having valid refugee claims. The final protection grant rate was greater than 90% in most years[v].[63, 71-73]

[u] For example, according to the Australian Human Rights Commission National Inquiry into Children in Immigration Detention*(The Forgotten Children, 2014*), on March 2014, children in Australian detention centres had been held for an average of 231 days; and by September 2014, the average length of detention for children and adults was one year two months.

[v] This refers to asylum seekers from Afghanistan, Iran, Iraq and Burma, and individual who are 'Stateless'. See: Royal Australasian College of Physicians. Policy on refugee and Asylum Seeker Health. May 2015. Sydney; Australia. Available from: https://www.racp.edu.au/docs/default-source/default-document-library/policy-on-refugee-and-asylum-seeker-health.pdf

(2) **Their date of arrival** - this determines how asylum seekers are processed and whether they are subject to offshore processing/resettlement.[62]

(3) **Their stage in the asylum claim process:**
- The majority of people who arrived after August 2012 have not had their claims for refugee status assessed.
- People who have had their claims assessed and declined at all stages of review may be described as 'finally determined'.[62]

8.2 Living circumstances of asylum seekers

Depending upon their means of arrival, date and arrival and stage in the asylum process, asylum seekers may be living in Australia in a variety of different circumstances.[62] Table 3 outlines the circumstances and entitlements for the different groups of asylum seekers, and detailed information about each group is provided below. Overall, asylum seekers may be living in the following circumstances:

(a) Held (locked) detention – onshore or offshore;
(b) Community detention;
(c) Living in the community on a bridging visa;
(d) Living in the community on a Temporary Protection Visa;
(e) Living in the community under other circumstances.[w]

8.3 Asylum Seekers in immigration detention

Immigration detention is the forced detention of individuals who are in Australia "unlawfully" as defined by the *Migration Act 1958.*[29] They may be unlawful be due to:

- Arrival in Australia without a visa (e.g. asylum seekers)
- Overstaying their visa
- Their visa being cancelled due to character or compliance grounds.[12]

Types of immigration detention include held and community detention. Detention occurs at onshore (mainland Australia) and offshore (Nauru and Papua New Guinea) locations.

8.3.1 Onshore Held Detention

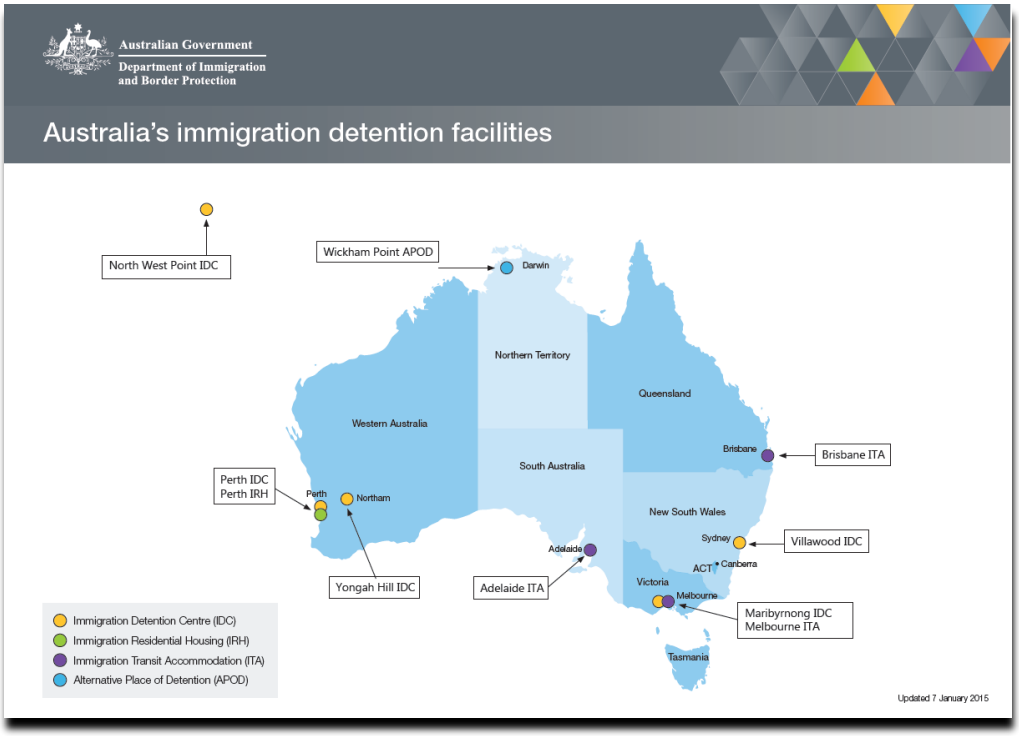
In Australia, this is a locked immigration detention facility (no freedom of movement), mandated for IMAs and people arriving by airplane who do not clear immigration. IMAs are now a minority of the detention population, with increasing numbers of people with cancelled or expired visas in held detention.

The map below illustrates the locations of held detention facilities on mainland Australia, however this information is subject to change. Whilst this map was current as of April 2016, four immigration detention facilities (Perth Immigration Residential Housing, Wickham Point Alternative Place of Detention,

[w] **Asylum seekers in the community also include:**
(a) People who arrived with a valid visa (lawful arrival to Australia): i.e. by airplane and have claimed asylum. People in this group may also be on bridging visas. This group are eligible to apply for permanent protection (See Onshore Humanitarian Programme).
(b) People who have had an initial (or later) claim rejected and are in the review process: the visa status of people in this group varies with their mode of arrival, time of arrival and processing pathway. Many will have a BVE although this visa may be of short duration and require renewal. A further group is those individuals who are 'finally determined' (found not to have a valid claim for protection) and who will be returned to their country of origin.

Maribyrnong Immigration Detention Centre and Villawood Immigration Detention Centre) have since been scheduled for closure in the 2016 federal budget.[74]

Figure 2: Map of mainland Australian immigration detention facilites



Source: https://www.border.gov.au/Complyingwithyourobligations/Documents/map-of-operational-facilities-april2016.pdf#search=map%20%20detention.[75]

As of 30 June 31 2016[18]:

- There were 1,577 people living in held detention facilities on Mainland Australia.
- The average length of time in held immigration detention was 441 days (with 23% of people in held immigration detention for over 2 years).[x 18]

There have been no children in held detention in Australia since April 2016, although there have been high numbers of children in immigration detention over the past three years, and some children have spent nearly three years in immigration detention. The number of children in held detention has varied. Between 2012-2016, the number of children in detention peaked in July 2013; with 1,992 children in held detention.[76, 77] There are currently (from April 2016) no IMA children in held detention on mainland Australia. There are still children in detention in Nauru.[78, 79]

[x] The average duration of detention has fluctuated. The shortest average length of held detention between 2012-2016 was 72 days, during the month of July 2013,76. Australian Government. Department of Immigration and Border Protection: Australian Border Force. Immigration and Detention and Community Statistics Summary, 29 February 2016 [Internet]. [cited 2016 March 23]. Available from: http://www.border.gov.au/ReportsandPublications/Documents/statistics/immigration-detention-statistics-29-feb-2016.pdf. at the time of peak numbers. Subsequently, changes in policy resulted in much longer periods in held detention.

8.3.2 Offshore Detention

Australian offshore processing centres (held detention) are currently found in the Republic of Nauru and on Manus Island (Papua New Guinea).[76] Offshore facilities now have freedom of movement.

Figure 3: Map of Nauru and Papua New Guinea

Source: http://www.internationalaffairs.org.au/events/resettlement-from-nauru-a-cautionary-tale/[80]

As of June 30 2016 there were 1,373 people living in offshore processing centres, of whom 49 are children (all in Nauru).[18] The date of arrival of an asylum seeker determined whether or not that person was subject to offshore processing and offshore resettlement as follows:[62]

- People who arrived by boat without a visa after 13 August 2012 and before July 19 2013 *could be* subject to offshore processing.
- People who arrived by boat without a visa after July 19 2013 *were* subject to offshore processing and offshore resettlement. However, some of this group remained in detention on Christmas Island or the mainland, and were then were included in the group which will have their protection claims processed under a new 'Fast Track Assessment' process (see Temporary Protection Visas).[81]
- People who arrived by boat (IMA) without a visa between 13 August 2012 and before 1 January 2014 who were not taken to an offshore processing centre will have their protection claims processed under a new 'Fast Track Assessment' process (see Temporary Protection Visas).[81] This also includes a small number of people who had previously submitted claims for permanent protection visas, where the claim was not finalised, and who are subject to retrospective application of temporary protection visas. It is important to note there were very few claims processed between late 2013 and early 2016.

Under current policies and laws, offshore resettlement applies to any asylum seekers arriving by boat arrivals in the future. The Department of Immigration and Border Protection website states: *"Australia will not grant a visa to anyone who tries to travel illegally by boat to Australia after 1 January 2014".*[82]

8.3.3 Community Detention

Asylum seekers who are released from held detention are able to live in the community while their immigration status is being determined.[4] In practice, Community Detention (CD) is residence in the community, in a house rented by the DIBP, with access to local community facilities, with some limitations including restrictions on night-time movement.

Asylum seekers in community detention are generally individuals who have experienced prolonged detention, and who have spent periods in offshore detention. The number of children in CD has varied, with a peak of 1,779 children in November 2013[76]. As of 30 June 2016, there were 623 people living in community detention, including 296 children.[18] The length time in CD is detailed as follows:

- 8.3% of people in community detention for ≤91 days
- 46.5% of people in community detention for ≤1 year
- 15.9% of people in community detention for 1-2 years
- 37.6% of people in community detention >2 years

Notably, there was no breakdown of the length of time in CD by adult/child status.[18]

8.4 Asylum seekers living in the community on a Bridging Visa

A bridging visa is a type of temporary visa, which allows a person to stay in Australia legally while their visa application is being determined[4]. A Bridging Visa E (BVE) may be granted to asylum seekers who have arrived in Australia by airplane. This group are eligible to apply for a permanent protection visa (see Onshore Humanitarian Programme). A BVE may also be granted to asylum seekers who arrive by boat without a valid visa (illegal maritime arrivals - IMAs). This group are only eligible to apply for Temporary Protection Visas (see Section 8.5), and most IMAs will have spent time in Held Detention. As of 30 June 2016, there were 28,163 asylum seekers living in Australia on a BVE of whom 4,073 were children.[18] The length of time granted on a BVE can vary. BVEs for asylum seekers are generally 12- month visas, but may be shorter.[4] Most asylum seekers (IMA) on a BVE have had work rights since 2015.

8.5 Asylum seekers on Temporary Protection Visas

Legislation[y] passed in December 2014 under a new 'Fast Track Assessment' process included reintroduction of temporary protection visas as either Temporary Protection Visas[z] (TPV, 3 years duration) or Safe Haven Enterprise Visas[aa] (SHEV, 5 years duration). As a result of this legislation, asylum seekers who arrive in Australia by boat and are found to have a valid claim are no longer eligible for a permanent protection visa.[19] They may only be granted a TPV or SHEV.[20-23] Once individuals are invited to apply for protection, they nominate the type of temporary protection visa (TPV or SHEV).

Asylum seekers who are successful in getting a TPV/SHEV have been found to be refugees. These visas allow individuals to work, but have a series of conditions attached. In order to fulfil the conditions of the SHEV visa, individuals have to work or study in regional Australia for a specified time period within the 5-year duration. After the specified TPV/SHEV time period, people must reapply for a further visa. Individuals on a TPV may reapply for a TPV; individuals on a SHEV visa, who meet the conditions of the visa, may be eligible to apply for one of several types of permanent visa under the Skilled or Family migration streams (Permanent Migration Programme).[24, 25]

[y] *Migration and Maritime Power Legislation Amendment (Resolving the Asylum Legacy Caseload) Act 2014.*
[z] TPV; subclass 785 XD.
[aa] SHEV; subclass 790

9. Unaccompanied minors

The DIBP define unaccompanied minors as "*a person under 18 years of age who arrives in Australia without a natural parent, or relative 21 years or older*"[83]. Children may enter Australia as an unaccompanied minor under a variety of pathways including:

- Unaccompanied refugee minors (known as unaccompanied humanitarian minors - UHM)
- Unaccompanied minors who are asylum seekers (UAM)
- Orphan relative visas
- Undocumented kinship care arrangements

Due to these different pathways of entry into Australia, this group are not part of Figure 1.

The legal status of unaccompanied minors is governed by the *Immigration Guardianship of Children Act 1946 Cth* (IGOC Act).[84] The IGOC Act specifies that the Minister of Immigration and Border Protection holds the legal guardianship for unaccompanied minors.[84, 85] Under the Act, UHM and UAM become wards of the Minister if they:

- Are less than 18 years of age;
- Arrived in Australia without a parent (excluding international adoptees); and
- Do not have a relative aged 21 years or older to care for them in Australia (those UAM are non-wards and their relative becomes their guardian).

The Minister of Immigration and Border Protection delegates the guardianship of UAM to a designated DIBP officer. UAM also have a DIBP case manager, Status Resolution Support Services case worker and custodian/service provider.[84] For refugee UAM (who have a permanent visa) the Minister delegates guardianship to state agencies, with a case manager and carer.

Of relevance to this report is the group of unaccompanied minors who come to Australia as asylum seekers (UAM). Children entering unaccompanied who are not asylum seekers (including UHM) have the same health entitlements as other Australia residents – however it is important to recognise they may have complex health issues and need specialised health services – particularly UHM and children arriving on orphan relative visas.

UAM are considered an extremely vulnerable group with complex needs, particularly those in detention. Senate estimates for February 2016 note there were 83 unaccompanied minors in community detention in Australia [73].

For more information, see:

- Royal Australasian College of Physicians. Policy on refugee and Asylum Seeker Health. May 2015. Sydney; Australia. Available from: https://www.racp.edu.au/docs/default-source/default-document-library/policy-on-refugee-and-asylum-seeker-health.pdf
- Australian Human Rights Commission. The forgotten children: National inquiry into children in immigration detention 2014. Sydney, 2014.

10. Healthcare for migrant children: specific responses to MOCHA

Specific responses to the MOCHA Round 2 Country Agent Questions (see Appendix 1) are provided below. MOCHA defines healthcare using the terms primary care, secondary care, emergency care, immunisation, screening and prevention programmes. According to the MOCHA definitions (see Glossary), "*Secondary care comprises inpatient and outpatient care and medical treatment provided by specialists*". In Australia, some hospitals, such as major tertiary children's hospitals come under the domain of Tertiary care. For the purposes of this report, tertiary and secondary care are considered together and grouped as 'secondary care'.

10.1 Entitlements to healthcare for children in asylum seeking families

1. a. Does the service delivery regulatory or commissioning framework for healthcare for children in your country include children in asylum seeking equally in the entitlements to care that are granted to children with permanent residency? Please answer in terms of:

Primary care (including type of care / location of treatment)?
Secondary care (including type of care / location of treatment)
Emergency care
Immunization
Screening and prevention programmes

1.b. Is this position underpinned by law, by operational regulations of the health provider, by regulation of the funding body, or by other means? Please specify briefly the law/regulation.

1.c. Are there any differences compared with resident children with regard to fees paid when accessing such health care?

1.d. How is this care funded?

1.e. Are there any conditionalities tied to receiving healthcare for children in this category e.g. administrative barriers etc.?

1 a – c.

Overview:

In Australia, relatively few healthcare entitlements for asylum seekers are prescribed by legislation; most are established through policy and guidelines and implemented at a state and territory level, with complex Commonwealth and state/territory funding arrangements. Where there are no national laws to determine healthcare entitlements for asylum seekers, healthcare access is determined at state/territory level by jurisdiction policy and may therefore vary for asylum seekers in the community. This situation is made more complex by the element of clinician and service provider flexibility and availability within any given policy. For an example of inter-state variation, see Box 1.

Healthcare entitlements for children and families who are asylum seekers also vary according to different living circumstances (see Section 8.2). Healthcare for asylum seeker children in immigration detention is provided under a national Department of Immigration and Border Protection (DIBP) framework (not state or territory policy). Healthcare is contracted by the Australian government to a private contractor, International Health and Medical Services (IHMS)[12]. IHMS provides (a) on-site care for people in held

detention, and (b) contracted community-based care for people in community detention - through IHMS-approved General Practitioners and pharmacies.[12, 13] People in held and community detention have no Medicare, Pharmaceutical Benefits Scheme (PBS) or Health Care Card (HCC). Emergency and acute healthcare is provided by local hospitals, and hospitals are reimbursed for costs by IHMs.[12, 14, 15]

Box 1. Some examples of state/territory variation in healthcare provision to Medicare ineligible asylum seekers

New South Wales (NSW): NSW public hospitals and mental health services must waive the fees for asylum seekers *living in the community* who are Medicare ineligible, for the following services:

- Emergency care for acute medical and surgical conditions, including admission;
- Elective surgery for conditions listed as Clinical Priority Categories 1 and 2 (with conditions);
- Ambulatory and outpatient care required to maintain health status of asylum seekers with acute and chronic health conditions (eg diabetes);
- Maternity services, including antenatal care;
- Mental Health services (inpatient and community based); and
- Urgent oral healthcare.[1]

Victoria: Victorian state policy mandates that Medicare ineligible asylum seekers receive full medical care (including emergency and elective care); including pathology, diagnostic, pharmaceutical and other services in Victorian hospitals. Medicare ineligible asylum seekers must not be billed (with exceptions – e.g. spectacles).[3] According to this policy, "*hospitals at their own discretion may choose to provide an extended level of service to Medicare ineligible asylum seekers where appropriate*".[3] However, even with these provisions, issues can arise at the frontline, including asylum seekers being incorrectly billed.[5]

Queensland: If an asylum seeker presents for public hospital services without a current Medicare card (such as a detainee asylum seeker, an asylum seeker on a Medicare ineligible bridging visa, or an asylum seeker whose Medicare eligible bridging visa or Medicare card has expired), fees are raised for those services (in accordance with the rates under Queensland Health's Fees and Charges Register) and are directed to the Department of Immigration and Border Protection or IHMS. However, individual hospitals and health services may elect to waive fees for asylum seekers who do not have current Medicare access or any other Commonwealth funded health assistance.[6]

Australian Capital Territory (ACT): The ACT policy *Public Health services to Medicare ineligible asylum seekers*, dictates that Medicare ineligible asylum seekers receive (free) full medical care including pathology, diagnostic, pharmaceutical and outpatient services in ACT public hospitals. This policy also states that Medicare ineligible asylum seekers must be given the same access as people with a HCC to public dental and community health services.[7]

Healthcare for children in offshore held detention facilities is provided by IHMS. Emergency and acute healthcare that cannot be provided onsite is provided by local hospitals.[16] There is evidence to suggest that the standard of healthcare in offshore detention centres and in Nauru and Papua New Guinea are below the standards of healthcare provided in Australian hospitals.[16, 17]

Healthcare entitlements for children seeking asylum who arrived by boat and are on a *current Bridging Visa E(BVE)* are generally the same as those granted to children with permanent residency; able to access Australia's universal healthcare system; Medicare. However, accessing care can be challenging (see Box 2). Access to the PBS and additional discounts on medication(s) depend on multiple factors including Medicare access and whether a person has Status Resolution Support Services (SSRS).[15, 86] SSRS providers fund the gap between HCC and PBS rates for people with a Medicare card.[bb] People on a BVE do not have access to a HCC[13].

[bb] For example: For with neither Medicare nor SRSS pay the full cost of medications with no safety net. People with Medicare but no SRSS receive the PBS rate for medications and the safety net threshold. People with SRSS (with or without Medicare) can access medications

Asylum seekers on Temporary Protection Visas have access to Medicare, the PBS, and a HCC (without the 2-year waiting period).[4, 11]

Asylum seeker children who arrived by airplane may not have Medicare or PBS access and face barriers to healthcare access. When considering the information in Sections 10.1.1 – 10.1.8, it is important to remember that asylum seekers who *arrive by airplane* will not all fit into any one asylum seeker category (i.e. BVE, Held Detention, Community Detention); as visa status is variable which results in variability in healthcare entitlements (see Table 3).

Table 3 summarises the entitlements and restrictions for asylum seekers.

Box 2: Challenges for asylum seekers on a Bridging Visa E when accessing Medicare

Asylum seekers would not qualify for Medicare under the normal Medicare eligibility requirements (see Medicare Eligibility). However, the Health Minister - under the *Health Insurance Act* - may permit non-citizens to access Medicare through a limited order. An order pertaining to the asylum seeker cohort expired on 31 December 2014 and was then renewed for 3 years. This has meant that asylum seekers with a valid bridging visa have subsequently been able to renew their Medicare.

However, some asylum seekers have had difficulty accessing healthcare, particularly due to their Medicare card expiring. There are two common scenarios:

1. A BVE may expire (thus Medicare access expires) before a person has had their immigration status determined due to the relatively short length of a BVE, +/- administrative delays.
2. Some people may then receive a further BVE, but may not renew their Medicare card.[2]

Between late 2013– 2014, between 30-50% of asylum seekers on BVEs had expired visas, and lost Medicare access.[2, 4] Currently this figure is approximately 10%. Whilst asylum seekers in this situation can still access healthcare, they are billed for any services and require a letter of supply from their SRSS provider to resolve this financial situation [2, 4].

prescribed by a GP - on script) for $6.10 (the same as the HCC rate). See http://refugeehealthnetwork.org.au/pharmaceuticals-for-asylums-seekers-in-the-australian-community/v

Table 3: Entitlements and restrictions for asylum seekers in varying circumstances

	Held Detention	Community Detention	Boat arrivals with Bridging Visa E (BVE) in the community	Airplane arrivals	TPV in community
Overview of Circumstance	Locked immigration detention facility (no freedom of movement). Mandated for Illegal Maritime Arrivals, and people arriving by airplane who do not clear immigration. Used for asylum seekers where BVE has been cancelled.	Asylum seekers who are released from held detention to live in the community while their immigration status is being determined[4].	These types of temporary visas permit people to stay in Australia legally while visa application is being determined[4]. If successful, eligible for temporary protection visa.	Entry on substantive visa then subsequent claim for protection; granted BVE to stay in Australia legally while visa application is being determined. If successful eligible permanent protection.	Asylum seekers who arrive in Australia by boat and are found to have a valid claim are no longer eligible for a permanent protection visa.[19] They may only be granted either a Temporary Protection Visa (3 years duration) or Safe Haven Enterprise Visas (5 years duration)[cc].[20-23] Asylum seekers who are successful in getting these visa have been found to be refugees.
Visa Status	No Status.	No Status.	Bridging Visa E (+/- expired).	Bridging visa (variable).	Temporary Protection Visa, Safe Haven Enterprise Visa, Temporary Humanitarian Concern Visa.
Social support	In detention	Through contracted agencies (Status Resolution Support Services -SRSS).*	SRSS - unless working.	Variable access to SRSS, lose access if working.	Not eligible for settlement support.
Healthcare	Healthcare provided by International Health and Medical Services (IHMS) in detention. Emergency and acute healthcare provided by local hospitals	Healthcare provided by IHMS-approved General Practitioners (GPs) and pharmacies.[12, 13] These GPs can refer people to allied health and specialist services with IHMS approval.[12]	Medicare conditional on having a valid BVE. Pharmaceuticals provided through PBS and gap cost to HCC equivalent) covered by SRSS.	Asylum seeker children who arrived by airplane may not have Medicare access, and face barriers to healthcare access. Variable access to Medicare. Significant barriers to	Medicare, the PBS, and a HCC (without the 2-year waiting period).

[cc] TPV; subclass 785 XD. SHEV; subclass 790

	Held Detention	Community Detention	Boat arrivals with Bridging Visa E (BVE) in the community	Airplane arrivals	TPV in community
Healthcare - Continued	and costs recovered from IHMS. [12, 14, 15] No Medicare, PBS or HCC.[14, 15]	No Medicare, PBS or HHC.[14, 15] Emergency and acute care is provided by public hospitals and costs are recovered from IHMS.		pharmaceutical access if no Medicare (no PBS, also no HCC). May have medications covered by SRSS (to HCC equivalent).	
Healthcare funding	The cost of this care is paid by IHMS, who are then reimbursed by the government[12].	The cost of this care is paid by IHMS, who are then reimbursed by the government.[12]	Government funded through Commonwealth (Medicare) and State (hospitals, community health) with some state/territory variation (e.g. ambulances).	Variable depending on access to Medicare (which is determined by type of visa). Variable State-based funding for non-Medicare eligible group.	Medicare.
Work Rights	No.	No.	Yes (from 12/2014, with renewal of BVE and conditional on valid BVE).	Generally yes, depending on conditions of entry visa.	Yes.
Income Support	No.	Yes (equivalent to 60% Special Benefit).	Yes (equivalent to 89% Newstart or Special Benefit).[dd]	No.	

**Asylum seekers in the community are supported through the Commonwealth-funded Status Resolution Support Services (SRSS) program; contracted to agency providers within the states and territories. There are different levels of support, depending on vulnerability, and individuals who are working lose access to SRSS.*

[dd] Newstart Allowance: Government-funded financial support for people who are looking for work or undertaking activities to find employment .
Special Benefit: Government-funded income support for people who are experiencing "severe financial hardship" and are unable to support themselves or their dependants. See www.humanservices.gov.au

10.1.1 Primary healthcare

Access to primary healthcare and the associated fee arrangements for asylum seeker children and families may differ from resident children depending upon visa status and associated living circumstances (also refer to Table 3):

- Bridging Visa E (BVE): Primary healthcare for people on a BVE is provided in the community through the usual Australian healthcare system. General Practitioners (GPs) provide general health and mental healthcare, catch-up immunisations, and Refugee Health Assessments (RHA). Notably, there is variability in the way that RHAs are delivered between the states/territories (e.g. type of healthcare practitioner, type of health service). GPs are available through community health centers (free), local bulk-billing doctors (free) or local private doctors (fees vary and there may be gap payments). Nurse delivered maternal and child health services (MCH) (free) provide preventive care including parenting advice and routine children's health and development checks from birth until school age. There is an out of pocket payment for medication for all patients, which may be at HCC or PBS rates, depending on Status Resolution Support Services support.[86]

- Community Detention: Primary healthcare for children and their families in community detention is provided in the community by IHMS-approved GPs. A public list of these individuals is not available. IHMS assign individuals a GP and pharmacy.[12] GPs refer individuals to allied health and specialist services as needed, pending IHMS approval.[12] The costs are paid for by IHMS, then IHMS is reimbursed by the Commonwealth government.[12]

- Onshore Held Detention: Primary care is provided in held detention by IHMS staff (GPs, nurses, counselors, psychologists).[12] Other services (e.g. psychiatric, dental, physiotherapy) are accessed after IHMS approval, by referral to an external provider.[12]

There is variation between the states for some entitlements. For example, in Victoria, refugees and asylum seekers have priority access to community health and dental services. This means that they are not placed on a waiting list but instead given the next appointment available.[3] This is not the case in NSW.

Funding: Primary healthcare is funded by the Commonwealth government, either directly via Medicare, or via IHMS reimbursement. For people referred to allied health and specialist services, the funding arrangements for this vary by jurisdiction. For example, in NSW, these services are largely privately funded. In comparison, in Victoria, allied health services for are free at public hospitals and community centres.[13]

Conditionalities: A current Medicare card is required for people on BVEs to avoid being billed for services (see Box 2). A Medicare card is also required in order to access subsidised medications via the PBS (see Box 2). People in held and community detention require IHMS approval in order to access services.

10.1.2 Secondary and tertiary healthcare

Access to secondary and tertiary level healthcare and the associated fee arrangements for asylum seeker children and families may differ from resident children depending upon visa status and associated living circumstances:

- Bridging Visa E: Specialist outpatient care occurs by GP referral, and is free when provided in public hospitals. Hospital inpatient care is provided by the public health care system (Medicare) free of charge. Private specialist services and private hospital care is generally inaccessible due to the associated fees (this is the same as for other vulnerable groups in Australia).

- Community Detention: Referrals to specialist services occur via IHMS providers. Care in hospital is provided by public hospitals.

- Onshore Held Detention: Specialist healthcare and other services (e.g. psychiatric services, dental services, physiotherapy) require referral. Services may be provided onsite (visiting health workers) or in the community (at an IHMs provider).[65] Local hospitals provide acute and emergency care.[65]

Funding: Secondary healthcare is funded by the government, either directly via Medicare, or via IHMS reimbursement.

Conditionalities: A current Medicare card is required by people on BVEs to access public secondary healthcare services, in order to avoid being billed (see Box 2). People in held and community detention require IHMS approval in order to access specialist services.

Specialised health services for refugees and asylum seekers: In Australia, there are services that specialize in refugee health (e.g. Refugee Health Clinics). Specialist mental health services for the survivors of torture and trauma are funded by the federal government, with additional funding for asylum seekers. These services are available in each state/territory.[ee] For example, in the Australia Capital Territory (ACT), Companion House provides primary health and mental healthcare to asylum seekers, refugees and new arrivals, including children, under a special agreement with ACT Health. There are child refugee health services in all states and territories.[13, 87]

10.1.3 Emergency care

Emergency and acute healthcare is provided by public hospitals to asylum seeker children in detention.[12] Asylum seekers on bridging visas can also access emergency and acute healthcare in public hospitals, however experts in immigrant health report that confusion can occur on the frontline, with asylum seekers being billed at international patient rates.

From a policy perspective, asylum seeker children have the same free access to emergency and acute public hospital care as resident children.

[ee] VIC: Victorian Foundation for Survivors of Torture; NSW: Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS); SA: Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS); QLD: Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT); ACT: Companion House; NT: Melaleuca Refugee Centre Torture and Trauma Survivors Service of the NT Inc; TAS: The Phoenix Centre.

Funding: Care for non-IHMS patients is through state/territory government funding for hospital services. IHMS is billed by public hospitals for the care of people who are in held or community detention.[88]

Funding arrangements for some emergency services may vary between states. For example, in Victoria, ambulance services (in an emergency) and public hospitals and related services are free for all refugees and asylum seekers, including those in community detention.[13ff] In New South Wales, community-based asylum seekers do not receive free ambulance services in an emergency, and they are billed. A fee waiver can then be requested, however this is not part of NSW State policy, and may not be granted. Fees for emergency care for acute medical and surgical conditions are waived by NSW public hospitals and mental health services.[1]

Conditionalities: no known conditionalities

10.1.4 Immunisation

Australia has a comprehensive vaccination program for children, the Immunise Australia Program. This program includes a schedule of recommended and government funded vaccinations, the National Immunisation Program (NIP) Schedule.[89] A national registry, the Australian Childhood Immunisation Register (ACIR), records vaccinations given to children and young people under 20 years of age[gg].[90] Prior to 2016, ACIR only recorded vaccinations for children aged <7 years.

Children of asylum seeking families arriving in Australia may be incompletely vaccinated with respect to the Australian NIP Schedule .[91] Catch-up vaccinations for children may be administered at different locations and by different healthcare providers, depending on the living circumstances of the asylum seeker children and their families:

- Bridging Visa E: Children of families on BVEs who did not receive vaccination in held or community detention or who have been incompletely vaccinated, can have catch-up vaccinations as part of a Refugee Health Assessment (see see Health Examinations for newly arrived migrants) or, as separate medical appointments.[4, 34]

- Community Detention: People in community detention who did not have vaccinations in held detention may be vaccinated in the community at IHMS-specified health service providers.

- Onshore Held Detention: Vaccinations may be provided in detention by IHMS.[92] Children leaving detention may not be fully vaccinated; Victorian research found that 44-53% of asylum seekers needed catch-up vaccinations after being released from immigration detention.[4]

In Australia, vaccinations are administered by General Practitioners (GPs) for the majority of the population although local government area (LGA) health services may provide vaccination, and there is significant variation between jurisdictions.[4, 50, 93] Vaccine healthcare providers vary by state. For example, in the State of Victoria catch-up vaccinations are provided through GPs (private practices and community health centres), LGA and public nurses (maternal and child health nurses). They may also be provided

[ff] Asylum seekers not in detention (held/community) are given a bill for emergency transportation costs, and the person's SRSS or another nominated support agency must then verify the person's status in order for the bill to be waived. See Victorian Refugee Health Network. Ambulance transport for asylum seekers [Internet]. [updated 2015 September 17; cited 2016 May 11]. Available from: http://refugeehealthnetwork.org.au/ambulance-transport-for-asylum-seekers-in-victoria/

[gg] Note: the registry has been for children < 7 years of age until 2016. This has now been extend to people <20 years of age.

at English language school (outreach programs), paediatric refugee health specialist clinics, or hospital based specialist clinics.[13]

Funding: Vaccines on the NIP Schedule are free for all children under 10 years of age.[94] Catch-up vaccinations are free until the end of 2017 for children/adolescents aged 10-19 whose families are eligible for family assistance payments, which is likely to be relevant for the majority of refugee children in Australia.[90] Asylum seeker children are not eligible for these family assistance payments, thus there is a potential gap for children aged 10-19 years.

There have been gaps in funding for vaccines given outside the NIP Schedule ages, and in general, migration is not well considered in Australian Immunisation policy. Some states provide specific eligibility for all asylum seeker children; in other jurisdictions there is less clarity on vaccine funding arrangements for asylum seeker children without Medicare. For example, in the State of Victoria, all child and adult asylum seekers are eligible for government-funded catch-up vaccines (with or without a Medicare card).[89, 94] However in the State of New South Wales (NSW), community-based asylum seeker children are not eligible for government funded vaccinations without a Medicare card[1].

Conditionalities and regulations: The Commonwealth *Social Services Legislation Amendment (No Jab, No Pay) Bill 2015*, effective from January 2016, mandates that children and young people < 20 years of age must be fully vaccinated (or have started an immunisation catch up program or have a medical exemption) in order to receive family assistance payments for certain childcare and tax benefits.[95, 96] These payments only apply to people who meet residency requirements, but this legislation will be relevant for people on a Temporary Protection Visa/Safe Haven Enterprise Visas as they are eligible for these family assistance payments.

There are also state-specific conditionalities for immunisations. For example, in the State of Victoria, separate *No Jab No Play* legislation, also effective January 2016, dictates that a child may only be enrolled in early childcare or kindergarten if fully vaccinated.[hh] Children who arrived in Australia as a refugee or asylum seeker are eligible for a 16-week grace period to start catch-up vaccinations after they enrol in childcare.[90, 95, 96]

10.1.5 Screening – see Health Examinations for newly arrived migrants

10.1.6 Prevention programs

Preventative health for asylum seeker children and families mainly occurs through the primary healthcare system. Whilst preventative health may not always be a clinical priority (in comparison with more immediate issues such as housing), a good GP will include preventative health as part of their clinical practice as they would for any resident (e.g. smoking cessation, pap smears, etc). Young children receive preventative well child healthcare through publicly funded maternal and child health nurses available in the community (availability varies between states). The Australasian Society for Infectious Diseases (ASID) and Refugee Health Network of Australia (RHeaNA) Guidelines for the post-arrival assessment of people from refugee-like backgrounds include preventative health assessments and investigations.[97]

[hh] Exceptions include children on a catch-up immunisation schedule or who are unable to be fully vaccinated for medical reasons.

10.1.7 Barriers to healthcare access

Asylum seekers and refugees may experience significant barriers to accessing healthcare. These may include, but are not limited to, language barriers, transport barriers, bureaucratic difficulties, unfamiliarity with the Australian health system and financial issues (thus dependency on public services which may be limited or have long waitlists).[4] Anecdotal evidence also suggests that even when there are guidelines about asylum seeker access to healthcare, they may not be consistently applied by frontline services, resulting in variability in access, and incorrect billing of asylum seekers for health services.

1.f Are unaccompanied children in this category awarded special entitlements to health care?

10.1.8 Unaccompanied minors

In general, unaccompanied minors living in the community have specialised support services, but not specialised health entitlements. Unaccompanied Humanitarian Minors (who arrive via the Humanitarian Programme as permanent residents) have the same health entitlements as Australian-born children. Unaccompanied Minors (UAM) (arrive as asylum seekers) in held and community detention - like other individuals in detention - receive healthcare from IHMS. Previously, UAMs in held detention received Status Resolution Support Services (SRSS) support, including carer support, transit support and independent observer services.[15] UAMs in community detention receive SRSS support, such as living with a full-time carer in a group house with other UAMs and a small allowance for personal items.[15] UAM are placed in community (not on a Bridging Visa E) in recognition of their vulnerability and support needs.

10.2 Entitlements to healthcare for undocumented children

2.a. Does the service delivery regulatory or commissioning framework for health care for children in your country include undocumented children, including children residing temporarily or passing through your country, and treat them equally with children granted permanent residency? Please answer in terms of: Primary care (including type of care / location of treatment) Secondary care (including type of care / location of treatment) Emergency care Immunization Screening and prevention programmes

2.a. According to the *Migration Act 1958: Section 189*, unlawful non-citizens (people whose temporary visa has expired or been cancelled or permanent residents -without citizenship- who may have their visa cancelled based on character grounds) are to be detained in immigration detention until they receive a visa or are removed from Australian.[64, 65] The DIBP reported that as of June 30th 2014, there were 62,100 people in Australia who had a temporary visa which had expired or been cancelled, of whom 1230 were aged 0-10 years, and 1600 were aged 11-20 years[20].

As unlawful non-citizens, undocumented migrant children do not meet the eligibility criteria for Medicare, the PBS or a HCC.[26-28] Without access to Medicare, one may infer that undocumented children could only receive treatment if (a) medical service providers were willing to forego any payment, or (b) if the child/parent/carer paid for the cost of any medical services. Whilst there is very little evidence available on this topic, there is potentially a disincentive for undocumented migrants to use health services, due to concerns they may be detected by immigration detention and detained.

Note: People from a country with a Reciprocal Health Care Agreement with Australia require a *valid visa* in order to access the subsidised health services that come under the agreement.[98]

2.b. Is this position underpinned by law, by operational regulations of the health provider, by regulation of the funding body, or by other means? Please specify briefly the law/regulation**.**

2.b. There are no laws/regulations pertaining to healthcare provision for undocumented children.

2.c. Are there any differences compared with resident children with regard to fees paid when accessing health care?

2.c. Yes (see question 2.a above). As healthcare is delivered by the states and territories, it is possible that there is variation in any fees paid *if* undocumented children are accessing healthcare (which is unknown). For example, in the State of NSW, frontline staff will request a Medicare card but not a visa. Patients will be treated regardless of whether or not they have a Medicare card, but without a Medicare card they will be charged costs (at international patient rates).[99]

2.d. How is this care funded?

2 .d. There is no government funding. One may infer that any care would be privately (out of pocket) funded or provided free or charge by a healthcare practitioner.

2.e. Are there any conditionalities tied to receiving healthcare for undocumented children, such as a duty to report to the authorities for health care staff, school attendance, administrative barriers etc.?

2.e. It is not known whether or not there are any conditionalities tied to receiving healthcare for undocumented children.

2.f Are unaccompanied children in this category awarded special entitlements to healthcare?

2.f. There are no known special entitlements to healthcare for unaccompanied children who are undocumented migrants.

10.3 Entitlements to healthcare for children of destitute EU citizens

3.a. Does the service delivery regulatory or commissioning framework for health care for children in your country include families and children of destitute EU migrants and treat them equally with children having permanent residency? Please answer in terms of:

- Primary care (including type of care / location of treatment)
- Secondary care (including type of care / location of treatment)
- Emergency care
- Immunization
- Screening and prevention programmes

3.b. Is this position underpinned by law, by operational regulations of the health provider, by regulation of the funding body, or by other means? Please specify briefly the law/regulation.

3.c. Are there any differences compared with resident children with regard to fees paid when accessing health care?

3.d How is this care funded?

3.e. Are there any conditionalities tied to receiving healthcare for children in this category e.g. administrative barriers etc.?

3.f Are unaccompanied children in this category awarded special entitlements to health care?

3.a → 3.f. As Australia is not a part of the EU, there is no specific legislation pertaining to destitute EU migrant children. There is no equivalent group of people in Australia based upon the MOCHA definition of 'children of destitute EU citizens' (see Glossary). This is because people entering the island of Australia must have a valid visa. In accordance with the *Migration Act 1958* people without a valid visa are considered a 'unlawful non-citizens' and are subject to immigration detention.[64, 65] The possible exceptions to this are New Zealand citizens living in Australia (see details below).

New Zealand residents and citizens in Australia

Prior to 1994, Australians and New Zealanders were able to visit, live and work in their reciprocal countries without applying for the authority to do so (under the *Trans Tasman Travel Arrangement, 1973).*[100]

As of 1 September 2014, a valid visa was required by all non-citizens in Australia.[100] At this time, a temporary visa became available specifically for New Zealanders; the Special Category Visa (SCV)[ii]. A SCV is received upon arrival at immigration and allows New Zealand passport holders to live, work or study in Australia indefinitely.[100] The SCV category is further subdivided into 'protected' and 'unprotected' SCV sub-categories. Protected SCV are for people who arrived in Australia prior to or on 26 February 2001. The SCV carries a health requirement (related to risk of Tuberculosis) and character requirement (criminal past/past deportation from Australia and elsewhere).[101]

A SCV is a temporary visa, thus SCV holders do not have the all same rights and benefits as Australian citizens or permanent residents.[102] To gain these rights, they must obtain permanent residency. However,

[ii] This was applied retrospectively to New Zealanders in Australia before that date.

New Zealanders can access Medicare[103] and the PBS under the RCHA between Australia and New Zealand.[104] Thus for Medicare-related services and PBS items, people who are citizens or permanent residents of New Zealand pay the same fees as Australian citizens or permanent residents.

Access to a HCC is more complex, and depends upon variables including the date of arrival in Australia.[102, 105, 106] Protected SCV holders have the same social security entitlements as other Australian residents and permanent residents (some exceptions, waiting periods apply).[102] Unprotected SCV holders can access some, but not all, of the social security entitlements available to Australian citizens and permanent residents. [102, 106]

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10.4 Health examinations for newly arrived migrants

4.a. Does the legal framework for health care for children in your country include any health examination/assessment for newly arrived children from other countries?

10.4.1 Overview

In order to migrate to Australia, children may be required to undertake certain health assessments. This is legislated by the *Migration Act 1958*[29] and the *Migration Regulations 1994*[30]. This legislation is operationalised through the following health examinations:

- (Compulsory) Immigration Medical Examination (IME) (all permanent migrants, and asylum seekers on grant of a substantive protection visa)
- (Voluntary) Departure Health Check (DHC) (Humanitarian Programme permanent migrants)
- Detention Health Assessment (asylum seekers in detention)

The Department of Immigration and Border Protection has specific guidelines for interpreting the Health Requirement of the *Migration Act* and *Migration Regulations.* The type of assessment required differs based upon variables such as the length of migration (permanent or temporary), the method of entry into Australia (airplane or boat), visa class, personal background and source country.[31] Health examinations also vary depending upon age. For example, children under 15 years of age are not usually required to have a blood test for human immunodeficiency virus, hepatitis B, hepatitis C and syphilis; and children under 11 years of age do not usually require a chest x-ray for tuberculosis.[31, 97]

Table 4 summarizes the health assessments as related to different migration pathways into Australia.

Table 4: Health assessments by migration stream

	Permanent Migrant (Skilled and Family streams)	Permanent Migrant (Humanitarian stream)*	Temporary Migrants	Asylum Seeker (Community detention, BVE)	Asylum Seeker (Held Detention)
Immigration Medical Examination	✓	✓	Health assessment varies depending on Visa type, country of origin, length of stay, intended activities whilst in Australia (eg healthcare, childcare) personal profile (e.g. pregnancy status or age), etc.[31]	✓ **	
Voluntary Departure Health Check		✓			
Detention Health Assessment				✓	✓
Refugee Health Assessment	Not applicable.	✓		✓	

**Syrian humanitarian entrants receive a combined immigration health examination and voluntary health departure check and have an extended screening protocol.*[97]

******* *An IME for asylum seekers is required when a substantive visa is granted.*

10.4.2 Immigration Medical Examination

The *Migration Act 1958* specifies the requirement of a valid visa to reside in Australia. Sections 60 and 65 of the *Migration Act 1958* give the government the power to require a health examination for a visa applicant and to grant, or refuse, a visa application based upon health criteria.[29] The *Migration Regulations 1994: Schedule 4 Public interest criteria and related provisions: 4005-4007* outlines the Health Requirement for migrants. The focus of the Health Requirement is to protect the population/government from conditions that are:

- of Public health significance (e.g. Tuberculosis),
- likely to require healthcare or community services,
- of high financial cost to the Australian healthcare system and community services, and/or
- adversely affecting access to healthcare and community services for Australian citizens and permanent residents.[30]

This legislation is operationalised through an Immigration Medical Examination (IME). Prior to entering Australia[ii], all permanent migrants (including children) must have a mandatory IME; a more limited health examination may apply to some temporary migrants. Due to changes in Migration Law (2012) there is a waiver of the Health Requirement for some visa types. For Offshore Humanitarian Programme entrants, the Health Requirement (health conditions and costs) is waived.[107, 108]

An IME occurs 3-12 months prior to travel, and depending on the results, a post-arrival health undertaking may be required. New guidelines for this examination include more extensive assessments for children, such as extended tuberculosis screening for children (Nov 20, 2015). The Australasian Society for Infectious Diseases (ASID) and Refugee Health Network of Australia (RHeaNA) Guidelines include the full details of this examination.

10.4.3 Voluntary Departure Health Check

Humanitarian Programme entrants may also undergo a second offshore health assessment, the voluntary Departure Health Check (DHC). It occurs in the week before traveling to Australia.[32] This voluntary assessment includes a "fitness to fly" assessment, measles-mumps-rubella and polio vaccines, anti-helminth treatment, screening for malaria and tuberculosis (and management if required), and other health screening as necessary.[4]

The DHC has both a public health and individual health needs focus. The Department of Immigration and Border Protection outlines the aims of this assessment.[32] Some aims (1-4) focus upon the needs of the individual child, whilst other aims (5) are to protect the resident population against health conditions that may be brought in to Australia:

1. To ensure the child is healthy enough to travel,
2. To determine if support is needed during their flight,
3. To allow provisions to be made onshore for health issues identified overseas,
4. To decrease the acute health issues in new arrivals.
5. Vaccination and anti-parasitic treatment before resettlement.[32]

[i]Note: Immigration Medical Examinations can occur onshore for onshore visa applications See Australian Government. Department of Immigration and Border Protection. Arranging a health examination [Internet]. [cited 2016 May 10]. Available from: http://www.border.gov.au/Trav/Visa/Heal/meeting-the-health-requirement/arranging-a-health-examination.

10.4.4 Detention Health Assessment

Children seeking asylum who arrive by boat will not have had a DHC or IME. Child asylum seekers in detention have a Detention Health Assessment.[4] There is no screening undertaken for asylum seeker children arriving by airplane who clear immigration (their health requirements will have been determined by their temporary visa type -see table 3).[4]

Detention Health Assessments are mandatory and are performed upon entry to immigration detention by IHMS. There are no published figures on uptake or whether screening is complete. Screening for children was limited prior to mid-2014, when children were not having blood testing or TB screening (except chest x-rays for children 11 years and older), including before being transferred offshore to Nauru.[4, 97]

Medical practitioners working in detention health have expressed serious concerns about the quality of Detention Health Assessments, specifically in relation (a) the standard of medical practice, (b) the quality of the assessment, and (c) the standards of care and the management of health problems discovered in detention health assessments.[4, 17]

There are no known conditionalities associated with a DHA.

Detention Health Assessments focus upon the physical and mental health needs of the individual. These assessments are also intended to protect the resident population against health conditions that might be brought into Australia, and are similar to the post-arrival Refugee Health Assessment. The protocol for Detention Health Assessments is not publically available.

10.4.5 Refugee Health Assessment

Australian guidelines recommend that all refugees and asylum seekers should be offered a voluntary comprehensive Refugee Health Assessment (RHA) in the first weeks/months after arrival in Australia (or after release from detention).[4, 33-35] Notably, asylum seekers arriving by airplane will not have had an Immigration Medical Examination, Voluntary Departure Health Check or a Detention Health Assessment.[97]

The aim of RHAs is to promote individual and public health. The assessment is a positive step towards optimising health, and addresses health inequity through the provision of 'catch up' immunisation, as well as diagnosis and treatment of unmanaged chronic conditions. These assessments have a strong focus on child health.[4, 36] The assessment specifics may vary according to the country of origin of the child and the pathway they have taken from the source country to Australia. The ASID/RHeaNA guidelines include full details of this examination. Overall, areas of health typically assessed include:

- Family and child priorities
- Communicable diseases
- Nutritional status and growth in children
- Oral Health
- Vision and hearing concerns
- Mental health, trauma exposure and development and behavioural concerns
- Catch-up immunisations
- Age assessments where required.[4, 13, 97]

The location of RHAs varies by state and territory. However, assessments usually occur at general practitioners, refugee health clinics and/or paediatric refugee health clinics. The uptake of these assessments is unknown. This is a voluntary assessment, which is funded by Medicare (for General Practitioners only, not specialists).[36]

The conditionalities of an RHA include:

- One-off service (but can be competed over multiple consultations); and
- In order to be covered by Medicare (for General Practitioners), the assessment must occur within 12 months of arrival, or the granting of a substantive visa.[97, 109]

4. b. Which categories of migrants are covered (e.g. asylum seeking, undocumented)?

4.b. The categories covered are permanent migrants, temporary migrants and asylum seekers. There is no known health screening/assessments for undocumented migrants living in the community.

The *Migration Act 1958*[64] and the *Migration Regulations 1994*[30] specify the health criteria which need to be met for a visa, which in turn typically line up with what could be considered categories of migrants (eg skilled visa, humanitarian visas).[30, 64]

4.c. Is it mandatory?

4.c. Assessments may be mandatory or voluntary:

- Immigration Medical Examination: Mandatory.
- Voluntary Departure Health Check: Voluntary.
- Detention Health Assessment: Mandatory.
- Refugee Health Assessment: Voluntary.

4.d. Is this service delivery focused above all on the needs of the migrant child, or is it adapted primarily to protect the resident population against health conditions which might be brought into the country?

4.d The focus of specific health assessments for newly arrived migrants varies by assessment type as follows (follow hyperlink):

- Immigration Medical Examination: see Section 10.4.2.
- Voluntary Health Departure Check: see Section 10.4.3.
- Detention Health Assessment: see Section 10.4.4
- Refugee Health Assessment: see Section 10.4.5.

11. Limitations

Immigration policy in Australia is a rapidly changing field with a high level of complexity and variability, particularly between different groups of asylum seekers. This report is not a comprehensive review of all literature, but rather aims to provide an overview of the circumstances and health entitlements of migrant children. Whilst this report includes issues which may be legal in nature, the report is not based upon legal expertise. Furthermore, whilst all efforts have been made to ensure this information is correct and current at the time of production (but not necessarily at the time of publication), complete accuracy cannot be guaranteed. Immigration Detention statistics are released on a monthly basis thus whilst they can indicate the current status quo, by the time of publication these statistics will be outdated. For the most recent statistical information on immigration detention, see www.border.gov.au. Several health policies and guidelines related to health entitlements for asylum seeker are currently under revision in some states and may have changed by the time this document is published.

12. Accompanying Documents

Royal Australasian College of Physicians. Policy on refugee and Asylum Seeker Health. May 2015. Sydney; Australia. Available from: https://www.racp.edu.au/docs/default-source/default-document-library/policy-on-refugee-and-asylum-seeker-health.pdf

Australian Government. Department of Immigration and Border Protection. Immigration Detention and Community Statistics Summary, 30 June 2016. Available from: http://www.border.gov.au

Australian Human Rights Commission. The forgotten children: National Inquiry into Children in Immigration Detention 2014. Sydney, 2014. Available from: https://www.humanrights.gov.au/our-work/asylum-seekers-and-refugees/publications/forgotten-children-national-inquiry-children

Appendices

Appendix 1: Round 2 country agent questions

WPG:

The questions below concern the national legal entitlements to healthcare in your country for migrant children with different administrative status. We are asking about the formal entitlements to healthcare as described in national laws and guidelines, and not the actual access in praxis. If you find that a law/regulation is not clear in a certain area we inquire about, simply answer: "unclear".

Policy for healthcare for migrant children

1. Entitlements to healthcare for children in asylum seeking families

1. a. Does the service delivery regulatory or commissioning framework for healthcare for children in your country include **children in asylum seeking** equally in the entitlements to care that are granted to children with permanent residency? Please answer in terms of:

- Primary care (including type of care / location of treatment)?
- Secondary care (including type of care / location of treatment)
- Emergency care
- Immunization
- Screening and prevention programmes

1.b. Is this position underpinned by law, by operational regulations of the health provider, by regulation of the funding body, or by other means? Please specify briefly the law/regulation.

1.c. Are there any differences compared with resident children with regard to fees paid when accessing such healthcare?

1.d. How is this care funded?

1.e. Are there any conditionalities tied to receiving healthcare for children in this category e.g. administrative barriers etc.?

1.f Are unaccompanied children in this category awarded special entitlements to healthcare?

2. Entitlements to healthcare for undocumented children

2.a. Does the service delivery regulatory or commissioning framework for healthcare for children in your country include **undocumented children, including children residing temporarily or passing**

through your country, and treat them equally with children granted permanent residency? Please answer in terms of:

- Primary care (including type of care / location of treatment)
- Secondary care (including type of care / location of treatment)
- Emergency care
- Immunization
- Screening and prevention programmes

2.b. Is this position underpinned by law, by operational regulations of the health provider, by regulation of the funding body, or by other means? Please specify briefly the law/regulation.
2.c. Are there any differences compared with resident children with regard to fees paid when accessing healthcare?
2.d. How is this care funded?
2.e. Are there any conditionalities tied to receiving healthcare for undocumented children, such as a duty to report to the authorities for healthcare staff, school attendance, administrative barriers etc.?
2.f Are unaccompanied children in this category awarded special entitlements to healthcare?

3. Entitlements to healthcare for children of destitute EU citizens

3.a. Does the service delivery regulatory or commissioning framework for healthcare for children in your country include **families and children of destitute EU migrants** and treat them equally with children having permanent residency? Please answer in terms of**:**

- Primary care (including type of care / location of treatment)
- Secondary care (including type of care / location of treatment)
- Emergency care
- Immunization
- Screening and prevention programmes

3.b. Is this position underpinned by law, by operational regulations of the health provider, by regulation of the funding body, or by other means? Please specify briefly the law/regulation.
3.c. Are there any differences compared with resident children with regard to fees paid when accessing healthcare?
3.d How is this care funded?
3.e. Are there any conditionalities tied to receiving healthcare for children in this category e.g. administrative barriers etc.?
3.f Are unaccompanied children in this category awarded special entitlements to healthcare?

4. Health examinations of newly arrived migrants

4.a. Does the legal framework for healthcare for children in your country include any health examination/assessment for newly arrived children from other countries? If yes,
4. b. Which categories of migrants are covered (e.g. asylum seeking, undocumented)?

4.c. Is it mandatory?

4.d. Is this service delivery focused above all on the needs of the migrant child, or is it adapted primarily to protect the resident population against health conditions which might be brought into the country?

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