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# The Migration Health Requirement

## The Migration Health Requirement

3.1 Most applicants for a temporary or permanent visa to enter Australia are required to fulfil the migration Health Requirements. Health assessments are made based on a range of criteria linked to the length of stay, purpose of visit and type of visa applied for.

3.2 Historically, permanent migrants and temporary visitors have been subject to some form of Health Requirement since the *Immigration (Restriction) Act 1901* (Cth). Essentially this prohibited the migration of persons with certain types of infectious or contagious diseases. It was repealed with the introduction of the *Migration Act 1958* (Cth) (the Act), which is in force to the current day, although with significant amendments to the original statute. The Act, like its predecessor, contained a list of prescribed diseases which would exclude persons from migration. In addition to the Act, Migration Regulations were introduced in 1989 which prescribed new health criteria and removed all reference to prescribed diseases, with the exception of tuberculosis. The Migration Regulations were updated in 1994 and introduced three Public Interest Criteria (PICs), as outlined in Chapter 2 to regulate Australia's Health Requirement.

3.3 The Department of Immigration and Citizenship (DIAC) suggests that there are a number of reasons behind the need for a Health Requirement. These are to:

- protect the Australian community from public health and safety risks;
- contain public expenditure on health care and community services; and

- safeguard the access of Australian citizens to health care and community services that are in short supply.[1]

3.4 An applicant for a visa will be deemed 'not to meet' the Health Requirement if they are considered a threat to public health in Australia (such as for having active tuberculosis) or where their disease or condition would result in significant cost to the Australian community or prejudice the access to health care by Australian citizens or permanent residents.

3.5 DIAC has stated that:

> Where this occurs a visa cannot be granted unless a "health waiver" is available. Currently, such waivers are only available for certain visa subclasses (mainly in the family and humanitarian visa streams)1. Waivers are only exercised in limited circumstances (e.g. where the decision-maker believes that there are significant compelling and compassionate reasons to do so).[2]

3.6 This chapter aims to provide an overview of the Health Requirement and the waiver provisions under the PICs of the Migration Regulations 1994. These provisions underpin the opportunity for a visa applicant to be granted a waiver. It also outlines the considerations taken into account by Medical Officers of the Commonwealth (MOCs) in assessing the Health Requirement and outlines the range of arguments in relation to it and its retention. There is also a discussion of health requirements as they apply in other nations.

## Description

3.7 The migration Health Requirement is administered by DIAC and is aimed primarily at the protection of public health and containing public health expenditure in Australia.[3] A range of other federal government agencies are also involved in the process including the Department of Health and Ageing (DoHA) and the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). Their roles are primarily in setting the policy agenda rather than the actual administration of the Health Requirement.

3.8 There are a number of core legislative elements of the Health Requirement as described earlier—the *Migration Act 1958* and the Migration

1 Department of Immigration and Citizenship, *Submission 66*, p. 5.

2 Department of Immigration and Citizenship, *Submission 66*, p. 5.

3 Migration Regulations 1994.

Regulations 1994, which contain the three PICs by which waivers under the Health Requirement are determined.

3.9 The Health Requirement delineates between permanent and temporary migrants to Australia. DIAC's *Fact Sheet 22* which outlines the Health Requirement states:

> All applicants for permanent visas, including the main applicant, partner and any dependants, must be assessed against the health requirement. Even if the applicant's partner and dependants are not included in the visa application, they must still be assessed against the health requirement.[4]

3.10 In relation to temporary visa applicants, *Fact Sheet 22* states:

> Applicants for temporary visas may be required to undergo a medical examination, chest x-ray and/or other tests depending on how long they propose to stay in Australia, their intended activities in Australia, their country's risk level for tuberculosis (TB) and other factors.[5]

3.11 Importantly, it must also be noted that applicants for classes of offshore humanitarian and refugee visas are also subject to the Health Requirement. Applications from this group of potential migrants may be rejected on a health-related ground. This issue will be discussed further in Chapter 5.

## Section 65 of the *Migration Act 1958* (Cth)

3.12 This section will examine s 65 of the *Migration Act 1958* (Cth) as it relates to the decision-making process in relation to the Health Requirement.

3.13 Section 65 of the Act deals with the 'decision to grant or refuse to grant a visa'.[6] Section 65(1)(a) and (b) states:

> (1) After considering a valid application for a visa, the Minister:
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> (a) if satisfied that:
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> (i) the health criteria for it (if any) have been satisfied; and

4 Department of Immigration and Citizenship, accessed May 2010 at <http://www.immi.gov.au/media/fact-sheets/22health.htm>.

5 Department of Immigration and Citizenship, accessed May 2010 at <http://www.immi.gov.au/media/fact-sheets/22health.htm>.

6 *Migration Act 1958* (Cth) s 65.

(ii) the other criteria for it prescribed by this Act or the regulations have been satisfied; and

(iii) the grant of the visa is not prevented by section 40 (circumstances when granted), 500A (refusal or cancellation of temporary safe haven visas), 501 (special power to refuse or cancel) or any other provision of this Act or of any other law of the Commonwealth; and

(iv) any amount of visa application charge payable in relation to the application has been paid;

is to grant the visa; or

(b) if not so satisfied, is to refuse to grant the visa.[7]

3.14 For the purposes of this report, a person with authority to act under s 65 of the Act (other than the Minister of Immigration and Citizenship) will be referred to as a "Department decision-maker".

3.15 In applying s 65 of the Act, a Department decision-maker must consider the health criterion named therein. Subsection 5(1) of the Act, provides the following definition for the 'health criterion' as specified in s 65:

> ***"health criterion"***, in relation to a visa, means a prescribed criterion for the visa that:
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> (a) relates to the applicant for the visa, or the members of the family unit of that applicant; and
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> (b) deals with:
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> (i) a prescribed disease; or
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> (ii) a prescribed kind of disease; or
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> (iii) a prescribed physical or mental condition; or
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> (iv) a prescribed kind of physical or mental condition; or
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> (v) a prescribed kind of examination; or
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> (vi) a prescribed kind of treatment.[8]

3.16 DIAC states that the effect of s 65 (in conjunction with the definition in s 5(1) is that:

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7 *Migration Act 1958* (Cth) s 65(1)(a) and (b).

8 *Migration Act 1958* (Cth) s 5(1).

> ... this section (together with Regulation 2.25A) allows for most decisions regarding whether someone meets the health requirement to be made by a Section 65 delegate (i.e. by a visa decision-maker without input from a medical officer).[9]

## Operation

3.17 This section will outline the current procedure in relation to the operation of the Health Requirement.

3.18 Following the receipt of a visa application by DIAC, the Department decision-maker must identify whether the applicant (or member of a family group in the case of a joint application) possesses a 'significant medical condition' which requires assessment. The need for such an assessment may be identified in several ways. The first is through self-identification by the applicant of a significant medical condition in the application process. The second is where Department decision-maker may ask an applicant to undergo an assessment on a risk management basis.[10]

3.19 Where there has been the identification of a significant medical condition:

> ...or the applicant has undertaken their medical examinations in a specified country, the results of their examinations must be referred to a Medical Officer of the Commonwealth (MOC) for an opinion as to whether or not they meet the health requirement. Consequently, a finding that the applicant meets or does not meet the health requirement (as long as they have completed the required examinations) will always be made by a MOC.[11]

3.20 The process that is followed by a MOC is addressed in Chapter 4 of this report. In most cases the decision made by an MOC is final (under Regulation 2.25A of the Migration Regulations 1994) and an applicant may be rejected on health grounds (unless a visa waiver applies), even where there are extenuating circumstances such as family, employer or financial support.

### Health waivers

3.21 The concept of a 'waiver' is central to the discussion within this report. A waiver of the Health Requirement is available to visa applicants who apply for visas in certain classes and as such, allows the Department

9 Department of Immigration and Citizenship, *Submission 66*, p. 8.

10 Department of Immigration and Citizenship, *Submission 66*, p. 8.

11 Department of Immigration and Citizenship, *Submission 66*, p. 8.

decision-maker to take into consideration factors which are not health-related when assessing visa applications.

3.22 As outlined earlier, Australia's health requirement is underpinned by the three key PICs outlined in Schedule 4 of the Migration Regulations 1994. These PICs outline broadly the criteria for assessment under the Health Requirement and that is applied to all visa applications. The full text of the PICs is provided at Appendix C.

- PIC 4005 applies to a majority of visas and sets out the standard Health Requirement criteria by which all visa applicants are assessed. This includes meeting 'significant cost' and 'prejudice to access' requirements;
- PIC 4006A applies to temporary long stay skilled business visas and provides access, at the Minister's discretion, to a waiver provided that the sponsoring employer undertakes to indemnify identified health-related costs; and
- PIC 4007 applies to a limited number of family stream, humanitarian and skilled visas and provides access to a waiver consideration at the Minister's discretion. This allows the Department decision-maker[12] to take into account other factors such as the 'compelling and compassionate circumstances' of the case, as well as financial and other offsets to the identified costs. [13]

3.23 In relation to these PICs, DIAC informed the Committee:

> A waiver of the health requirement is available where PIC 4006A or PIC 4007 is attached to the relevant visa subclass. Currently, these PICs apply to limited visas in the humanitarian and family streams. This has generally been the case in the past as well - with it traditionally only considered appropriate to allow for a health waiver in humanitarian cases or where the family members of Australian citizens or permanent residents are involved. [14]

3.24 This traditional approach has meant that the majority of permanent visa applicants, including for permanent skilled visa applicants (the largest migration program) have no waiver option. If either PIC 4006A or PIC 4007 is attached to a visa then a waiver option provides that additional

12 *Migration Act 1958* (Cth) s 65.

13 See discussion Mr Matt Kennedy, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 24 February 2010, p. 7.

14 Department of Immigration and Citizenship, *Submission 66*, p. 12.

considerations may be given to the application by the Department decision-maker.

3.25 Under PIC 4007 the visa applicant will have the opportunity to provide additional medical reports and other evidence of economic, social or other circumstances to offset costs identified by the MOC. As noted, consideration under PIC 4006A depends on the willingness of a sponsoring employer to provide a financial undertaking to offset the identified costs.[15]

3.26 DIAC advises that in nearly all cases 4006A visa waivers are granted.[16] However, under PIC 4007 waiver considerations, if the health costs identified by the MOC significantly exceed the 'significant cost' threshold and may 'prejudice' access to services in short supply to other Australians, then the waiver may not be granted.

3.27 Chapters 5 discusses waiver arrangements applying to visas in family and refugees streams. Chapter 6 looks at waiver issues for skilled migration visas.

## Factors considered under the Health Requirement

3.28 MOCs take into account a number of factors when assessing applicants in relation to the Health Requirement. The first of these is where the MOC assesses that a significant cost may be incurred by the Australian community as a result of the health needs of the applicant. A further consideration is given to 'prejudice to access' and is applied in cases where it is considered that the healthcare or service needs of a particular applicant may prejudice the access to a particular healthcare treatment or service for an Australian citizen or resident.

### The significant cost threshold

3.29 In assessing an applicant under the Health Requirement the MOC will determine whether the heath care and community service costs attributable to a particular illness or condition will exceed the 'significant cost' threshold. A visa applicant will be deemed 'not to meet' the Health Requirement if it is considered that the cost of their treatment will be a significant burden on the Australian community.

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15 As discussed in Chapter 6, Assurance of Support (AoS), or bonded visa, opportunities also apply for one other PIC 4005 visa class.

16 Dr Paul Douglas, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 17 March 2010, p. 5.

3.30 A threshold in relation to this cost has been prescribed by DIAC and currently stands at $21 000. The calculations of the threshold stem from the 'Notes for Guidance' series of papers which are provided to MOCs in making cost estimations. There are a number of criticisms in relation to this threshold which will be discussed below.

3.31 In relation to the threshold, DIAC informed the Committee that:

- costs are considered to be significant where a MOC assesses that the potential costs of the applicant's disease or condition to the Australian community in terms of health care and community services are likely to be more than $21000;
  - ⇒ this threshold has been calculated on the average per capita health care and community service costs for Australians over a minimum period of 5 years, plus a loading of 20% to take into account rapid increases in average expenditure on health and community services.[17]

3.32 In terms of this methodology, DIAC told the Committee:

> I think it is fair to say that the current methodology does not take into account possible financial contributions from the Australian community... It may well be an issue that needs to be at least considered as to whether it actually gets factored into the formulation.[18]

3.33 DIAC added:

> ...The MOCs assess on the likely cost. In other words, they are looking at the very high probability that this is going to be the cost. In the notes for guidance we talk about the 65 per cent to 70 per cent probability. If it does not meet that 65 per cent or 70 per cent likelihood then that cost will not be applied. It is an important point. The health economist who has developed the notes-for-guidance papers has indicated that, because of that test, we significantly undercost applicants on the whole when they do not meet the health requirements.[19]

3.34 One of the criticisms of the significant cost threshold is that it is too low and does not provide sufficient consideration for the costs of an applicant's health and community services needs.

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17 Department of Immigration and Citizenship, *Submission 66*, p. 9.

18 Mr Peter Vardos, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 24 February 2010, p. 3.

19 Dr Paul Douglas, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 17 March 2010, p. 16.

3.35 The Committee asked what the cost to the Australian health system would be over a person's lifetime. DIAC responded:

> There is very little evidence about utilisation of health services and what the costing behind that is. There have been some recent studies done which showed that migrants, on the whole, cost less to the community from health and community resource utilisation, in that we have a selective process about who comes and who does not come. Within a generation, though, the cost of migrants is the same as it is for the general Australian community. [20]

### Review of the threshold

3.36 DIAC has informed the Committee that there is a process underway to review the current $21 000 significant cost threshold. DIAC told the Committee that:

> On the whole, the MOCs have been using a costing that was applied way back in 2000 and has not actually been escalated or changed since that time. So the cost is probably very much under cost in what they currently do.[21]

3.37 DIAC further explained to the Committee:

> That costing was done in the 2002-03 financial year. There has been no formal annual review process for that. We are in discussions with the Department of Health and Ageing and other agencies to look at how we might review that costing on a more regular basis, but we have not had formal feedback from those agencies yet.[22]

3.38 DIAC told the Committee that in relation to the review:

> ...We are taking, basically, a two-stage approach to it: we are using the current methodology to update it, subject to some information we are seeking from the Department of Health and Ageing on prejudice to access in terms of a broader range of services that raising the threshold might encompass... The formula itself... is almost a decade old, and it was developed in consultation with the

20 Dr Paul Douglas, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 17 March 2010, p. 13.

21 Dr Paul Douglas, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 17 March 2010, p. 11.

22 Dr Paul Douglas, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 17 March 2010, p. 13.

> Department of Immigration, the then Department of Health and the Department of Family and Community Services.[23]

3.39 In the context of the current system, the Committee welcomes the review of the 'significant cost threshold'. The Committee considers this review to be a priority issue for DIAC and urges DIAC to expedite the review and amend processes accordingly. There are a range of factors which need consideration and the Committee looks forward to the results of the review when it is completed.

### Assumptions of future cost

3.40 Currently, in calculating the costs under the 'significant cost threshold', MOCs use the guidance provided in the 'Notes for Guidance' series of papers. Each of these papers contain tables outlining the annual cost of a range of health treatment and community service options available to the visa applicant. In calculating the costs of the threshold, an MOC uses the formula outlined by DIAC earlier and arrives at an estimated threshold cost for each applicant.

3.41 Many submissions to the inquiry were however critical of the fact that the costs provided in the 'Notes for Guidance' series made assumptions based on the future health treatment and community services that would be utilised by a visa applicant. This includes access to social security benefits such as a Disability Support Pension (DSP). It is argued by some that many disabled migrants will not use the entire spectrum of services available to them at all given times, as assumed in the calculation of the threshold.

3.42 Mr Peter Papadopoulos of the Law Institute of Victoria told the Committee:

> While Medical Officers of the Commonwealth, I am told, have a lot of information available to them when they make their decisions, I have found that the decisions tend to be routine. No matter what level of Down syndrome or HIV a person might have, the costings are the same.[24]

3.43 The Multicultural Development Association states:

> Calculating the future costs associated with disability over a person's life time is a tremendously difficult process; a process that

23 Mr Matt Kennedy, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 24 February 2010, p. 2.

24 Mr Peter Papadopoulos, Law Institute of Victoria, *Committee Hansard*, Melbourne, 18 February 2010, p. 14.

> is sometimes ad-hoc with significant margins for subjective interpretation. Further, the health assessment does not take into account whether or not services will actually be utilised or whether individuals are able to self fund the costs associated with their illness or disability. More importantly, it does not take into consideration the contribution that the family make as a whole to Australia or to their communities as in the case of Dr Moeller who was filling a skill shortage in rural Victoria.[25]

3.44 The Royal Australasian College of Physicians states:

> The RACP believes that people with disability may be rejected because of untested assumptions about future costs associated with their disability. It is difficult to rationally and fairly assess the costs associated with disability or illness over a person's life time, and arguably there is significant room for interpretation in this process. Indirect discrimination against migrants with disability may also occur because the evidentiary requirements are not sufficiently strong, for example in relation to accurately quantifying the future costs to the community of illness or disability.[26]

3.45 Ms Mary Ann Gourlay states:

> The costs estimate regarding what now becomes only a possible provision of services is to be made 'regardless of whether the health care or community services will actually be used in connection with the applicant'.[27]

3.46 Mr Phil Tomkinson provides the Committee with a personal example:

> ...as with my own daughter, a child who they said would not speak, would not be able to self-care and would never be employable tomorrow morning will get up, feed herself, catch her own transport and go to work. Assessing people at a young age is a very flawed method.[28]

3.47 Dr Susan Harris Rimmer from Australian Lawyers for Human Rights suggests that there are a number of things that Australia's health requirement does not pick up:

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25 Multicultural Development Association, *Submission 20*, pp. 7– 8.

26 Royal Australasian College of Physicians, *Submission 80*, p. 9.

27 Ms Mary Anne Gourlay, *Submission 25*, p. 16.

28 Mr Phil Tomkinson, Queensland Parents for People with a Disability, *Committee Hansard*, Brisbane, 28 January 2010, p. 16-17.

> If we were thinking about costs to our health system, we know obesity and diabetes are an enormous cost to our health system. We do not test for that. Our health matrix does not pick up wealthy businessmen from the US who might have a heart attack the minute they get here due to their heavy executive role. So all the assumptions we are making about cost do have value judgements behind them. We do not cost general migrants. We do not cost migrants from developed countries.[29]

3.48 Down Syndrome Western Australia states:

> Anecdotally, however... many families [are] attempting to migrate to Australia with a member with a disability, who have repeatedly advised the Immigration authorities that they would willingly undertake to provide full medical and health insurance, cover all costs associated with education, and provide any required assurance that their family member will not become reliant on social welfare benefits, and I have never heard of a family in these circumstances which has been permitted or has been offered this option.[30]

3.49 As an example of changing approaches to disability and subsequent costing changes, the Committee asked DIAC about the impact of most children with a disability now being schooled in mainstream schools. Importantly, this change would affect the method of calculating special education costs. Dr Paul Douglas, DIAC replied:

> There are two factors I would like to go back to. One is the threshold issue. Basically, that is looking at the current expenditure that the Australian government provides to the public services related to community and health care. It has not at any stage taken on board the costs that may be contributed by the people with a disability. With regards to the current changes that have happened with regard to mainstream schooling, we have had sessions with the Department of Education and Training and they tell us what the current processes are. So MOCs are provided up-to-date training in the current environment.[31].

3.50 The Royal College of Australasian Physicians commented on this point:

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29 Dr Susan Harris Rimmer, Australian Lawyers for Human Rights, *Committee Hansard*, Canberra, 18 November 2009, p. 5.

30 Down Syndrome WA (Western Australia), *Submission 57*, p. 7.

31 Dr Paul Douglas, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 24 February 2010, p. 4.

> There has been a trend towards students with severe or profound core activity limitations attending ordinary schools rather than special schools.[32]

3.51 In terms of the actual calculations of significant cost, many submissions to the Inquiry have outlined difficulties in understanding how an MOC has arrived at a particular cost estimate.[33] This is especially so when many visa applicants are willing to demonstrate their capacity to offset such costs. However, under the present system, the opportunity to demonstrate both the capacity and willingness to offset costs is not available to the majority of visa applicants.

## Committee Comment

3.52 The Committee understands the difficulty faced by MOCs in determining the 'significant cost threshold' in relation to individual cases. These include the fact that the calculation does not consider aspects such as whether the family of an applicant has the resources to indemnify any of the costs associated with the care of the applicant or whether the applicant possess any skills themselves which would allow them to undertake some of their own care or make an economic contribution to reduce their future costs. Many submissions to the inquiry were also critical of the fact that an MOC may not be in the best position to assess future costs, irrespective of the guidance provided. These aspects will be considered in detail in later Chapters of this report.

3.53 However, it is evident to the Committee that the review of the significant cost threshold is a priority as the Committee considers that the threshold is too low.

32 Royal College of Australasian Physicians, *Submission 85*, p. 4.

33 See for example National Association of People Living with HIV/AIDS (NAPWA), *Submission 67*, p. 15 and Ms Gillian Palmer, *Submission 19*, p. 3.

**Recommendation 1**

**The Committee recommends that the Australian Government raise the 'significant cost threshold' (which forms part of the Health Requirement developed under the Migration Regulations 1994) to a more appropriate level. The Committee also recommends that the Department of Immigration and Citizenship quickly complete the review of the 'significant cost threshold'**

## Prejudice to access

3.54 Under the Health Requirement, in addition to the 'significant cost threshold', visa applicants are also assessed on the dimension of 'prejudice to access'. DIAC states that this is where a visa applicant is assessed as having a disease or condition that would be likely to:

> ...prejudice the access of Australian citizens or permanent residents to health care and community services.[34]

3.55 There are a small number of diseases or conditions which underpin this criteria:

- dialysis;
- organ transplants;
- blood/plasma products, including coagulation factors and immunoglobulin;
- fresh blood, or blood components, for people with rare blood groups; or
- knee and hip joint replacements.[35]

3.56 DIAC also describes the 'health care and community services' that this criteria is taken to include:

- hospital services (i.e. both inpatient and outpatient care);
- residential, nursing home and palliative care;
- community health care and consultations (e.g. general practitioners, specialists, allied health and other health-care providers, if subject to a public subsidy);
- rehabilitation services;
- disability services;

34 Department of Immigration and Citizenship, *Submission 66*, p. 5.

35 Department of Immigration and Citizenship, *Submission 66*, pp. 10–11.

- supported education and accommodation;
- home and community care;
- special education; and
- social security benefits (e.g. disability income support, employment assistance).[36]

3.57 Chapter 2 of this report considered some of the services available in Australia to persons with a disability as provided by the Commonwealth. It should be noted that there are also a range of services provided by State and Territory governments which cater to the needs of disabled residents. The Committee understands that there are financial constraints and it is important to ensure that the needs of those currently resident in Australia are catered for in the first instance.

3.58 It would appear that the principle of 'prejudice to access' is a sound one in assessing migration applicants. However, there were many criticisms raised regarding how the prejudice to access criteria is applied, in particular that in the case of disability it may assume a full use of services for that condition rather than assessing the likely use of services for that individual.

3.59 Reforming the application of the prejudice to access criteria and developing a more tailored assessment methodology are addressed later in the report.

## The Health Requirement in other nations

3.60 The Committee took evidence relating to how other nations administer their own health requirements. Canada, New Zealand, United Kingdom and the United States all have legislation requiring migration screening for health conditions.

3.61 Each of these nations screen for disease or conditions that might pose a public health risk or concern. Identified communicable diseases which would exclude entry include tuberculosis (TB), untreated syphilis and leprosy.[37]

3.62 As in Australia, Canada, New Zealand and United Kingdom identify a range of non-communicable diseases or conditions which may be considered to impose significant costs or demands on public health systems and services. HIV is no longer identified as a communicable disease for the purpose of migration screening, but temporary residency

36 Department of Immigration and Citizenship, *Submission 66*, p. 10.

37 Department of Immigration and Citizenship, *Submission 66,* Attachment J.

restrictions may apply and permanent residency may depend on the availability of a waiver.[38]

3.63 The United States (US), which has a private insurance based health system, supports a more generous approach to entry by people with a disability, whereby clients may indemnify against health costs by submitting a binding affidavit for support.[39] The US statute specifically states that age, health, family status, assets, resources and financial status, education and skills must be taken into account when deciding if an applicant may become a public charge.[40]

3.64 The European Union (EU) has taken a lead in removing discretion on the basis of disability from its migration law in keeping with the EU's *Charter of Fundamental Rights*. The Charter codifies basic human rights and precludes all discrimination against people with a disability. Consistent with this, the submission from Jasmin Reinartz, an individual, advised that Germany does not treat people with a disability differently to other visa applicants and has abolished the health assessment as part of the visa procedure altogether.[41]

3.65 The Committee notes that New Zealand has a new *Immigration Act (2009)* which will not include health criteria for entry but provides for screening for threat or risk to security, public order or public interest. The provisions of the new Act will come into force in late 2010, until which time the provisions of the *Immigration Act 1987* apply.[42]

## Comparable nations: Canada and New Zealand

3.66 Canada was cited as a comparable nation to Australia, with a similar public health system and similar migration composition, but offering a more progressive model for migration health assessment than the Australian system.

3.67 A summary of key differences between the Canadian and Australian system is as follows:

38 Department of Immigration and Citizenship, *Submission 66,* Attachment J.

39 Advocacy, Disability, Ethnicity, Community (ADEC), *Submission 23*, pp. 11-13.

40 Advocacy, Disability, Ethnicity, Community (ADEC), *Submission 23*, pp. 11-13.

41 Jasmin Reinartz, *Submission 106,* p. 1.

42 A summary of the Immigration Bill as passed at third Reading and see New Zealand Department of Labour accessed May 2010 at <http://www.dol.govt.nz/actreview/faqs/01.asp>

- **Canada prohibits entry of person who is a health risk or threat or might 'reasonably cause excessive demands on services'**. [43] This is comparable to Australia's 'significant cost' threshold, but Canada's methodology for assessing excessive demands appears more detailed and tailored to circumstances than does Australia's. Canada applies complex formulas for what constitutes 'excessive demand'.[44]
- **In Canada, the medical officer must consider the circumstances of the individual in assessing for 'excessive demand'**, ie the potential to offset costs. In Australia medical officers assess for likely service use and costs for the degree of disability or condition under the hypothetical person test, regardless of whether the services will be used.
- **Canada requires a concurrence of opinion between at least two medical officers on the immigration health decision**[45] compared with the one decision by the Medical Officer of the Commonwealth in Australia. In Australia the MCO's opinion is final.
- **Canada screens only for current and probable duration of conditions** in projecting service requirements over a five to 10 year period of stay. Australia assesses for past diseases or conditions and incidence of these in family members under the 'one fails, all fail' rule for a minimum of five years plus a 20 per cent loading.
- **Canada does not have a limited waiver system**. If any applicant is refused by the medical officer on a health or 'excessive demand' basis they have the opportunity to bring a 'credible plan' to the Immigration officer to demonstrate they can offset costs (by care of a family member, use of private sector services ). In Australia, additional information is only taken if a waiver option is available, ie only for a limited number of employer -sponsored visas, some skilled visas and limited humanitarian and family stream visas.
- **Canada provides an exception to the health cost requirement** for all spouse/partners and family members of Canadian sponsors, and for refugees and protected persons and their families. The health test applies to all offshore applicants in Australia, with exception only provided for the Onshore Protected Visa.

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43 Section 38 of *Canadian Immigration and Refugee Protection Act 2001;* Mary Ann Gourlay, *Submission 25,* pp. 20-21; Advocacy, Disability, Ethnicity, Community (ADEC), *Submission 23*, p. 9.

44 National Ethnic Disability Alliance (NEDA), *Submission 1.1*, pp. 6–8.

45 Canadian High Commission, *Submission 86,* p. 3.

3.68 New Zealand's previous policy, under the *Migration Act 1987*, was very explicit in providing that a certain level of incapacity would result in a refusal under its health requirement. However, it also provided that New Zealand's medical officers may also assess factors such as benefits to the community, family connections and length of stay as well as projected health and services costs in making an assessment. [46] Where a qualified professional disputes the opinion of a medical assessor, a second opinion from a different medical assessor will be sought.[47]

3.69 New Zealand's Minister for Immigration the Hon. Dr Jonathan Coleman has advised the Committee that the new Immigration law will not bring substantial change to New Zealand's immigration health policy, which will continue to be certified by the Minister under the Act and interpreted by the Immigration New Zealand Operational Manual.[48] The Committee notes that the Operational manual is under law a public document, and so provides a greater degree of transparency than the Australian system.[49]

3.70 It was noted in evidence that New Zealand, among a number of other countries, provides quotas for people with a disability or for specific health conditions.[50] New Zealand has a specific quota for refugees with a disability. New Zealand also accepts up to 20 known HIV positive refugees every year under a quota system. [51]

## Committee comment

3.71 The Committee notes that comparable nations such as Canada, New Zealand, the US and EU nations all administer some form of migration health requirement which restrict or place conditions on the migration of those with a disability or medical condition.

3.72 Australia's Health Requirement is instrumental in the detection of such things as infectious diseases. The Health Requirement also contains Australia's public health expenditure. It is for these reasons that the Committee concludes that some form of Health Requirement remains a necessary part of Australia's migration policy.

46 Department of Immigration and Citizenship, *Submission 66,* p. 50.

47 Advocacy, Disability, Ethnicity, Community (ADEC), *Submission 23*, p. 10.

48 Under *Immigration Act 2009* s22. See New Zealand Department of Labour, *Submission 111.*

49 Published under requirements of section 13A of the *Immigration Act 1987*. See Immigration New Zealand, *Operations Manual*, accessed 4 May 2010, at <http://www.immigration.govt.nz /opsmanual/index.htm>

50 See Dr Susan Harris Rimmer, *Committee Hansard*, Canberra, 18 November 2010, p. 2.

51 Ms Kerrin Benson, Multicultural Development Association, Brisbane, *Committee Hansard*, 28 January 2010, p. 30; Department of Immigration and Citizenship, *Submission 66,* p. 50.

3.73 While recommending the retention of a Health Requirement in an amended form, the Committee acknowledges that there are significant deficiencies in the current regulations prescribing its criteria and operation. The following chapters outline criticisms regarding the current form of Health Requirement and the Committee makes a number of recommendations for reform of that Requirement.

**Recommendation 2**

**The Committee recommends that the Australian Government adopt a contemporary Health Requirement for prospective permanent and temporary migration entrants under the Migration Act 1958 (Cth).**

**The Committee recommends changes to the Health Requirement include changes to the assessment criteria, processes and waiver options. These are outlined in subsequent recommendations.**

## Criticisms of the Health Requirement

3.74 The Committee has received in evidence a large number of criticisms of the Health Requirement generally. The Australian National Audit Office in their 2007 audit also made recommendations for change relating to the administration of the migration Health Requirement.

### Australian National Audit Office Report

3.75 In 2007, the Australian National Audit Office (ANAO) released a report on the administration of the Health Requirement. Some of the key recommendations relevant to the present inquiry were:

- that DIAC ensure that 'Notes for Guidance' and other guidelines for MOCs were up to date, and
- that DIAC (in conjunction with the Department of Health and Ageing) formulate current and comprehensive advice as to what constitutes a 'threat to public health.'

3.76 DIAC accepted all eight of the ANAOs recommendations and informed the Committee of progress towards their implementation.[52] DIAC commented that:

> We had an internal auditor who came and reviewed the progress of the ANAO recommendations at the end of last year. They indicated there had been significant implementation of those recommendations. In fact, the implementation of a number of those recommendations has been completed. The estimated time frame to complete the implementation of those recommendations is some time in the next 12 months.[53]

3.77 The Committee is pleased with the Department's progress towards the implementation of the ANAOs recommendations. It looks forward to being kept informed of the progress and implementation all of the ANAOs recommendations.

## Balancing public interest with social and economic contribution

3.78 The Committee's inquiry has examined the tension which exists between the issues of public interest and that of the public benefit gained by the migration of disabled immigrants. The public interest is clearly that which is identified in part by the PICs – namely, the threat to public health from certain diseases (tuberculosis in particular). It is also a relevant consideration to examine the impact on public health expenditure where there are concerns that a prospective migrant will be a heavy financial burden on the taxpayer or will deny an Australian citizen or permanent resident access to treatment options or services to which they are entitled.

3.79 On the other hand, there is an immense public benefit gained by Australia in terms of the net benefit of the social and economic contribution made by persons with a disability and their families. The Committee has taken a large volume of evidence in relation to the positive impact that many disabled migrants have or would make to Australia.

### Public interest

3.80 The public interest is an important consideration as it underpins Australia's sovereignty as an entity capable of choosing its residents. The three PICs which form part of the Migration Regulations 1994 outline the

52 Department of Immigration and Citizenship, *Submission 66*, pp. 16 – 17.

53 Dr Paul Douglas, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 17 March 2010, p. 16.

circumstances under which the Minister (or delegate) may grant a visa. Key to this is the protection of the Australian community from major threats to public health or heavy burdens on public health expenditure.

3.81 On this point, the Committee has heard a range of views which include asking for all cost considerations to Australia in relation to the migration of disabled persons to be discontinued.[54]

3.82 It would seem irresponsible to abandon all notions of cost consideration. This is not only because of the public policy grounds under which the Health Requirement is established, but also as a result of the duty that is owed to provide those currently in Australia with the best access to the services and treatment which is available in a climate of finite resources.

3.83 A key argument in relation to the Health Requirement has been the savings to the Australian community as a result of its operation. DIAC informed the Committee that in relation to the 1 586 clients who were refused visas on 'health grounds' in the 2008-09 financial year:

> It is estimated that the more than $70 million health and community service costs would have resulted if these visas had been granted.[55]

3.84 However in response to this, Dr Harris Rimmer from Australian Lawyers for Human Rights told the Committee:

> ...We have to be very cautious of statements like that... it is a very reductionist view of cost. We have no idea what impact those 1,586 people would have made on the Australian economy. It only took one Frank Lowy as a refugee many years ago to make an enormous impact on the Australian economy. It only took one Ron McCallum, who you have taken evidence from, to make an enormous impact on the study of law in Australia. It only took one Graeme Innes, who you also took evidence from, to make a huge contribution to human rights in this country. So I was very nervous about that particular figure, (a) because it is plucked out of the air and (b) because it again does not represent the costs lost to Australia from rejecting that category of people.[56]

3.85 The Committee is well aware of the resource constraints placed on service providers however there is merit in not taking a view of the migration of

54 See for example Left Right Think Tank, *Submission 52*, p. 5.

55 Department of Immigration and Citizenship, *Submission 66*, p. 42.

56 Dr Susan Harris-Rimmer, Australian Lawyers for Human Rights, *Committee Hansard*, Canberra, 18 November 2009, p. 2.

disabled persons that is purely based on cost concern. The contributions of migrants to Australia should not be forgotten and their exclusion should be based on 'legitimate, objective and reasonable' criteria.

3.86 Accordingly, it would seem appropriate that any discussion of public interest balances cost impact with potential economic and social contribution.

## Social and economic contribution

3.87 Countering cost concerns is the argument in relation to the possible social and economic benefit gained by Australia by the entry of disabled migrants. The Committee has taken a great deal of evidence in relation to individuals who have been denied the right to migrate to or remain permanently in Australia as a result of their disability or the disability possessed by one of their family members. There are many instances where Australia would be a much richer society for the contribution, both socially and economically, that could be made by individuals who have been denied visas or rights to migration on the basis of their disability.

3.88 There have been many cases where but for the Health Requirement, the applicant would have met the criteria outlined for a visa. This is particularly so in cases where the applicant holds particular skills or is the child of an applicant who holds particular skills which would be of benefit to Australia. It applies equally to many refugees or asylum seekers who have legitimately applied for migration to Australia as a result of the difficult situations which they have encountered in their home countries.

3.89 Submissions to the Inquiry highlight the fact that there is a very economic-cost related view in the assessment of individuals under the Health Requirement. Many submissions also highlight the need for social and economic contributions to be accounted for in the overall assessment of entry to Australia.[57]

3.90 Professors Mary Crock and Ron McCallum AO, among others, considered that there are existing models to assess benefit against 'costs':

> If it is possible to estimate what a person is likely to cost a society, it must be possible to estimate also the likely contributions that a person might make. Actuarial assessments are made routinely in the life insurance business. Given the parameters for the selection of the skilled migrants who currently dominate Australia's migration program, factors to consider would be easy to identify.

57 See for example Multicultural Mental Health Australia, *Submission 53*.

> They would include: age; occupation; career trajectories; and relationships take into account the value of keeping a family unit together for mutual support and advancement. In the latter respect, any balancing test should acknowledge the role that a disabled person plays as a focus and often as a point of cohesion within a family unit. [58]

3.91 They argue that the 'net' benefit accruing to Australian life is not considered, only the cost which Australia must incur as a result of permitting such migration. Further examples of this in relation to family, humanitarian and refugee migration are considered in Chapter 5.

3.92 The National Ethnic Disability Alliance submitted to the Committee:

> Migration is not a drain on the Australian Government. The fiscal impact of migration is positive for the Australian Government in the long term. Of the 72,400 people who settled in Australia in 2007-08, it can be estimated that the net contribution of these migrants and refugees to the Australian Government over the next 10 years will be $2.31 billion dollars. The evidence suggests that there are only small number of migrants and refugees who fail the health requirement. In 2007-08 only 686 people who underwent the full health assessment failed to meet the requirement... It is difficult to see how admitting the 686 people who did not meet the of health and community services that would compromise access to services by other Australians health requirement in the same year would lead to an excessive cost in the provision of health and community services that would compromise access to services by other Australians.[59]

3.93 The Royal Australasian College of Physicians states:

> Significant cost' is currently set at $21,000 and the Commonwealth medical officer is to be guided by the annual per capita health and welfare expenditure for Australians. Potentially, this unfairly disadvantages many skilled migrants, who in some cases have a demonstrated capacity to meet future costs associated with disability. The policies also deprive Australia of valuable skills from individuals who are excluded because they or a family member has disability. Existing migration processes also fail to

58 Professor Mary Crock and Professor Ron McCallum AO, *Submission 31*, p. 3.

59 The National Ethnic Disability Alliance, *Submission 1*, pp. 6-7.

> account for the broad social contribution that might be made by applicants for example, to families and communities.[60]

3.94 Down Syndrome Victoria suggests:

> ...no account is taken of the economic and social contribution which migrants and refugees with a disability may make to the Australian community. The absence of assessment of potential benefits suggests an assumption that there are none. This assumption is not only erroneous but offensive to the many Australians with a disability who are currently productive, participating members of the community.[61]

3.95 In relation to the operation of the system itself, Mrs Catherine McAlpine told the Committee:

> ... If the system fails to recognise the inherent discrimination in existing policy and concedes to a cost based system, then the assessment system must be transparent, evidence based and standardised. It is also only fair that the potential benefits must be assessed as well as costs. Benefits must also include the non-economic contribution that people with disabilities and their families make to the life of the community.[62]

3.96 The Castan Centre for Law and Human Rights and Rethinking Mental Health Laws Federation Fellowship submitted a detailed proposal for amendment and reform of the PICs for all visas. In particular, it provided a draft Schedule for PIC 4005 to include the following new criteria to take into account possible offsets to assess a visa application at the first consideration by the decision- maker:

> (a) the economic and social contributions that the applicant and/or the applicant's dependents ('the applicants') are likely to make to Australia. This can include:
>
> (i) educational and trade qualifications;
>
> (ii) the applicants' capacity to earn (and pay taxes);
>
> (iii)the employment prospects for the applicants in Australia;
>
> (iv) the nature of the work that the applicants undertake and whether there is an unmet need for this in Australia
>
> (v) any cultural benefits that the applicants may bring to Australia;

60 Royal Australasian College of Physicians, *Submission 80*, p. 10.

61 Down Syndrome Victoria, *Submission 35*, p. 4.

62 Mrs Catherine McAlpine, Down Syndrome Victoria, *Committee Hansard*, Melbourne, p. 43.

(vi) any voluntary work that the applicants have done in the past or is likely to do in the future.[63]

### Social Contribution

3.97 Many submissions to the Inquiry noted that in determining eligibility under the Health Requirement, there is no capacity to consider the significant social contribution to Australia which could be made by potential migrants with a disability.

3.98 The Committee heard many stories of instances where successful individuals and those who were yet to reach their full potential have been denied permanent visas to Australia on the basis of their disability. One of the most powerful stories was given to the Committee by Ms Sharon Ford. She said of her daughter, who has Down Syndrome:

> She is also better known in our local community than any of the rest of the family. She delivers Meals on Wheels as part of her Duke of Edinburgh's Award. She belongs to the local guiding community. She takes care of her money and saves it for things that she really wants— something that other members of the family find quite difficult. In April she will travel to Adelaide to represent Victoria in gymnastics at the Special Olympics National Games. A good part of the cost of that she has worked to pay for herself and, ironically indeed, if she is successful in Adelaide she may travel to Greece in two years time to represent Australia.[64]

3.99 Another story provided to the Committee was that of Abebe Fekadu. Mr Fekadu was a paraplegic who was granted asylum in Australia in 1998. He was granted Australian citizenship in 2007, however, while in immigration detention:

> Abebe was encouraged to become involved in weight lifting to develop the upper body strength he needed to push his manual wheelchair. Although Abebe had never been involved in sporting events, he began power lifting and entered his first professional competition in 2002. Abebe went on to take the title of Australian champion in 2004, 2005, 2006 and 2007. In 2008 he was granted a 'talent visa' in acknowledgment of his sporting achievements and skills and as a result was able to participate and win gold at the Arafura Games in Darwin in May 2007. This was a proud moment for Abebe as he was able to compete for the first time as an

63 Castan Centre for Human Rights Law and Rethinking Mental Health Laws Federation Fellowship, *Submission 36* , pp. 14, 17-18.

64 Ms Sharon Ford, *Committee Hansard*, Melbourne, 18 February 2010, p. 27.

> Australian Citizen. Abebe followed this success to compete in the Beijing Olympics in 2008 where he was placed 9th in his division.[65]

3.100 Further accounts of persons with a disability who have made a social contribution to Australia are provided in Chapters 5.

3.101 One of the matters that has been brought to the attention of the Committee is that there is currently no measure in use by DIAC which quantifies a person's social contribution. Unless a waiver is available in very specific visa categories, the Health Requirement does not allow for such assessments on social or economic contributions to be made.

3.102 The National Ethnic Disability Alliance submitted to the Committee:

> There is no framework in current processes to measure the social contribution of individuals and weigh these against potential costs. This means that individuals who might make a strong social contribution - working with other migrants, in caring roles, volunteering, as part of a family unit, providing skills or knowledge, etc - are still excluded if they don't meet the health requirement.[66]

3.103 Dr Harris Rimmer from Australian Lawyers for Human Rights spoke of the need to add measures of a person's social contribution:

> One of the things that we want is for our migration program to be objective, transparent and fair. It is obvious that we often then want to take a quantitative measure that can be safe from objection... For someone with a job offer as a doctor we can very quickly say that that person will be worth so much over their lifetime in the economy. It is much harder to make a decision about how much a child, say, with mild Down syndrome might contribute to the economy, if they receive the right services over their lifetime. We know that they might—many do in Australia—and there is less quantification around those measures, but they do exist.[67]
>
> In the disability national policy framework that is being discussed at the moment—the discussion paper is called something like Access for all; the National Disability Strategy—one of the things it does is quantify how much we are losing in labour market because

65 AMPARO Advocacy Inc., *Submission 40*, p. 5.

66 The National Ethnic Disability Alliance, *Submission 1*, p. 20.

67 Dr Susan Harris Rimmer, Australian Lawyers for Human Rights, *Committee Hansard*, Canberra, 18 November 2009, p. 3.

> we are not utilising the skills of people with disabilities. In fact, it has been a policy framework for both governments to say that social inclusion is important. People with disabilities should be encouraged to work where possible and the issue is to break down barriers to their full participation in the workplace. So, some of that economic modelling quantification has been done for domestic purposes. There is no reason that we could not draw upon that for the migration program. It just makes a different set of assumptions.[68]

3.104 Dr Gabrielle Rose from the Cerebral Palsy League told the Committee:

> ... the legislation around this issue is still stuck in a welfare model of disability, which is probably a bit 1960s to 1970s. We have moved with the CPRD, with social integration and social inclusion. The whole Commonwealth government agenda has changed and yet this legislation has not. It is still stuck in the 1960s and 1970s in a punitive welfare model where it is going to be a cost and burden on our society. You will probably find that 80 to 90 per cent of people with a disability contribute to the economy and culture in amazing ways. I am keen to see the legislation changed.[69]

3.105 The Migration Law Program at the ANU College of Law states:

> ...The health requirement can only maintain its legitimacy if it encapsulates the social model of disability as reflected in the Disability Convention. The social model recognises the inherent equality of persons with a disability and their human value beyond an economic assessment of the cost of that disability.[70]

3.106 These views represent just some of the many taken by the Committee in relation to this aspect. It is clear that many consider our current migration assessment process regards a person with a disability as an economic liability and not as a person who can and will make a meaningful social contribution to Australia.

### Economic contribution

3.107 Unlike social contribution, economic contribution is readily quantifiable. The Committee has also taken much evidence on this matter. Many of the

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68 Dr Susan Harris Rimmer, Australian Lawyers for Human Rights, *Committee Hansard*, Canberra, 18 November 2009, pp. 3-4.

69 Dr Gabrielle Rose, Cerebral Palsy League, *Committee Hansard*, Brisbane, 28 January 2010, p. 12.

70 Migration Law Program, *Submission 59*, p. 9.

accounts provided to the Committee relate to persons who possess very high level skills and who have a child suffering a disability. In many cases these families have been rejected on the basis of the 'one fails, all fail rule' which under the Health Requirement excludes the family unit on the basis of the disability of one of its members (this rule is discussed further in the following section).

3.108 Other evidence has pointed to the fact that many potential migrants make significant economic contributions through their participation in the workforce and, in many cases, their economic contribution far outweighs the costs associated with their disability.[71]

3.109 The National Ethnic Disability Alliance states:

> At present, the economic contribution of a potential visa applicant with disability is not weighed against assessed health costs as part of the migration health requirement. Further the ability of individuals and families to directly meet their own health costs is not taken into account: for example by demonstrating ability to provide for future costs ... This means that individuals who have the potential to make a strong economic contribution to Australia - including those who might contribute valued skills and experience - are excluded from a visa as a result of the health test.[72]

3.110 Dr Dinesh Wadiwel of the National Ethnic Disability Alliance has told the Committee:

> I think if you constrain economic contribution to ability to participate in the workforce then naturally your point stands, but that is not the totality of economic contribution. People know we have a GST, so there is a direct way that any individual who consumes in our society will contribute fiscally to the government. People, because they eat, they live, they breathe, they need to be housed, contribute economically in terms of creating economic productivity in the community...[73]

3.111 Queensland Parents for People with a Disability Incorporated state:

> However many people with disability do not require significant funding and are educated, employed, pay tax and are a

71 See for example: Australian Federation of AIDS Organisations (AFAO), *Submission 68*, p. 12.

72 The National Ethnic Disability Alliance, *Submission 1*, p. 19.

73 Dr Dinesh Wadiwel, National Ethnic Disability Alliance, *Committee Hansard*, Sydney, 19 November 2009, p. 26.

> contributing, valued part of the Australian community — just like people who do not have disabilities.[74]

3.112 The Royal Australasian College of Physicians states:

> ...indirect discrimination against migrants with disability may occur by inadequate procedures to take into account an applicant's ability to pay for the costs attributable to their own disability or illness. Where an employer undertakes to cover the medical expenses, an exemption may be given (Migration Regulation 1994, Sch 4, 4006A (2)), but not where the applicant gives such an undertaking (although this is a factor taken into account in the exercise of the Minister's own waiver). The applicant's own means of support (including private health insurance coverage or support by family members or others) is not considered in the medical cost assessment made by the Medical Officer. Again, if the legitimate policy aim is the protection of scarce health resources, it is arguable that it cannot be a necessary and proportionate means of attaining that objective to screen out those who can fund their own treatment and therefore would not burden resources.[75]

3.113 Deaf Australia states:

> Deaf people have been and are making important contributions to the Australian economy and the community in general. There are deaf professionals, for example community workers who provide services for Deaf and hard of hearing people who need help with seek of employment or need counselling to resolve issues. There are deaf artists who provide a range of entertainment services for young people and people in general.[76]

3.114 Mrs Maria Gillman told the Committee in relation to her sister:

> Una meets all of the requirements for this visa and, as a professional person, she is able to support herself and make an economic contribution to Australia. The social contribution that someone with her character would make is immeasurable.[77]

3.115 One of the major sources of frustration reported by submitters is in relation to circumstances where one child of a skilled family is deemed not

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74 Queensland Parents for People with a Disability Incorporated, *Submission 17*, p. 4.

75 Royal Australasian College of Physicians, *Submission 80*, p. 11.

76 Deaf Australia, *Submission 21*, p. 4.

77 Mrs Maria Gillman, *Committee Hansard*, Melbourne, 18 February 2010, p. 31.

to meet the Health Requirement. AMPARO Advocacy relates the following story:

> A husband and wife, who had come to Australia under the skilled migration program, were employed in well paid professions and in the process of applying for permanent residency. All indications were that their application would be successful. However prior to a decision being made by the Department of Immigration and Citizenship the woman gave birth to a beautiful baby girl who is also profoundly deaf. The parents desire to welcome and celebrate the birth of their baby, and to understand what deafness would mean for their child was seriously marred by a formal government letter stating that because their child is profoundly deaf they do not meet the health requirement for the relevant visa. The cost of a cochlear implant was cited as the reason for the determination of 'significant cost' and failure to meet the health assessment, despite the parent's willingness to pay for this.[78]

3.116 On this point, Professor Mary Crock told the Committee:

> ...where the accident of birth in Australia, do give rise, I think, to humanitarian obligations on the part of Australia, and these obligations are generally recognised. In my experience it does not make much of a difference who is in power—whether it is Liberal or Labor or whatever. Unfortunately it often comes down to knowing the minister and being able to petition on behalf of the child. But these cases happen all over the world. Disability happens. It is just part of life, and it reduces us as a country enormously if we are not able to deal with that in a humane fashion. If we are going to regard ourselves as a compassionate country, that believes in human rights, then surely you have to start with the child that is born with a disability on our shores. A child should not be condemned to death or to serious discrimination if they have been born in Australia—if that is going to be the consequence of sending them back.[79]

3.117 From these examples, and the many more provided to the Committee, it is clear that many disabled persons and their families have the ability to make meaningful and productive contributions to Australia. Many submissions to the Inquiry came from those who possess a diverse range of skills which are valuable to Australia.

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78 AMPARO Advocacy Inc., *Submission 40*, p. 4.

79 Professor Mary Crock, *Committee Hansard*, Sydney, 11 November 2010, p. 20.

3.118 While the Health Requirement assesses possible health costs to Australia and savings through visa refusals to those who do not meet the Health Requirement, in this accounting there should equally be a consideration of loss of skills and loss of opportunity to socially and economically enrich Australia's population.

### Committee Comment

3.119 Most noteworthy of the criticisms regarding the current application of the Health Requirement is its inflexible nature. There was a perceived failure to account for the social and economic contributions that could be made by individuals with a disability or condition. This is especially so because many visa categories do not come attached with waiver provisions which would allow 'contribution accounting' to be made.

3.120 The Committee considers that any assessment of health costs must balance this with an assessment of likely social and economic contribution. Currently this is not possible across many visa classes. The Committee considers that, regardless of visa class or current access to waiver consideration, Department decision-makers should be empowered to make an overall assessment of an application of individuals or family groups rather than have an outcome prescribed by cost concerns with no accounting of contribution or offsets.

**Recommendation 3**

**The Committee recommends that the Australian Government amend Schedule 4 of the Migration Regulations 1994 to allow for the consideration of the social and economic contributions to Australia of a prospective migrant or a prospective migrant's family in the overall assessment of a visa.**

## Separation of disease from disability

3.121 There is a view that the current Australian Health Requirement subscribes to an outdated view of disability. The Requirement does not make the distinction between combined elements of infectious disease and other types of disability (such as physical and intellectual disabilities). The Committee has received a number of submissions which suggest that this conflation should be corrected.

3.122 When asked whether he believed that the Government should differentiate between disability and other forms of medical illness, Mr Kevin Cocks of Queensland Advocacy Incorporated told the Committee:

> ... The majority of people with disability are not sick. They may have some health conditions that anybody without a disability will have, so the first important thing is that we have to get a demarcation point for an understanding of the separation of sickness and impairment.[80]

3.123 Ms Maureen Fordyce of AMPARO Advocacy Incorporated informed the Committee:

> ... The issue is that the current assessment tool is a medical tool that tries to determine the cost of disability using the same tool that you use to determine the cost of health issues, and the current assessment is more suited to medical issues such as determining the cost of treatment for someone with TB than determining the cost that a young baby who was born deaf will incur over their lifetime...[81]

3.124 Mr Peter Papadopoulos from the Law Institute of Victoria told the Committee:

> ... There is a difference between somebody with tuberculosis or SARS or ebola and someone who has Down syndrome, and yet they seem to be assessed in the same way and under the same criteria. I think it would remove a lot of the emotion from the debate if we actually separate things that are public health issues as opposed to cost and prejudice issues.[82]

3.125 The Migration Institute of Australia suggests:

> *Schedule Four criteria to specifically address the issue of 'disease or condition' separately from other criteria*
>
> Under current Schedule Four criteria, and as previously outlined, addressing an applicant's 'disease or condition' forms only part of the either the 4005, 4006A and 4007 health criteria.

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80 Mr Kevin Cocks, Queensland Advocacy Inc., *Committee Hansard*, Brisbane, 28 January 2010, p. 9.

81 Ms Maureen Fordyce, AMPARO Advocacy Inc., *Committee Hansard*, Brisbane, 28 January 2010, p. 15.

82 Mr Peter Papadopoulos, Law Institute of Victoria, *Committee Hansard*, Melbourne, 18 February 2010, p. 13. Supported by Federation of Ethnic Communities Councils of Australia, *Submission 24*, p. 4.

> The issue then of 'disease or condition' (which includes, but is not limited to disability) [then] will placed within a framework where this assessment, based on an updated and clarified model, could be considered as a separate and distinct issue from the other health components of the Schedule Four criteria.[83]

3.126 Ms Maurene Horder from the Migration Institute of Australia stated that the Committee should focus on:

> ... the need to distinguish between disease, and the public health concerns that may exist properly in our community, and the question of disability. They often meet different social definitions and social requirements. The issue that has been brought to my attention is that by using a 'health' based or a disease based definition and whacking in disabilities, rather than using the UN convention's definition of disability, which is very much a social definition, we have muddied the waters or mixed the pot in a way that means we do not think we are necessarily serving the interests of prospective migrants to Australia and visa holders ...[84]

## Committee comment

3.127 It is clear to the Committee that there must be a distinction between the cost of infectious diseases which are a threat to public health, and the assessment of cost and contribution for those with disabilities. On one hand, the Australian Government has a duty to protect the residents who are currently in Australia. However, there is a need to ensure that Australia's migration program provides a balanced and modern means of assessing the cost and contribution of potential migrants to Australia. It is inappropriate to conflate assessments of communicable diseases and conditions of a disability.

83 Migration Institute of Australia, *Submission 34*, pp. 5 – 6.

84 Ms Maurene Horder, Migration Institute of Australia, *Committee Hansard*, Sydney, 12 November 2009, p. 40.

### Recommendation 4

**The Committee recommends that the Australian Government amend the Migration Regulations 1994 (in particular Public Interest Criteria 4005, 4006A and 4007) so that the assessment of diseases and medical conditions are addressed separately from the assessment of conditions as part of a disability.**