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Enabling Australia

Inquiry into the Migration Treatment of Disability

Joint Standing Committee on Migration

June 2010
Canberra

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Foreword

1.1 Australia is a nation which is proud of its cultural diversity and rich pluralist heritage. Each year, Australia welcomes tens of thousands of new immigrants under its well organised family, humanitarian and skilled migration programs. The positive contribution of these immigrants, both social and economic, made to Australia's prosperity and vitality is clear.

1.2 One aspect of Australia's migration policy is the need for all prospective permanent and temporary migrants to undergo health assessments. Such assessments are in place to protect Australians from threats to public health brought from overseas and to contain public health expenditure. The current arrangements, known as the migration Health Requirement, fall under the auspices of the Migration Regulations 1994, under the *Migration Act 1958* (Cth).

1.3 Through its Inquiry into the Migration Treatment of Disability, the Joint Standing Committee on Migration heard that the majority of people seeking permanent or temporary migration to Australia have little difficulty in fulfilling the requirements under this Health Requirement. However, the Inquiry has found that the current Health Requirement reflects old-fashioned approaches to disability in particular and so unfairly discriminates against those who have disability.

1.4 Our present migration regulations explicitly assume disability, or conditions associated with a disability, to be a cost burden to the wider community. Consequently the system assesses each potential immigrant with a disability against a threshold of 'significant cost' to Australia's public health and community service system. This theoretical cost is mandated in the assessment of immigrants with a disability irrespective of whether these services are actually used. The current system also assesses whether the applicant's condition may prejudice access to health and community services by Australian citizens and permanent residents.

1.5 In the vast majority of cases, no account is taken of the applicant's or their family's ability to contribute socially and economically to the Australian

community and, if this is indeed an economic cost to their immigration, whether or not this is outweighed by other factors such as the potential contribution of other skilled family members whose immigration is linked to or even dependent on the individual with a disability.

1.6 This is an outmoded approach and the Committee has determined that is should be replaced with a more modern form of a health requirement which has scope to positively recognise individual or overall family contributions to Australia.

1.7 Through the course of the inquiry, the Committee took evidence from many and varied interests including the Department of Immigration and Citizenship and other federal departments, community organisations assisting persons with a disability, and individuals who have suffered as a result of the current arrangements. Many of the stories related to the Committee told of the difficulties faced by people who have a disability or have a family member with a disability in their attempts to migrate permanently or temporarily to Australia.

1.8 Most extreme were the accounts of family applications which were denied solely because a child in that family had a disability. Other evidence included persons who could make valuable social and economic contributions to Australia, but were prevented from doing so as a result of the theoretical assessed costs of their disability to the Australian community. In these assessments, the current system provides limited opportunity to consider the individual circumstances of a family, the actual health and community services likely to be accessed, and other factors such as the skills of the applicant or family. Moreover, the Committee also received a great deal of evidence relating to Australia's international obligations under a number of international treaties.

1.9 In this report, the Committee has made 18 recommendations to the Government, which it considers will make the current arrangements fairer to persons with a disability. Among the Committee's recommendations are that:

- Where a person does meet the Health Requirement, there is also the capacity to consider the social and economic contributions made by a visa applicant or their family,
- separate assessments be made for diseases or conditions perceived to be a threat to public health and those conditions linked to disability,
- the decision making processes of Medical Officers of the Commonwealth (who assess the Health Requirement) be made more transparent and that information on costs assessments be provided to prospective visa applicants,

- families not be unfairly disadvantaged under the Health Requirement as a result of a member of that family being a person with a disability; and
- that offshore refugee applicants who have a disability or other health condition have access to the consideration of a waiver of the Health Requirement.

1.10 I am confident that the recommendations made in this report will provide a fairer and more migration transparent system and assessment process for persons with a disability seeking to migrate to Australia. These recommendations will ensure that Australia continues to have a strong, prosperous and vibrant community partially based on migration, including migrants with a disability whose applications to come to this country are considered in a more modern, enlightened and indeed utilitarian manner for their benefit and the benefit of all Australians.

1.11 In concluding, I would like to thank Members of the Committee for their hard work and dedication in reaching the outcomes that we have determined. I would also like to thank Committee Secretary, Dr Anna Dacre and her staff, Inquiry Secretary, Mr Muzammil Ali and Senior Research Officer, Ms Loes Slattery for their synthesis of the many hundreds of pages of evidence into the Committee's final report and for the smooth organisation of the Committee's meetings and hearings around Australia. Finally, I would like to thank all of the submitters and witnesses to the inquiry, who have bravely told their stories and contributed to a new migration policy for the future.

Mr Michael Danby MP
Chair

Membership of the Committee

Chair	Mr Michael Danby MP
Deputy Chair	Hon Danna Vale MP
Members	Senator Catryna Bilyk
	Senator Sue Boyce
	Mrs Yvette D'Ath MP
	Mr Paul Fletcher MP *(from 10 February 2010)*
	Mrs Joanna Gash MP *(from 10 February 2010)*
	Mr Petro Georgiou MP *(to 10 February 2010)*
	Senator Sarah Hanson-Young
	Senator Anne McEwen
	Mr Scott Morrison MP *(3 February – 10 February 2010)*
	Dr Sharman Stone MP *(to 3 February 2010)*
	Mr Tony Zappia MP

Committee Secretariat

Secretary	Dr Anna Dacre
Inquiry Secretary	Mr Muzammil Ali *(from January 2010)*
	Ms Anna Engwerda- Smith *(to December 2009)*
Research Officers	Ms Loes Slattery
Administrative Officers	Ms Tamara Palmer
	Ms Carly Scholes
	Ms Claire Young

Terms of reference

The Committee has been asked to inquire into the assessment of the health and community costs associated with a disability as part of the health test undertaken for the Australia visa processing.

The Committee shall:

- Report on the options to properly assess the economic and social contribution of people with a disability and their families seeking to migrate to Australia.
- Report on the impact on funding for, and availability of, community services for people with a disability moving to Australia either temporarily or permanently.
- Report on whether the balance between the economic and social benefits of the entry and stay of an individual with a disability, and the costs and use of services by that individual, should be a factor in a visa decision.
- Report on how the balance between costs and benefits might be determined and the appropriate criteria for making a decision based on that assessment.
- Report on a comparative analysis of similar migrant receiving countries.

List of abbreviations

ABS Australian Bureau of Statistics

ACT Australian Capital Territory

AFDO Australian Federation of Disability Organisations

ANAO Australian National Audit Office

ANU Australian National University

AoS Assurance of Support

CALD Culturally and Linguistically Diverse

CAPA Council of Australian Graduate Associations

CRC Convention on the Rights of Persons with the Child

CRPD Convention on the Rights of Persons with a Disability

CSL Critical Skills List

DDA Disability Discrimination ACT 1992 (CTH)

DEEWR Department of Education, Employment and Workplace Relation

DIAC Department of Immigration and Citizenship

DoHA Department of Health and Ageing

DSP Disability Support Pension

ENS Employer Nomination Scheme

EU Europe Union

FaHCSIA Department of Families, Housing, Community Services and Indigenous Affairs

FECCA	The Federation of Ethnic Communities' Councils of Australia
GMS	General Migration Stream
HALC	HIV/Aids Legal Centre Inc.
HIV	Human immunodeficiency virus
IARC	Immigration Advice and Rights Centre
ICF	International Classification of Functioning, Disability and Health
INZ	Immigration New Zealand
JSCOT	Joint Standing Committee on Treaties
LIV	Law Institute of Victoria
MDA	Multicultural Development Association
MOC	Medical Officer of the Commonwealth
MODL	Migration Occupations Demand List
MOU	Memorandum of Understanding
MRT	Migration Review Tribunal
NDA	National Disability Agreement
NDS	National Disability Strategy
NEDA	National Ethnic Disability Alliance
NIA	National Interest Analysis
NSW	New South Wales
PAM 3	Procedures Advice Manual 3
PIC	Public Interest Criteria
QAI	Queensland Advocacy Incorporated
QNU	Queensland Nurses Union
QPDD	Queensland Parents for People with a disability
RACP	The Royal Australasian College of Physicians
RCOA	Refugee Council of Australia
RMOC	Review Medical Officer of The Commonwealth
RRT	Refugee Review Tribunal

RSMS	Regional Sponsored Migration Scheme
SDAC	Survey of Disability, Ageing and Carers (2004)
SHP	Special Humanitarian Program
SOL	Skilled Occupation List
STARTTS	NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors
TB	Tuberculosis
UK	United Kingdom
US	United States
UN	United Nations
UNCRPD	United Nations Convention on the Rights of Persons with a Disability
UNHCR	The United Nations High Commissioner for Refugees
UWA	University of Western Australia

List of recommendations

3 The Migration Health Requirement 25

Recommendation 1 38

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'.

Recommendation 2 43

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.

Recommendation 3 55

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.

Recommendation 4 58

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.

4 Decision making processes....................59

Recommendation 5....................77

The Committee recommends that the Department of Immigration and Citizenship make the current 'Notes for Guidance' publicly available. It further recommends that, when such papers are revised, their updated version be placed on the Department's website as soon as possible. 'Notes for Guidance' and associated background information should also be referred to in the Department's Fact Sheets for prospective visa applicants.

Recommendation 6....................77

The Committee recommends that the Department of Immigration and Citizenship publish on the Department's website the cost calculation methodology used by Medical Officers of the Commonwealth in assessing the costs associated with diseases or conditions under the Health Requirement.

Recommendation 7....................78

The Committee recommends that the Department of Immigration and Citizenship provide each applicant with a detailed breakdown of their assessed costs associated with diseases or conditions under the Health Requirement.

Recommendation 8....................79

The Committee recommends that the Australian Government remove from the Migration Regulations 1994 the criterion under Public Interest Criteria 4005, 4006A and 4007 which states that costs will be assessed 'regardless of whether the health care or community services will actually be used in connection with the applicant'.

The Committee also recommends that the Australian Government revise the approach which assesses visa applicants' possible health care and service needs against 'the hypothetical person test'. This test should be revised so that it reflects a tailored assessment of individual circumstances in relation to likely healthcare and service use.

Recommendation 9....................79

The Committee recommends that the Australian Government amend Regulation 2.25A of the Migration Regulations 1994 in a manner which does not bind the Minister of Immigration and Citizenship to take as final the decision of a Medical Officer of the Commonwealth in relation to 'significant cost' and 'prejudice to access' issues, and provides scope for Ministerial intervention.

Recommendation 10 94

The Committee recommends that visa decision-makers in the Department of Immigration and Citizenship be provided with the discretion to consider mitigating factors for any visa stream once a 'does not meet' the Health Requirement decision is received from a Medical Officer of the Commonwealth. These factors may be used to mitigate the 'significant cost threshold'.

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Recommendation 11 129

The Committee recommends that the Australian Government review the operation of the 'one fails, all fails' criterion under the Migration Regulations 1994 to remove prejudicial impacts on people with a disability.

Recommendation 12 129

The Committee recommends that the Australian Government amend the criterion for assessing waivers to the Health Requirement to include recognition of the contribution made by carers within the family as an offset to health care or community services costs identified in the process.

Recommendation 13 129

The Committee recommends that the Australian Government review the requirements for health inspections for short term visas under the Family Visits program.

Recommendation 14 134

The Committee recommends that the Australian Government amend the Migration Regulations 1994 to provide access to consideration of a waiver to offshore refugee visa applicants involving disability or health conditions on compelling and compassionate grounds.

Consideration should also be given to extended family members for the same treatment in the same circumstances.

Recommendation 15 138

The Committee recommends that the Department of Immigration and Citizenship create a priority visa category for refugees who have sustained a disability or condition as a result of being a victim of torture and trauma. The Committee recommends that similar visa consideration is provided to immediate family members within the offshore refugee program.

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Recommendation 16 160

The Committee recommends that the Australian Government work with State and Territory Governments to expand the waiver option to the Health Requirement for skilled migration visa classes to a broader range of skilled visa categories, targeting areas of skill shortages and rural and regional development schemes.

Recommendation 17 163

The Committee recommends that the Australian Government investigate the introduction of a voluntary bond or other scheme for visa applicants to indemnify against, or manage health care or community services costs assessed under the Health Requirement of the *Migration Act 1958* (Cth).

The Committee recommends that any introduction of such a bond or other scheme should not prejudice those applicants that are unable to provide a surety.

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Recommendation 18 185

The Committee recommends that as part of its proposal to amalgamate Australian discrimination law, the Australian Government review the *Disability Discrimination Act 1992* (Cth) with particular reference to the section 52 migration exemption, to determine its legal implications for migration administration and conduct expert consultations on its impact on people with a disability.

1

Introduction

1.1 Since Federation, Australia's migration policy has undergone many changes. Australia has experienced times of large migration intakes to meet the demands of new infrastructure projects and skill shortages. Australia continues to seek skilled migrants to meet skill shortages in key labour areas. Australia also has an extensive family reunion, humanitarian and refugee migration program. Over the generations, migrants regardless of their background or reasons for choosing Australia have added to the cultural diversity of our nation.

1.2 However, Australia has also always maintained its sovereign right to determine annual migration numbers and to select migrants who meet predetermined criteria. Currently Australia requires temporary and permanent migrants entering Australia to meet a Health Requirement under the *Migration Act 1958* (Cth).

1.3 This ensures that we safeguard our community against the spread of infectious diseases. However the Health Requirement also assesses any condition (which may be conditions resulting from a disability) of a potential migrant or their family member which may require health care or access to health services in Australia.

1.4 It is the application of this Health Requirement, and in particular the assessment methodology and assumptions that underpin its current operation, which are the focus of this inquiry.

1.5 Social attitudes to disability have progressed, as have opportunities for those with a disability or medical condition to engage with and contribute to the community. Similarly the capacity to safely manage many diseases has improved. Accordingly it is timely to consider whether it is now appropriate to reform our migration policy, and the migration legislation and regulations that underpin it, in order to reflect these changes, particularly in regard to our treatment of people with a disability.

Terms of Reference

1.6 In 2008 the Joint Standing Committee on Treaties inquired into the United Nations *Convention on the Rights of People with a Disability* and recommended an inquiry into Australia's migration treatment of people with a disability.[1] The Australian Government response to the Treaties Committee report agreed to the recommendation and in August 2009 the Minister for Immigration and Citizenship referred the inquiry to the Joint Standing Committee on Migration.

1.7 The Terms of Reference for the inquiry determined that the Migration Committee shall:

- report on the options to properly assess the economic and social contribution of people with a disability and their families seeking to migrate to Australia
- report on the impact on funding for, and availability of, community services for people with a disability moving to Australia either temporarily or permanently
- report on whether the balance between the economic and social benefits of the entry and stay of an individual with a disability, and the costs and use of services by that individual, should be a factor in a visa decision
- report on how the balance between costs and benefits might be determined and the appropriate criteria for making a decision based on that assessment, and
- report on a comparative analysis of similar migrant receiving countries.

1.8 On 13 August 2009 the Committee Chair, Mr Michael Danby MP, launched the inquiry stating:

> Potential migrants with disabilities and their families are currently treated under the migration system as costs to our society, and there is little scope to take into account the contributions they might make to their community and workplace.
>
> Under the terms of reference we will be examining whether the balance between the economic and social benefits of the entry and

1 See Response to Recommendation 2, *Government Response to Report 95 of the JSCOT,* Response for the Australian Government, Chapter 2: 'Convention on the Rights of People with Disabilities', 4 February 2010, accessed April 2010 at <http://www.aph.gov.au/house/committee/jsct/reports.htm>

stay of an individual with a disability, and the costs and use of services by that individual, should be a factor in a visa decision.[2]

Approach of the Inquiry

1.9 The Committee sought the views of people with a disability, employers, business organisations, disability and community services providers, advocacy groups, and other interested individuals or community stakeholders.

1.10 The Committee also asked for personal accounts from those who have had difficulties getting a visa due to a disability, disease or condition, or have a friend or family member who have experienced those difficulties. To assist submitters to frame their responses, the Committee posed the following general questions:

- Is the current process for assessing a visa applicant against the health requirement fair and transparent?
- What types of contributions and costs should be considered?
- How do we measure these?
- Are there additional factors that should be considered?
- Do you have personal experience of this?
- What principles should apply to the assessment of visa applications against the health requirement? Should there be exceptions?

1.11 The Committee received 113 submissions to the Inquiry. While most submissions came from Australian citizens or people residing in Australia awaiting a visa decision, the Committee was also contacted by a number of people outside Australia whose visa had been refused or who were waiting the outcome of a visa decision. The full list of submissions is at Appendix A.

1.12 The Committee held a number of public hearings and roundtables for the inquiry. These were held in Canberra, Sydney, Brisbane and Melbourne. The full list of witnesses and public hearings is provided at Appendix B.

1.13 The Committee endeavoured to ensure that all venues for public hearings were accessible and that proceedings of the inquiry were available in a range of formats to ensure access by those with a vision or hearing

2 Parliamentary Joint Standing Committee on Migration, Mr Michael Danby MP and the Hon. Mrs Danna Vale MP, 'New Inquiry Launched into Migration Treatment of Disability', *Media Release*, 13 August 2009.

impairment. In addition, the Committee made use of Auslan and other interpreters to assist witnesses present their views to the Committee.

Structure of the Report

1.14 The Committee considers that current migration legislation and regulation does not reflect changed social attitudes to disability or changed opportunities for those with a disability to make a valued contribution to the community. Consequently systemic change is required in order to enable a more modern and individual assessment of people with a disability who apply to enter Australia on a permanent or temporary visa.

1.15 Migration and in particular the various visa categories and conditions attached to each visa is a complex field. This report has not attempted to make recommendations relating to specific visa classes or criteria. Some recommendations will apply to particular visa streams. Rather, the Committee's emphasis has been to set out the principles that should inform migration policy as it relates to the treatment of people with a disability and to the health assessment of applicants.

1.16 Chapter 2 considers Australia's current approaches to disability and the development of the National Disability Strategy which aims to deliver better services to people in Australia. Current Commonwealth supported payments and services provided to people with a disability are explored. The Chapter also considers Australia's migration legislation and regulations that prescribe the processes for assessing migration applicants and their families.

1.17 Chapter 3 considers in more detail the Health Requirement that forms part of the *Migration Act 1958* (Cth). The Health Requirement specifies the minimum state of health that potential visa applicants are required to possess to be granted a permanent or temporary visa to migrate to or remain in Australia. The Chapter details the Health Requirement's key criteria and examines issues such as the cost methodology used to assess health care and access to services. The Chapter also looks at how the operation of the Migration Act reflects broader societal attitudes that confuse disability and disease.

1.18 Chapter 4 examines decision-making processes in conduct of the health assessment and visa decisions. It first considers the role of Medical Officers of the Commonwealth (MOCs) who are the primary assessors of health under the migration Health Requirement. The decision of an MOC

is final in determining whether a visa applicant 'meets' or 'does not meet' the Health Requirement. They are provided with 'Notes for Guidance' which allow for a calculation under the 'significant cost threshold' and 'prejudice to access' requirements. Their processes have been criticised for lack of transparency and consistency, difficulty in obtaining second opinions and the difficulty in interpreting decisions.

1.19 Secondly Chapter 4 considers the decision-making processes followed by the Department of Immigration and Citizenship (DIAC). The Department's decision-makers usually receive applications. They make the decision to refer an applicant to an MOC if the applicant is deemed to have a 'significant medical condition' which may impact on their eligibility for a visa. Chapter 7 explores a number of avenues of appeal available to the applicant following a decision that the applicant 'does not meet' the Health Requirement,

1.20 Australia's Family and Refugee and Humanitarian migration programs reflect our international commitments to promote family reunification and to provide a safe haven for people escaping from the threat of persecution or violence. The current system raises a number of issues for family visa applications and humanitarian visa applications. Chapter 5 evaluates this evidence and considers a more harmonised and holistic approach to applicant assessments.

1.21 Chapter 6 considers the situation of skilled people with a disability, or with family members with a disability, who wish to enter Australia under the Skilled Migration Program. Recent initiatives to offset or indemnify possible costs are considered, alongside a range of other proposals.

1.22 Finally Chapter 7 examines the interaction of Australia's migration treatment of people with a disability, and Australia's ratification of the United Nations *Convention on the Rights of Persons with a Disability* (2008). Consideration is also given to the impact of the exemption of the *Migration Act 1958* (Cth) and the Migration Regulations 1994 from the *Disability Discrimination Act 1992* (Cth).

2

Australia's current approach to disability

Introduction

2.1 This chapter considers Australia's current approach to disability and the environment that this approach creates with respect to Australia's migration policy. Australia is a country with a rich migration history. Approximately 45 per cent of all Australians were born overseas or have at least one parent who was born overseas.[1]

2.2 Australia's migration program has historically focussed on shortfalls in the labour market, including addressing skill shortages. However, it can also be said that Australia has one of the best resettlement programs for humanitarian settlement.[2] Australia has been viewed internationally as having a vibrant, multicultural society, reflective of the origins of many of its residents.

2.3 Australia is a nation built on migration, and the contribution of migration to Australia cannot be underestimated. Migration history shows that Australia has placed a premium on the health of incoming persons, migrants, who are generally healthier than the resident population. They contribute in positive ways to the productive diversity of Australia through investment in housing, cultural diversification of urban areas, the establishment of new businesses, the supply of products, the provision of

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1 Australian Bureau of Statistics (ABS), Census 2006 data cited in *ABS. 1301.0 Year Book 2008- County of Birth,* accessed April 2010 at <http://www.abs.gov.au/ausstats/abs@.nsf/0/F1C38FAE9E5F2B82CA2573D200110333?opendocument>

2 *United Nations High Commissioner for Refugees,* Mr António Guterres, March 2009, quoted Department of Immigration and Citizenship, *Annual Report 2008-09,* Secretary's Overview, accessed April 2010 at <http://www.immi.gov.au/about/reports/annual/2008-09/html/overview/the-secretarys-review.htm>

new and different skills, and through other types of entrepreneurial activities.[3]

2.4 This Chapter will examine the migration Health Requirement and provide a brief statistical overview of migration in Australia. It then provides some background on Australia's disability policy and Australia's capacity to provide health and community services for disabled persons.

Migration legislation and the health requirement

2.5 This section provides a brief overview of migration legislation and the Health Requirement. A more detailed examination of the operation of the Health Requirement is provided in the following Chapter. The Committee is aware that the operation of the Migration Act 1958 (Cth) results in disability being assessed under the Health Requirement. The Committee sees this approach as problematic. This is discussed in greater detail further in the report.

2.6 Migrants to Australia have to meet Health Requirements in order to be eligible for certain visa classes of entry. These requirements aim to minimise the burden of planned migration on the health care system, to prevent the spread of contagious diseases, and to protect Australia's record of good health.

2.7 Although other factors may be implicated, studies have suggested that pre-migration screening appears to ensure migrants have better physical health on arrival and in ensuing years, compared with the Australian-born population.[4] This is reflected in longer life expectancy, lower death and hospitalisation rates, and a lower prevalence of some lifestyle-related risk factors. In 2004–05, for example, total hospital separation rates for Australia born persons in 2004–05 was 24 per cent higher (at 352.7 per 1 000 population) than for the overseas-born population (at 285.2).[5]

2.8 Pre-migration screening contributes to a lower incidence of core-activity limitations and disabilities among migrants (5.6 per cent and 16.7 per cent

3 Vision Australia, *Submission 37*, p. 2.

4 Other factors, such as reduced accessing of services among migrants may contribute to this. Dr Paul Douglas, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 17 March 2010, p. 14.

5 Australia Health and Welfare Institute 2004, quoted in K Carrington, A McIntosh and J Walmsley (eds), *The Social Costs and Benefits of Migration into Australia*, Centre for Applied Research in Social Sciences, University of New England, Commonwealth of Australia, 2007, pp. 36; 248.

respectively) than for the Australia-born population (6.5 per cent and 21 per cent respectively). This reflects the younger cohort of newer migration waves, those born in North East Asia, compared with migrants from the United Kingdom whose rate of disability has risen after decades in Australia.[6]

2.9 Using data from the Australian Bureau of Statistics (ABS) and the Department of Family and Community Services (now the Department of Families, Housing Community Services and Indigenous Affairs (FaHCSIA)), Disability Services Census, the Federation of Ethnic Community Councils of Australia (FECCA) has estimated that there are about one million people from a culturally and linguistically diverse background with a disability living in Australia. [7]

2.10 FECCA advised that the rate of occurrence of disability among migrants is comparable to the general community. Although there are fewer people with a disability coming into the country because of the Health Requirement, which controversially includes disability, some migrants come here as able-bodied people but acquire a disability whilst in Australia. FECCA also advises that there is a higher incidence of work related disability among adult migrants because many engage in manual labour or lower paid jobs. [8]

Migration Act 1958 (Cth)

2.11 The object of Australia's migration legislation is 'to regulate in the national interest, the coming into, and presence in, Australia of non-citizens'.[9] *The Migration Act 1958* (the Migration Act) introduced a planned migration system involving migrant intake targets, caps and quotas for various visa streams. [10]

2.12 **Sub-section 5(1)** of the Migration Act sets out prescribed criteria for the visa that the health requirement:

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6 K Carrington, A McIntosh and J Walmsley (eds), *The Social Costs and Benefits of Migration into Australia,* Centre for Applied Research in Social Sciences, University of New England, Commonwealth of Australia, 2007, pp. 36; and see Table 3A.2.2, p. 248

7 Federation of Ethnic Community Councils of Australia, *Submission 24*, p. 6.

8 Federation of Ethnic Community Councils of Australia, *Submission 24*, p. 6.

9 *Migration Act 1958* (Cth) s 4(1).

10 K Carrington, A McIntosh and J Walmsley (eds), *The Social Costs and Benefits of Migration into Australia,* Centre for Applied Research in Social Sciences, University of New England, Commonwealth of Australia, 2007, p. 36.

(a) relates to the applicant for the visa, or the members of the family unit of that applicant (within the meaning of the regulations); and

b) deals with:

(i) a prescribed disease; or

(ii) a prescribed kind of disease; or

(iii) a prescribed physical or mental condition; or

(iv) a prescribed kind of physical or mental condition; or

(v) a prescribed kind of examination; or

(vi) a prescribed kind of treatment;

2.13 Key sections for administration of the Health Requirement are:

- **Section 60**—provides that the Minister may require that an applicant undergo an examination of that person's 'health, physical condition or mental condition' by a 'person qualified to determine the applicant's health' as a precondition to the grant of certain classes of visa, and
- **Section 65**—requires the Departmental decision-maker to use this medical opinion to make a decision on the visa application. If the visa decision-maker is satisfied that the applicant has met the 'health criteria' and the other criteria prescribed by the Act or Regulations for that visa, he or she is to grant the visa. If the Department decision-maker is not satisfied, the visa must be refused.
- **Section 52** of the *Disability Discrimination Act 1992* (Cth) (DDA)—exempts the application of the DDA to the Migration Act and Migration Regulations 1994.

2.14 Key sections in terms of enabling legislation are:

- **Section 496**, which enables the Minister to delegate power to consider and decide whether a visa applicant meets the health requirement, and to delegate to another person the power to consider all aspects of the application.
- **Section 474** (privative clause decisions), which provides that all decisions made under the Migration Act are final:

(1) A privative clause decision:

(a) is final and conclusive; and

(b) must not be challenged, appealed against, reviewed, quashed or called in question in any court; and

(c) is not subject to prohibition, mandamus, injunction, declaration or certiorari in any court on any account.[11]

Migration Regulations 1994

2.15 Schedule 4 of the Migration Regulations 1994 contains the criteria of assessment for the health requirement, known as Public Interest Criteria (PICs). There are three PICs which attach to various visa subclasses: PIC 4005, 4006A, and 4007. These are outlined in Appendix C.

2.16 **PIC 4005** provides the general (or standard) test for all permanent or provisional visa classes. It requires that an applicant:

- be free from tuberculosis or any disease or condition which may provide a threat to public health in Australia or a danger to the Australian community;
- be free from any a disease or condition which would require health care or community services or meet medical criteria for the provision of such services during the period of the applicant's proposed stay in Australia; and
- not require health care or community services that would impose significant cost on the Australian community, or prejudice access of an Australian citizen or permanent resident to health care or community services.

2.17 These requirements are to be met by the applicant ***regardless*** of whether the level of health care or community services determined by the examining medical officer will actually be used in connection with the applicant.[12] Additionally, the applicant must provide an undertaking to have further health assessments on entering Australia if this is requested by the Medical Officer of the Commonwealth (MOC).[13]

2.18 These standard requirements are also contained in the other two PICs. The significant difference is the potential that a waiver of the Health Requirements may be granted for certain visa subclasses:

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11 *Migration Act 1958* (Cth) s474 (2) states that for the purposes of the section, 'privative clause decision means a decision of an administrative character made, proposed to be made, or required to be made, as the case may be, under this Act or under a regulation or other instrument made under this Act (whether in the exercise of a discretion or not), other than a decision referred to in subsection (4) or (5) [these do not include health decisions].

12 Migration Regulations 1994, *Schedule 4*, PIC 4005, (c) (ii).

13 Migration Regulations 1994, *Schedule 4*, PIC 4005 (d).

- **PIC 4006A**— applies to 457 (Temporary Business - Long Stay) visas and, until recently, the subclass 418 (Educational)visa.[14]
  - ⇒ A waiver may be provided where the applicant's employer has given the Minister a written undertaking that the relevant employer will meet 'all costs' related to the disease or condition that causes the application to fail to meet the requirements of the health test;[15]
- **PIC 4007** —applies to some family, humanitarian, second stage business skills and permanent sponsored skilled visas where (a) the applicant satisfies all other criteria for the grant of the visa applied for; and (b) the Minister is satisfied that the granting of the visa would be unlikely to result in:

  (i) undue cost to the Australian community; or

  (ii) undue prejudice to the access to health care or community services of an Australian citizen or permanent resident.[16]

2.19 A further distinction applies to onshore and offshore applicants. The requirements set out in PICs 4005-4007 do not apply to protection visas made onshore (ie subclass 866 visas), whereas those regarding offshore refugee and humanitarian visas are subject to the health requirement (visa subclasses 200 to 204).[17]

2.20 Under **Migration Regulation 2.25 (A)** Department decision-makers are required to seek the opinion of an MOC, and without this opinion they cannot make a decision on a visa. Once the MOC has delivered the opinion, the Department decision-makers (and, if required) the Migration or Refugee Review Tribunal must accept the opinion of the MOC as to whether an applicant meets the health requirement. [18]

Statistics

2.21 Australia's annual migration intake is substantial. Migrants to Australia arrive under a range of permanent and temporary visa arrangements and for a variety of reasons including those related to employment or family

14 Law Institute of Victoria, *Submission 88*, p. 6; NB. The Educational Visa 418 was repealed in September 2009. See Discussion in Chapter 6.

15 Migration Regulations 1994, *Schedule 4*, PIC 4006A (2), and see Law Institute of Victoria, *Submission 88*, p. 6.

16 Migration Regulations 1994, *Schedule 4*, PIC 4007 (2).

17 Castan Centre for Law and Human Rights and Rethinking Mental Health Laws Federation Fellowship, *Submission 36*, p. 8.

18 Mr Nicholas Torkington, Department of Immigration and Citizenship, *Committee Hansard*, 17 March 2010, p. 1; Law Institute of Victoria, *Supplementary Submission 88.1*, p. 5.

reunion. Australia's substantial humanitarian migration program also assists many people migrate to Australia from situations of displacement for a variety of reasons.

2.22 The Annual Report of the Department of Immigration and Citizenship (DIAC) provides a range of statistics in relation Australia's overall migration program. [19] In 2008–09, Australia admitted a total of 171 318 migrants who it is estimated will make an $851 million contribution to the Australian economy within the first year of arrival.[20]

2.23 In March 2009, in response to a difficult economic climate, the permanent migration program planning levels for 2008–09 were revised down to just under 172 000 places from the original planning level of some 190 000 places. Of this, the skilled migration component was reduced by 14 per cent, or 18 500 places. At the same time there was an increase in the proportion of employer and state sponsored components, which support Australian industry by ensuring that critical in-demand skill shortages are addressed.

2.24 These demand driven elements of the skilled migration program contributed to nearly 45 per cent of the total skilled migration program.[21] The reduction and restructuring of the skilled migration program, in the wake of the global economic crisis, was a demonstration of the responsiveness of the migration program to achieve the maximum economic and social benefit for Australia.

2.25 In 2008–09, 101 280 subclass 457 visas were granted to temporary skilled workers and their dependants. This was a decrease of 8.4 per cent compared with the previous year. By June 2009, the number of applications lodged was 40 per cent lower than those lodged in September 2008, in response to changes in the labour market flowing from the global economic crisis.

2.26 Under the Humanitarian program 13 507 visas were granted, including 788 visas in the 'woman at risk' category. The intake was drawn from the three priority regions of Africa, Asia, and Middle East/South West Asia.

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19 Department of Immigration and Citizenship, *Annual Report 2008-09*, Secretary's Overview, accessed April 2010 at <http://www.immi.gov.au/about/reports/annual/2008-09/html/overview/the-secretarys-review.htm>

20 Department of Immigration and Citizenship, *Annual Report 2008-09*, Secretary's Overview,, accessed April 2010 at <http://www.immi.gov.au/about/reports/annual/2008-09/html/overview/the-secretarys-review.htm>

21 Department of Immigration and Citizenship, *Annual Report 2008-09*, Secretary's Overview, accessed April 2010 at <http://www.immi.gov.au/about/reports/annual/2008-09/html/overview/the-secretarys-review.htm>

2.27 On 9 August 2008, the Temporary Protection visa arrangements were abolished. From 1 July 2009 the '45 day rule' which denied work rights and Medicare access to some protection visa applicants was also abolished.

Statistics in relation to the Health Requirement

2.28 The focus of this report is essentially in relation to the migration Health Requirement which stems from the legislative obligations placed on the migration intake by the *Migration Act 1958* (Cth). As described later in this report, all applicants for a visa for permanent or temporary migration to Australia are subject to this Health Requirement. The stringency of the requirement is dependent on the type of visa applied for, the purpose and length of the proposed stay in Australia.

2.29 DIAC administers the Health Requirement for migrants and visitors to Australia. Overall, in 2008–09, a total of 1 586 clients were refused on 'health grounds'.[22] DIAC informed the Committee that:

> Of these clients:
>
> - 36 failed to meet the health requirement on public health grounds;
> - 360 actually failed to meet the health requirement on cost or prejudice of access grounds
> - 282 had a family member who failed to meet the health requirement on health costs/prejudice of access grounds (i.e. they were not granted a visa due to the "one fails all fails" rule for permanent visas - i.e. all applicants for the visa as well as any non-migrating dependants must meet the health requirement).
> - 864 failed to undergo required health assessments and hence were refused a visa
> - 44 clients were refused an ETA and asked to apply for another visa product so that their health could be properly assessed due to a previous adverse health result.[23]

2.30 From the statistics presented, it can be seen that rejections of visa on the basis of health grounds account for only a small percentage of those who have applied to come to Australia (although a number of applicants refuse to undergo the health assessment). The Committee's focus is on the reasons why this group of people were excluded from migrating to

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

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

Australia and the implications of amending the Health Requirement assessment criteria.

Australian disability policy

2.31 This section considers disability policy in Australia and the legislation which prevents discrimination on the basis of disability.

Definition of disability

2.32 The definition of disability has changed significantly in recent decades, with the emphasis moving from a simple medical focus on an individual's impairment to an appreciation of the person's capacity to engage in the community.

2.33 This is reflected in the definition of disability under the World Health Organisation's international framework for describing and measuring health and disability, the *International Classification of Functioning, Disability and Health* (ICF). The ICF advises that:

> … disability is an umbrella term for impairments, activity limitations and participation restrictions. It denotes the negative aspects of the interaction between an individual with a health condition based on clinical diagnosis and that individual's contextual factors, limitation of environment and personal factors.[24]

2.34 ABS provides an interpretation of this in its *Survey of Disability, Ageing and Carers* (2004), Australia's principal data source on disability participation in Australia.[25]

2.35 For the purposes of the survey, a person is defined as having a disability if they report at least one of 17 impairments, health conditions, limitations or restrictions which has lasted, or is likely to last, for at least six months and restricts everyday activities.

2.36 Four levels of core-activity limitation are determined based on whether a person needs help, has difficulty or uses aids or equipment with any of the

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24 World Health Organisation, accessed May 2010 at <http://www.who.int/classifications/icf/en/>

25 Australian Bureau of Statistics, *4430.0—Disability,Ageing and Carers: Summary of Findings, 2003,* September 2004, accessed May 2010 at <http://www.ausstats.abs.gov.au/Ausstats/ubscriber.nsf/0/978A7C78CC11B702CA256F0F007B1311/$File/44300_2003.pdf>

core activities (communication, mobility or self care). A person's overall level of core-activity limitation is determined by their highest level of limitation in these activities.

2.37 The four levels of limitation are:

- profound: the person is unable to do, or always needs help with, a core-activity task
- severe: the person
  - ⇒ sometimes needs help with a core-activity task
  - ⇒ has difficulty understanding or being understood by family or friends
  - ⇒ can communicate more easily using sign language or other non-spoken forms of communication.
- moderate: the person needs no help but has difficulty with a core-activity task
- mild: the person needs no help and has no difficulty with any of the core-activity tasks, but
  - ⇒ uses aids and equipment
  - ⇒ cannot easily walk 200 metres
  - ⇒ cannot walk up and down stairs without a handrail
  - ⇒ cannot easily bend to pick up an object from the floor
  - ⇒ cannot use public transport
  - ⇒ can use public transport but needs help or supervision
  - ⇒ needs no help or supervision but has difficulty using public transport.[26]

2.38 The Australian Institute of Health and Welfare (AIHW) estimates that this very broad construct of disability would indicate that 3.9 million Australians (20 per cent of the population) had a disability in 2003.[27]

Disability Discrimination Act 1992

2.39 The Federal *Disability Discrimination Act 1992* (DDA) makes disability discrimination unlawful and aims to promote equal opportunity and access for all people with disabilities within Australia. [28]

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26 Australian Bureau of Statistics, *4430.0—Disability, Ageing and Carers: Summary of Findings, 2003,* September 2004, pp. 72–73, accessed May 2010 at http://www.ausstats.abs.gov.au/Ausstats/subscriber.nsf/0/978A7C78CC11B702CA256F0F007B1311/$File/44300_2003.pdf

27 The Australian Institute of Health and Welfare, 'Disability in Australia: Trends in Prevalence, Education, Employment And Community Living', *Bulletin 61*, June 2008, p. 1.

28 Australian Human Rights Commission, Disability Rights Homepage, accessed May 2010 at <http://www.hreoc.gov.au/disability_rights/>

2.40 **Disability is** defined in s 4 of the DDA to cover loss of physical or mental functions, malformation or disfigurement of the body, learning disorders, disorders or diseases which affect mental perceptions or behaviour as well as the presence of organisms in the body either causing or capable of a disease or illness. [29]

2.41 Disability is thus defined broadly to cover both physical illnesses and other conditions. The section further specifies that the definition applies to disability that presently exists; or previously existed but no longer exists; or may exist in the future (including because of a genetic predisposition to that disability); or is imputed to a person.

2.42 Sections 5 and 6 of the DDA respectively prohibit both direct and indirect discrimination on the basis of disability, indicating that:

- **Direct discrimination** is where someone receives less favourable treatment than a person without a disability in similar circumstances.
- **Indirect discrimination** occurs when a rule or condition that applies to everyone particularly disadvantages people with disabilities.

2.43 Part 2 of the DDA deals with the prohibition of disability discrimination in the workplace and public life. Section 29 prohibits both direct and indirect discrimination in the administration of Commonwealth programs.

2.44 However, s 21(b) of the DDA qualifies that discrimination is not unlawful it would impose unjustifiable hardship on the discriminator. In determining whether hardship is unjustifiable, all relevant circumstances should be taken into account, including (among others):

- the nature of the benefit or detriment likely to accrue to, or to be suffered by, any person concerned;
- the effect of the disability of any person concerned;
- the financial circumstances, and the estimated amount of expenditure required to be made, by the first person; and
- the availability of financial and other assistance to the first person. [30]

2.45 The burden of proving that something would impose unjustifiable hardship lies on the person claiming unjustifiable hardship.[31]

29 *Disability Discrimination Act 1992* (Cth).

30 Cited in Human Rights Law Resource Centre, *Submission 54*, p. 8.

31 *Disability Discrimination Act 1992* (Cth) s. 11 (2).

Australia's capacity in assisting persons with disability

Background

2.46 While it may be that there are exclusionary elements of Australian migration law, there is also the issue of, if such barriers are relaxed, whether Australia has the necessary policy and infrastructure to assist new migrants with a disability. This is examined in the context of the current levels of service provision, policy and funding.

2.47 As highlighted earlier, the AIHW found that approximately 20 per cent of Australians suffered some form of disability in 2003. The Royal Australasian College of Physicians suggest that in terms of trends:

> Between 1981 and 2003 there was a trend towards people with severe or profound core activity limitations living in the community. The trend was strongest in those aged 5 - 2 9 years. The trend shows clearly the importance of service programs to support carers, and to support the stability of community living arrangements.[32]

2.48 The Committee contends that as of 2010, it is very likely that this trend has continued. These statistics stress the need for a more organised and structured approach to disability policy and service provision.

2.49 To this end, the Committee understands that FaHCSIA is currently working with the States and Territories to reform and improve disability services.[33] The policy framework for this reform stems from the National Disability Agreement (NDA) which aims to establish the National Disability Strategy (NDS). Briefly, these core frameworks are:

- **National Disability Strategy**—is a holistic framework being developed for release in 2010 to deliver disability and other mainstream services. The NDS will advance commitments made under the United Nations Convention on the Rights of Persons with Disabilities (ratified July 2008) and the Optional Protocol to the Convention (accession in September 2009), and
- **National Disability Agreement**—replaced the Commonwealth State and Territory Disability Agreement on 1 January 2009 and will provide the States and Territories with $5 billion over five years to assist people

32 Royal Australasian College of Physicians, *Submission 80*, p. 5.

33 Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), *Submission 71*, pp. 1–2.

with a disability into more sustainable living arrangements and also support families and carers.[34]

2.50 The NDS is currently being evolved in consultation with community stakeholders with the advice of the National People with Disabilities and Carer Council, established for the purpose.[35]

2.51 In addition, the Senate Community Affairs Committee is conducting an Inquiry into Planning Options and Services for People Ageing with a Disability.

2.52 The Committee also notes the upcoming inquiry into Disability Care and Support which is being conducted by the Productivity Commission. The Committee notes that:

> The Commission has been asked to examine the feasibility, costs and benefits of replacing the current system of disability services with a new national disability care and support scheme that:
>
> - provides long-term essential care and support
> - manages the costs of long-term care
> - replaces the existing funding for those people covered by the scheme
> - takes account of the desired and potential outcomes for each person over a lifetime, with a focus on early intervention
> - provides for a range of coordinated support options — accommodation, aids and appliances, respite, transport, day programs and community participation
> - assists the person with the disability to make decisions about their support
> - provides for people to participate in education, training and employment where possible.[36]

2.53 The Committee looks forward to the outcomes of this inquiry which is due to report by July 2011.

Services and resources available

2.54 Some submissions to the present inquiry make note of the current service and resource arrangements available to disabled persons in Australia. All

34 Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), *Submission 71*, pp. 1–2.

35 Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), *Submission 71*, p. 1.

36 Australian Productivity Commission, *Disability Care and Support Issues Paper*, May 2010, accessed May 2010 at <http://www.pc.gov.au/projects/inquiry/disability-support/issues>

such services come at a cost to Government, whether Commonwealth, State or Territory and need to cater for disabled persons currently in Australia. Resources are finite and priority must be given to current Australian citizens and eligible residents.

2.55 The Health Requirement, as discussed in this report, specifically provides consideration for prejudice to access of services available to Australian residents. It is prudent that these aspects are examined in the context of the debate relating to the immigration of disabled persons.

2.56 FaHCSIA has advised that migrants are subject to limitations on what and when they may receive in terms of services and welfare payments.[37] In lieu of receiving such payments, under certain visa classes Australian citizens sponsoring relatives must provide an Assurance of Support (AOS) to DIAC to cover any possible welfare costs. These Assurances usually cover two years or ten years, the period of exclusion of migrants from many support services.[38]

Disability Support Pension (DSP)

2.57 The key social security payment derived by those with a disability is the Disability Support Pension (DSP). It is:

> ... a payment made to people with disability who are unable to work for at least 15 hours per week at or above the relevant minimum wage, or be re-skilled for any work, for more than two years because of their disability. DSP claimants must be aged 16 or over but under the qualifying age for Age Pension (currently 65 years for men and 64 years for women) at date of claim lodgement.[39]

2.58 The majority of social security payments provide that there is a waiting period for newly arrived migrants, before access is available. For the DSP, this period is ten years, unless the disability occurred whilst the person was resident in Australia. FaHCSIA has informed the Committee that:

> Refugees and former refugees are exempt from all waiting periods for social security pensions and benefits (other than Special Benefit) and therefore have immediate access. They are exempt

37 Department of Families, Housing, Community Services and Indigenous Affairs, *Submission 71*, p. 3.

38 Department of Immigration and Citizenship, *Fact Sheet 34—Assurance of Support*, accessed May 2010 at <http://www.immi.gov.au/media/fact-sheets/34aos.htm>

39 Department of Families, Housing, Community Services and Indigenous Affairs, *Submission 71*, p. 3.

> from the ten year residence requirement for DSP and Age Pension. Family members of refugees and former refugees (at the time the refugee or former refugee arrived in Australia) are also exempt from the two year residence requirement for Carer Payment.[40]

2.59 Cabramatta Community Centre has told the Committee that the ten year moratorium on the DSP should be removed to improve settlement outcomes. It cites numerous cases studies to indicate the:

> … stark difference between the contributions that they can make if they are able to access assistance with their disability as opposed to the contribution they can make if they are not able to access support.[41]

2.60 The Centre further adds:

> Cabramatta Community Centre assists a large number of migrants who have arrived in Australia on a spouse or other visa but in their own right would be eligible for refugee status. These migrants are required to wait 10 years before having access to the Disability Support Pension even though as refugees they would not face this wait. This 10 year wait brings enormous financial and emotional pressure on them and their families and supporters and it can prevent the individuals, their families and supporters from successfully settling and making a more significant contribution to Australia.[42]

2.61 This is but one of a range of comments received by the Committee in this regard. There is an argument to suggest that in circumstances where a visa applicant has been granted a permanent visa, they should be eligible for any payments with the same consistency as access to other forms of social security benefit.

Financial assistance to carers

2.62 The benefits available to carers are one example of where a two year waiting period applies. Financial assistance is provided either as the Carer Payment or the Carer Allowance. These payments are made to those who support people with a disability, a severe medical condition or the frail aged. There is a two year waiting period for the Carer payment, which provides income support to those out of employment due to carer

40 Department of Families, Housing, Community Services and Indigenous Affairs, *Submission 71*, p. 3.

41 Cabramatta Community Centre, *Submission 28*, p. 3.

42 Cabramatta Community Centre, *Submission 28*, pp. 7-8.

responsibilities. There is no waiting period for the Carer Allowance, an income supplement for those providing daily care to a person.[43]

2.63 Other services and support for carers include:

- **Support for seniors—** the Age Pension at a Commonwealth cost of $28.1 million for 2008–09, or for those not eligible, the Commonwealth Seniors concession allowance at half a million dollars for 2008–09. The Age Pension has qualifying period of ten years from the date of permanent residency.[44]
- **Utilities allowances and rail concessions—**the Utilities Allowance is paid to all recipients of the Age pension, the DSP and the Carer payments. Expenditure for the program in 2008–09 was $1.15 million. Railway concessions are also provided with $6.9 million allocated over 2008-09.[45]
- **National partnership agreement concessions—**from 1 January 2009 Reciprocal Transport Concessions were provided for Seniors Card holders to the value of $1.9 million and compensation of $1.18 million (through the Treasury portfolio) paid to State and Territories to provide concessions on core services, such as municipal and water rates, utilities, motor vehicle registration and public transport.[46]

Other key programs and services

2.64 There are a range of other programs and services which are provided by the Government. The access to these by newly arrived migrants varies and some are accessible immediately.

- **National Mental Health and Disability Employment Strategy**—part of the Government's Social Inclusion Agenda, carried primarily by the Department of Education, Employment and Workplace Relations (DEEWR). The strategy attracts $1.23 billion for employment services for those with a disability. Additional budget allocations (2008–09) provided $6.8 million for skills accreditation to receivers of the DSP,

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43 Department of Families, Housing, Community Services and Indigenous Affairs, *Submission 71*, pp. 3-4.

44 In this section all estimates are rounded down to nearest. See Department of Families, Housing, Community Services and Indigenous Affairs, *Submission 71*, pp. 7–8.

45 Includes value of Economic Security Strategy payments made to Commonwealth Seniors Health Card holders, Department of Families, Housing, Community Services and Indigenous Affairs, *Submission 71*, p. 7.

46 Department of Families, Housing, Community Services and Indigenous Affairs, *Submission 71*, pp. 7–8.

and further funds for the Employment Assistance Fund and the Innovation Fund.[47]

- **Australian Disability Enterprises**—the Government invests $200 million annually to employ people in 610 disability enterprises. FaHCSIA also provides funding for training and assistance to jobseekers and workers with a disability. There is no residency requirement. [48]
- **Helping Children with Autism**—$190 million has been allocated over four years to June 2012 to provide support services for Autism Spectrum Disorders. Permanent residency is a requirement but there is no waiting period.[49]
- **National Disability Advocacy Program**—$14.5 million was offered to 63 organisations under this program which assists people with disabilities overcome barriers (such as physical access, discriminatory attitudes, neglect). No residency requirements under the program.[50]
- **Outside School Hours Care for Teenagers with Disability**—$5.1 million in additional funding for four years in the 2009 Budget, to extend care for 12 to 28 year olds, bring total funding to $27.6 million. There is no residency requirement for the program.[51]
- **Disability Employment Network**—provides specialist assistance to job seekers with disability who require ongoing support to find and maintain employment. Eligible persons are those with (or likely to have) a disability, who have reduced capacity for communication, learning or mobility, or require support for an extended period.[52]
- **Vocational Rehabilitation Services**—provides comprehensive intervention, combining vocational rehabilitation with employment assistance. The program aims to enable job seekers with an injury,

47 Department of Families, Housing, Community Services and Indigenous Affairs, Submission 71, p. 4.

48 Department of Families, Housing, Community Services and Indigenous Affairs, *Submission 71*, p. 5.

49 Department of Families, Housing, Community Services and Indigenous Affairs, *Submission 71*, p. 4.

50 Department of Families, Housing, Community Services and Indigenous Affairs, *Submission 71*, p. 4.

51 Department of Families, Housing, Community Services and Indigenous Affairs, *Submission 71*, p. 7.

52 Department of Education, Employment and Workplace Relations, *Submission 97*, p. 13.

disability or health condition achieve sustainable employment to their maximum capacity.[53]

2.65 Other mainstream services include:

- **Job Services Australia**— Job seekers entering Australia under the skilled migration or family reunion programs are eligible for limited support in searching for employment. Humanitarian entrants are eligible immediately from the date of their arrival in Australia. Some providers provide specialised assistance for those from Culturally and Linguistically Diverse (CALD) backgrounds.[54]
- **English as a Second Language— New Arrivals Program**— provides funding to non-government education authorities to assist with the cost of delivering intensive English language tuition to eligible, newly arrived primary and secondary school students. [55]

2.66 **Additional programs, with estimated expenditure for 2009–10**—the National Auslan Interpreters Service ($5 million); National Information and Captioning Services ($352 000); Postal Concession for the Blind ($7.5 million); Print Disability Services ($1.4 million); Harmonisation of Disability Parking Permit Schemes ($1.6 million for 900 000 new permits) and the National Companion Card Scheme with funding of $41.7million over three years to 2013. There are no residency requirements for these programs.[56]

53 Department of Education, Employment and Workplace Relations, *Submission 97*, p. 14.
54 Department of Education, Employment and Workplace Relations, *Submission 97*, p. 13.
55 Department of Education, Employment and Workplace Relations, *Submission 97*, p. 17.
56 Department of Families, Housing, Community Services and Indigenous Affairs, *Submission 71*, p. 7.

3

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:
>
> (a) if satisfied that:
>
> (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:
>
> (a) relates to the applicant for the visa, or the members of the family unit of that applicant; and
>
> (b) deals with:
>
> (i) a prescribed disease; or
>
> (ii) a prescribed kind of disease; or
>
> (iii) a prescribed physical or mental condition; or
>
> (iv) a prescribed kind of physical or mental condition; or
>
> (v) a prescribed kind of examination; or
>
> (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:

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

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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.

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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

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.

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.

4

Decision making processes

4.1 There are two key agents in the decision making processes for the Health Requirement and visa assessments. This Chapter considers the role and operation of Medical Officers of the Commonwealth (MOCs) and role of operation of Department decision-makers. Both operate under Migration regulations and guidelines which detail methodologies for various assessments.

4.2 The Chapter considers limitations on the scope to make decisions based on individual circumstances, the consistency and transparency of decisions made, and review mechanisms.

Medical Officers of the Commonwealth

4.3 The decisions made by Medical Officers of the Commonwealth (MOCs) are crucial to the operation of the Health Requirement as outlined in Chapter 3. The opinion expressed by an MOC in relation to whether a visa applicant either 'meets' or 'does not meet' will affect an individual's ability (or even whole family's ability) to apply for a visa to remain in or permanently migrate to Australia.

4.4 This MOC opinion is gained in situations where either the applicant or Departmental decision-maker identifies that the applicant has a 'significant medical condition'. In such a circumstance, the Department decision maker is obliged to ask the applicant to undergo an assessment under the Health Requirement as outlined in Chapter 3. This assessment is performed either by a Panel Doctor based overseas (in the case of offshore applicants) or by a MOC for applicants in Australia.

4.5 The authority for the health assessment stems from s 60(1) of the *Migration Act 1958* (Cth) which states:

> (1) If the health or physical or mental condition of an applicant for a visa is relevant to the grant of a visa, the Minister may require the applicant to visit, and be examined by, a specified person, being a person qualified to determine the applicant's health, physical condition or mental condition, at a specified reasonable time and specified reasonable place.[1]

4.6 Medical Officers of the Commonwealth (MOCs) are qualified medical practitioners employed by the Department of Immigration and Citizenship (DIAC) and are charged with undertaking assessments as required by the Health Requirement under the Migration Regulations 1994.

4.7 The decision made by a MOC is final and must be applied by a Departmental decision-maker. In cases where the Health Requirement is assessed by a Panel Doctor, the decision is able to be reviewed by an MOC. The final nature of an MOCs decision is brought about through Regulation 2.25A(1) and (3) of the Migration Regulations 1994:

> (1) In determining whether an applicant satisfies the criteria for the grant of a visa, the Minister must seek the opinion of a Medical Officer of the Commonwealth on whether a person (whether the applicant or another person) meets the requirements of paragraph 4005 (a), 4005 (b), 4005 (c), 4006A (1) (a), 4006A (1) (b), 4006A (1) (c), 4007 (1) (a), 4007 (1) (b) or 4007 (1) (c) of Schedule 4....
>
> (3) The Minister is to take the opinion of the Medical Officer of the Commonwealth on a matter referred to in subregulation (1) or (2) to be correct for the purposes of deciding whether a person meets a requirement or satisfies a criterion.[2]

Offshore assessment by Panel Doctors

4.8 A Panel Doctor is a medical practitioner (or radiologist) appointed by the Australian Government to perform medical examinations (as per the Health Requirement) on visa applicants who have applied from outside Australia. Medical examinations conducted overseas in relation to the

1 *Migration Act 1958* (Cth) s 60(1).

2 Migration Regulations 1994 (Cth) r 2.25A(1) and (3).

Health Requirement are generally only acceptable if conducted by accredited Panel Doctors.

4.9 In terms of the ability of Panel Doctors to make adequate assessments under Australian law, DIAC informed the Committee:

> ... They work on what we call a panel network. In other words they are doctors who we have screened—looked at their credentials—and provided with some training in how to undertake a medical assessment for immigration purposes. [3]

4.10 There has been some criticism of the attitude and understanding of requirements by Panel Doctors. For example, Ms Gillian Palmer commented in relation to the assessments made by Panel Doctors:

> Whether or not an applicant meets the health requirement is a totally arbitrary decision, made by the MOC alone, based on nothing but documents supplied via a Panel Doctor. These documents may not be sufficient because a lot of the Panel Doctors in the UK cannot be bothered to do their own part of the job properly. They simply collect high fees for conducting the most brief and cursory of examinations. If a known medical condition is either apparent or is disclosed to the Panel Doctor, they do not seem to know what (if any) additional information the MOC will require. They prefer simply to get the bundle of papers on its way to Australia and then they leave it to the MOC to provide a "shopping list" of any other information that the MOC might want... Frequently the MOC simply makes a decision on the basis of the half-information provided, without asking for anything more.[4]

4.11 Another submission to the inquiry noted of a Panel Doctor in the United Kingdom, that:

> This doctor collected a very high fee for conducting the most brief and cursory of examinations and we were very displeased by his service...he did not understand the reasoning behind our medical if I had not disclosed to him that our son had a disability and did not know that the MOC would require any additional information![5]

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3 Dr Paul Douglas, Department of Immigration and Citizenship, *Committee Hansard*, 24 February 2010, p. 11.

4 Ms Gillian Palmer, *Submission 19*, p. 4.

5 Name Withheld, *Submission 27*, p. 2.

Committee comment

4.12 The Committee understands the valuable role that is played by Panel Doctors in respect of migration health screening for Australia's Health Requirement. Panel Doctors assists DIAC and its Australian-based MOCs in processing applications in a more timely fashion.

4.13 It may be however that the assessments made by some in the panel network is not as stringent as would be expected of an Australian MOC.

4.14 The Committee sees value in DIAC continuing to maintain the training of doctors on the panel network in relation to the Health Requirement. This training should encompass information in relation not only to the medical requirements of MOCs in making assessments but also information about the policy which underpins the Health Requirement.

4.15 The Committee note this will be particularly important following any revision to the Health Requirement assessment process and criteria.

Current assessment procedures

4.16 There are a range of factors that an MOC must consider in relation to the Health Requirement. Foremost of these, following the referral of an applicant for an assessment, is to establish whether a health waiver exists for the particular visa category that the applicant is applying for.

4.17 By way of information for potential migrants, DIAC's *Fact Sheet 22* provides a brief outline of the Health Requirement:

> Applicants for a permanent visa will be asked to undergo a medical examination, an x-ray if 11 years of age or older and an HIV/AIDS test if 15 years of age or older, as well as any additional tests requested by the Medical Officer of the Commonwealth (MOC).[6]

4.18 In relation to temporary migrants, DIAC reserves the right to outline the health tests required and potential visa applicants:

> ...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.[7]

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

7 Department of Immigration and Citizenship, website <http://www.immi.gov.au/media/fact-sheets/22health.htm>, accessed 18 May 2010.

4.19 DIAC have told the Committee that in terms of the testing of visa applicants:

> All people who elect to come here permanently undergo similar testing. That testing is undertaken by a panel doctor who is appointed to our panel. They will undertake a physical examination and a chest x-ray if they are 11 years or older, and an HIV blood test if they are 15 years or older. That information is recorded on forms that we provide to the doctors or through an electronic system and then they are forwarded to the immigration department for assessment. There are a large number of countries where we have said we are happy with the x-ray reporting, and those countries have what we call 'local clearance'. In other words the admin staff can look at what the doctor has provided and automatically clear that information. From some other countries, or where a doctor has provided what we call a B recommendation on that initial assessment, the application is forwarded to a Medical Officer of the Commonwealth in Sydney for review. They base their assessment on the information that has been provided.[8]

4.20 Following assessment by an MOC, the applicant is provided with feedback from the MOC in relation to whether they have met the Health Requirement or not. All applicants have the opportunity to provide additional supporting material to the MOC at this stage and the initial decision may be altered.

Notes for Guidance

4.21 As part of making an assessment under the Health Requirement, MOCs are provided with a series of papers called 'Notes for Guidance'. There are 18 such papers which each consider a separate disease or condition which an MOC may encounter in relation to a visa applicant. DIAC informed the Committee that the series of papers include:

- a general "Principles Paper" which is currently being updated to:
  - ⇒ outline the legislative and policy framework within which MOCs must operate;
  - ⇒ provide MOCs with broad guidance when assessing visa applicants within this framework;

8 Dr Paul Douglas, Department of Immigration and Citizenship, *Committee Hansard*, 24 February 2010, p. 11.

  - ⇒ provide guidance regarding what constitutes a lawful MOC opinion;
  - ⇒ explain DIAC's approach in determining what constitutes a "significant cost"; and
  - ⇒ explain in brief the approach to unit costings adopted in the Notes for Guidance papers.
- 18 separate papers which provide disease/condition specific costing information to help ensure the consistency of MOC opinions and costings are due to be completed by mid 2010. The HIV paper has already been completed, together with the ophthalmology and hepatitis papers.[9]

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

> The Notes for Guidance are a suite of papers. There are 20 conditions papers and—they are in the department's submission as well—you get an idea of the kinds of diseases and conditions they deal with... it says circa 1991 was the last update. The figures relating to disability support pension are quite different to what the disability support pension criteria relate to today. The research in terms of workforce participation which supports the assumptions underneath these papers for people with disabilities is very out of date....[10]

4.23 The HIV/AIDS Legal Centre Inc told the Committee that, for example:

> One of the things about notes for guidance ... or guidelines for Medical Officers of the Commonwealth in relation to a range of other conditions are not known by the community and are not known by the applicant. They are available for those who subscribe or are required to subscribe to the policy guidelines... There is no transparency.[11]

4.24 It is clear that the 'Notes for Guidance' series are an essential tool of assessment for MOCs. They are relevant for both assistance with the policy parameters which underpin the Health Requirement and also to provide MOCs with information on the costings used when calculating the 'significant cost threshold' as outlined in Chapter 3.

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

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

11 Mr Lachlan Riches, HIV/AIDS Legal Centre Inc, *Committee Hansard*, Sydney, 19 November 2009, p. 55.

4.25 These papers are currently only available to legal practitioners and migration agents on a fee-paying basis through the Legendcom system, described later in this chapter. This information would also be of use to many prospective visa applicants considering migrating to Australia. There appears no valid reasons for the current lack of transparency.

Revised Notes for Guidance (2010)

4.26 Comments made to the Committee alluded to the out of date nature of the costing guidance in the 'Notes for Guidance' series. The Committee understands that a new set of 'Notes for Guidance' papers will be released by DIAC in 2010.

4.27 DIAC told the Committee, that in relation to the revised 'Notes for Guidance':

> There are 19 papers for the *Notes for Guidance*. We have three papers that have already been published on the legend system and we have another one which has been endorsed by the College of Psychiatrists which has not yet been published on legend. We have five other papers which have been final drafts and are currently with the College of Physicians awaiting their endorsement of the clinical content of those papers. Our anticipation is that we still have another eight to 10 papers to complete. We have been told by the contractor that they should be complete by the end of this financial year.[12]

4.28 DIAC also told the Committee that:

> The minister recently agreed that the notes for guidance ... will be published on LEGEND and therefore publicly available as they are updated.[13]

Assessment benchmarks

4.29 Assessments against the Health Requirement require applicants to demonstrate an assessed level of health and functionality. Assessments are very circumstantial and it is not the Committee's prerogative to examine the testing procedures used. The Committee has however taken

12 Dr Paul Douglas, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 17 March 2010, p. 6.

13 Mr Matt Kennedy, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 24 February 2010, p. 5.

some evidence on the key benchmark used in assessment - the hypothetical person test.

The hypothetical person

4.30 One of the more controversial elements of assessments made under the Health Requirement is the benchmark of the 'hypothetical person.' This test essentially assesses the level of a visa applicant's disability and measures that against the health and community services which a person currently resident in Australia with the same condition would be eligible to access.

4.31 The measure is controversial in that many visa applicants believe that they are unlikely to access the full spectrum of payments and services available to them. Many submissions to the inquiry argue that not even persons permanently living in Australia with a similar condition would currently access the entire set of benefits available to them. Applicants are also concerned by this test as it does not take into consideration the resources that the applicant (or their family) has to offset the costs of the payments and services which they may be eligible for.

4.32 DIAC provided the Committee a history of the hypothetical person test:

> The hypothetical test was something that was instituted following a legal decision that was made with regard to a child with an intellectual disability associated with Downs. The courts at that stage believed that the MOCs were not adhering to the legislation in that they were individualising their opinion based on that individual client. Their reading of the legislation was that that was not the intent of the legislation. They had to look at this hypothetical person who had the same form—in other words the same condition—to the same severity and look at what they might be able to use if they were able to access those services here in Australia. We have no idea what the individual may or may not end up using.[14]

4.33 DIAC provided the Committee with a number of examples of the way the hypothetical person test operated. The first one being that:

> Let us say that an applicant has Down syndrome. Down syndrome is not a condition that we would talk about. It would be the other associated factors with Down syndrome—so the child might have

14 Dr Paul Douglas, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 24 February 2010, p. 15.

> an intellectual impairment which is associated with Down syndrome, so the condition is the intellectual impairment. So we will look at the intellectual impairment. We will look at the level of that intellectual impairment—it might be mild, moderate, moderately severe or severe. If it is a child with a mild intellectual impairment, we will then look at what the hypothetical person in Australia of the same age, with the same level of impairment, might be eligible to use here in Australia.[15]

4.34 The second example provided by DIAC stated:

> ...For instance, look at a person who might have paraplegia. According to the form and level of condition for the hypothetical person here in Australia they would be eligible for a disability support pension. Under the previous arrangements MOCs would have asked the individual, 'Are you employed?' Once the hypothetical test came in, that became a little bit of a grey area for the doctors. So now in those situations we would go back to the client and ask, 'Can you provide me with an employment history?' Then they would do a hypothetical test as a person who has paraplegia which is life long but who has been fully employed. They would do that as the hypothetical person here in Australia.[16]

4.35 In defending the use of the hypothetical person test, DIAC suggested that:

> ...the hypothetical test actually makes it a little bit easier to be much more consistent with the decision-making and apply the rules fairly, looking at this from a population perspective. If we go down the waiver path later on, I think it is good to separate that decision so that we can see the clear, medical, functional impairment facts, compared to what someone might look for as the broader contribution this person might make to society.[17]

4.36 There were a number of submissions to the inquiry and witnesses who recounted experiences of those subject to the test. Ms Chantelle Perpic draws the Committee's attention to Full Federal's Court's decision in *Imad v Minister for Immigration and Multicultural Affairs*, where Heerey J

15 Dr Paul Douglas, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 17 March 2010, p. 14.

16 Dr Paul Douglas, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 24 February 2010, p. 15-16.

17 Dr Paul Douglas, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 24 February 2010, p. 16.

upheld the validity of the Migration Regulations 1994, in relation to the 'hypothetical person' test (as applied in PIC 4005) and stated that:

> ...It is not a prediction of whether the particular applicant will, in fact, require health care or community services at significant cost to the Australian community. This meaning is rendered, in my view, clear beyond argument by the concluding words beginning with "regardless".
>
> The intention behind this regulation is understandable, particularly in the light of reg 2.25A. One would expect that a medical officer would be able to assess the nature of a disease or condition and its seriousness in terms of its likely future requirement for health care. On the other hand, one would not expect a medical officer to inquire into the financial circumstances of a particular applicant or any family members or friends or other sources of financial assistance.[18]

4.37 Mr Papadopoulos of the Law Institute of Victoria told the Committee:

> One of the main reasons decision makers, including the medical officer of the Commonwealth, cannot take into account the visa applicant's circumstances is the indefinite article in 'a person' as it appears in the health criteria. It does not say 'the person' or 'the visa applicant' and their disease and condition; it says 'a person with the visa applicant's condition'. Essentially that divorces any consideration of the individual circumstances of the visa applicant and their family or what they might bring to Australia, and it reduces it to just a generic idea of what HIV is, what Down syndrome is and so forth. So it does not really assess the particular nature of their disease or condition, or other aspects of their personality in the visa decision.[19]

Criticisms of the MOC processes

4.38 Many submissions have been critical of the processes adopted by MOCs, especially in relation to the transparency of the decision-making process, the stance in relation to internal reviews and the difficulty in interpretation of decisions, especially those in relation to 'significant cost'.

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18 Ms Chantelle Perpic, *Submission 63*, p. 2.

19 Mr Peter Papadopoulos, Law Institute of Victoria, *Committee Hansard*, Melbourne, 18 February 2010, p. 19.

Transparency and consistency of decisions

4.39 One of the key criticisms has been the issue of the lack of transparency and consistency in MOC decisions. Several submissions to the Inquiry commented on the fact that many visa applicants are surprised at the estimated costs of treatment established by MOCs. Many visa applicants do not understand how their costs under the 'significant cost' threshold have been established and feel that estimations have been applied arbitrarily.

4.40 As outlined in Chapter 3, the Committee understands that many of these costs are standardised and are applied against the 'hypothetical person' test.

4.41 In this regard, DIAC told the Committee:

> One of the issues with individual comments about whether we are consistent or not is that individuals commenting on other cases do not know the full range of circumstances. So it can be a matter of what the eye perceives rather than the reality. One of the things we do do is that any waivers involving health care and community costs of $200,000 or more go to our central decision maker, who is a director of the health integrity projects—effectively, somebody involved long term in health policy and in the application of health policy. We have a single decision maker, and we introduced that so that we would get consistency of approach.[20]

4.42 The Immigration Advice and Rights Centre Inc stated:

> There is a distinct lack of transparency in relation to the health criteria under Australian immigration law. This means that it is very difficult in advance for people to know what conditions or disabilities will cause them to fail the health test. In order to enable applicants to make an informed decision about applying for a visa there should be published information on average cost calculations for specified disabilities or conditions and information on how this is calculated.[21]

4.43 The Immigration Advice and Rights Centre Inc adds:

> This lack of transparency continues in relation to the opinion provided by the MOC which generally provides very little guidance in relation to exactly how their opinion was formed. The

20 Mr Matt Kennedy, Department of Immigration and Citizenship, *Committee Hansard*, 24 February 2010, pp. 7-8.

21 Immigration Advice and Rights Centre Inc, *Submission 30*, p. 13.

> provision of more detailed reasons and explanations would enable a more meaningful response from applicants and would enable them to address those issues more pointedly in any application for review by a RMOC.[22]

4.44 The Australian Federation of Disability Organisations referred to MOCs:

> Any interpretation that the Convention can continue to allow discriminatory assessments by Migration medical personnel as to the extra cost of disability is a breach of human rights. These medical personnel have no specialist expertise in the provision of disability services and its costs other than the outdated stereotype that all persons with disability are a burden on society and must be locked away in institutions. These medical personnel do not make their assessments available to the people they are assessing or to Advocacy Organisations supporting these person. In fact there is doubt that a comprehensive assessment detailing the extra cost of disability compared to the cost to the community of a non-disabled person is ever undertaken.[23]

4.45 Mr Papadopoulos of the Law Institute of Victoria told the Committee:

> Medical officers of the Commonwealth are obviously experts in making decisions relating to whether somebody has a disease or condition, but the point I would like to add and conclude on—and it is in our submission—is that perhaps the quality of the decision-making process could be improved by separating the decision in relation to cost and assigning it to another specialist, perhaps a health economist, who is able to make a more accurate assessment of the cost arising from a particular disease or condition.[24]

4.46 Mr Papadopoulos added that the opinions provided by MOCs need:

> ... to specify things that it is based upon up-to-date medical information and that it considers medical and other information put forward by these applicants and their families. Where that information is contrary to their opinion, they need to deal with that and specify why it has not been given any weight rather than dismiss it altogether. Currently the opinions—if you have seen them—come out as a computer generated document. I have seen probably 400 or 500 and it takes me about 12 seconds to review

22 The Immigration Advice and Rights Centre Inc, *Submission 30*, p. 15.

23 Australian Federation of Disability Organisations, *Submission 6*, p. 5-6.

24 Mr Peter Papadopoulos, Law Institute of Victoria, *Committee Hansard*, Melbourne, 18 February 2010, p. 15.

> them because they are all the same except for on the second page where you will find the disease or condition specified and one word might vary.[25]

4.47 The Immigration Advice and Rights Centre Inc stated:

> The assessments by the MOC are binding and there is no independent review process. This is particularly concerning given that the MOC may not have the relevant expertise to be making the assessments that they are making - for example, it requires very specialized knowledge and expertise to be able to make assessments and forecast the prognosis, treatment or effects of a particular disability or condition. Only a specialist should be able to do this.[26]

4.48 It is clear that many submissions to the inquiry are critical of the situation that it is an MOC which makes a decision in a domain not related to health – specifically those in relation to 'significant cost' and 'prejudice to access'. It is argued that an MOC does not have the expertise, however guided, to arrive at an estimate of the health and community service costs of a particular applicant. Such factors, although standardised in the 'Notes for Guidance' series of papers, do not account for the many individual differences between applicants including employment prospects and the availability of health and community services.

Action following negative assessment

4.49 This section considers the action that can be taken following an assessment by an MOC that an applicant 'does not meet' the health requirement. The key issue here is that of second opinions, given that currently, in most cases, the decision of the MOC is final. The following section provides an overview of the formal appeal mechanisms available to visa applicants following an MOC decision that the applicant 'does not meet' the Health Requirement.

4.50 DIAC has told the Committee that:

> Where a MOC finds that an applicant does not meet the health requirement, the applicant is given the opportunity to comment, where natural justice provisions apply, and put forward any

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

26 The Immigration Advice and Rights Centre Inc, *Submission 30*, p. 13.

> additional information which the MOC must consider. A new MOC opinion will be provided if this information is materially different.
>
> If the applicant does not provide any new information or the MOC considers that the new medical information is not materially different, then the visa will be refused on health grounds. The applicant may, as discussed above, be entitled to appeal to the Migration Review Tribunal (MRT).[27]

4.51 The Migration Institute of Australia advised that the client is automatically disadvantaged in waiver considerations, because the MOCs decision remains final:

> The difficulty comes then when they actually seek independent medical advice on this person's disease or condition and put it in the health waiver submission. The department will come back and state that it does not match up with what the Medical Officer of the Commonwealth has stated, and it is the medical officer of the Commonwealth's decision that prevails. That is where the difficulty lies for an agent. They may have a very good case for a health waiver but when it comes to getting that medical advice, if it does not meet the Medical Officer of the Commonwealth's decision, then the health waiver may fail.[28]

4.52 Further, Mr Peter Papadopoulos of LIV stated:

> The problem is that the policy guidance is under that regulation, but you cannot use that policy unless it is lawful, and the way the law is currently drafted you cannot take that into account. So it is a very arbitrary sort of approach. Essentially, you have a regulation which says the minister is bound by the medical officer of the Commonwealth's opinion. It has gone all way to courts—and they have tried to carve that open—but the courts have come back and said, 'The wording of the legislation is this. Therefore, even though it is a refusal, it is lawfully made and that's all we can do. We cannot take into account other circumstances.'[29]

4.53 Second opinions on medical assessments are available in limited circumstances following a 'does not meet' decision by a MOC. As stated above, following a 'does not meet' decision, an applicant is able to

27 Department of Immigration and Citizenship, *Submission 66*, p. 13.

28 Migration Institute of Australia, *Submission 34*, p. 42.

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

provide additional information which may be taken into consideration by the MOC.

4.54 The Committee asked whether visa applicants could receive a second medical opinion in relation to a decision. DIAC told the Committee:

> It depends on the visa classes they are applying under...In all cases of a negative decision, all applicants have the chance to provide additional information or additional reports, and the MOCs will then reconsider the original decision. When they get the additional information, probably 50 per cent of applicants find that the MOCs change their minds.[30]

4.55 DIAC made a number of comments in relation to the internal review procedures used by the Department in the circumstances where an applicant 'does not meet' the Health Requirement. These centred around peer review, where decisions are examined with other MOCs. DIAC has told the Committee:

> There is a formal peer review process but, at the end of the day, it is an individual MOC who would make that decision. That is usually based on advice and assistance that he may have had in discussions with other MOCs. That is internal—within DIAC itself....
>
> ...There are some cases which are very straightforward, and obviously those cases are not discussed with other MOCs, but it is in those cases where there might be some question about what the costing might be or whether this person actually meets or does not meet the health requirement where that process works.[31]

4.56 DIAC further told the Committee:

> We also have a process where every 'does not meet' decision is discussed with other medical officers of the Commonwealth so that they are certain that they are making the right decision and doing it in a way that is fair to the client. I think the 'fair and reasonable' aspect is always there. Additionally, we have a fail-safe mechanism that all 'does not meet' decisions by MOCs are reviewed by one of my senior doctors and, if he thinks there has been an error in judgment, he will go back to the original MOC

30 Dr Paul Douglas, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 24 February 2010, p. 15.

31 Mr Paul Douglas, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 17 March 2010, p. 12.

> and ask them to review their original decision to see whether they think they have not considered all the facts.[32]

4.57 The Immigration Advice and Rights Centre Inc was critical of this process and stated:

> ...While a person who fails the health test is provided with an opportunity to comment in relation to the opinion of the MOC, in most cases this is meaningless where there is no health waiver provision. In a few cases additional information may be provided in response to this, which is then given to the MOC for them to reconsider their opinion. In lmmigration Advice and Rights Centre's experience this reconsideration will in most cases not result in a change of the opinion formed by the MOC.[33]

4.58 The Committee understands that many who have failed the Health Requirement are critical of the process following the receipt of a 'does not meet' decision. As it is understood by the Committee, where a decision is given a 'does not meet' classification, visa applicants have the opportunity to provide additional information for consideration by the MOC. If the decision remains as one that 'does not meet' the Health Requirement, that case is reviewed internally by a senior medical practitioner employed by DIAC who may recommend that the MOC reconsider their decision.

4.59 The current situation is, however, that the decision made by the initial MOC is unable to be amended, unless it is by an RMOC at the direction of the Migration Review Tribunal. This issue is discussed later in the Chapter as part of a decision-maker's capacity to provide a more holistic assessment based on the circumstances of the individual.

Interpretation of decisions

4.60 Many visa applicants use the services of migration agents to correctly lodge their visa applications. The migration agent role is important in assisting potential applicants to produce the evidence required not only by DIAC, but also any additional supporting information which is required by an MOC to alter a 'does not meet' decision in relation to the Health Requirement.

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32 Dr Paul Douglas, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 24 February 2010, p. 12.

33 The Immigration Advice and Rights Centre Inc, *Submission 30*, p. 12.

4.61 This additional information may include specialist reports, obtained independently of the visa assessment process, and at considerable expense to the visa applicant. There is no guarantee that any additional information which is presented by a visa applicant to an MOC following a 'does not meet' decision will be taken into consideration or will hold sufficient weight to change an initial decision.

4.62 The Committee has taken some evidence on the difficulties faced by migration agents in assisting their clients in gaining a favourable outcome. The key issues in this regard are that migration agents have difficulty interpreting the decisions made by MOCs especially in relation to the calculation of 'significant cost'.

4.63 The Migration Law Program at the ANU College of Law stated that:

> Migration agents report difficulties in getting a meaningful breakdown of the overall costs as assessed by Medical Officer of the Commonwealth and the extra costs that can be involved in attempting to access such details.[34]

4.64 The Migration Institute of Australia commented:

> Migration agents will often be very cautious in their advice when looking at the health criteria simply because a migration agent does not know the full extent of diseases or conditions that a person might have. They are using their knowledge through other sources and the Department of Immigration is using their guidance notes on particular diseases and conditions. The two may not necessarily meet up and giving advice to a client is often very difficult.[35]

4.65 The Migration Institute of Australia also commented that:

> The difficulty comes when an agent is faced with a person's disease or condition and they might not have any knowledge about it, nor should they because they are not medically qualified. The difficulty comes then when they actually seek independent medical advice on this person's disease or condition and put it in the health waiver submission. The department will come back and state that it does not match up with what the Medical Officer of

34 Migration Law Program, ANU College of Law, *Submission* 59, p. 5.

35 Mr Brian Kelleher, Migration Institute of Australia, *Committee Hansard*, Sydney, 12 November 2009, p. 41.

> the Commonwealth has stated, and it is the medical officer of the Commonwealth's decision that prevails.[36]

4.66 Ms Knight from the Law Institute of Victoria told the Committee:

> It is a very complicated and frustrating thing when there is this system with a binding opinion but you cannot reach into that binding opinion to look at the reasonableness or the very factors that that decision maker has considered. It goes against principles of administrative law and it is very frustrating.[37]

4.67 Mr Robert McRae, a solicitor and President of Queensland Advocacy Inc told the Committee:

> If you are sitting in China and you want to know what this health requirement is, there is nothing there that helps you decide what it is apart from perhaps if you have tuberculosis or a number of other conditions that are specified there. There is no reference to disability, for example Down syndrome, so you could read that and all other forms similar to that through and there is no reference to anything other than obesity in one case, tuberculosis and HIV. That is about it. I have a form here issued by the Australian embassy in China. Again there is nothing much that helps people. I think it is a fraud.[38]

Committee Comment

4.68 A number of criticisms have been raised regarding the MOC decision making and review process. Firstly, the Committee is concerned at the lack of transparency regarding the 'Notes for Guidance' series of papers which provide a basis for MOC decision making and the Committee recommends that the 'Notes for Guidance' series be made available to potential visa applicants.

4.69 There are many individuals and families who seek to migrate to Australia each year and it is clear from the evidence to this Committee that many of these persons make applications without information regarding the

36 Mr Brian Kelleher, Migration Institute of Australia, *Committee Hansard*, Sydney, 12 November 2009, p. 42.

37 Ms Jo Knight, Law Institute of Victoria, *Committee Hansard*, Melbourne, 18 February 2010, p. 19.

38 Mr Robert McRae, Queensland Advocacy Incorporated, *Committee Hansard*, Brisbane, 28 January 2010, p. 7.

Health Requirement and its implications, such as cost. The Committee believes that the provision of such information including the ease of access to this information will assist prospective migrants and their migration agents to make well-informed and timely decisions about whether to migrate to Australia.

4.70 The Committee is pleased to note that the Minister for Immigration and Citizenship has determined that the revised suite of Notes for Guidance will be made available online. However, the Committee recommends that meantime the current papers in the series should be made available as a matter of priority.

Recommendation 5

The Committee recommends that the Department of Immigration and Citizenship make the current 'Notes for Guidance' publicly available. It further recommends that, when such papers are revised, their updated version be placed on the Department's website as soon as possible. 'Notes for Guidance' and associated background information should also be referred to in the Department's Fact Sheets for prospective visa applicants.

4.71 Ensuring that the 'Notes for Guidance' are publicly and freely available will greatly improve transparency. However, as an explanatory background to the 'Notes for Guidance', the Committee considers that information should be available on how costs for each condition are calculated.

Recommendation 6

The Committee recommends that the Department of Immigration and Citizenship publish on the Department's website the cost calculation methodology used by Medical Officers of the Commonwealth in assessing the costs associated with diseases or conditions under the Health Requirement.

4.72 The current practice is for an applicant to receive an estimated cost of the condition which has been assessed by the MOC. No explanation is provided as to the breakdown of the assessed costs and how these are calculated. The Committee does not consider this appropriate and recommends that all applicants are provided with a detailed account of their assessed costs.

Recommendation 7

The Committee recommends that the Department of Immigration and Citizenship provide each applicant with a detailed breakdown of their assessed costs associated with diseases or conditions under the Health Requirement.

4.73 The Committee understands the need for MOCs to have a benchmark in making assessments in relation to the Health Requirement. The 'hypothetical person test' provides such a vehicle. However it is limited in its application to being able to total the costs of services and support available to be accessed by a particular individual. There is no account of the fact that not all individuals (regardless of whether they currently have the right to permanently reside in Australia or not) will access each and every service or payment to which they are eligible.

4.74 The Committee does not support this current approach and considers it unjustly discriminates against those with a disability who are productive and contributing community members. The Committee is adamant that this hypothetical person test must be revised to enable an approach more tailored to patterns of individual use. This would allow for an assessment based on likely service utilisation, rather than service availability.

Recommendation 8

The Committee recommends that the Australian Government remove from the Migration Regulations 1994 the criterion under Public Interest Criteria 4005, 4006A and 4007 which states that costs will be assessed 'regardless of whether the health care or community services will actually be used in connection with the applicant.'

The Committee also recommends that the Australian Government revise the approach which assesses visa applicants' possible health care and service needs against 'the hypothetical person test'. This test should be revised so that it reflects a tailored assessment of individual circumstances in relation to likely healthcare and service use.

4.75 The Committee is also concerned that under the present system, the opinion presented by an MOC is taken as final. The 'significant cost' threshold which is calculated takes into account only the costs involved to the Commonwealth and the States and Territories of an applicant using health and community services. This decision, by virtue of regulation 2.25A of the Migration Regulations 1994, must be taken as final by the Minister.

4.76 In limited circumstances, a waiver is available which allows for consideration to be given to the ability of the applicant to defray some of this cost. The waiver also allows for consideration to be given to the potential contribution that a visa applicant will make to Australia. However, in many classes of visa, this waiver is unavailable and consequently the MOC opinion is final.

Recommendation 9

The Committee recommends that the Australian Government amend Regulation 2.25A of the Migration Regulations 1994 in a manner which does not bind the Minister of Immigration and Citizenship to take as final the decision of a Medical Officer of the Commonwealth in relation to 'significant cost' and 'prejudice to access' issues, and provides scope for Ministerial intervention.

Department decision-makers

4.77 DIAC manages Australia's immigration intake. Each year, it assists many thousands of individuals and families to successfully migrate to Australia under a variety of migration programs. Part of this responsibility includes the administration of the Health Requirement under the *Migration Act 1958* (Cth).

4.78 Department decision-makers, employed by DIAC, play a crucial role in the assessment of visa applications and in the determination of whether a 'significant health condition' exists. Department decision-makers are required to be well informed and trained to identify such health conditions for referral to either a Medical Officer of the Commonwealth (MOC) or a panel doctor overseas. The Committee asked DIAC about the background of Departmental decision-makers. DIAC replied:

> We come from many disciplines, as all public servants do, but we have very dedicated decision-making training for our officers because it has to be lawful decision making within the framework of the Migration Act et cetera ... but we have a very comprehensive process of training our decision makers, for example, before they go overseas, whether they are in state or territory offices or whether they are protection visa decision makers or general migration decision makers or whatever.[39]

4.79 DIAC informed the Committee about the level of experience held by Department decision-makers:

> The delegation level is that it has to be made by at least an executive level 1 officer. Overseas, an executive level 1 is a principal migration officer—so the manager of the post. Most people who get to that level have a long history of employment in the department. They have gone through the induction and training to be a decision maker in the department. But before you go on an overseas posting everyone goes on a six-week overseas training course, and that covers issues like the health requirement, interviewing and decision-making techniques...
>
> Onshore, the training would vary more from state to territory, because it is at state and territory offices... Entry level is normally at the APS3 level, and to move from an APS3 to an executive level 1 you would normally already have extensive experience deciding

39 Mr Peter Vardos, Department of Immigration and Citizenship, *Committee Hansard*, 24 February 2010, pp. 7-8.

> visa applications as well as having the basic training in legal decision making, writing decision records and interview techniques.[40]

4.80 DIAC contends that Departmental decision-makers undergo much training and assessment in relation to the decisions that they make. However, their decision making is limited by the lack of flexibility in the Migration Regulations 1994. The Committee has received a number of comments in relation to the role that it is believed that Departmental decision-makers should be able to play.

4.81 Dr Harris Rimmer from Australian Lawyers for Human Rights told the Committee:

> We want immigration officials to use their common sense because they are the ones with the family sitting in front of them. Departmental officials need to receive better levels of training around some of these issues. They need to feel that they have the freedom to make common-sense judgements and also that those common-sense judgements can be reviewed where possible. The medical officer of the Commonwealth's decisions cannot be reviewed, and I think that is the problem in this case.[41]

Assessment procedures

4.82 This section discusses the assessment processes which are followed by a Department decision-maker.

4.83 Following the lodgement of an application, the Department decision-maker may identify an applicant as having a 'significant medical condition' as outlined under the Health Requirement. The application is then referred to an MOC. If the applicant is based overseas, a medical assessment is generally conducted with a panel doctor, the results of which, if returned with a decision which 'does not meet' the Health Requirement, may be cleared by the Department decision-maker at a number of overseas posts in circumstances where a visa waiver is available (known as local clearance).[42]

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40 Mr Nicholas Torkington, Department of Immigration and Citizenship, *Committee Hansard*, 17 March 2010, p. 7.

41 Dr Susan Harris Rimmer, Australian Lawyers for Human Rights, *Committee Hansard*, Canberra, 18 November 2009, p. 13.

42 Mr Nicholas Torkington, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 17 March 2010, p. 4.

4.84 In the circumstance where a significant medical condition is identified (and a waiver is not available) or the application was lodged at a post where local clearance is not possible, the medical reports are forwarded to the Department's Health Operations Centre in Australia. It is here where an MOC makes an assessment of the medical report issued by the overseas panel doctor in relation to whether the applicant meets the Health Requirement or has access to waiver provisions.[43]

4.85 DIAC commented on the differences between:

> ... the role of the medical officers of the Commonwealth versus the decision makers. The way the regulations are structured—and the regulation is regulation 2.25A—with some exceptions the visa decision maker is required to seek an opinion from a medical officer of the Commonwealth as to whether or not someone meets the health requirement. Unless one of the exceptions applies, the visa decision maker cannot assess the health requirement without getting the MOC opinion. The second part of that regulation is that, once you have got the MOC opinion, you are required to treat that opinion as correct.[44]

4.86 The Department told the Committee:

> ...If the opinion is that they do not meet the health requirement and there is a waiver available, the medical officer also provides a costing advice, which indicates what the cost attached would be and the waiver to access....[45]

4.87 The Department decision-maker is then provided with this decision for discussion with the applicant. It is at this point where the Department decision-maker has the ability to exercise a waiver, if one is available under that visa class. Where the MOC returns a 'does not meet' assessment and the visa applied for is of the type where a waiver is available, the Department decision-maker is able to seek further information from the applicant. Following this, DIAC told the Committee:

> ...the visa decision maker will then look at all of the information that is presented and will consider whether or not to exercise the waiver. They will look at the medical opinion, the costing, any

43 Mr Nicholas Torkington, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 17 March 2010, p. 4.

44 Mr Nicholas Torkington, Department of Immigration and Citizenship, *Committee Hansard*, Melbourne, 17 March 2010, p. 1.

45 Mr Nicholas Torkington, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 17 March 2010, p. 4.

> further information that is provided by the applicant and any compassionate or compelling circumstances. The costings are done on a hypothetical person, but when you are looking at the waiver you do look more at the applicant's actual circumstances— that is, their ability to defray some of the costs of a hypothetical person.[46]

4.88 The Department decision-maker is thus in a position where their decisions require a high level of expertise in asserting waiver elements.

Consistency of decisions

4.89 One of the key issues raised by many submissions is that decisions made by Department decision-makers are not consistent.

4.90 DIAC told the Committee:

> ... if the cost was over a certain level, $200,000, all the cases go to a director in Canberra who gives a recommendation on the waiver or advice to the processing office... They do not make the actual decision but they provide advice and a recommendation, which is usually accepted in almost all cases. My understanding is that it is accepted by the decision maker. ... But there are some things that are basically pretty much accepted as compelling or compassionate in all circumstances—for example, if it is a refugee case, a split family case or a woman at risk case. Those ones are pretty much always waived. There is guidance for decision makers to look at things. For example, if it is a partner case and the partner is not able to join the applicant in their own country, that is given substantial weight. If the sponsor has extremely close ties with the Australian community, that is also given substantial weight ...you are looking at all the individual circumstances ...[47]

4.91 DIAC also told the Committee:

> ...we do have a referral process if it is over a certain costing amount. I think the process is consistent. Obviously, because you are looking at individual circumstances with the waiver the result will vary. Of two people with the same condition, one may be waived and the other not depending on their individual

46 Mr Nicholas Torkington, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 17 March 2010, p. 4.

47 Mr Nicholas Torkington, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 17 March 2010, p. 5.

> circumstances. I would not necessarily see that as an inconsistent result. It is that one person might have stronger factors in favour of the waiver than the other one.[48]

4.92 In relation to this, DIAC added:

> We have developed within the department a decision-making template for all people to step them through the waiver opinions process. That was developed by the health policy section about 18 months ago. I would say with confidence that, since that has been put in place, there has been much greater consistency between the different decision makers.[49]

4.93 Down Syndrome Western Australia provided an example of the inconsistency of the application of the Health Requirement. In this case, Dr Edi Albert, an academic based in Tasmania (who had a son suffering Down Syndrome) failed the Health Requirement in the process of applying for permanent residency (the visa class applied for stipulated that no Health Requirement waiver was available). Dr Albert was provided with the opportunity to respond to the report of the MOC and did so. Down Syndrome Western Australia commented that:

> ...within weeks, the family was advised that all their visas had been granted. They were not required to go through the Migration Review Tribunal and with no further examination their assessment was rewritten to show that infant son was no longer deemed to pose a possible future cost to the community.[50]

4.94 Down Syndrome Western Australia contrasted Dr Albert's case with the well known case of Dr Bernard Moeller in Victoria. In that case, following the Department's rejection of a permanent residency visa, the Minister for Immigration and Citizenship stated:

> Where a Medical Officer of the Commonwealth has assessed a visa applicant as having a health condition that is likely to result in a significant cost to the Australian community or prejudice the access of Australians to health care or community services, the law requires that this decision must be accepted by the department.[51] [emphasis in submission].

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48 Mr Nicholas Torkington, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 17 March 2010, p. 7.

49 Dr Paul Douglas, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 17 March 2010, p. 7.

50 Down Syndrome Western Australia, *Submission 57*, p. 13.

51 Cited in Down Syndrome Western Australia, *Submission 57*, p. 14.

4.95 Ultimately, the decision in relation to the Moeller's was overturned through Ministerial discretion, however the case highlights the apparent inconsistencies in assessments and outcomes.

4.96 It is imperative that Departmental decision-makers make consistent decisions in relation to each case. As outlined earlier in this report, it is also important that decisions made by MOCs are also consistent in the application of all aspects of the Health Requirement.

4.97 The following sections outline two tools used by Department decision-makers to achieve consistent decisions.

Procedures Advice Manual 3 (PAM 3)

4.98 The key resource for Department decision-makers is the Procedures Advice Manual 3 (PAM 3). The PAM 3 provides Department decision-makers with advice regarding the procedure for the processing of visa applications including some interpretive advice regarding decisions made by MOCs. DIAC has submitted to the Committee:

> *PAM3:Sch4/4005-4007 The Health Requirement* (the Health PAM), provides advice and guidance to visa decision-makers about:
>
> - which health assessments are required for particular applicants;
> - how they should be undertaken; and
> - the process for making a decision as to whether the applicant meets the health requirement.[52]

4.99 The Law Institute of Victoria has told the Committee:

> Other matters relevant to the health requirement are set out in the Procedures Advice Manual 3 (PAM3), Schedule 4, 4005-4007, including:
>
> - Health examination requirements for temporary visa cases, including by Country and period of stay;
> - Health examination requirements for permanent/provisional visa cases;
> - Delegations, record-keeping, and clearance processes for assessment of applicants against the health requirements; and
> - Guidance for assessing cases against the PIC, including health waiver and health undertaking provisions.[53]

4.100 Australian Lawyers for Human Rights states:

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

53 Law Institute of Victoria, *Submission 88*, p. 7.

> The Procedures Advice Manual 3 also provides guidance as to how the health waiver is to be exercised. In particular, officers are to consider the following in making this assessment:
>
> - the opinion of the MOC
> - any compassionate or compelling circumstances
> - whether the applicant has met all other visa criteria
> - the ability or potential for the applicant and their supporters to mitigate costs
> - the degree of care required, and the private care and support that is available
> - other relevant factors such as education, skills, job prospects, assets and income, whether minor children will be affected, location of family members and sponsors, the merits of the case, and the applicant's immigration history.[54]

Legendcom

4.101 Another resource available to Department decision-makers and also to migration agents, lawyers and the general public (on a fee-paying basis) is the Legendcom database. DIAC's website states that:

> LEGENDcom is an online database of migration and citizenship legislation and policy documents. It is an essential resource library of these materials...
>
> LEGENDcom contains current and historical versions of the following:
>
> - Migration Act 1958 and associated Migration Regulations (since 1 September 1994)
> - Citizenship Act 1948 and associated Citizenship Regulations (since 10 April 1997)
> - Other Migration and Citizenship related legislation
> - Procedures Advice Manual 3
> - Migration Series Instructions
> - Australian Citizenship Instructions
> - Legislative Instruments (including Section 499 Directions and Gazette Notices).[55]

4.102 DIAC told the Committee that Legendcom:

54 Australian Lawyers for Human Rights, *Submission 11*, p. 12.

55 Department of Immigration and Citizenship, website: <http://www.immi.gov.au/business-services/legend/about.htm> accessed May 2010.

> ...is the legislation and the regulations; it is not policy. The policy, in fact, is explained in the submission we gave to the committee, and it is not a hidden thing. Policy advice is available.[56]

4.103 Ms Jo Knight from the Law Institute of Victoria told the Committee that Legendcom:

> ...is a subscription based service and it is usually lawyers migration agents who fork out for the privilege of accessing that database; it is not something that the general public can access.[57]

4.104 DIAC clarified this in a submission:

> Current departmental policy instructions are publicly available via the department's on-line subscription service LEGENDcom, which is available:
>
> - at the public libraries and institutions that participate in the LDS, the Commonwealth Library Deposit and Free Issue Schemes or
> - by paid subscription.[58]

4.105 DIAC also told the Committee that:

> I do not think there is any process to try and stop people getting the information. In fact, we daily get emails from individuals, law societies and migration agents asking for information and interpretation of how we do these things. We answer those emails and regularly provide documentation for people. Some people want that done personally, and I have gone out and provided education sessions for the Migration Institute, medical groups and other groups. We are quite happy to provide those ongoing discussions. It is fairly easy to tell people how it works under the policy, so at any stage we are more than happy to do that.[59]

4.106 Both the PAM 3 and Legendcom are available to Department decision-makers in the processing of visa applications. DIAC believes that these systems allow decision-makers to apply the law in a consistent and transparent fashion. It is still the case however that Department decision-makers retain some element of discretion in the decision making process where a waiver is available. This is discussed in the following section.

56 Mr Matt Kennedy, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 24 February 2010, p. 12.

57 Ms Jo Knight, Law Institute of Victoria, *Committee Hansard*, Melbourne, 18 February 2010, p. 25.

58 Department of Immigration and Citizenship, *Submission 66.1*, p. 2.

59 Dr Paul Douglas, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 24 February 2010, p. 14.

Discretion of decision makers

4.107 Another issue highlighted to the Committee is the discretion of decision-makers. At present, when an MOC presents an opinion, particularly a 'does not meet' decision, it has to be accepted as final by Department decision-makers unless the visa applicant has applied in a visa category where a waiver is available.

4.108 The Committee asked DIAC whether it would prefer its officers to have more discretion in the decision-making process. DIAC responded:

> ...the short answer to your question is, yes, I think for a whole range of reasons, including practical and efficient administration of the migration program, allowing people in when there are compelling circumstances to grant them a visa...there is a need for an expansion of the waiver.[60]

4.109 In cases where a waiver is available, DIAC noted:

> In terms of the waiver factors ... the visa decision maker makes that decision, not the MOC. They have in front of them the MOCs assessment and the MOCs assessment of the likely long-term cost of health and community services... They look at the impact on Australian citizens' children, because sometimes children are involved—a child who might be an Australian citizen of a parent who is not an Australian citizen...They also look at the individual's ability to mitigate the costs; the ability to mitigate prejudice to access, which is a particularly contentious area—that is access to services by Australians and permanent residents, which is something that does attract some attention if people think that somebody coming from offshore is going to take a service that is not freely available—and perhaps where a spouse cannot join.[61]

4.110 The Committee asked to what extent there was capacity for a visa decision-maker to decide on compassionate grounds. Mr Peter Vardos replied:

> ...once a finding is made by a Medical Officer of the Commonwealth, decision-makers in DIAC are bound by it. So if there is no waiver attached to the particular visa class then that is the end of the story for us. We have no further flexibility and the

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60 Mr Peter Vardos, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 24 February 2010, p. 5.

61 Mr Matt Kennedy, Department of Immigration and Citizenship, *Committee Hansard*, 24 February 2010, p. 7.

only pathway open would be to review and, ultimately, to seek ministerial intervention. I think one of the reasons we are quite happy for this issue to be addressed is because there are cases—whether they fall in the family stream or the skilled stream—where the principal applicant is very worthy of a grant of a visa. But where a member of the family fails a health requirement then our hands are tied. So I sympathise with the issues that are being put to you.[62]

4.111 The Committee has heard that the decisions of MOCs are final and that they must be abided by Departmental decision makers. Mr Peter Vardos of the DIAC stated that this:

...does cause frustration on the part of decision makers who can see that there are broader compelling circumstances that should be taken into account, but there is no waiver.[63]

4.112 DIAC has also submitted to the Committee:

...it is DIAC's view that there would be benefit in widening the circumstances in which economic gains which might be offered by the applicant, could be a consideration in the visa decision.

There are a number of ways in which additional decision-making flexibility could be introduced, including:

- allowing an applicant's individual circumstances (i.e. their personal circumstances as well as the severity and nature of their condition) to be taken into account as part of the assessment as to whether they meet the health requirement, for any visa application.
- allowing individual circumstances to be considered as part of the assessment as to whether the applicant meets the health requirement, for a specified range of visa classes.[64]

4.113 DIAC has qualified this by stating:

Careful consideration would need to be given to the range of factors a visa-decision maker could have regard to when considering a waiver for a wider range of visa classes. Waivers are currently decided by visa decision makers. Where the cost to the health budget is estimated to be more than $200,000, the visa

62 Mr Peter Vardos, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 24 February 2010, pp. 4-5.

63 Mr Peter Vardos, Department of Immigration and Citizenship, *Committee Hansard*, 24 February 2010, p. 5.

64 Department of Immigration and Citizenship, *Submission 66*, p. 25.

> decision maker takes advice from a central policy adviser. DIAC would propose to retain this approach for a wider range of waivers, to ensure consistent application of policy settings and given the significant economic implications of a decision to grant a waiver in these circumstances. DIAC may also look at whether if a condition may extensively or substantially prejudice access to services for the Australian community that waiver may not apply in the same manner as public health risks cannot currently be waived.[65]

4.114 The Law Institute of Victoria states it also has concerns in relation to the MOCs role in preparing a health waiver costing advice.[66]

4.115 Professors Ron McCallum AO and Mary Crock have submitted to the Committee that:

> The best option for returning the regime to one that is not overtly discriminatory towards persons with disabilities is to amend the regulations to allow immigration officials, including merits review bodies, to weigh the costs that might be associated with the admission of an individual with disabilities against the benefits that might flow from admitting the individual and his or her family. Medical doctors could retain the function of determining the disease or condition affecting the applicant. Immigration officials would then be empowered to consider a range of other factors in making the decision whether or not to grant a visa.[67]

4.116 The Royal Australasian College of Physicians stated:

> In Australia, it is the opinion of a single medical officer about the disability condition of a visa applicant that is held sufficient to support adverse differentiation against the person on the basis of disability. Requiring two or more concurring medical opinions may be an important safeguard against arbitrary or unjustifiable differentiation against the disabled, in circumstances where medical opinions can reasonably differ on questions such as the severity of the disability and the care and treatment (and thus the expense) required. While there is ordinarily an avenue of merits review in Australia through the Migration Review Tribunal, which can re-evaluate the factual basis of the decision, the Tribunal is not itself a medically-qualified body and is therefore not in a position

65 Department of Immigration and Citizenship, *Submission 66*, p. 25.

66 Law Institute of Victoria, *Submission 88*, p. 12.

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

> to provide expert reconsideration of medical opinions (as opposed to the weighting and legal evaluation of that expert medical opinion).[68]

4.117 Department decision-makers are highly skilled and have a range of resources at their disposal. A limiting factor in the decision-making process, however, is the reliance on a waiver being applicable for that visa class before factors outside of health may be considered.

4.118 Given the evidence presented, it is apparent that there is little flexibility in the system, especially in circumstances where a waiver option is not available. In such cases, the last, and often unsuccessful resort, is to the Minister's discretion.

Delays in processing

4.119 Many submissions and witnesses commented on the fact that there was a delay in the processing of visa applications. The Committee understands that the processing of applications is an involved process and may be delayed by such things as the need to seek additional information from applicants or seeking clarification from MOCs regarding decisions.

4.120 Some evidence however pointed to unacceptable delays. For example, Mr James Muir told the Committee that in regards to a rejected application on behalf of his sister-in-law:

> ...we were told verbally, shortly after our application in 2005, that she had not been accepted and that the process now was that we could apply for a tribunal hearing, which we agreed to, and that we would receive a letter stating all of this and explaining all of this. It was three years later that we actually received that letter.[69]

4.121 Ms Knight of the Law Institute of Victoria commented on the delays encountered in processing applications:

> ...in terms of people not really knowing when their paperwork might have been sent to the medical officer of the Commonwealth, and then the delays that can happen there. I think it comes back to the transparency about what is being considered and the process...
>
> It is most acute in offshore offices and health issues...it depends on the quality of the advocate that someone can afford or find, and you are particularly disadvantaged when you are applying

68 Royal Australasian College of Physicians, *Submission 80*, pp. 9 – 10.

69 Mr James Muir, *Committee Hansard*, 28 January 2010, pp. 38 – 39.

> offshore. ... A lot of it is to do with processing and it just sort of disappearing into the system, and with not having much access to the people who are making those decisions—let alone understanding what this 'medical officer of the Commonwealth' is.
>
> ... And often you will be waiting a year to be looked at by the Migration Review Tribunal ...[70]

4.122 Susan Laguna of the Multicultural Disability Advocacy Association told the Committee that:

> We have been involved in cases where we had to wait for eight to 10 years, by which time sponsors had already died. There was one case of a family who lives in Albury. The husband had cancer and the wife applied for a carer visa for a relative to come, but he died before the relative could come. There was also one case of a man, about 40. The immigration office dragged its feet and took a long time in processing the child visa application—he had Down syndrome—and the father died, despite the fact that the immigration agent had informed that the father was very sick and wanted to finalise things. It took about eight years.[71]

4.123 DIAC commented on the suggestion that there were delays in the system in respect to appeals:

> As to appeals, the Migration Review Tribunal is an independent body from the department. They do have guidelines, and the principal member issues guidelines to members as to the timeliness of appeals. But it is not something that the department can directly control. My understanding is that the tribunal has made significant improvements in productivity in a number of areas, but, as I say, the time taken to do an appeal is largely outside the department's control.[72]

4.124 As stated, there are obviously a number of reasons, primarily administrative, as to why delays might occur in the processing of applications. Some of the evidence presented, however, point to unacceptably long delays in communicating decisions to visa applicants.

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70 Ms Jo Knight, Law Institute of Victoria, *Committee Hansard*, Melbourne, 18 February 2010, pp. 24-25.

71 Ms Susan Laguna, Multicultural Disability Advocacy Association, *Committee Hansard*, Sydney, 12 November 2009, p. 62.

72 Mr Nicholas Torkington, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 17 March 2010, p. 11.

Committee Comment

4.125 The Committee considers that the expedient processing of visas is a core function of the Department and undue delays are a serious matter. The Department is urged to consider the reasons behind these delays and identify where the blockages are in the current system.

4.126 In regards to the process of decision-making and the capacity DIAC decision-makers to exercise discretion and make individual assessments, the Committee make a number of comments.

4.127 As outlined earlier, a health waiver may only be exercised after a 'does not meet' decision in relation to the Health Requirement is given for a visa applicant who applies for a visa in a limited range of categories. There is an argument to say that the Health Requirement should form part of a more holistic decision-making process rather than being, in many cases, the factor which will cause a visa to be denied. This is not to say that the Health Requirement should be ignored, rather that mitigating circumstances should be taken into account, especially in relation to the 'significant cost threshold' element of the Requirement. The ability to account for mitigating circumstances should be available in all visa streams – family, humanitarian and skilled – not simply for a specified few eligible for waiver consideration, as is currently the case.

4.128 In the Committee's view, decision-makers should have greater discretion to consider mitigating factors following a 'does not meet' MOC decision. The Committee considers that, following the receipt of a visa application, if a 'significant medical condition' is identified, the applicant should be referred to an MOC or panel doctor for assessment under the Health Requirement, as is currently the case.

4.129 If a 'does not meet' decision is returned, the Department decision-maker should be in a position to consider the circumstances of mitigation which are available to the visa applicant as discussed in this chapter. This should include the economic contribution of the entire family or any significant social contributions – especially in situations where the applicant has strong family connections to Australia. The financial resources that the applicant has at their disposal should be considered, especially where family members have offered to indemnify the Commonwealth in relation to health costs.

4.130 In summary, further to the earlier discussion regarding consideration of social and economic contribution, it is the view of the Committee that the

capacity to consider mitigating factors should be available across all visa streams and not limited to those with a waiver.

Recommendation 10

The Committee recommends that visa decision-makers in the Department of Immigration and Citizenship be provided with the discretion to consider mitigating factors for any visa stream once a 'does not meet' the Health Requirement decision is received from a Medical Officer of the Commonwealth. These factors may be used to mitigate the 'significant cost threshold'.

Review mechanisms

4.131 There are a limited number of review mechanisms available to visa applicants. This section considers the Migration Review Tribunal and the Refugee Review Tribunal, and review of a decision through Ministerial discretion.

4.132 As discussed in Chapter 3, the Migration Regulations 1994 provide that a visa application is to be rejected by an MOC if costs and services for a particular level of condition are judged to be beyond the 'significant cost threshold' for a given period, irrespective of whether these costs and services are used. [73]

4.133 A waiver consideration gives an opportunity to the applicant to provide information to offset these costs, but is only available for certain limited visa categories attached to PIC 4007 or 4006A. The former provides for a waiver consideration at the discretion of the Minister which is assessed against set criteria, the second accepts an undertaking of an employer, again at the Minister's discretion.

4.134 Under PIC 4007, the Department decision-maker can take into account the following factors to offset 'significant' costs identified by the MOC, including:

- the merits of the case (i.e. compassionate and/or compelling circumstances)
- qualifications and employment prospects of the applicant in Australia;

73 Migration Regulations 1994, *Schedule 4.* PIC 4005.

- established links in Australia including community and economic ties;
- assets and income; and
- availability of care and support from family members or other bodies.[74]

4.135 If the waiver is not granted the only option is to pursue avenues of appeal through the Migration Review Tribunal (MRT). This process of appeal can be expensive and time consuming, particularly for the least advantaged applicants under the system. Further obstacles are in the legal constrictions and lack of medical expertise of the MRT, which tend to result in a repeat rejection of a visa, making Ministerial discretion the last resort.[75]

Migration Review Tribunal and Refugee Review Tribunal

4.136 The website of the Migration Review Tribunal and Refugee Review Tribunal states:

> The Migration Review Tribunal (the MRT) and the Refugee Review Tribunal (the RRT) provide an independent and final merits review of decisions made in relation to visas to travel to, enter or stay in Australia. The MRT reviews decisions made in respect of general visas (e.g. visitor, student, partner, family, business, skilled visas) and the RRT deals with decisions made in respect of protection (refugee) visas.
>
> The Tribunals are established under the *Migration Act 1958* and the Tribunals' jurisdiction and powers are set out in the Migration Act and in the Migration Regulations 1994. All Members and staff are cross-appointed to both Tribunals and the Tribunals operate as a single agency for the purposes of the *Financial Management and Accountability Act 1997*.[76]

4.137 DIAC advised:

> The primary objective of merits review is to ensure that the correct or preferable decision is reached on the facts before the review body. The Tribunals, in addition to the Tribunal's specific powers, operate within the same legislative framework as the visa decision

74 Procedures Advice Manual 3, Schedule 4.4005-4007.97.3, quoted in ANU Migration Program School of Law, *Submission 59*, p. 8.

75 Mr Mark Dreyfus QC MP, *Submission 109*, p. 2.

76 Migration Review Tribunal and Refugee Review Tribunal, website: <http://www.mrt-rrt.gov.au/> accessed May 2010.

> makers. Therefore, the Tribunal, like the visas decision maker, is bound by the findings of the MOC (reg. 2.25A(3)). The Tribunal however, can consider new information.[77]

4.138 As an example, Down Syndrome Western Australia cites the case of Dr Bernard Moeller:

> In the Moeller case too, it is also worth noting that the MRT process was not able to reach the decision that Evans reached, that the family's net contribution was positive. The MRT was also bound to accept the view of the CMO of the 'costs' of the person with disability and is not empowered to take into consideration the factors which led Evans to reverse the MRT's decision, namely the benefit to the community of the family as a whole.[78]

4.139 DIAC has informed the Committee that as part of the MRT's process in relation to a review of a decision relating to the Health Requirement, an applicant has the ability to obtain a new health assessment from a Review Medical Officer of the Commonwealth (RMOC). However, if the RMOC is also of the opinion that the applicant does not meet the Health Requirement then both the Tribunals and DIAC are bound by this decision. [79]

4.140 DIAC noted in this regard that:

> If they have a review right to the MRT, they can actually get a formal second opinion—a review medical officer for the Commonwealth appearing as part of that review. So that is a formal right to get a second opinion.[80]

4.141 Following rejection by the Tribunals, an applicant is able to make an appeal to the Federal Magistrates Court, which has the capacity to remit the Tribunal's decision for review. Ministerial intervention is also available where the decision by the Department is affirmed by the Tribunal. [81]

4.142 When asked as to whether the MRT takes into account the fact that an assessment is being made on a child, for example, whose potential is yet to be reached, Mr Papadopoulos told the Committee:

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77 Department of Immigration and Citizenship, *Submission 66*, p. 13.

78 Down Syndrome Western Australia, *Submission 57*, p. 15.

79 Department of Immigration and Citizenship, *Submission 66*, p. 13.

80 Mr Nicholas Torkington, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 17 March 2010, p. 6.

81 Department of Immigration and Citizenship, *Submission 66*, p. 13.

> ...The MRT's powers are inquisitorial—it has an inquisitorial function; it can take into account various information. It largely relies on the applicants and their representatives to put forward information to it and to put the arguments forward... The MRT itself stands in the shoes of the departmental decision maker and the process is simply repeated; they just rely on the opinion of the review medical officer of the Commonwealth and, like the minister and the delegate, are bound to apply it.[82]

4.143 The impact of the current attenuated review process was regarded as particularly detrimental to the family reunification of refugees and humanitarian entrants. The Committee heard many stories of families in extreme stress:

> One Afghan client that I now have has a baby with a disability, and the process has taken so long that his wife is saying: 'I don't believe you anymore. I don't believe that you really want to bring me.' He now has to quit his job and go to Pakistan to convince his wife. The visa is about to be granted, but his wife has almost pulled the pin and is saying, 'I don't believe you anymore.' So he now has to give up his job, go to Pakistan, look after her and make sure that she believes that he really wants her. So those are additional costs, and that happens quite often. People often do not understand the process, and a lot of time, effort and money have to be put into convincing them that they have not been abandoned by their relative in Australia.[83].

Ministerial discretion

4.144 The final review process in a number of cases is an appeal to the Minister's discretion. Essentially this occurs when an applicant has exhausted all other avenues to successfully be granted a visa to either migrate to or remain permanently in Australia.

4.145 The exception to Ministerial discretion, according to the Law Institute of Victoria are:

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

83 Ms Marg Le Suer, Refugee and Immigration Legal Service, *Committee Hansard*, Brisbane, 28 January 2010, pp. 24-25.

> Health requirements relating to (a) tuberculosis or (b) other threats to public health in Australia or dangers to the Australian community cannot be waived by the Minister in any case.[84]

4.146 Evidence to the Committee suggests that the process of Ministerial discretion is relatively discretionary and many applicants that reach this stage do so following extensive media coverage of their cases.

4.147 DIAC states:

> Where the Tribunal is required to affirm the Department's refusal decision, it is; however, open to the applicant to request that the Minister intervene in his or her case. The Minister is then able to take into account the applicant's individual circumstances, including any compelling or compassionate reasons why a visa should be granted.[85]

4.148 Mr Don Randall MP, Member for Canning, reported a constituent's experience to indicate an overreliance on Ministerial discretion to resolve permanent residency issues:

4.149 Earlier this year I assisted a family awaiting ministerial intervention on their application for permanent residency as one of them had failed the health requirement as they had been diagnosed with HIV. In this case the family were more than happy and capable of providing the medical care when and if required for their family member's illness. They run several successful businesses in the local area and employ a number of Australians. Their daughter has just started at a local school and only knows Australia as her home. They love the lifestyle, people and culture of Australia and want nothing more than to permanently settle here. This family put in an application for permanent residency knowing that it would be refused and then refused again on appeal to the Migration Review Tribunal, leaving ministerial intervention as the only option for a grant of permanent residency. After personally meeting with them I could see first hand the emotional toll the uncertainty of their application was having on them. There obviously needs to be reform to a system that makes ministerial discretion the only avenue for this family to gain permanent residency.[86]

4.150 Mrs Maria Gillman was also demoralised by a system in which she saw herself as 'ultimately forced to go begging to the Minister on hands and

84 Law Institute of Victoria, *Submission 88*, p. 6.

85 Department of Immigration and Citizenship, *Submission 66*, p. 13.

86 Mr Don Randall MP, Member for Canning, *Submission 110*, p. [2].

knees 'as sponsor for her multi-skilled but sight impaired sister. She provided a report of the trajectory from rejection under PIC 4005 to review:

> As Una's sponsor, I was able to apply to the Migration Review Tribunal for a review of the decision to refuse Una a skilled migration visa. I first had to apply for an opinion from a review medical officer of the Commonwealth, as the Migration Review Tribunal could only overturn the decision if the review medical officer of the Commonwealth overturned the opinion of the medical officer of the Commonwealth, which was based on the report of the panel doctor. The RMOC upheld the opinion of the MOC and in October 2007 the Migration Review Tribunal was bound to affirm the decision not to grant Una a visa, which meant that my application to the MRT had failed. I was then able to appeal to the Minister for Immigration and Citizenship to request that he exercise his public interest powers, which enabled him to grant me a more favourable decision than the MRT and ultimately enabled him to grant Una a visa. Even if the minister decides to grant her a visa, it is my understanding that he is not compelled to grant Una the visa that she has applied for. Instead, he can decide to grant her a visa in a different class. [87]

4.151 Uniting Justice in Australia states:

> While the Health Requirement is waived for some refugees and migrants by ministerial discretion, this exemption process is arbitrary and inconsistent. The exercise of the minister's powers is non-reviewable and non-transferable, making it an inadequate substitute for transparent legal and regulatory protection of the human rights of those with disabilities.[88]

4.152 The Immigration Advice and Rights Centre states:

> ...While Ministerial intervention can be effective in isolated cases, it often only arises as a result of media coverage and/or community support. For those who are unable to clearly articulate their compassionate claims (eg due to language barriers, social isolation or as a direct consequence of their disability) the result is not always so positive.[89]

87 Mrs Maria Gillman, *Committee Hansard*, 18 February 2010, pp. 31-32.

88 Uniting Justice in Australia, *Submission 48*, p. 4.

89 Immigration Advice and Rights Centre, *Submission 30*, p. 13.

4.153 Additionally, it was reported that a significant number reported of cases were progressed by representations from Members of Parliament.

4.154 Mr Mark Dreyfus QC MP, Member for Isaacs, advised the Committee of his representations to the Minister on behalf of constituent with HIV whose visa was rejected under PIC 4005 criteria, with no waiver option.

4.155 Reporting on the case, Mr Dreyfus remarked that the system overall lacked transparency and consistency. He also noted the lack of a waiver opportunity under PIC 4005, the limited review capabilities of the MRT, the lack of obligation to investigate to RMOC opinions and the legislative definition of significant cost as major problems in the system.[90]

4.156 Mr Andrew Bartlett of the Ethnic Communities Council of Queensland told the Committee:

> ...any system that basically requires people to hope that they will get the right at answer at the ministerial discretion stage, which is the case wherever there is no health waiver in place, is, apart from anything else, going to involve a lot more administrative costs to the taxpayer. You have to go through the initial application, the appeal and then you get to the minister. It is not good public policy to have that as a matter of your best hope of getting reasonableness.[91]

4.157 The Migration Law Program at the Australian National University suggests:

> Because there is no health waiver available under Public Interest Criterion 4005, a migration agent is frequently put in a position where they have to advise a client to submit a visa application which they know is likely to fail, with a view to eventually putting their case to the Minister to exercise his or her personal discretion to grant a visa. The 'safety-valve' of the Minister's discretionary powers is there to redress the compassionate and humanitarian circumstances of individual cases that fall between the cracks of the rigid codified system of visa criteria, including the unwaivable health criterion 4005. Resort to personal appeals to the Minister has obvious disadvantages including the lack of certainty of the outcome, the delay in waiting for an uncertain outcome, and perhaps most damaging to the welfare of the family and the

90 Mr Mark Dreyfus MP QC, *Submission 109,* p. 2.

91 Mr Andrew Bartlett, Ethnic Communities Council of Queensland, *Committee Hansard,* Brisbane, 28 January 2010, pp. 10-11.

> community. Since a decision of a Tribunal is a prerequisite to the Minister's personal discretionary powers being activated, there is also the added costs burden of additional appeals to the Migration Review Tribunal.[92]

4.158 Ms Kione Johnson submitted to the Committee that:

> The Minister is only likely to exercise this power if the applicant can demonstrate 'unique or exceptional circumstances', including threats to their personal safety, considerations of the role of the family unit, the rights of the child, whether refusal would cause considerable hardship to an Australian citizen, or whether the applicant could provide 'exceptional economic, scientific, cultural or other benefit' to Australia.[93]

Committee Comment

4.159 Evidence to the Committee suggests that in most cases which are related to the Health Requirement, applications are rejected in the first instance. This leads to much frustration on the part of visa applicants especially because many have gone to considerable time and expense in the application process. Many also have trouble understanding the complex process in relation to appeals of decisions.

4.160 An appeal for Ministerial discretion is the absolute last resort and is also unsuccessful in many cases. All other avenues of appeal must have been exhausted to be in a position to appeal to the Minister’s discretion. Ultimately, very few visa applicants reach this stage: many having given up as a result of the lengthy and costly process. Some of those who have had the advantage of such decisions have been subject to high levels of media attention.

4.161 The Committee contends that this option is not one that is available to everyone nor is it transparent or practical. It is preferable for flexibility and greater review options through waivers or consideration of additional factors to be form part of the assessment process.

4.162 The Committee notes that currently very few visa categories have attached to them provision for a waiver which would enable a Department decision-maker to consider mitigating factors for significant cost test, as

92 Migration Law Program, *Submission 59*, pp. 5-6.

93 Ms Kione Johnson, *Submission 62*, p. 4.

outlined in the Health Requirement. Mitigating factors may include the ability to offset health costs through employment or the resources of other family members. Other mitigating factors could include the applicant's social and family ties to Australia. The Committee has recommended an increase in the capacity of decision-makers to apply discretion in considering individual cases.

4.163 A further concern raised during the inquiry was the reliance placed on both the Migration or Refugee Review Tribunals and the process of Ministerial Intervention. The Committee has heard that there are many cases that are appealed through both mechanisms, rather than being dealt with at Department level. The Committee believes that the option for Ministerial intervention is one that should be reserved for circumstances that are extraordinary and profound in nature. The majority of cases should be able to be determined in a fair and consistent manner, appropriate to individual cases through MOC and DIAC decision-making processes.

4.164 The Committee contends that the recommendations in this report regarding increasing transparency, providing greater discretion for decision-makers and individual assessments of costs contribution will vastly improve the fairness and robustness of the system. In particular, the Committee considers that greater discretion at the DIAC decision-maker level to consider mitigating factors would reduce the need for many applicants to proceed through the Migration Review Tribunal and seeking Ministerial intervention.

5

Family, humanitarian and refugee migration

5.1 Australia’s Migration Program has two main components, the skilled stream and the family stream. A third much smaller category is provided by the Humanitarian and Refugees program.

5.2 The Skilled Migration Program is by far the largest migration program taking 67 per cent of all entrants. Many families apply to come to Australia to fill jobs under both temporary and permanent visas, and after settling may wish to sponsor other family members offshore to reunite with them in Australia.[1]

5.3 The focus of the Family stream is the reunification of immediate family members of an Australian sponsor, with 75 per cent of visas granted to partners of Australian citizens and permanent residents. The remaining recipients comprise children, parents, remaining relatives, carers and aged dependent relatives of applicants.[2]

5.4 The Humanitarian and Refugee streams focus on protection for visa applicants at risk of persecution or violence in other nations. Those found to be refugees onshore are granted a Protection Visa (subclass 866) for which the health requirement is waived. Offshore applicants and family members must meet the Health Requirement. Of the total of 171 318 places under the migration program, 13 750 places were allocated to the Humanitarian Program for 2009-10.[3]

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1 The Department of Immigration and Citizenship, *Fact Sheet 24—Over View of Skilled Migration*, accessed May 2010 at <http://www.immi.gov.au/media/fact-sheets/24overview_skilled.htm>

2 Department of Immigration and Citizenship, *Annual Report 2008-09*, 1.1.2 Output Family Migration, accessed May 2010 at <http://www.immi.gov.au/about/reports/annual/2008-09/html/outcome1/output1-1-2.htm#table7>

3 Department of Immigration and Citizenship, ‘The Year at A Glance’ Table, accessed May2010 at <http://www.immi.gov.au/about/

5.5 The family and humanitarian migration streams reflect Australia's international commitments to protect the family as the fundamental unit of society and to provide a safe haven for people in other nations who are escaping from the threat of persecution or violence.

5.6 This chapter evaluates evidence relating to the experience of families across the visa streams that have been negatively affected by Australia's migration Health Requirement. The impact on families in the skilled migration stream is also considered here. Further issues relating to the skilled migration are considered Chapter 6.

Programs and statistics

Family stream

5.7 Family stream migrants are selected on the basis of their family relationship with their sponsor in Australia. **Table 1** shows the four main categories with corresponding visas and Public Interest Criteria (PIC) governing assessment of the Health Requirement for each category.

5.8 The Department of Immigration and Citizenship (DIAC) advises that the family stream is a growing category of migration, with numbers increasing from 32 040 visas in 1998–99 to 56 366 visas in 2008–09.[4] Due to increased demand, DIAC adjusted the cap upwards for parent visas during 2009–10, and introduced a new provisional visa category for the Dependent Child (subclass 445).[5]

reports/annual/2008-09/html/overview/the-year-at-a-glance.htm>

4 In 2008–09 a total of 171 318 people were granted migration visas to Australia. The family stream comprised 34 399 spouse visas, 689 interdependent visas, 7 010 prospective marriage visas, 3 238 child visas (including adoption), 8 500 parent visas and 2 530 preferential and other family visas (including orphan relatives). Department of Immigration and Citizenship, *Annual Report 2008-2009*, 1.1.2 Family Migration, accessed May 2010 at <http://www.immi.gov.au/about/reports/annual/2008-09/html/outcome1/output1-1-2.htm#table7>

5 Department of Immigration and Citizenship, *Annual Report 2008-09*, 1.1.2 Family Migration, accessed May 2010 at <http://www.immi.gov.au/about/reports/annual/2008-09/html/outcome1/output1-1-2.htm#table7>

Table 1 Family stream visa categories with relevant Public Interest Criteria classification [6]

Category	Visa	PIC	Description
Partner	100 (P), 309 (Prov) 801 (Prov) 820 (Extended)	4007	Partner: the spouse or de facto partner (including same-sex partners) of the Australian sponsor
	300 (T)	4007	Prospective Marriage: a fiancé overseas who plans to marry their Australian sponsor after travelling to Australia
Child	101 (P) 445 (Prov) 802 (Residence)	4007	Dependent child: the child or stepchild of the Australian sponsor
	102 (P)	4007	Adopted child: a child adopted overseas
	117 (P)	4005	Orphan relative: a child who is unmarried, not in a de facto relationship and is under 18 years at the time of application who cannot be cared for by either parent.
Parent	103 (P) 804 (P)	4005 *	Parent category
	864 (P) 884(Prov)	*	Contributory parent category, which provides more spaces, has higher visa charges and larger Assurance of Support (AoS) bond (with a longer AoS period).
Other family	114 (P) 838 (P)	4005	Aged Dependent Relative: single
	116 (P) 835 (P)	4005	Remaining Relative: a person who has no near relatives outside Australia and is the brother, sister, child or step equivalent of an Australian citizen, Australian permanent resident or eligible New Zealand citizen
	116 (P) 837 (P)	4005	Carer: a person willing and able to give substantial care or continuing assistance to an Australian relative or member of their family who has a medical condition that impairs their ability to attend to the practical aspects of daily life. The need for assistance must be likely to continue for at least two years.
	461 (T)	4007	NZ Citizenship Family relationship

Source *(T) Temporary Residency visa. (P) Permanent residency visa (Prov) Provisional*
** If under subclass 676: 4007, other wise 4005*

5.9 In 2009–10 the planning level for the family stream was set at 60 300 visas, which represents 35.7 per cent of the total Migration Program (the overall planning level for 2009-10 was set at 168 700).[7]

6 Department of Immigration and Citizenship, *Fact Sheet 29–Overview of the Family Stream,* accessed May 2010 at <http://www.immi.gov.au/media/fact-sheets/29overview_family.htm> and see DIAC *Submission 66,* Attachment C.

Refugee and humanitarian program

5.10 Australia's refugee and humanitarian program has two components:

- the **Onshore (asylum or protection) component**, which offers protection to people in Australia who meet the refugee definition in the United Nations Convention relating to the status of Refugees, and
- the **Offshore (resettlement) component**, which offers resettlement for people outside Australia who are in need of humanitarian assistance.[8]

5.11 DIAC advised that the number of applications for resettlement received is far greater than the visas available each program year. For instance, in 2007–08 more than 47 000 persons applied and around 10 800 were granted visas. In the 2008–09 the majority of visas were for refugee and humanitarian applicants offshore: 11 010 visas were granted under the offshore component, and 2 497 program countable visas granted under the onshore component.[9]

5.12 As shown on **Table 2** visa applications in the refugee and humanitarian categories have a PIC 4007 classification, meaning that they are subject to the Health Requirement but a waiver consideration can be conducted at the Minister's discretion.

Waiver options and statistics

5.13 As indicated above, all visa applicants must be assessed under the Health Requirement excluding the Refugee and Humanitarian stream Onshore Protected visa which is exempted under human right commitments.

5.14 Applicants applying under visas classified by PIC 4005 will be passed or failed on that test by the Medical Officer of the Commonwealth (MOC). A limited number of visas in the Family and Humanitarian streams (under

7 Department of Immigration and Citizenship, *Annual Report 2008-09*, 1.1.2 Family Migration, accessed May 2010, <http://www.immi.gov.au/about/reports/annual/2008-09/html/outcome1/output1-1-2.htm#table7>

8 Department of Immigration and Citizenship, Visas, Immigration and Refugees, Refugee and Humanitarian Program, accessed May 2010 at <http://www.immi.gov.au/visas/humanitarian/>

9 Department of Immigration and Citizenship, Visas, Immigration and Refugees, Refugee and Humanitarian Program, Overview of the Offshore Humanitarian Program, accessed May 2010 at <http://www.immi.gov.au/visas/humanitarian/offshore/>and DAIC, 1.2.1 Offshore Humanitarian Program, accessed April 2010 at < http://www.immi.gov.au/about/reports /annual/2008-09/html/outcome1/output1-2-1.htm>

PIC 4007) have access to consideration of a waiver at the Minister's discretion. [10]

Table 2 Refugee and Humanitarian visa categories with Public Interest Criteria classification [11]

Category	Visa	PIC
Refugee	200 (P)	4007
In Country Special Humanitarian	201 (P)	4007
Global Special Humanitarian	202 (P)	4007
Emergency Rescue	203 (P)	4007
Woman at Risk	204 (P)	4007
Onshore Protected	866 (P)	None*

*Key: (P) Permanent residency visa * Health requirement is waived*

5.15 If PIC 4007 applies a Department decision-maker will assess any economic and other factors which may offset any health and community service costs associated with the granting of the visa. If these costs are not found to be 'undue' the visa will be granted.[12]

5.16 As discussed in the next Chapter, a waiver option also exists for limited skilled stream applicants under PIC 4006A where an employer provides an undertaking to cover health costs. More recently additional skilled stream visas have been provided with a waiver option under PIC 4007. [13]

5.17 DIAC's submission provides that over 2008–09:

- The most common health condition for which a waiver was acquired was HIV. A waiver was provided in 59 cases for which DIAC estimates a cost to Australia of $14 018 000.
- Other common conditions were intellectual impairment (26 cases, estimated cost $11 666 000) and cancer (10 cases at estimated cost $751 500).
- Waivers were granted to 42 applications for Subclass 457 (temporary skilled) visas.

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

11 Department of Immigration and Citizenship, *Fact Sheet 29—Overview of the Family Stream*, accessed May 2010, http://www.immi.gov.au/media/fact-sheets/29overview_family.htm, DIAC *Submission 66*, Attachment C.

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

13 Mr Neil Torkington, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 24 February 2010, p. 6.

- 138 onshore cases achieved waivers after a refusal on the basis of a family member's health.
- Almost all onshore waivers related to partner visa cases within the family stream and were granted.
- 150 cases with significant health problems achieved waivers offshore.[14]

The 'one fails, all fail' rule

5.18 The *Migration Act 1958* (Cth) contains the health criteria for assessment of the Health Requirement. Sub-section 5(1) states that the criteria:

> …relates to the applicant for the visa, **or the members of the family unit of that applicant** (within the meaning of the regulations)

5.19 Regulation 1.12 of the Migration Regulations 1994 defines the 'family unit' to include any dependent children under the age of 18, regardless of the custody or access arrangements in place.[15]

5.20 Under these provisions, all individuals included in the visa application, as well as any non-migrating dependants, must meet the Health Requirement on health costs and prejudice of access grounds.[16] As the Public Interest Advocacy Centre/NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) noted, the Health Requirement is thus a 'one fails, all fail' criterion:

> …if any members of the family unit should fail to meet the Health Requirement, and no health waiver is available, no family member will be granted a visa. This includes the applicant seeking to satisfy the primary criteria for the particular type of visa applied for. [17]

5.21 According to DIAC's statistics the 'one fails, all fail' rule supported a significant percentage of visa refusals on health grounds during the 2008-09 financial year: of 360 failed on the basis cost or prejudice to access, 282 were refused on the basis that:

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14 The Department of Immigration and Citizenship, *Submission 66*, Attachment G, p. 43.

15 Migration Regulations 1994 (Cth).

16 The Department of Immigration and Citizenship, *Submission 66*, Attachment G, p. 42.

17 Public Interest Advocacy Centre/NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors, *Submission 87*, p. 7.

> …they were not granted a visa due to the "one fails all fails" rule for permanent visas - i.e. all applicants for the visa as well as any non-migrating dependants must meet the health requirement.[18]

5.22 The broad impact of this criterion was well recorded in the evidence: this requirement was regarded as highly discriminating towards people with a disability and their families, in stark contradiction to Australian's international obligations to protect family unity.[19]

5.23 Queensland Parents for People with a Disability (QPPD) stated:

> When families who have a member with a disability are treated in a less favourable manner than others it has the potential to impact most severely on the person with the disability. QPPD shares the view expressed by most experienced advocates for people with disabilities: that a strong family unit is the most effective support and safeguard for a person with a disability. Any policy that leads to depriving the person with a disability of the support of their family network has the potential to cause them a great deal of harm.[20]

5.24 The Federation of Ethnic Communities' Councils of Australia states:

> ...the 'one out all out' provision in the Migration stream can exclude a whole family unit from the grant of visas on the grounds that a single member has a disability, without necessarily giving adequate weight to the positive contributions that the person with a disability and the family unit as a whole may potentially make both socially and economically.[21]

5.25 Submissions to the inquiry took issue in particular to the application of the rule to all family members, irrespective of whether they are in the application for migration or not.

5.26 Ms Sharon Ford saw the requirement as both discriminatory and illogical:

> One family was denied entry to Australia because the principal applicant had a child with Down syndrome from a previous relationship. The visa application did not include this young man with Down syndrome, since he lived with, and would remain living with, his mother. Yet the father, with his partner and their

18 The Department of Immigration and Citizenship, *Submission 66*, Attachment G: statistics, p. 42.

19 Professor Patricia Harris, *Submission 2*, p. 3.

20 Queensland Parents for People with a Disability, *Submission 17*, p. 1.

21 Federation of Ethnic Communities' Councils of Australia, *Submission 24*, p. 7.

> family were denied a visa on the basis that his son, for whom a visa was not sought, did not meet the health criteria.[22]

5.27 In a similar vein, the Immigration Advice and Rights Centre (IARC) held that the rule imposes an unnecessary administrative hurdle:

> The adoption of the "one fails, all fails" rule in the Australian migration system leads to extremely unfair outcomes for the families of persons with a disability. We fail to see any justifiable reason for the application of the health criteria to family members who are not applying to migrate to Australia. If such family members were to later seek entry to Australia then their visa application would be assessed in light of the health criteria, which would be applied to them at that time. This is the appropriate time for consideration of any health issues, not when another member of their family is migrating.[23]

5.28 A disturbing consequence of the 'one fails, all fail' requirement is that dependent family members with a disability are being abandoned to facilitate the separate migration of other family members.

5.29 The Australia Lawyers for Human Rights advised:

> The Health Requirement is designed so that if one fails, all fails and so we know that the operation of this policy has often resulted in children with a disability being left behind while other members of the family migrate, especially in refugee cases...[24]

5.30 Mr Brian Kelleher of the Migration Institute of Australia reported that families were put in the invidious position of waiting until a dependent child with a disability turns eighteen, so that the family could make an independent application:

> The whole family was refused because the health criterion is a 'one fails all fail' rule. In that example of the son who was blind, the family had to wait a few more years in which he was not part of the family unit before they tried again.[25]

5.31 Professor Mary Crock confirmed from her research that the policy is having a distorting affect on families, with children often the main victims:

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22 Ms Sharon Ford, *Submission 74*, p. 9.

23 Immigration Advice and Rights Centre, *Submission 30*, p. 10.

24 Australia Lawyers for Human Rights, *Submission 11*, p. 14.

25 Mr Brian Kelleher, Migration Institute of Australia, *Committee Hansard*, Sydney, 12 November 2020, p. 45.

> I have a particular research interest in children and immigration in this respect. One of the points where the health rules really bite hardest is in their impact on children. Unfortunately, there are families who will literally cast off a family member. The policy is unhealthy at so many different levels because it actually reinforces stereotypes; it forces migrants, sometimes, to act dishonestly because they are supposed to tell us about family members; and it has a horrendous impact on the child.[26]

5.32 The Refugee Council of Australia (RCOA) provided an explanation of this noting that waiver provisions attached to some family stream and refugee and humanitarian visas promote these distortions:

> The waiver process allows for consideration of the alternative care and welfare arrangements in place for a non-migrating dependant and Schedule 2 of the *Migration Regulations* allows for a waiver of the health requirement for a non migrating dependant 'if the Minister is satisfied that it would be unreasonable to require the person to undergo assessment in relation to that criterion'. It is our understanding that the combination of these discretionary provisions would allow for a family that otherwise met the criteria to make the extremely difficult decision to apply to leave behind an ordinarily dependent family member who might not meet the standard health requirement.[27]

5.33 Dr Susan Harris Rimmer, representing Australian Lawyers for Human Rights, observed:

> …if you are making someone choose between saving their life and staying with their child, often the family will make the decision that the mother will stay because the mother is not the target of the persecution but the father is, and the father will leave. Australia is one of the few countries that forces people to take that sword of Damocles sort of decision.[28]

5.34 As demonstrated by evidence, the 'one fails, all fail' rule can have a substantial impact on a family unit. Many applicants who have failed this requirement have been unable to understand the rationale behind it, especially in the situation where not all members of a family are seeking to migrate, or where the parents of children with a disability have the ability

26 Professor Mary Crock, *Committee Hansard*, Sydney, 12 November 2020, p. 13.

27 Refugee Council of Australia, *Submission 105*, pp. 6–7.

28 Dr Susan Harris Rimmer, Australian Lawyers for Human Rights, *Committee Hansard*, Canberra, 18 November 2020, p. 6.

to make an economic impact to Australia and also contribute to the costs associated with their child's disability.

The Moeller and Kiane cases

5.35 Many submissions to the inquiry referred to the migration treatment of the Moeller and Kiane families to indicate the severity of problems imposed by the 'one fails, all fail' criterion on families with disabled children.[29]

5.36 The case studies on these matters (see **Case Studies 5.1 & 2**) raise a number of general considerations of relevance to the impact of the Health Requirement on families. In particular:

- **The impact of the cost assessment of children**
  - ⇒ There appears to be a predominance of cases where the acceptance of a whole family will hinge on the outcome of the medical assessment of a dependent child or dependent relative.
- **Many family stream visas and permanent residency visas do not have a waiver option, meaning no cost offsets will be considered**
  - ⇒ In the event of rejection under the 'one fails, all fail' rule, even where there is a waiver, the cost assessment on disability means most applicants have no recourse but to seek Ministerial discretion after a visa rejection and a lengthy process of appeal.
- **Offshore family members of Australian permanent residents are unduly affected by the rule**
  - ⇒ if immediate family members of an Australian permanent resident or protected visa holder are offshore they will be subject to the health requirement, and all will be rejected if one member has a disability.

5.37 The following analysis covers evidence on these issues.

29 Professor Patricia Harris, *Submission 2*, p. 3; Queensland Nurses Union, *Submission 5*, p. [3]; Australian Federation of Disability Organisations, *Submission 6*, pp. 9–10; Australian Lawyers for Human Rights, *Submission 11*, pp. 13–20; Multicultural Development Association, *Submission 20*, p. 7; Advocacy, Disability, Ethnicity, Community (ADEC), *Submission 23*, pp. 7-8; Professors Ron McCallum AO and Mary Crock, *Submission 31*, Attachment 1, pp. 14-15; Cerebral Palsy League, *Submission 36*, p. 6; Refugee Council of Australia, *Submission 105*, pp. 8–9.

Case Study 5.1

Dr Bernhard Moeller—rural doctor and family and the 'one fails, all fail' rule

Dr Moeller was German GP practicing in rural Victoria on Temporary Long Stay 457 visa. The Moeller family was refused permanent residency because of 13 year old Lukas Moeller's Down Syndrome.

No waiver was available under the permanent skilled visa (PIC 4005) so the Migration Review Tribunal duly rejected the Moeller's application for review of their case. However, following representation by members of Federal and State Parliaments and media attention, the case was quickly resolved.

Exercising his discretionary powers the Minister intervened to waive the Health Requirement in recognition of the 'compelling and compassionate' circumstances, including Dr Moeller's considerable contribution as a rural based medical practitioner to offset any 'undue' costs.

Source *Australian Lawyers for Human Rights,* Submission 11, *pp. 17-19.*

Case Study 5.2

Mr Shahraz Kiane—protected refugee's family and the 'one fails, all fail' rule

Mr Kiane was an asylum seeker who received protection in Australia in 1997 and sought to sponsor his wife and children to join him.

Mr Kiane's Split Family Protection visa application was rejected on the basis that the Health Requirement was not met by one of his children, an eight year old girl with cerebral palsy and epilepsy. The visa has a waiver (PIC 4007) consideration, during which family members in Australia offered to guarantee financial and other support.

After four and half years in appeal, Mr Kiane subsequently set fire to himself in protest in front of Parliament House in Canberra in 2001. He later died of his injuries. In its report on the case, the Commonwealth Ombudsman expressed 'serious concerns about the fairness and professionalism of [the] decision-making process'.

Source *Refugee Council of Australia,* Submission 105, *pp. 8-9; Professors Ron Mc Callum AO and Mary Crock,* Submission 31, *Attachment 1, p. 15.*

The methodology for health cost assessments

5.38 In Chapter 3 of the report the Committee evaluated evidence relating to the calculation of significant cost and medical assessment conducted under the Health Requirement.

5.39 In this section the Committee focuses on the effectiveness and impact of the cost methodology when applied to children with a disability in conjunction with the Health Requirement's 'one fails, all fail' criterion.

Assessing health costs for children

5.40 Perhaps the strongest message of the inquiry was that the medically based cost assessment made under the Health Requirement is most flawed when applied to children with a disability.

5.41 Dr Susan Harris Rimmer and Dr Kristin Natalier objected to the underpinning assumption that children with a disability are a set deficit, with no potential for development or growth:

> Defining child applicants with reference to costs reflects and reinforces a conceptualisation of disability as a deficit and as largely unproductive. Able-bodied children are presumed to be in the process of developing (intellectually, physically, emotionally) into productive citizens … but this expectation is denied to children living with a disability, whose potential engagement in the labour market is denied.[30]

5.42 The Royal Australasian College of Physicians observed:

> Assessing a child's economic worth without considering the contributions of the family as a whole or the child's own potential, can lead to unjust decisions.[31]

5.43 The Australian Lawyers for Human Rights stated:

> Disabled Children are disproportionately impacted by the operation of this seemingly objective legal scheme because the heath requirements asks the MOC to calculate costs including education and pension costs over a person's lifetime and thus children are more likely to cross the $200 000 barrier than adults. Children are not usually the primary applicant so their particular

30 Dr Susan Harris Rimmer and Dr Kristin Natalier, *Submission 7*, p. 6.

31 The Royal Australasian College of Physicians, *Submission 80*, p. 8.

> situation or prospects are not considered at any stage in the process, unlike applicant adults.[32]

5.44 The Committee received a disturbing number of submissions and testimonies which cited a child with a disability as the reason behind a family's rejection under the Health Requirement. In response to these accounts, the Committee sought to establish the extent to which children with a disability are the reason for visa refusals under the 'one fails, all fail' rule.

5.45 DIAC was asked how many of the 282 cases refused under the 'one fails, all fail' rule involved a dependent child with a disability as the person refused. The Department could provide no more detail than the following:

> According to the Department's 2008-09 data, there were 44 people who were refused a visa because of some form of intellectual impairment. Of these, 26 were children, (the youngest 2 years, the oldest 15 years).[33]

5.46 DIAC's Chief Medical Officer Dr Paul Douglas clarified that it is not the condition itself which results in a visa rejection, but the calculation of health costs over time, and this calculation most impacts on children and the young:

> Legally everyone is assessed. There are no set diseases, circumstances or conditions which mean that people will not meet the health requirement, but practically we know that, if people are young enough and have a severe enough condition, it is almost automatic that they will not meet the health requirement….[34]

5.47 Commenting on this, Mr Peter Papadopoulos of the Law Institute of Victoria (LIV) told the Committee that the bulk of the health costs estimated for children with Down Syndrome is attributable to their ability to access a Disability Support Pension (DSP). He noted:

> The problem is that the criteria which assess for DSP—under table 10, schedule 1B of the Social Security Act—mean that you are assessing children against criteria which apply to adults. So how on earth can you make a robust decision in relation to how much somebody is going to cost when you are talking about a four-year-old child? You are not sure really whether or not they are going to

32 The Australian Lawyers for Human Rights, *Submission 11*, p. 14.

33 Department of Immigration and Citizenship, *Submission 66.1*, p. 2

34 Dr Paul Douglas, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 17 March 2008, p. 14.

> have moderate or mild Down syndrome. You are basing the entire visa decision on that one word.[35]

5.48 Ms Sharon Ford queried how can one 'reasonably assess quantitatively either the future economic or future social cost or contribution of any individual?' She suggested:

> If cost estimates are to continue to be applied then it should be to each and every applicant. And it must be a realistic assessment of costs based on the applicant's health and prognosis *at the time of application,* defined by standardised estimates and guidelines which are available for public scrutiny. The process of attempting to calculate the future cost of health and community services should be discontinued. It is impossible and the outcome meaningless in any real context.[36]

Costs 'regardless of use'

5.49 Another objection raised in relation to the cost methodology was the criterion set out in the PIC 4005, 4006A and 4007 which states that decision-makers should consider the likelihood of 'significant cost' to the Australian community:

> '…regardless of whether the health care or community services will actually be used in connection with the applicant'.[37]

5.50 Submissions suggested this was an illogical approach. Carers New South Wales stated:

> The most important issue for migrants with a disability and their families in the health requirement assessment is that the rigid criteria does not take into account whether the individual with a disability would actually utilise community services. The decision is made, in essence, on a hypothetical assumption of the use of the health and community services that a person in the same circumstances would use or may be eligible for, regardless of whether the health care or community services will actually be used by the applicant.[38]

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

36 Ms Sharon Ford, *Submission 74,* p. 4.

37 *Migration Regulations 1994, Schedule 4,* and see The Department of Immigration and Citizenship, *Submission 66,* Attachment B.

38 Carers New South Wales, *Submission 71,* p. 6.

5.51 The author of another submission had made an application for a permanent visa but was rejected on the basis of projected DSP costs associated with his child, who has mild spina bifida:

> In October 1997, I wrote a letter to the Immigration Minister and raised some serious concerns about the quality and integrity of the medical assessment done by an Australian government doctor. I asked for a detailed calculation of "significant cost" on the basis of which my visa application was denied. The minister indicated that my daughter was going to be eligible for A$ 1,950 per year disability allowance. There was nothing on the record to suggest that I was going to apply for the said disability benefit if my application for a migrant visa was approved. My family was not going to qualify for the said benefit due to our financial standing.[39]

5.52 The submitter reports that his daughter now attends one of the top United States' liberal art colleges and is thriving despite being judged deficient under the Australian system. [40]

5.53 Ms Lauren Swift referred to the body of case law testing the application of the 'regardless of use' criterion. She notes that in *Iguanti v Minister for Immigration and Multicultural Affairs*,[41] for example, the judgments went against the position that the PIC 4005 is invalid because it is illogical. This case has been seen to reinforce the view that it is reasonable to assess against potential cost to the community and that the MOC should not be required to take into account the potential to offset such costs. [42]

5.54 Ms Swift submitted that the finding is not consistent with Australia's commitments under Article 2 of the United Nations *Convention on the Rights of Persons with a Disability* (CRPD) and is discriminatory:

> …by not taking into account financial means, there is no way an applicant can overcome the hurdle of proving there will be no resulting burden on the state. This is an assumption not made for people without a disability.[43]

5.55 A number of other cases, such as *Robinson v Minister for Immigration and Multicultural and Indigenous Affairs*[44] which involved a child with Down Syndrome, were also cited in evidence to indicate the difficulty of

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39 Name Withheld, *Submission 108*, p. 2.

40 Name Withheld, *Submission 108*, p. 6.

41 *Iguanti v Minister for Immigration and Multicultural Affairs [2001] FCA 1046.*

42 Lauren Swift, *Submission 60*, p. 21.

43 Lauren Swift, *Submission 60*, p. 21.

44 *Robinson v Minister for Immigration and Multicultural Affairs [2005] 148 FCR 182.*

achieving a successful outcome once rejected under the Health Requirement.[45]

Cost offsets

5.56 It was apparent to the Committee that there is a need to have a greater recognition in the legislation of factors that might offset the negative projected cost calculations for assessment of children of under current arrangements.

5.57 The Committees notes that Canada provides a set benchmark for the calculation of health costs and that all applicants may seek a second medical opinion and provide additional information which sets out how costs may be offset following a refusal based on health or service costs.[46]

5.58 Ms Kione Johnson, research student, has expertise on the Canadian migration systems:

> In Canada, when economic migrants are considered they are allowed to take into account the fact that the family may have significant private assets available to meet the cost of the disability. So the economic reasons behind the migration are taken into account rather than immediately dismissing the family on the grounds of disability. In terms of family migration and the policies behind family migration, you are not allowed to discriminate against an immigrant who is applying for a spouse or child visa simply on the grounds of excessive cost. The only reason you can exclude them is if they are a public health risk. In that case, you are giving better effect to the policies behind those areas of those forms of migration.[47]

5.59 Ms Stephanie Booker of immigration specialists Clothier, Anderson and Associates stated:

> Significant weight should be given to a family's capacity to pay for the care of disabled family members in Australia. As the regulation currently reads, even with the waiver criterion, 4007

45 See the Department of Immigration and Citizenship, *Submission 66,* Attachment I for a list of other relevant cases. For analysis of the Robinson case see Freehills Law Firm, *Submission 56* and Attachment. Also see Australian Lawyers for Human Rights, *Submission 11*, p. 11; Advocacy, Disability, Ethnicity, Community (ADEC), *Submission 23*, p. [8], Lauren Swift, *Submission 60,* p. 21.

46 NSW Disability Discrimination Legal Centre (DDLC) (Inc.), *Submission 55*, pp. 14–15.

47 Ms Stephanie Booker, Clothier, Anderson and Associates, *Committee Hansard,* Sydney, 12 November 2010, p. 13.

> leads to a scenario whereby decision makers are bound to take into consideration costs to the community—and these are theoretical costs, not actual costs—even if those costs would not be borne by the community. [48]

5.60 Ms Mary Ann Gourlay, Carers New South Wales and Dr Susan Harris Rimmer emphasised the importance of carers, often women, who care for a family members with a disability. Dr Harris Rimmer noted:

> Dr Moeller cannot be Dr Moeller without his wife. If we want Dr Moellers, generally we need to take their wives and children and understand that that is part of the package that makes him economically as well as socially valuable.[49]

5.61 The Public Interest Advocacy Centre/STARTTS advised:

> In many cases, the MOC cost assessment is based on the assumption that an applicant with a disease or condition would access all available health and community services. This assumption however ignores the fact that in many cases strong family and cultural ties mean that applicant's with a disease or condition would be more likely to be cared for by a family member and less likely to be put into care.[50]

5.62 Another submission emphasised the importance of extended family as carers in Asian communities. It described the circumstances of a young Asian man with severe autism, unable to speak and very lonely. Greater discretion to include extended family, not just immediate family, under the carer visa (PIC 4005) was recommended to:

> ... enable the Australian community to take advantage of family networks as they exist among migrants both first generation and second generation that can provide the support and care that would delay or permanently reduce the dependence on services that are much more expensive. I refer to the difference in cost in offering accommodation support in the family home as compared to the cost of providing for public accommodation with support services.[51]

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48 Ms Stephanie Booker, Clothier Anderson and Associates, *Committee Hansard*, Melbourne, 18 February 2010, p. 30.

49 Ms Mary Ann Gourlay, *Submission 25*, p. 37, Carers New South Wales , *Submission 71*, p. 1; Dr Susan Harris Rimmer, *Committee Hansard*, 12 November 2010, p. 11.

50 Public Interest Advocacy Centre/NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors, *Submission 87*, p. 8.

51 Name Withheld, *Submission 12*, p. 2.

The experience of family visa applicants

5.63 While DIAC offers a range of visa categories to assist family reunification it is notable that among those without a waiver option (under PIC 4005) are the family stream visa categories of:

- Parent;
- Contributory Parent;
- Aged Dependent Relative;
- Sole Remaining Relative
- Orphaned relative,
- Carer, and
- Family visits.

5.64 As the IARC noted, these visa categories apply to individuals who could be considered to be the most needy in the migration stream.[52]

5.65 As part of its inquiry, the Committee solicited opinions from Senators and Members of Parliament about Australia's migration health requirement and its impact on their constituents. The Parliamentary Secretary for Disability and Children's Services, the Hon. Bill Shorten MP indicated in his submission that most correspondence to him on migration matters related to Australian family members who were trying to assist a relative in another country to migrate to Australia, often after their visa has been rejected.[53]

5.66 Among the many moving stories received in this category, were those relating to Sole Remaining Relative visas, often made on behalf of siblings with a disability or aged parents.

5.67 Mrs Cynthia Sierra Muir, an Australian citizen, advised the Committee of the situation of her sister and legal ward Carmen (Maria) Sierra Diaz. Ms Diaz was to be deported to Spain by the Australian Government because of a mild intellectual disability after failing the Health Requirement. In contrast to the home provided with the Muirs in Australia, Carmen would

52 Immigration Advice and Rights Centre, *Submission 30*, p. 2.

53 The Hon. Bill Shorten MP, Parliamentary Secretary for Disability and Children's Services, *Submission 112*, p. 1.

have had to leave for the country of her birth, where she has never lived, without carers or relatives, see **Case Study 5.3** following.[54]

5.68 It was apparent to the Committee that even where waiver options existed, many Australian citizens or ex-permanent residents are being put in an untenable position by the Health Requirement.

Case Study 5.3

Australian citizen seeking a sole remaining relative visa for her sister

Ms D has an intellectual impairment due to anoxia at birth. She was born in Spain but lived most of her life in France. After the death of her parents, her sister Mrs M, an Australian Citizen, became Ms D's sole and legal guardian.

Mr and Mrs M brought Ms D to Australia in June 2005 soon after her mother and carer died. They applied for Ms D's residency under a Sole Remaining Relative visa type 3344.

In November that year the visa application was rejected on the basis of costs associated with Ms D's disability. Her sister was told she could appeal following receipt of written advice. This did not arrive until three years later in 2008. The family was advised that within 28 days the M's either must pay a $1 400 Migration Tribunal appeal fee or fly Ms D back to Spain without care options at the other end.

Ms D underwent additional tests to confirm her IQ. The family did not obtain any additional health assessment on the basis that the MOC had found Ms D to be in good health. However, she did not pass the test because of her intellectual disability.

Ms D can take care of herself but cannot perform complex tasks, such as taxation returns, banking etc, which her sister, as her legal guardian, carries out. She has a loving home with her sister and husband and their two children, and has friends in the community.

After long years of waiting, the family have no certainty that Ms D will not be deported to Spain, where she has no relatives, friends or support of any kind. The M's are still waiting for the decision of the Migration Review Tribunal.

Source *Mrs Cynthia Muir,* Submission 3, *pp. 2-3.*

54 Mrs Cynthia Sierra Muir, *Submission 3*.

Case Study 5.4

Family unity overruled for an Australian returned resident

Mrs G is an Australian permanent resident (on a resident return visa since 2006) who sponsored her husband B of 28 years for a Subclass 309 Spouse visa in April 2008. Their 25 year old son J has a severe intellectual and physical disability and was named as a dependent in their application. The G's other son A is in Australia studying at university in Melbourne and is also a permanent resident.

The family had been living in Hong Kong where B was employed as a pilot. He is now an internationally-recognised aviation safety consultant. The visa application, lodged at the Australian Consulate-General in Hong Kong, was refused on 10 June 2009. The reason given was that son J could not to satisfy the Public Interest Criterion 4007 of the Migration Regulations 1994.

The Medical Officer of the Commonwealth (MOC) had determined that, over a lifetime, J's impairment and disability could cost the community approximately $2 100 000. The degree of prejudice to access to health and community services was considered to be only moderate. It was additionally noted that despite husband B's employability (aviation safety is an area of critical skills shortage in Australia and over the world) his age reduced any potential tax benefit of his employment in Australia.

The Gs maintained that the MOC did not give sufficient regard to moderating factors, such as the family's links to the Australian community (both the mother and son A), the benefit of B's skills and Mrs G's work as a qualified riding instructor for the disabled and as a nursery nurse. In addition was the family's independent capacity to care for J, their previous contributions to the community, and their significant family assets and property.

The case is currently before the Migration Review Tribunal. The pressure on the family is significant, particularly for Mrs G, who is depressed by her long struggle to return to Australia, and their son A, who must commute between countries to keep in contact with his family.

Source *Clothier, Anderson and Associates*, Submission 98*; and see Ms Stephanie Booker, Clothier, Anderson and Associates*, Committee Hansard, *Melbourne, 18 February 2010, pp. 30 36, and Mr A Greeves, p. 38.*

5.69 Clothier, Anderson and Associates advised of the case of Brian and Nicola Greeves whose dependent spouse visa application (a permanent visa assessed under PIC 4007) was rejected under the 'one fails, all fail 'rule despite their connections to Australia (Nicola's status is as a former Australian resident and her other son's residence in Australia) and the couple's considerable professional expertise, skills and assets. This underlined the need for some offsets against the 'significant cost threshold'. See **Case Study 5.4**, above.[55]

Case Study 5.5

Australian step-father's new family rejected under the Health Requirement

An Australian born citizen married a woman overseas who had a fourteen year old daughter from a previous marriage. The man wanted to live with his new wife and step-daughter in his country of birth, so he brought them back to Australia. He was unaware at this time that his step-daughter's disability would pose insurmountable difficulties to his dream.

The family's application for permanency was rejected because the child failed the Heath Requirement. The parents appealed to the Migration Review Tribunal. The processing of their application and the appeal process took over two and a half years.

During this time, their child was denied access to state primary school education and was not eligible for support from Disability Services Queensland. The Queensland Education Department would only allow the child to attend school if the parents paid full fees for her education and additional fees to access special education. These fees were to be paid up-front, at a total of approximately $20 000 annually, which the family could not afford.

The child consequently could not attend school for the entire two and half years and was deprived of the necessary developmental learning and social interaction with other children that attending school provides.

The stress became too great for the family, with a new son born during this time, they returned to the home country of the mother and child.

Source *AMPARO Advocacy Incorporated,* Submission 40, *p. 2.*

55 Clothier, Anderson and Associates, *Submission 98.*

5.70 Maureen Fordyce of AMPARO Advocacy Incorporated provided an update on the circumstances of an Australian stepfather and teenager with a mild intellectual disability, see **Case Study 5.5.** She stated:

> With that wait of 2½ years and what it did to that family I think the cost far outweighs any cost that the Australian community would have incurred had they been allowed to stay in Australia. What I did not mention in our submission, because we did not know it at the time, was that that family have since returned home, but they have also placed their child in an institution and are looking at coming back to Australia.[56]

5.71 Adopted children qualify for a visa with a PIC 4007 waiver option. Mr Robert McRae, a migration agent and president of Queensland Advocacy Inc, advised of an Australian couple working in Fiji who adopted two children, one with a disability. Despite achieving a first class medical assessment by paediatricians in NSW, the child with a disability was rejected under the Health Requirement:

> So we have a system that puts two Australians, who had actually had a medical assessment of one of their children because they were aware of this thing called a health requirement, in a position where they and their adopted child without a disability could come into Australia but the adopted child with the disability could not.[57]

5.72 The Skilled Migration stream is the largest migration program, and many families who are victims of the 'one fails, all fail' rule are on a provisional skilled visa seeking permanent residency after many years in Australia (this stream is considered in the following chapter).

5.73 While in Australia on Temporary 457 skilled visas, Dr Fiona Downes and her husband, also a doctor, were advised that their toddler Eamon had autism. Eight years later, and after two more children were born, the family applied for permanent residency (PIC 4005 visa) only to be rejected on the basis of Eamon's condition.[58] Dr Downes wrote to the Committee:

> Account should be taken of the devastating effect of a refusal of residency on the health of the individual concerned. Eamon came to Australia as a 7 months old baby, and if our application had

56 Ms Maureen Fordyce, AMPARO Advocacy Inc., *Committee Hansard*, Brisbane, 28 January 2010, p. 6.

57 Mr Robert McRae, Queensland Advocacy Inc., *Committee Hansard*, Brisbane, 28 January 2010, pp. 6–7.

58 Dr Fiona Downes, *Submission 103*, p. [1].

> been unsuccessful he would have had to leave his home aged 10 years. This would be a major set back for any child but for a child with Autism who wants and needs familiarity, it would likely cause regression and potentially irreversible loss of function.[59]

5.74 Another category of families affected by the operation of the Health Requirement's 'one fails, all fail' criterion were refugee and humanitarian visa applicants with disabled relatives.

Case Study 5.6

The Health Requirement and an Iraqi refugee family

A refugee family left Iraq and went to Syria where they stayed for a couple of years. They had a daughter with a mild intellectual disability who was about fourteen or fifteen years old. The family applied to come to Australia as refugees but were rejected as their daughter had not met the Health Requirement. It was decided to arrange a marriage for her so that she would no longer be included in the family unit. The family's second application was accepted and they came to Australia as refugees.

The daughter stayed in Syria with her husband. Unfortunately, less than a year after the rest of the family left, the marriage broke down. The daughter was still very young and now had a baby son without anyone to look after them. This situation put the refugee family in Australia under great financial and emotional strain.

Prior to the breakdown of the marriage the family were sending all of their Centrelink funds to support the couple. After the separation the father twice went to Syria to support his daughter and grandson, staying for a couple of months and then returning to try to save or borrow money. He was forced to borrow from small institutions at very high interest rates. This caused further financial hardship to the family and their rent was in arrears.

The family tried to bring the daughter to Australia under the family reunion or last remaining relative visa, but without success. The strain on the family was intense. The father started spending his money on drinking because of the stress and frustration. The family was split up. The parents lost focus on bringing up their children in Australia. The children got into trouble at school and were out on the streets. The parents had relationship issues between them.

Source: Mrs Yamamah Khodr-Agha, Fairfield Migrant Resource Centre, Cabramatta Community Centre, Committee Hansard, *Sydney, 12 November 2009, pp.68-69.*

59 Dr Fiona Downes, *Submission 103*, p. [2].

5.75 The Cabramatta Community Centre has dealt with many Iraqi families who have been trying to reunite with disabled relatives.[60] Mrs Yamamah Khodr-Agha reported the story of a teenager with a mild intellectual disability who was forced into an early marriage by the Health Requirement's 'one fails, all fail' rule (see **Case Study 5.6)** above.[61]

Case Study 5.7

The impact of HIV and the 'one fails, all fail' rule on a West African refugee extended family

A West African refugee in Australia sought to sponsor his extended family— his uncle, brother and sister and their immediate families—on a Global Special Humanitarian visa subclass 202. Two significant events occurred during this time: the sponsor's sister, a woman in her late twenties, died and her young son was then adopted by his uncle.

The family of thirteen members underwent medical tests for the Health Requirement. During these tests two family members discovered that they were HIV positive. One of these was the orphaned teenage boy. Discovering that their HIV positive status could affect their relatives' applications, he and the other positive applicant decided to withdraw from the process. At this point, they were informed of the 'one fails, all fail' policy.

The stress on discovery of the policy for all involved was very significant, and particularly for the two rejected under the test, who found out simultaneously about their HIV positive status and its potential to destroy the hopes of their extended family for a better life. Meanwhile in Australia the sponsor and his family, all of whom are torture victims, remain extremely fearful for their relatives in West Africa.

Prior to the health checks, positive indications had been given by the case officer in the humanitarian section of the Australian Embassy in Pretoria. The family sought advice from the HIV/Aids Legal Centre which made submissions of appeal on their behalf in early 2007.

Three years later those applications are still pending.

Source *HIV/Aids Legal Centre,* Submission 69, *p. 12.*

5.76 Australia is one of 59 countries out of 108 that applies migration restrictions on HIV positive people.[62] The HIV/Aids Legal Centre Inc.

60 Cabramatta Community Centre, *Submission 28*, p. 2.

61 Mrs Yamamah Khodr-Agha, Fairfield Migrant Resource Centre, Cabramatta Community Centre, *Committee Hansard*, Sydney, 12 November 2009, pp. 68-69.

62 Australian Capital Territory Human Rights Commission, *Submission 76*, p. 3.

(HALC) advised of the outcome for a teenage orphan whose HIV status was identified during the health test (in **Case Study 5.7)**.[63]

Visiting relatives

5.77 A discrete but important issue for family reunification was the capacity for people with a disability to visit relatives in Australia.

5.78 Dr Gabrielle Rose, Cerebral Palsy League, saw that the family visit program is discriminatory and not in keeping with family unification principles. The situation of a political refugee trying to arrange a visit from his parents reveals endemic problems:

> He arrived in Australia in 2000. So that the family could come and see whether he was okay, the department of foreign affairs expected him to put $30,000 on the table to assure that the mother and father would go back home. Then he had to pay this astronomical amount for all the health checks. His parents were in the vicinity of 70 years old. They had normal health problems—a little bit of high blood pressure; the mother had had a mastectomy—so they had been involved in the health system in their own country on a regular basis. It was not as though they were unhealthy for their age. They were coming over to Australia for only three months. But for that refugee to find about $40,000 to $50,000—after the flights, after the health checks, after the $30,000 deposit—I thought was an incredible ask of that family.[64]

5.79 Mr JP Tempest, a migration agent, also identified repeated health checks as an issue for clients with schizophrenia wishing to visit relatives in Australia on temporary tourist visas or sponsored family visit visas. On each visit, the applicant had to be assessed again by a different Medical Officer of the Commonwealth and risk a refusal. [65]

5.80 Mr Tempest concluded that while excluding the permanent migration people who are a health risk is justifiable, it is discriminatory to exclude people who have a disability or a condition for visits to relatives in Australia:

63 The HIV/Aids Legal Centre Inc., *Submission 69*, p. 11.

64 Dr Gabrielle Rose, Cerebral Palsy League, *Committee Hansard*, Brisbane, 28 January 2010, p. 14.

65 Mr JP Tempest, *Submission 18*, p. 6.

> To refuse a family member on the basis of cost is abhorrent and flies in the face of human dignity. It causes both considerable stress to both the applicant and the sponsor'.[66]

Committee Comment

5.81 From the evidence taken, it appears that the 'one fails, all fail' rule is discriminatory against families when a disabled member is involved. The consideration of non-migrating members has a prejudicial effect, with which could be ameliorated simply by assessing the individual of concern at the time of migration (if ever that occurs).

5.82 It is also appropriate that health care or continuing costs are assessed according to an individual's need, rather than the current 'regardless of use' approach. The Committee has earlier recommended a change to this approach.

5.83 As set out in Chapter 3, the Committee also considers that, if visa applications are to be assessed for the whole family unit, then it is only reasonable that there be opportunities to offset 'significant costs' against the 'sum benefit' to Australia of the family.

5.84 This should include consideration of the potential to defray cost through family carer and other arrangements under a broader range of visas.

5.85 Finally, the Committee considered that the current Health Requirement imposes undue hardship on families that include a member with a disability wanting to visit Australia. This should be reviewed.

66 Mr JP Tempest, *Submission 18*, p. 6.

Recommendation 11

The Committee recommends that the Australian Government review the operation of the 'one fails, all fails' criterion under the Migration Regulations 1994 to remove prejudicial impacts on people with a disability.

Recommendation 12

The Committee recommends that the Australian Government amend the criterion for assessing waivers to the Health Requirement to include recognition of the contribution made by carers within the family as an offset to health care or community services costs identified in the process.

Recommendation 13

The Committee recommends that the Australian Government review the requirements for health inspections for short term visas under the Family Visits program.

Onshore/offshore refugee and humanitarian programs

5.86 Australia's refugee and humanitarian program offers protections not afforded to visa entrants entering under the general migration program. The 1951 United Nations *Convention Relating to the Status of Refugees* defines a refugee as a person who:

> …owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country.[67]

5.87 The Refugee Council of Australia advised:

67 Article 1(2), *Convention Relating to the Status of Refugees* 1951 accessed 10 May 2010 at UN Documents Gathering a Body of Global Agreements <http://www.un-documents.net/crsr.htm>.

> Australia's Humanitarian Program sits within a challenging global context. The United Nations High Commissioner for Refugees (UNHCR) reports that, at the end of 20081 there were some 42 million forcibly displaced people worldwide, comprising 15.2 million refugees (5.7 million of whom were in protracted situations2), 827,000 asylum-seekers and 26 million internally displaced persons, with a further 6.6 million identified stateless persons in need of humanitarian assistance. Developing countries are host to approximately 80 per cent of the world's refugees.[68]

5.88 The Committee notes that Australia has one of the largest resettlement programs among developed nations.[69] It manages its refugee and humanitarian migration intake under two streams of treatment —Onshore and Offshore, the:

- **Onshore Program** settles recognised refugees in accordance with our international obligations; and
- **Offshore Program** (Special Humanitarian Program (SHP**))** category is for people who, while not being refugees, are subject to substantial discrimination amounting to a gross violation of their human rights in their home country.[70]

5.89 DIAC's rationale for the different treatment is as follows:

> Some countries receive large numbers of asylum seekers and focus their efforts on assisting those who claim protection under the Refugee Convention. As Australia receives comparatively few asylum seekers we go beyond our international obligations and work closely with UNHCR to help protect refugees in other countries through resettlement.[71]

5.90 The United Nations High Commissioner for Refugees (UNHCR) has statutory obligations to supervise the application of the Refugees Convention. The UNHCR submitted that, while Australia has a strong record of onshore resettlement of refugees holding 'protection' visas, our

68 The Refugee Council of Australia, *Submission 105*, p. 2.

69 United Nations Human Rights Commissioner for Refugees (UNHCR), *Submission 82*, p. 5.

70 Department of Immigration and Citizenship, 'Who is Eligible? Overview of the Offshore Humanitarian Program' accessed May 2010 at < http://www.immi.gov.au/visas/humanitarian/offshore/>.

71 The Department of Immigration and Citizenship, Refugee and Humanitarian Issues: Australia's Response, June 2009 p. 16, accessed May 2010 at <http://www.immi.gov.au/media/publications/refugee/ref-hum-issues/ref-hum-issues-june09.htm>.

offshore processes do not meet International obligations under Article 33 (1) Refugee Convention.[72]

5.91 In keeping with international obligations, Australia waives the Health Requirement for onshore protection visa applicants (Subclass 866). However, the Health Requirement stands for Offshore Refugee and Humanitarian visas. As shown earlier in **Table 2,** all Offshore Refugee, Humanitarian Emergency Rescue and Woman at Risk visas have PIC 4007 waivers attached.[73]

5.92 Submissions to the inquiry acknowledged Australia's commitment to refugee and humanitarian resettlement under the protected program but, like the UNHCR, many strongly opposed the imposition of the Health Requirement on the offshore stream.[74]

5.93 The Public Interest Advocacy Group/STARTTS advised:

> The refugee applying overseas and all members of their family including migrating and non-migrating dependants must satisfy the health testing requirements found in Schedule 4, PIC 4007 unless the Minister is satisfied that it would be unreasonable to require the person to undergo assessment in relation to the health criteria, for example, a situation where submitting to a health test may put the applicant's life at risk. If the refugee applying overseas or a family member fails to satisfy the health test, no medical treatment is provided. The application is simply refused, unless the Minister (or delegate) waives the Health Requirements.[75]

5.94 The Refugee Council of Australia (RCOA) also identified anomalies in the current approach noting:

> Incongruously, the onshore protection program is numerically linked to the SHP, such that every onshore protection visa grant translates into a deduction from the number of places available for offshore humanitarian resettlement. Australia is the only country

72 United Nations High Commissioner for Refugees (UNHCR), Regional Office for Australia, New Zealand Papua New Guinea and the Pacific, *Submission 82*, pp. 3–4.

73 Castan Centre for Law and Human Rights and Rethinking Mental Health Laws Federation Fellowship, Faculty of Law Monash University, *Submission 36*, p. 8.

74 Castan Centre for Law and Human Rights and Rethinking Mental Health Laws Federation Fellowship, Faculty of Law Monash University, *Submission 36;* p. 11.

75 Public Interest Advocacy Centre/NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors, *Submission 87*, p. 18.

> to have established a numerical link between the fulfilment of its protection obligations and its resettlement quota.[76]

5.95 The RCOA opposed the policy on the basis that both streams serve distinctive but equivalent purposes, in protecting vulnerable people from risk of persecution or violence, which merits equal migration treatment.[77]

5.96 The HIV/Aids Legal Centre stated:

> Where an applicant meets all other criteria for a humanitarian type visa, the threat to their safety, the risk of persecution and the general humanitarian and compassionate circumstances must always merit grant of a visa, consistent with Australia's international treaty obligations, regardless of the estimated health costs of the applicant. A humanitarian applicant cannot be less worthy of assistance and a visa merely by dint of their having a disability or their health status. Surely by definition they are more in need, their circumstances more dire, and by extension they are all the more appropriate for grant of a humanitarian type visa because of their health condition or disability.[78]

5.97 The Multicultural Development Association (MDA) advised that meeting the Health Requirement adds to the trauma already experienced by refugees with a disability, as the most vulnerable and disadvantaged migrant group.[79] MDA advised:

> Most visa assessments are not undertaken at refugee camps but in the closest metropolitan city, and the journeys that are required are often long. For those that have been found with medical conditions like tuberculosis, clients are required to be treated for a lengthy period of time until their conditions improve and are able to be given a clean bill of health to travel.
>
> For many it means having to stay for an indeterminate period outside camps until their results have been delivered. What this means is that people are hiding in cities where they may be further discriminated against, or at risk of injury or death because of their ethnicity or disability. Further because they are refugees they are not counted in any riots or incursions that may break out because they have no status and are invisible. This is especially dangerous

76 Refugee Council of Australia, *Submission 105*, p. 5.

77 Refugee Council of Australia, *Submission 105*, p. 5.

78 HIV/Aids Legal Centre, *Submission 69*, p. 12.

79 Multicultural Development Association, *Submission 20*, p. 9 and see United Nations Human Rights Commissioner for Refugees (UNHCR), *Submission 82*, p. 5.

> for single women, children, the elderly or those with disability or heath conditions that are vulnerable targets and unable to avail themselves of places of safe refuge.[80]

5.98 Some submitters raised the option of using 'split family visas' as a viable template to facilitate the equitable processing of offshore family cases. DIAC advises that to qualify for a split family visa:

> People applying to be resettled in Australia as the immediate family member of a permanent Humanitarian (including Permanent Protection) or Resolution of Status visa holder must be proposed for entry to Australia by that family member. The applicant's relationship to the proposer must have been declared to the department before the grant of the proposer's visa.[81]

5.99 RCOA saw the benefits of treating all offshore applications under split family visas, in that:

> In the case of a Protection Visa (onshore applicant) proposer, the family member will be issued an SHP visa. "Split family" applications are also subject to a "compelling reasons" criterion. While this is a regulatory requirement, DIAC's current policy stipulates that this criterion is satisfied without further enquiry, in most cases, because the existence of close family ties in Australia is considered to be a sufficiently compelling reason.[82]

5.100 The Castan Centre for Law and Human Rights and Rethinking Mental Health Laws Federation Fellowship considered that this discretion on 'compelling' grounds should be clarified in the law:

> We also note that even if currently DIAC or the Minister for Immigration is using their discretion to waive the health cost criteria in relation to offshore refugee and humanitarian applicants (with the effect that the health criterion is not usually applied to this category of applicants), then this practice should be clarified and codified via abolition of the health cost requirement for these applicants.[83]

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80 Multicultural Development Association, *Submission 20*, p. 4.

81 For the purposes of the visa an immediate family member is either the proposer's partner, dependant child or, if the proposer is not 18 or more years of age, the proposer's parent,. Department of Immigration and Citizenship, Split Family Visa, Who is Eligible? accessed May 20010 at <http://www.immi.gov.au/visas/humanitarian/offshore/immediate-family.htm#b>.

82 Refugee Council of Australia, *Submission 105*, p. 6.

83 Castan Centre for Law and Human Rights and Rethinking Mental Health Laws Federation Fellowship, *Submission 36*, p. 12.

Committee comment

5.101 Currently all offshore refugee and humanitarian applicants are subject to the Health Requirement, although consideration of a waiver is available.

5.102 The Committee considers that the situation of refugees who may not meet the Health Requirement due to disability or health considerations warrants special attention and should be considered under compelling and compassionate grounds, particular for family reunion purposes.

Recommendation 14

The Committee recommends that the Australian Government amend the Migration Regulations 1994 to provide access to consideration of a waiver to offshore refugee visa applicants involving disability or health conditions on compelling and compassionate grounds.

Consideration should also be given to extended family members for the same treatment in the same circumstances.

Torture and trauma

1.1 It was apparent to the Committee that special consideration is needed to assists a class of refugees and their families who have sustained extremes of violence resulting in a disability in their home countries.

1.2 Multicultural Development Association (MDA) is Queensland's largest settlement agency, assisting approximately 1 100 newly arrived refugees annually. It currently has a working case load of 3 500 migrants and refugees in total.[84]

1.3 Over the last five years, MDA has settled approximately 32 families from Sierra Leone and 72 families from Liberia. The submission advises that Sierra Leonean and Liberian refugees are among a discrete but large group of refugees who have been permanently affected by civil war, in this instance, being victims of mass amputations by rebel militia. However, despite the scale of the problem none of MDA's refugee cases have been amputees. [85]

1.4 Ms Kerrin Benson from MDA's indicated that the Health Requirement is having its heaviest impact on the most vulnerable:

84 Multicultural Development Association, *Submission 20,* p. 3.

85 Multicultural Development Association, *Submission 20,* p. 5.

> In the last five years we have settled 5½ thousand newly arrived refugees and there would probably be no more than a handful of those people with physical disabilities, so an enormous proportion of people are not getting through in the refugee program. There are 10,000 amputees in Sierra Leone. Certainly, most of the people we work with would have some extended family member or close friend with some kind of physical impairment from the civil and social conflict at home. Broken legs, amputations or having been shot, slashed or macheted are very common problems. Severe physical problems from rapes in camps are also quite common.
>
> We are not seeing very many of those people but we are hearing a lot of stories from people who are unable to reunite with their family members.[86]

5.103 The extreme stress imposed on relatives unable to unite with family members in war zones was widely recorded in evidence. MDA provided the story of two young Rwandan women settled in Australia who were denied a visit from their amputee mother, see **Case Study 5.8**.

5.104 Ms Adama Kamara, from Sierra Leone, reported the situation of another young countrywoman who had come Australia hopeful of reuniting one day with her mother and sister:

> This happened quite recently: a sister had her lower left leg amputated. [The applicant] was trying to reunite with her mother, her sister and her sister's three children. She got the rejection letter saying that [her sister] did not meet the health test. As she explained it to me, she is a zombie. She has been in Australia for eight years. She has worked. Given the fact that she could live in the same country as her sister, her mother and her niece and nephews and be safe, to get the rejection letter has had so much effect. She said she started thinking about all the trauma that she experienced during the war. She said: 'What's going to happen to these people now that they can't actually live with me? What is going to happen?' So I think we really need to look at the health criteria and the impact it has when people are rejected on that basis.[87]

86 Ms Kerrin Benson, Multicultural Development Association, *Committee Hansard*, Brisbane, 28 January 2010, p. 29.

87 Ms Adama Kamara, Private Capacity, *Committee Hansard*, 12 November 2009, p. 64.

Case Study 5.8

Rwandan mother rejected for civil war injuries

Two young Rwandan women of mixed Hutu and Tutsi ethnicity fled war and genocide in their country, leaving family behind and arrived in Australia in 2003.

Both sisters were in their twenties and had endured significant trauma as a result of genocide, they had been displaced from their Homelands and separated from family. During this time they also suffered discrimination as a minority group because of their mixed ethnicity. As young women they had also been targeted by ever present groups of soldiers who utilised rape as a weapon of war.

In 2004 an application was lodged for their mother to join them in Brisbane. The application took approximately four months to be processed, but was ultimately rejected. Their mother had failed to meet the Health Requirement according to the legislation. The health problems identified were the result of civilian attack during the civil war. She had suffered serious gunshot wounds to both her legs, resulting in disfigurement and permanent disability.

Subsequently, the sisters applied for a family visit visa for their mother, but this too was rejected on the basis of her disability. After being educated and successfully settled in Australia for eight years, one of the young women has returned to Rwanda fearful for her mother's welfare.

Source *Multicultural Development Association*, Submission 20, *pp. 5-6; and see Ms Kerrin Benson, MDA*, Committee Hansard, *Brisbane, 28 January 2010, pp. 29 -30.*

5.105 MDA's Ms Benson advised that these extremely destabilising experiences result in higher health and community service demands: 'I think settlement would be less resource intensive if people were able to reunify with their families'.[88]

5.106 Ms Marg Le Seur of the Refugee and Immigration Legal Service observed that if arrangements were more generous it would be unlikely that the number of applicants would substantially increase. One factor is the obstacles to migration in countries of origin, including the civil war or political oppression that the people are fleeing. Ms Le Seur stated:

88 Ms Kerrin Benson, Multicultural Development Association, *Committee Hansard*, Brisbane, 28 January 2010, p. 30.

> Refugees are probably a very different kind of cohort to other people who are migrating. Generally, they are just trying to find safety. They are fleeing their country and they are trying to get some safety. They are hopeful of reuniting with their family once they get some safety themselves. That is the primary driver. So generally I would say that our refugee clients are fairly unsophisticated about the system and they are just hopeful that they will be able to be reunited.[89]

5.107 Other witnesses emphasised that people with a disability can contribute, and will provide benefit to the community over time. Ms Ricci Bartels, Cabramatta Community Centre, observed that services are available to assist amputees become productive members of the community:

> Initially it would cost us a bit of money to find a limb and to rehabilitate the amputee to be able to use that limb. That will cost us some money. If that person is from a different culture and background then one needs to work with how that person feels about being an amputee, just like we do with people from an English language background, and work with them in their rehab. But when that is done these people are ready to make a contribution, whether they are Australian-born or whether they come here. It comes back to it not being a ledger that just stands still at cost. It is a ledger that is not just short term; it is a ledger that is lifetime.
>
> It is a ledger that should take into account the contributions made by family and community who are very likely working, earning and paying their taxes and therefore making their contributions to all the things we have as rights or need to run a decent, civil society.[90]

5.108 Ms Adama Kamara concluded:

> To sum up, the need for protection overrides any issue of cost. I think we need to stop thinking of people as a cost. We all have contributions that we can make to the community, regardless of amputation. There are aids and equipment that Australia has that can assist someone to contribute to the community.[91]

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89 Ms Marg Le Seur, Refugee and Immigration Legal Service, *Committee Hansard*, Brisbane, 28 January 2010, p. 28.

90 Ms Ricci Bartels, Cabramatta Community Centre *Committee Hansard*, Sydney, 12 November 2009, pp. 69–70.

91 Ms Adama Kamara, *Committee Hansard*, 12 November 2009, p. 64.

Recommendation 15

The Committee recommends that the Department of Immigration and Citizenship create a priority visa category for refugees who have sustained a disability or condition as a result of being a victim of torture and trauma. The Committee recommends that similar visa consideration is provided to immediate family members within the offshore refugee program.

6

Skilled migration and disability

Introduction

6.1 Australia's migration programs have traditionally been seen as being labour-driven programs. Over the years, some of the nation's largest infrastructure programs have relied on the skills of migrants who have subsequently called Australia home.

6.2 Australia's modern migration program has been a model for skilled migration used in other nations—the United Kingdom, for example, has just introduced the points system used by Australia for the new category of skilled visas.[1]

6.3 Australia's skilled migration stream accepts by far the largest number of migration entrants and is a major contributor to the Australian economy. In 2008-09 the skilled migration stream accounted for 67 per cent of the total national migration program.[2]

6.4 There are four main visa categories with a wide number of visas available, including independent skilled temporary or permanent visas, business visas and employer sponsored schemes. Some programs offer opportunities to apply for permanency after a temporary visa has been held. However, few of these visas have a waiver opportunity and

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1 Dr Susan Harris Rimmer, Australian Lawyers for Human Rights, *Committee Hansard*, 18 November 2010, p. 9.

2 The Department of Immigration and Citizenship, *Fact Sheet 24— Over View of Skilled Migration*, accessed May 2010 at <http://www.immi.gov.au/media/fact-sheets/24overview_ skilled.htm>.

applicants with a disability may be rejected under the Health Requirement, even if they meet the skills and attributes required for the visa class they are applying for.

6.5 This chapter examines some of the issues raised regarding skilled migrants with a disability, or with family members with a disability, who wish to enter Australia under the Skilled Migration Program.

Programs and statistics

6.6 The Department of Immigration and Citizenship (DIAC) fact sheet on skilled migration notes that:

> The Australian Government continues to emphasise skilled migration, while maintaining a commitment to family reunion migration. The migration to Australia of people with qualifications and relevant work experience helps to address specific skill shortages in Australia and enhances the size and skill level of the Australian labour force.[3]

6.7 DIAC further notes that the skilled migration stream aims to:

- strengthen the economic and budgetary benefits from granting permanent residence visas to skilled and business migrants;
- address key and emerging skill shortages, particularly in regional Australia; and
- expand business establishment and investment.[4]

6.8 There are four main categories of skilled migration:

- The **General Migration stream** (GMS) which encompasses a range of permanent points-tested visas.[5] The highest scores under the current test are for occupations in demand requiring specialised training, and then for general degree levels. Points are then awarded on a scale for age, English proficiency and other factors including Australian work or

3 The Department of Immigration and Citizenship, *Fact Sheet 24-Over View of Skilled Migration*, accessed May 2010 at <http://www.immi.gov.au/media/fact-sheets/24overview _skilled.htm>.

4 Department of Immigration and Citizenship, *Annual Report 2008-09*, 1.1.1 Output Economic Migration, accessed May 2010 at <http://www.immi.gov.au/about/reports/annual/2008-09/html/outcome1/output1-1-1.htm>.

5 Department of Immigration and Citizenship, *Annual Report 2008-09*, 1.1.1 Output Economic Migration , accessed May 2010 at <http://www.immi.gov.au/about/reports/annual/2008-09/html/outcome1/output1-1-1.htm>.

study experience, regional living and study, partner qualifications or state or territory government nomination.[6]

- **Employer Sponsored migration** which allows employers to nominate/sponsor personnel from overseas to work in Australia in skilled occupations through a number of visa options on a permanent basis. The following categories apply:
  - ⇒ **The Employer Nomination Scheme** (ENS)—allows Australian employers to nominate overseas workers for permanent residence in Australia to fill skilled vacancies in their business.
  - ⇒ **The Regional Sponsored Migration Scheme** (RSMS— designed to encourage migration to regional and low population growth areas of Australia. Employers in these areas can nominate overseas workers for permanent residence to fill skilled vacancies in their business.
  - ⇒ **Labour Agreements**—are formal arrangements to recruit a number of overseas skilled workers. Both temporary and permanent visas can be granted under the agreement. Agreements are generally effective for two to three years.
  - ⇒ **State Sponsored schemes**—target the supply of labour in key occupations identified as in shortage by State and Territory governments.
- **Business skilled program** to encourage successful business people to settle in Australia and develop new business opportunities; and
- **Distinguished talented stream** which issues visa to people with special or unique talents of benefit to Australia, such as sportspeople, artists, and musicians.

Skilled migration and the health requirement

Skilled visas and waiver options

6.9 Australia requires visa applicants to undergo a health assessment for most permanent visas and for temporary entry visas (subject to length of

6 As discussed later, these priorities are under review. See DIAC, General Skilled Migration (GSM) Points Test Review, accessed May 2010 at <http://www.immi.gov.au/skilled/general-skilled-migration/pdf/faq-points-test.pdf>.

stay and the country of origin's risk level for tuberculosis (TB) and other factors).[7]

6.10 With the exception of some provisional visas, the majority of GMS visa applications, both independent and sponsored, are assessed under PIC 4005 which provides no waiver option. All applicants for permanent visas including the main applicant, spouse and any dependents must be assessed against the Health Requirement.8

6.11 As discussed earlier, there is currently no scope within Schedule 4 of the Migration Regulations 1994 for an assessment to include consideration of the economic and social contribution of people with a disability and their families unless the visa has a waiver option.

6.12 Until recently two visa classes under the skilled stream offered waivers. These were the Temporary Skilled (Business–Long Stay) 457 visa and the Educational sub-class 418 visa. Both of these had a PIC 4006A classification, meaning that a waiver would be considered at the Minister's discretion on the undertaking of an employer.[9] The Educational visa (Subclass 418) was repealed on 14 September 2009.[10]

6.13 In October 2006, the Government introduced visa subclasses 846, 855, 856 and 857 which have a PIC 4007 waiver arrangement. These visas were introduced to address the experiences of those who have been living and working under renewable skilled 457 business class visas, but had been rejected when applying for permanent residency visas (under PIC 4005).[11]

6.14 The new visa program allows for visa holders who have lived in Australia in a Specific Regional area for two years and worked for one

7 Department of Immigration and Citizenship, *Fact Sheet 22– The Heath Requirement*, accessed May 2010 at <http://www.immi.gov.au/media/fact-sheets/22health.htm>.

8 Department of Immigration and Citizenship, Health Assessments Required for Visa Applicants, accessed May 2010 at <http://www.immi.gov.au/allforms/health-requirements/>.

9 Department of Immigration and Citizenship, *Annual Report 2008-09*, 1.1.1 Output Economic Migration , accessed May 2010 at <http://www.immi.gov.au/about/reports/annual/2008-09/html/outcome1/output1-1-1.htm>.

9 Department of Immigration and Citizenship, Health Requirement for Temporary Entry into Australia, Form 1163i, accessed May 2010 at < http://www.immi.gov.au/allforms /pdf/1163i.pdf> ; and see New South Wales Government, *Submission 96*, p. 6.

10 The Educational Visa (Subclass 418) accessed May 2010 at <http://www.immi.gov.au/ skilled/skilled-workers/ev/>.

11 Department of Immigration and Citizenship, *Submission 66*, pp. 12–13.

year on a temporary visa to apply for permanent residency. These visas are subject to State and Territory agreement.[12]

6.15 Skilled visa applicants therefore have a range of visa options, but few provide for a waiver consideration. Additionally, under the Health Requirement, skilled visa categories face a double but distinct assessment.

6.16 The Council of Australian Graduate Associations (CAPA) informed the Committee:

> Applicants' qualifications, professional experience and skills are each assessed on a points-based system, while health and character requirements are assessed independently as part of the application process. Health assessment criteria require mandatory medical examinations, and these apply to both the main visa applicant and any family members relevant to the application.[13]

6.17 Under these arrangements skilled applicants who have all the requisite qualifications (and points) for a visa, and may even have a job offer in Australia, can be rejected on the Health Requirement if they or a member of their family have a disability.

Permanent skilled visas

6.18 Applicants for Permanent skilled visas may apply for specific occupational visas identified on the SOL, skilled independent and sponsored independent, skilled designated area and skilled Australian sponsored, employer or state nominated visas, skilled regional sponsored, skilled overseas student and business schemes, both independent or sponsored. Except for the category of second stage skilled and business visas discussed later in this section, all of these visas are assessable under PIC 4005, which offers no waiver.[14]

6.19 The Committee was informed that the lack of a waiver option for the majority of permanent skilled visas means that applicants have limited opportunity to defray identified health costs, despite their capacity to do so.

6.20 The Royal College of Australasian Physicians stated:

12 Department of Immigration and Citizenship, *Submission 66,* pp. 12–13.

13 Council of Australian Graduate Associations, *Submission 101,* p. 4.

14 See Department of Immigration and Citizenship, *Submission 66*, Attachment C.

> 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.[15]

6.21 HIV/Aids Legal Centre Inc. (HALC) and others maintained that the skill points assessment under the GMS provides all the confirmation needed of the economic advantage in accepting a particular applicant:

> For applicants with a disability in the skilled migration stream, they would already have a sound assessment of their economic contribution to Australia by virtue of their satisfaction of the other criteria for the skilled visa they apply for. Having met the points test for a skilled stream visa, the economic benefit to Australia test is already met and in many instances in order to meet that points test, the main applicant would need to show a history of working in an area relevant to the application. This would demonstrate the expected economic benefit to Australia in granting the visa to such a person and his or her family.[16]

6.22 Numerous accounts were provided to the Committee by people who had applied for permanent skilled visas but were rejected on the basis of their own disability, or who had relatives who were rejected on this basis, or were rejected under 'the one fails, all fail' rule due to a family member's impairment.

6.23 One example involved a Subclass 886 Skilled Sponsored (full fee) Visa application. Ms Simran Kaur was the primary applicant on behalf of herself and her husband in August 2009. Her application was refused on the basis of Ms Kaur's blindness. In an attachment to the submission, Vision Australia supported Ms Kaur citing her exemplary personal record, qualifications and professional experience in community sector work with people with a disability, see **Case Study 6.1,** following.

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

16 HIV/Aids Legal Centre Inc., *Submission 69*, p. 13.

Case Study 6.1

Skilled community worker rejected because of vision impairment

Ms K is a migrant from India living with extended family in Victoria. She was refused a Skilled Sponsored Subclass 886 visa in October 2009 because she has a vision impairment, which would make her eligible for the receipt of a Disability Support Pension (DSP). This is irrespective of whether Ms K chooses to apply for the DSP or not and regardless of the fact that current Social Security regulations prohibit her eligibility for 10 years.

Ms K speaks four languages and is a highly skilled community and welfare worker. Her first paid professional role in India was an associate social worker in the Inclusive Education Department, working with children with disabilities, their families, schools and the teaching staff with Action for Ability Development and Inclusion, a national disability non-government organisation. Subsequently, she worked as an HIV counsellor for the prevention of parent to child transmission of the disease with the Punjab States Aids Control Society.

In Melbourne she obtained a diploma in community welfare, having completed both undergraduate and post-graduate qualifications in social work in India. She has undertaken work experience placements as part of her recent qualification in Australia. She writes and types all her work using voice output software and is completely comfortable with standard phone technologies.

Ms K has been diagnosed with retinal macular dystrophy, which causes loss of central vision, yet she has been assessed as having a high level of competency in all aspects of daily living. She utilises a range of strategies at home to prepare, cook and serve food and to maintain herself and her home and externally while shopping and in the work place. Ms K's case is supported by Vision Australia.

Ms K and her husband's families and support structures are located in Australia, including Ms K's mother and only sibling. Her failure to gain permanent residency would force her to return to India, leaving her family here in Australia. Ms K's case was recently rejected by the Migration Review Tribunal and submissions will be made for consideration of Ministerial discretion under the *Migration Act 1958* (Cth), s 351.

Source *Clothier, Anderson and Associates,* Submissions *98 and 98:1 p. 14 and Attachment A, Vision Australia, and subsequent advice.*

6.24 Commenting on the case Clothier, Anderson and Associates stated:

> Ms Kaur has much to offer to the Australian community and is more than willing and able to work in such a community, for the benefit of Australians. However, she has not been given the chance, merely because the Medical Officer of the Commonwealth has concluded that she will be entitled to a pension that she has no intention of claiming, potentially at a cost to the community of over $21,000.00 over the next 5 years.[17]

6.25 Ms Stephanie Booker of Clothier, Anderson and Associates informed the Committee that the case has now been referred to Migration Review Tribunal (MRT), which is likely to be a lengthy and costly process for the applicant.[18]

6.26 As mentioned earlier, the situation of Mrs Maria Gillman and her sister Una Thysse provided another example of the enormous emotional, financial and time investment made by skilled people with a disability attempting to negotiate the process of rejection and appeal.[19]

6.27 Mrs Gillman was sponsoring her sister under a Permanent Skilled Australian Sponsored visa 138 (PIC 4005), however the visa application was rejected on the basis of her sisters' disability, see **Case Study 6.2.**[20]

6.28 Ms Thysse, who was blinded in an accident at 21, currently volunteers in a mission in South Africa. She wrote to the Committee:

> …I am a very active member of the staff where I am currently working, in a leadership position and making valuable contributions to the organization. I see no reason why I should be treated as a second-rate citizen of any country or deemed simply a mouth to feed while have intelligence, reason, hands to work with and a will to make a success of my life and see success in the lives of those I have contact with.[21]

17 Clothier, Anderson and Associates, *Submission 98.1*, p. 2.

18 Ms Stephanie Booker, Clothier, Anderson and Associates, *Committee Hansard,* Melbourne, 18 February 2010, pp. 29–30.

19 Mrs Maria Gillman, *Committee Hansard,* Melbourne, 18 February 2010, p. 29.

20 Name Withheld, *Submission 29,* p. 1.

21 Ms Una Thysse, *Submission 93,* p. 1.

Case Study 6.2

Sisters seeking reunion under a skilled Australian sponsored visa

Ms G sponsored her sister U, a resident of South Africa, under a Class BQ Subclass 138 Skilled Australian Sponsored visa in November 2006.

U has multiple qualifications and initially pursued a career in the performing arts, enrolling in a Bachelor of Arts degree with a major in drama. Two months before her 21st birthday she was, however, blinded in a street accident involving the side mirror of a passing vehicle. Less than two years after this, U returned to university full time and completed a Bachelor of Arts degree majoring in psychology. She worked as a rehabilitation counsellor, continued to develop her artistic talents and furthered her qualifications.

Following the deaths of her parents and a marriage break up she decided to migrate to Australia to be with her only sister. Living by herself in South Africa had become increasingly dangerous and so U moved into the mission where she volunteers, effectively institutionalising herself.

In July 2007 U failed to meet the Migration Health Requirement and her skilled visa application was rejected. Despite her skills and qualifications, it was assumed that U, as a totally blind person, would automatically receive the Disability Support Pension, resulting in significant cost to the Australian community.

As sponsor to the application, Ms G was able to take the matter to the Migration Review Tribunal (MRT). In October 2007 the original Medical Officer of the Commonwealth opinion was confirmed by the Review Medical Officer, and the MRT was bound to affirm the decision not to grant U a visa. This opened an opportunity for appeal to the Minister for Immigration and Citizenship to exercise his public interest powers.

Ms G made a comprehensive application to the Minister in December 2008 on behalf of U. The applicants were advised that on 19 February 2010 their matter would be referred to the Minister. At the time of writing, the Minister's decision is still pending

Source *Mrs Maria Gillman*, Committee Hansard, *Melbourne,18 February 2010, pp. 3, 39; and* Submissions *Name Withheld* 29 *& Ms Una Thysse*, 93.

6.29 Ms Sharon Ford, the wife of an academic with a child with Down Syndrome, was rejected under the 'one fails, all fail' rule for a permanent employer sponsored visa, see **Case Study** 6.**3.**

Case Study 6.3

Academic research project on hold due to the 'one fails, all fail' rule

A United Kingdom academic was appointed as Principal Researcher for a University of Western Australia/CSIRO project and applied to migrate to Australia with his family in 1998 under an Employer Nominated Permanent residence visa.

The family's application was refused on the basis of costs attributable to the applicants' four year old daughter, C, who had Down Syndrome. The Medical Officer of the Commonwealth had judged at that time that C 'would be likely to require additional educational resources beyond mainstream education' and 'supported employment in the future at significant cost to the Australian community.'

In 2000 the decision was successfully overturned by the Migration Review Tribunal, at which time the family's statement of expectations for C and the additional 14 testimonies provided had an apparent impact on the review process. The 18 months intervening saw the family living in three different countries, at times separately, as the father took up temporary posts. Meanwhile, the research project at UWA, which was bound by funding deadlines, was kept on hold because the principal researcher was unable to secure a visa.

Today the family are Australian citizens and C, now sixteen, is the recipient of a Duke of Edinburgh Award. C engages in charity work, belongs to a guiding community, saves her earnings, and in April represented Victoria as a gymnast in the Special Olympics National Games in Adelaide.

Source *Ms Sharon Ford,* Submission 74, *and see* Committee Hansard, *Melbourne, 18 February 2010, p. 26-27.*

6.30 Ms Ford reported the upheaval caused in her family's life over the eighteen months it took to resolve the case through the MRT:

> Whilst awaiting the outcome, my partner and I were obliged to put our lives on hold and to live in separate countries. His position in the UK had come to an end, while he had accepted a position at the University of Western Australia which he was unable to take up. We were "fortunate" that he was able to take up a temporary

> position in Sweden, while I remained in the UK at my job and with our two preschool aged children. When this no longer proved viable we moved as a family to Brazil, where my partner also took up a temporary post. Meantime a research project bound by funding deadlines was standing idle at UWA because the principal researcher was unable to secure a visa. One can only wonder about the "significance" of the cost to Australia that this entailed.[22]

6.31 Ms Kione Johnson commented in relation to the 'one fails, all fail' rule, that:

> The application of this policy in such circumstances, without allowing for consideration of the family unit's personal resources, may produce results which come to undermine the purpose of skilled migration.[23]

Temporary and provisional visas

6.32 Temporary visas comprise a range of skilled visas, provisional business class visas, temporary education sector visas for students, academics, as well as regional and employer schemes, both sponsored and unsponsored.[24]

6.33 These visas may be offered over a range of time from one day to four-years and are renewable. Some, such as the Skilled–Regional Sponsored (Provisional) Visa (Subclass 475), have options for permanency after a qualifying period of living and working in a community.[25]

6.34 As noted above, the bulk of temporary visa options are currently designated under PIC 4005. Until recently, only two Temporary Skilled visa categories offered a waiver on the basis employer sponsorship (PIC 4006A). These were the Temporary Skilled (Business—Long Stay) Visa 457 and the Educational visa (Subclass 418), for educational workers, which have a PIC 4006 waiver.

6.35 The Committee notes that the Subclass 418 visa was repealed on 14 September 2009, and that a number of other temporary visas have also

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22 Ms Sharon Ford, *Submission 74*, p. 8.

23 Ms Kione Johnson, *Submission 62*, pp. [44–45].

24 Department of Immigration and Citizenship, *Submission 66*, Attachment C.

25 Department of Immigration and Citizenship, Skilled – Regional Sponsored (Provisional) Visa (Subclass 475), accessed at May 2010 at <http://www.immi.gov.au/skilled/general-skilled-migration/475/>

been temporarily suspended, including the Regional Sponsored (Provisional) Visa (Subclass 475) mentioned above.[26]

6.36 The situation of Dr Siyat Hillow Abdi, see **Case Study** 6.**4,** alerted the community to the impact of the Health Requirement on highly skilled people with disability. Dr Abdi, who has been blind since birth, was denied a permanent skilled visa after completing his Doctorate in Disability Studies at Flinders University in South Australia. Blind Citizens Australia advised:

> Dr Abdi was the first teacher who is blind to be registered as a teacher by the South Australia Teachers Registration board yet under the application of the Health Requirement of the Act Dr Abdi does not qualify for Australian residency. Clearly people like Dr Abdi have the potential to add to the social, cultural, educational and economic value of the vibrant and diverse fabric that is Australia.[27]

Case Study 6.4

Dr Siyat Hillow Abdi — blind educator refused permanent residency

Dr Abdi is a Kenyan-born academic, blind since birth, who specialises in disability studies. Dr Abdi completed his Doctorate at the Flinders University of South Australia and was the first blind person to become a registered teacher in the state. Alongside his studies Dr Abdi was active in the community volunteering in a range of roles including as a mentor for young African refugees.

In 2009 Dr Abdi' s application for permanent residency was refused due to his blindness under the Health Requirement. Dr Abdi's case was supported by Blind Citizens who wrote to Senator Chris Evans, Minister for Immigration and Citizenship, urging the Minister to intercede on Dr Abdi's behalf by invoking his public interest power under section 417 of the *Migration Act 1958* (Cth).

Dr Abdi has since been granted a temporary residency visa and has subsequently accepted a senior position with the South Australian agency Disability SA.

Source *Blind Citizens Australia, Submission 44, pp.6, 7&9; Council of Australian Postgraduate Associations,* Submission 101, *p. 6.*

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26 The Educational visa (Subclass 418) accessed May 2010 at <http://www.immi.gov.au/skilled/skilled-workers/ev/>

27 Blind Citizens Australia, *Submission 44*, pp. 6-7.

Permanency for temporary and provisional visa holders

6.37 After a qualifying period, and subject to certain conditions, temporary visa holders may apply for a permanent visa. For people with a disability, the only alternative can be to apply for an Employer Nominated Scheme (ENS) visa, which will allow a waiver on the undertaking of the sponsor to pay any health costs.

6.38 Dr Paul Douglas of DIAC described the operation of the employer sponsored waiver under the 457 visa, and options for renewal or permanency:

> For the 457, where they have nominated a period of time they are coming for, be it one year, two years, or up to four years, it is looked at in regard to whether the employer is happy to support that and what the other circumstances are around it. So that may be waived on that opinion. If they apply onshore for an additional visa or a new visa then under the employer nominated schemes and the employee sponsored schemes, if it is more than $100,000, it has to go to the states and territories and they will provide some opinion as to whether they are happy to support it in that regard, as explained by Mr Kennedy at the last meeting. If it is less than $100,000, it goes to the visa delegate, who will look at the compelling compassionate circumstances.[28]

6.39 Evidence before the Committee indicated that a majority of temporary visa holders, at the end of the contractual period, either seek to renew the visa or make an application for permanent residency. DIAC advised, for example, that a total of 39 170 permanent residency or provisional visas were granted to people who last held a Temporary Skilled (Business — Long Stay) Visa 457.[29] CAPA also noted that two thirds of all international students intend to stay in Australia; of these students around 95 per cent plan to gain permanent residency before or immediately after graduation.[30]

6.40 However, as DIAC's Mr Torkington confirmed problems can arise when a provisional visa expires and application for permanent visa is made:

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28 Dr Paul Douglas, *Committee Hansard*, Canberra, 17 March 2010, pp. 2–3.

29 Department of Immigration and Citizenship, *Annual Report 2008-09*, 1.1.1 Output Economic Migration , accessed May 2010 at <http://www.immi.gov.au/about/reports/annual/2008-09/html/outcome1/output1-1-1.htm>

30 The Council of Australian Graduate Associations, *Submission 101*, p. 6.

> …sometimes the person meets the health requirement for a short stay but for a longer period they do not meet the health requirement. If there is no waiver available for that type of visa, there is nothing the department can do about that.[31]

New initiatives to address skill shortages

6.41 The Minister for Immigration and Citizenship, Senator Chris Evans, has recently announced the release of the new Skilled Occupation List (SOL) following suspension of the Migration Occupations in Demand List (MODL) in 2008 and temporary application of the Critical Skills List (CSL).[32]

6.42 The new SOL *Fact Sheet* provides that the new skills list will reduce the number of occupations from 400 to 181, with a focus on higher skill employment:

> The new list is focused on targeting specialised occupations that require a long lead time of formal education and training. It includes managerial, professional, associate-professional and trade occupations. The list of occupations will be reviewed annually but it is expected that it will be relatively stable over time. [33]

6.43 Additionally, the new program will focus on employer sponsored jobs, moving away from the emphasis on skilled independent visa under the previous arrangement. It was further announced:

> The Minister will be recommending that the Governor-General in Council make amendments to the *Migration Regulations 1994* to give effect to the framework in which this new list would be applied. The new SOL is proposed to commence on 1 July 2010.[34]

6.44 The Committee heard that, at present, the system is turning away nurses and health professionals in critical areas need.

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31 Mr Nicholas Torkington, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 17 March 2010, p. 3.

32 Department of Immigration and Citizenship, The New Skilled Occupation List (SOL), accessed May 2010 at <http://www.immi.gov.au/skilled/general-skilled-migration/pdf/factsheet-new-sol.pdf>

33 Department of Immigration and Citizenship, The New Skilled Occupation List (SOL), accessed May 2010 at <http://www.immi.gov.au/skilled/general-skilled-migration/pdf/factsheet-new-sol.pdf>

34 Department of Immigration and Citizenship, The New Skilled Occupation List (SOL), accessed May 2010 at <http://www.immi.gov.au/skilled/general-skilled-migration/pdf/factsheet-new-sol.pdf>

6.45 The Queensland Nurses Union (QNU) advised that, in that State, there is a critical shortage of nurses across public and private hospitals and aged care facilities (conservative estimates put this at around 1 400 nurses).[35] Yet despite this, the application for a 457 visa from two nurses with skills in critical shortage were rejected due to a child's disability, see **Case Study 6.5.**

Case Study 6.5

UK nurses with skills in critical shortage rejected under the Health Requirement

A United Kingdom (UK) specialist haemodialysis (renal) nurse was in Australia on a Temporary Long Stay 457 visa after a approaching an international recruitment agency. His wife, also a registered nurse, and four children underwent a medical assessment in the UK during which a mild intellectual disability was identified in one child.

In October 2008 the Department of Immigration and Citizenship (DIAC) rejected the family's application for permanent residency based on the findings of the Medical Officer of the Commonwealth that the nine year old son had a level of intellectual impairment which would require specialist education services costing $40 000 over four years.

Queensland Health (QH) advised that it would not provide DIAC with the requisite undertaking to meet community service or health costs during the duration of the family's stay. QH also rejected an undertaking by the applicant to meet costs.

The family stayed in the UK where their child has since been assessed as ready for mainstream schooling with some additional support. The recruitment agency has reported a fall in applicants for Australia among this skilled cohort since the advent of the case.

Queensland Nurses Union has conducted an assessment of additional costs attributable to the child in a mainstream school setting, which were in the range of $2 700 annually for a teacher's aide four days a week.

Source Queensland Nurses Union, Submission 69, p. 14, and see Ms Beth Mohle, Committee Hansard, *Brisbane, 28 January 2010, p. 41.*

6.46 Commenting further on the case at hearings, QNU's Ms Beth Mohle noted that, as a result of current requirements, Australia not only lost

35 Queensland Nurses Union, *Submission 5*, p. 2.

two skilled professionals in shortage (with the renal nurse being in the severe skill shortage category), but also damaged its competitiveness in the global skills market.[36] The QNU submission records:

> Our members international recruitment agency informed us that a number of registered nurses have withdrawn their applications as a result of learning about the adverse impact that immigration laws have had on families of their peers and the possibility that an assessment of a secondary applicant may result in their family members not meeting the heath requirement.[37]

6.47 QNU noted that the benefits to Queensland Health of filling these skilled nursing positions would have far outweighed the costs of mild intellectual impairment.[38] To remedy the issue, QNU recommended that a specific appeal process for people with a disability, standardised assessment and more transparency under Ministerial discretion should be adopted.[39]

6.48 Other witnesses commented on the negative impact of Australia's Health Requirement on our competitiveness for skilled people.

6.49 Wavelength International is a medical recruitment business which assists a large volume of medical doctors of all grades and allied health professionals into jobs in public and private medical institutions in Australia, New Zealand, Singapore and Canada. Wavelength described the obstacles placed before a senior nurse who wished to come to Australia. Despite having a willing sponsor for the 457 temporary visa, the disincentives were too great for the nurse and her husband, an academic, to risk the change.[40] (See **Case Study 6.6**.)

6.50 The circumstances of Dr Fiona Downes and her husband, both Specialist Emergency Physicians, demonstrates the potential risk taken on temporary migration, when a dependent child is later diagnosed with a disability. **Case study 6.7** describes how the family of six was almost driven offshore after eight years because of their son's autism.

6.51 Mr Andrew Bartlett, appearing on behalf of Ethnic Communities Council of Queensland, maintained that creating the right ethos or 'vibe' is

36 Ms Beth Mohle, Queensland Nurses Union, *Committee Hansard*, Brisbane, 28 January 2010, p. 41.

37 Queensland Nurses Union, *Submission 5*, p. [4].

38 Queensland Nurses Union, *Submission 5*, pp. [2–3].

39 Queensland Nurses Union, *Submission 5*, pp. [2–3].

40 Wavelength International, *Submission 102*, p. 2.

important if Australia is to have success in attracting doctors and health professionals:

> … it is a simple fact that with regard to the developed world longer term, in certain areas of skills there will be a lot of competition globally. I do not think that is going to change. Like a lot of areas, it serves us well—whether it is on a purely economic competitive basis or on some of those looser general terms of being seen to be more engaging, welcoming and encouraging of diversity—to have more recognition of the wider contributions people make. It gives us extra advantages over countries that do not do that.[41]

Case Study 6.6

The emotional impact of the Health Requirement—obstacles to skilled emigration

An experienced senior nurse living in the United Kingdom wanted to migrate to Australia. A GP clinic in Australia extended an employment offer to the nurse but one of her children suffered from Down Syndrome, and had a mild intellectual impairment.

Aware of the Health Requirement, the nurse did extensive research and found a private specialist college which could teach the child life skills so that he would have reasonable prospects of employment in the future. The GP clinic was keen to sponsor the nurse and was willing to sign the 4006A health waiver undertaking to secure a Temporary Long Stay visa 457.

The nurse applied for the visa but the child did not pass the health test. She had been aware of the probability that her child would not pass, but the Medical Officer of the Commonwealth's decision, which was based on a generic profile of a Down syndrome sufferer, was emotionally disturbing for her. She still retained hopes of applying for permanent residence in the future.

The nurse was then faced with a difficult choice. Should she and her husband, an academic, give up their well paid jobs in the United Kingdom to move to Australia on a 457 visa? Even if they did so, they would have to apply later for a permanent visa application, possibly take their case to the Migration Review Tribunal Appeal, and then on to a Ministerial request.

With several years of uncertainty ahead, the nurse decided that it would be too stressful for her and her family to take their chances in Australia.

Source *Wavelength International,* Submission102*, p. 2.*

41 Mr Andrew Bartlett, Ethnic Communities Council of Queensland, *Committee Hansard*, 28 January 2010, p. 5.

Case Study 6.7

Not in the 'public interest'—Emergency skilled doctors and family rejected after eight years in Australia

In January 1998 Dr D and her husband, both junior doctors trained in the United Kingdom, came to Australia on 442 Temporary Residence visas. The couple were accompanied by their two children: a daughter aged three years and a son E, aged seven months.

Dr D and her husband both enrolled in the training program with the Australasian College of Emergency Medicine (ACEM) and worked towards gaining Fellowship (FACEM) as Emergency Medicine Specialists.

Over the next eight years the family continued to live in Australia having their Temporary Residence visas renewed on an annual basis. In July 1999, however, toddler E had been diagnosed with Autism, and so each application for his visa renewal was referred to the Medical Officer for the Commonwealth for approval. The application was always granted, subject to further medical reports.

During this time two other daughters were born to the family, in 2003 and 2004. Dr D and her husband were both successful in obtaining FACEM and gained positions as Staff Specialist Emergency Physicians with HNE (Hunter New England) Health. They submitted an application for permanent residency in 2006. The application was refused as E did not meet the Health Requirement.

The family realised that their only hope of remaining in their home in Australia was to seek Ministerial Intervention. They applied to the Migration Review Tribunal and then to the Minister.

On September 2007, they were granted permanent residency at the Minister's discretion, after living under a 'truly horrible cloud' for over a year. Dr D and family became Australian Citizens in February 2010.

Source *Dr Fiona Downes*, Submission 103, *pp. 1-2.*

6.52 Dr Susan Harris Rimmer of the Australian Human Rights Lawyers stated:

> There are academics who will not come to Australia, and why would they when their child will be put through this process? They do not want them to have to go through the intrusive medical checks. Why would they when they can go to Canada or the US and not go through that process? The skilled migration category now globally is highly competitive. We cannot assume that we will attract these high-powered executives if we keep the current system that we have. That is only going to affect that tiny elite part, but, in terms of return to the national economy, that might be very significant.[42]

6.53 The Government has now introduced a suite of skilled visa categories to provide greater flexibility following problems identified in the Moeller case. Visa subclasses 846, 855, 856 and 857, under the Employer Nominated stream, offer permanent skilled visas with a health waiver provision under PIC 4007.[43]

6.54 DIAC described the evolution of the new visas:

> In late 2008, a high profile case involving a doctor in a regional area, brought to light the need to pursue a skilled health waiver option with State and Territory participation. Following this case the Minister wrote to State and Territory leaders seeking their agreement to participate.
>
> To date all States and Territories, except New South Wales have now been designated as participating jurisdictions under the new arrangements. Visa applicants from States and Territories that have not yet signed up have been offered the opportunity to have their visa decision delayed until such time as the State or Territory has made a decision regarding their participation.
>
> Some participating states have now signed a Memorandum of Understanding (MOU) outlining the agreed implementation and operational arrangements with the Department. Under the MOU arrangements, in cases where the potential health care and community service costs are estimated to be $100 000 or more, or prejudice to access is 'substantial' or 'extensive', the relevant jurisdiction will be consulted for their view on whether they

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42 Dr Susan Harris Rimmer, Australian Lawyers for Human Rights, *Committee Hansard*, Canberra, 18 November 2009, pp. 11–12.

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

> support a waiver being exercised. The States and Territories will have an advisory role not a determinative role.[44]

6.55 However, as DIAC submission states:

> …these provisions required State and Territory agreement in order to operate - and until 2009, such agreement had not been acquired, consequently no waivers were available.[45]

6.56 The Migration Institute of Australia was positive about the new visas:

> The recent 4007 health waiver for certain skilled visa applicants that live in or intend to live in a participating state or territory has certainly been a positive advent and welcomed by many.[46]

6.57 However, issues were raised about the cost of the proposal and its administration. The Australian National University School of Law Migration Program noted:

> …the question of cost will inevitably arise with this proposal. Any legislation which relates to health walks a tight-rope, balancing the needs of the Commonwealth and the States. While the Commonwealth is in charge of migration and can implement the policies it requires, any changes to the health requirement have implications for the State-run public healthcare systems and social services. [47]

6.58 DIAC's Mr Torkington further advised:

> Obviously, I cannot speak for the state governments; but, if you expand it to more visa subclasses, it would have a greater impact on state health systems. You would have to go back to them and get their views again. Certainly, most of them were quite enthusiastic about signing up for skilled classes because they can see the benefits for the state. [48]

6.59 Mr Mark Dreyfus QC MP, Member for Isaacs, reported on a constituent with HIV who failed the Health Test for a PIC 4005 assessed permanent visa. Mr Dreyfus supported the new expanded employer sponsored visa classes but had concerns that state governments would not support the measure:

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44 Department of Immigration and Citizenship, *Submission 66*, pp. 12–13

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

46 The Migration Institute of Australia, *Submission 34*, p. [6].

47 Migration Law Program, Australian National University College of Law, *Submission 59*, p. 9.

48 Mr Nicholas Torkington, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 17 March 2010, p. 8.

> Although there is now a provision for waiver of the health criterion for onshore applicants for subclass 856 (ENS) and 857 (RSMS) visas, this is dependant upon the state in which the applicant lives certifying that it will accept the costs associated with the health condition, and remains unavailable for applicants applying for these visas outside of Australia. Such a waiver, if made available for all permanent subclasses, could have been appropriately utilised in JPl's case, given JPl's ability to significantly contribute to the Australian community by being an employed, tax-paying resident who is working for a regional employer and passing JPl's skills to local workers.[49]

6.60 The Committee notes that the New South Wales (NSW) Government is the sole remaining government not to have committed to the rollout of the new 4007 visas. [50] In its submission, the NSW Government notes that it supports the measure but as the State with the largest influx of migrants, it would expect a heavier financial impact. The submission provided an itemised costing for expanded waivers in terms of education, migrant English, health and other costs.[51]

Committee comment

6.61 The Committee is pleased to note the new visa categories which provide options to balance health costs with skilled work contributions. The Committee also considers that a more comprehensive program for expansion of the waiver option is required to include a broader range of skilled visa categories, especially for skill shortages and rural and regional development schemes.

6.62 The Committee is of the view that this would not only support the acceptance of more able and skilled people with a disability it would also advertise Australia as a progressive community likely to attract the most valued applicants needed to fill skill shortages.

6.63 The Committee recognises that the expansion of these schemes may put extra pressure on State health and community care budgets.

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49 Mr Mark Dreyfus QC MP, Member for Isaacs, *Submission 109*, p. 2.

50 Mr Nicholas Torkington, Department of Immigration and Citizenship, *Committee Hansard*, Canberra, 17 March 2010, p. 8.

51 NSW (New South Wales) Government, *Submission 96*, p. 8–11.

6.64 In this regard, the Committee urges the Federal Government to recognise these challenges and facilitate State and Territory support for these schemes as part of the Government's national health reform and National Disability Strategy agendas.

Recommendation 16

The Committee recommends that the Australian Government work with State and Territory Governments to expand the waiver option to the Health Requirement for skilled migration visa classes to a broader range of skilled visa categories, targeting areas of skill shortages and rural and regional development schemes.

Personal indemnification options

6.65 Many submitters saw that in addition to recognition of the social and economic contributions of migrants in assessment criteria for waivers, there should be some contractual opportunity to offsets cost, at least for those in the skilled stream who have the capacity to make such commitments.

6.66 The Committee is aware that the Australian system currently provides an Assurance of Support (AoS) scheme for contributory aged parents and employment sponsored visas. However, there is no option for other individuals applying under other visa categories to provide any undertaking to cover heath costs under current system.

6.67 *Fact Sheet 34* on the AoS provides that:

> An AoS is a legal commitment by a person (not necessarily the sponsor) to repay to the Australian Government certain welfare payments paid to migrants during their respective AoS period.
>
> It is also a commitment to provide financial support to the person applying to migrate (the assuree), so that the assuree will not have to rely on social welfare payments. [52]

6.68 DIAC's Mr Matt Kennedy explained that the AoS system works by the lodging of a bond. Any access that is made by the application to social

52 *Fact Sheet 34— Assurance of Support*, accessed May 2010 at <http://www.immi.gov.au/media/fact-sheets/34aos.htm>

services or benefits is deducted from that bond. The AoS can also apply to partner visas but the system has limited jurisdiction and is at the discretion of the visa decision maker.[53]

6.69 DIAC raised concerns about any expansion of the personal assurances program noting that the measure only addresses the cost aspect not 'prejudice to access ' concerns:

> The other thing that is very clear about insurance is that people continually miss the prejudice to access issues, in that the health requirement also covers those things that are in short supply in Australia and that we do not have enough of to provide.[54]

6.70 DIAC also noted that the system could throw up anomalies in this regard:

> Even if they demonstrate the ability to take out extensive health cover, what happens if that individual then falls on hard times and can no longer afford the $2,000, $3,000 or $4,000 a year that they need for comprehensive health cover. Do you say, 'You promised that you would maintain that'?[55]

6.71 The HIV/AIDS Legal Centre (HALC) did not support a bond arrangement, regarding this as prejudicial to less affluent visa applicants. As an alternative it proposed a 'buy in' provision to offset the health assessment. HALC suggested:

> For disabled applicants in the work stream a 2 or 5 year continued work capacity might be applied. A requirement for holding and using health insurance (this would require a limitation on Medicare access to those applicants). Alternatively an increased impost via taxation might be applied as a cost of entry provision. An incremented taxation impost spanning over 5-10 years would significantly defray the estimated lifetime costs the migrant is considered to bring, without unnecessarily burdening the migrant family. Such a scheme would have some popular appeal.[56]

6.72 Mr Iain Brady, Principal Solicitor with HALC added:

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53 Mr Matt Kennedy, Department of Immigration and Citizenship, *Committee Hansard*, Melbourne, 24 February 2010, p. 17.

54 Dr Paul Douglas, Department of Immigration and Citizenship, C*ommittee Hansard*, Melbourne, 24 February 2010, p. 17.

55 Mr Peter Vardos, Department of Immigration and Citizenship, C*ommittee Hansard*, Melbourne, 24 February 2010, p. 16.

56 HIV/AIDS Legal Centre Inc., *Submission 69*, p. 18.

> …we were thinking in terms of an additional 1.5 per cent or some additional impost on Medicare as a buy-in.[57]

6.73 The Committee notes that Canada and United States provide options for personal indemnification against health costs:

- 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. Families may also submit a binding affidavit for support.[58]
- The Canadian immigration law provides that if an applicant is refused by the medical officer on an '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).[59]

Committee Comment

6.74 The Committee considers there is merit in providing opportunities family members of applicants to indemnify costs across the visa streams. While there are concerns that such a proposal might be inequitable for some streams, it would appear also to be inequitable to exclude the option for offsets for those wanting to engage in such a scheme.

6.75 The Committee recommends that a bond, 'buy in' or credit management plan as applied in Canada be considered as an additional option for visa applicants. The Department may determine whether the mechanism should be offered as capped or a quota system for people with a disability. The Committee notes that quotas have been used effectively in New Zealand and some other countries to facilitate targeted migration of people in this cohort.[60]

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57 Mr Iain Brady, HIV/AIDS Legal Centre Inc., *Committee Hansard*, Sydney, 12 November 2010, p. 53.

58 Advocacy, Disability, Ethnicity, Community (ADEC), *Submission 23*, pp. 11–13.

59 High Commission of Canada, *Submission 86*, p. [2].

60 See Dr Susan Harris Rimmer, *Committee Hansard*, Canberra 18 November 2010, p. 12.

Recommendation 17

The Committee recommends that the Australian Government investigate the introduction of a voluntary bond or other scheme for visa applicants to indemnify against, or manage health care or community services costs assessed under the Health Requirement of the *Migration Act 1958* (Cth).

The Committee recommends that any introduction of such a bond or other scheme should not prejudice those applicants that are unable to provide a surety.

7

Australia's international obligations and domestic exemptions

7.1 To this point, this report has focused on the effect of Australia's domestic policy in relation to the migration Health Requirement under the *Migration Act 1958* (Cth). In particular, it has considered the impact of the Health Requirement on visa applicants along with an assessment of the processes used in the assessment of the Requirement.

7.2 However, given the nature of migration policy, this inquiry has also considered Australia's migration policy in an international context. In this regard, many inquiry respondents asked the Committee to consider Australia's migration health requirement having regard to Australia's international obligations.

7.3 This Chapter explores Australia's international obligations under relevant treaties before assessing their significance for the migration treatment of disability under the *Migration Act 1958* and its regulations. Finally, calls for the removal section 52 of the *Disability Discrimination Act 1992*, which exempts Migration law and its administration from the force of that Act, are assessed.

International obligations

7.4 Australia is signatory to a number of international treaties or instruments. Principal among these is the United Nation's (UN) *Convention on the Rights of Persons with a Disability* (the CRPD or Disability Convention) which was

ratified by Australia on 18 July 2008. It is the main international instrument for the human rights protection of the rights and freedoms of people with a disability.[1]

7.5 Also raised in evidence was the UN *Convention on the Rights of the Child* (the CRC or Children's Convention) was ratified by Australia in December 1990. It safeguards the rights of children and provides associated protections for family participation and unity.[2] While the Children's Convention is relevant to the present inquiry, evidence primarily centred around Australia's obligations under the Disability Convention.

United Nations Convention on the Rights of Persons with a Disability

7.6 Australia was an active contributor to UN discussions for the Disability Convention and had significant input into its eventual form. Australia was one of the first countries to become signatory to the Convention, and subsequently to ratify it. [3]

7.7 The Disability Convention provides comprehensive protections and directly prohibits discrimination against people with a disability as discrete social group. It is one of the key international agreements helping to strengthen the rights of persons with a disability. Article 1 (1) of the Disability Convention states:

> The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.[4]

7.8 The Convention establishes 50 Articles and an Optional Protocol.[5] It provides a comprehensive framework to address societal barriers underpinned by eight guiding principles guaranteeing non-

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1 Australian Treaties Series, *Convention on the Rights of Persons with a Disability, National Interest Analysis Reference: [2008] ATNIA 18*, accessed March 2010 at <http://www. austlii.edu.au/ cgi-bin/sinodisp/au/other/dfat/treaties/2008/12.html?query=Disabilities>.

2 United Nations *Convention on the Rights of the Child*, accessed April 2010 at <www.unicef.org/ crc/index_30160.html>.

3 Australian Treaties Series, *Convention on the Rights of Persons with a Disability, National Interest Analysis Reference: [2008] ATNIA 18*, accessed March 2010 at <http://www.austlii.edu.au/cgi- >bin/sinodisp/au/other/dfat/treaties/2008/12.html?query=Disabilities >.

4 United Nations Enable—Rights and Dignity of Persons with Disabilities, *Convention on the Rights of Persons with Disabilities*, accessed March 2010 at <http://www.un.org/disabilities/ default.asp?id=150>.

5 The Optional Protocol enables the Convention's elected monitoring mechanism, the United Nations Committee on the Rights of Persons with Disabilities.

discrimination, equality of opportunity, full participation and inclusion in public life. The Convention protects the family and the rights of the child, prohibits degradation and harsh treatment, and articulates rights to access public infrastructure, education, accommodation, standards of living and health care.[6]

7.9 As discussed later in this Chapter, the Convention is not enforceable on state parties (individual nations party to the Convention), however, it requires that domestic law and government programs be in harmony with treaty obligations. In particular, Articles 4 and 5 require state parties to ensure laws are not in contravention to obligations for non-discrimination under the treaty.

7.10 Additionally, the Convention sets out a framework for the monitoring and review of measures undertaken by states to comply with their obligations. In particular, Disability Convention Article 34 establishes the United Nations Committee on the Rights of Persons with Disabilities (the Disability Committee) as an elected independent monitoring mechanism.

7.11 Articles 33 and 35 require State Parties to set up national mechanisms to monitor implementation of the Convention's precepts and to provide a 'full and comprehensive report' of the measures within two years, and at least every four years after that.[7]

Ratification and interpretative declaration of the Disability Convention

7.12 Australia's ratification of the Disability Convention was supported by the Australian Government on the conviction that Australia was already in compliance with its 'immediate obligations' under that and the relevant ratified international conventions.[8]

7.13 The Department of Immigration and Citizenship (DIAC) submission to this inquiry stated:

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6 United Nations Enable—Rights and Dignity of Persons with Disabilities, *Convention on the Rights of Persons with Disabilities*, accessed March 2010 at <http://www.un.org/disabilities/default.asp?id=259> and see Professor Ron McCallum and Professor Mary Crock, *Submission 31*, Attachment 2, Background Operation of the CRPD.

7 From the entry into force of the present Convention for the State Party concerned. United Nations Enable—Rights and Dignity of Persons with Disabilities, *Convention on the Rights of Persons with Disabilities,* Article 35 – Reports by State Parties, accessed March 2010 at <www.un.org/disabilities/default.asp?id=259>.

8 Australian Government, *Australian Treaty National Interest Analysis – Category 1 Treaty, [2008*], *ATNIA 18,* from para 8, and see paras. 32; 34 accessed March 2010 at <http://www.austlii.edu.au/au/other/ dfat/nia/2008/18.html>.

> Ratifying the Convention is part of the Government's broader longer term commitment to improving the lives of both people with a disability and their families and comes as part of a significant set of reforms of Australia's disability laws.
>
> Australia's declared understanding is that the Convention does not create a right for a person to enter or remain in a country of which he or she is not a national, and that it does not impact on Australia's health requirements for non-nationals seeking to enter or remain in Australia, where these requirements are based on legitimate, objective and reasonable criteria.
>
> Australia remains at the forefront of upholding the rights of people with disabilities, and this Convention is part of the Government's broader longer term commitment to improving the lives of both people with a disability as well as their families.[9]

7.14 This position was based on the Government's impact analysis (NIA) and the assessment of the treaty conducted prior to ratification of the Disability Convention.[10] The assessment was conducted by the Joint Standing Committee on Treaties (JSCOT) which found that that ratification of the Convention provided an opportunity 'to resolve any inconsistencies and effect positive reforms 'under the migration health requirements. It recommended that:

> …in the light of the ratification of the Convention, it would be timely to carry out a thorough review of the relevant provisions of the Act and the administrative implementation of migration policy to ensure that there is no direct or indirect discrimination against persons with disabilities.[11]

7.15 In ratifying the Disability Convention, Australia also lodged an interpretive declaration outlining Australia's understanding of its obligations under the Convention. Many submissions questioned the status of Australia's interpretive declaration, especially in relation to the

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9 Department of Immigration and Citizenship, *Submission 66*, p. 24.

10 Before ratification of a treaty the Australian Government prepares an Australian National Interest Analysis (NIA) which assesses the potential economic, social and other impacts of ratification. See Australian Government, *Australian Treaty National Interest Analysis – Category 1 Treaty*, [*2008], ATNIA 18,* accessed March 2010 at <http://www.austlii.edu.au/au/other/dfat/nia/2008/18.html> .

11 Recommendation 2, JSCOT, 'Convention on the Rights of Persons with Disabilities', *Report 95: Review into Treaties tabled on 4 June, 17 June, 25 June and 26 August 2008,* October 2008, p. 17 and for recommendation see p. 23.

Health Requirement and compliance with Australia's international obligations.

7.16 Paragraph 3 of Australia's interpretive declaration stated in regard to migration law:

> Australia recognizes the rights of persons with disability to liberty of movement, to freedom to choose their residence and to a nationality, on an equal basis with others. Australia further declares its understanding that the Convention does not create a right for a person to enter or remain in a country of which he or she is not a national, nor impact on Australia's health requirements for non-nationals seeking to enter or remain in Australia, where these requirements are based on legitimate, objective and reasonable criteria.[12]

7.17 The United Nations Enable website explains that under treaty law a State Party may lodge a reserve or interpretative declaration to qualify or clarify its compliance with a treaty it has ratified noting:

> A reservation is a statement that purports to exclude or modify the legal effect of a treaty provision with regard to the State or regional integration organization concerned. The statement might be entitled "reservation," "declaration," "understanding," "interpretative declaration" or "interpretative statement." However phrased or named, any statement that excludes or modifies the legal effect of a treaty provision is, in fact, a reservation. A reservation may enable a State or regional integration organization that would otherwise be unwilling or unable to participate in the Convention or Optional Protocol to so participate.[13]

7.18 The Migration Law Program, Australian National University (ANU) College of Law, argued that an interpretive declaration has limited jurisdiction under international law and, accordingly, that the Government should not seek to avoid obligations under it:

> It is our understanding that this is to be considered an interpretive declaration and not a reservation to those articles protecting the

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12 United Nations Enable—Rights and Dignity of Persons with Disabilities, *Reserves and Declarations - Australia*, accessed March 2010 at <http://www.un.org/disabilities/default.asp?id=475>.

13 United Nations Enable—Rights and Dignity of Persons with Disabilities, *Chapter Four; Becoming a Party to a Protocol or Convention*, accessed April 2010 at <http://www.un.org/disabilities/default.asp?id=232>

> equal rights of persons with disability to liberty of movement, to freedom to choose their residence and to a nationality, which the declaration otherwise confirms. As such, it is not to be considered a "catch-all" protection for any policy relating to immigration against the full application of the rights recognised by the Convention.[14]

7.19 Castan Centre for Human Rights and Rethinking Mental Health Laws Federation Fellowship took a similar view, recommending amendments to the current health assessment criteria and migration law to bring Australia into compliance.[15]

7.20 Professor Ron McCallum AO, 2010 Chairman of the United Nations Disability Committee, saw the lodging of Australia's interpretative declaration as an example of 'overabundant legislative caution'. He observed that the Disability Convention already permits decisions in areas of migration and movement to be 'reasonable and proportional'. He argued, however, that the migration rules are not being applied in a 'reasonable and proportional manner'. [16]

7.21 In a similar vein, the Australian Federation of Disability Organisations (AFDO) cited the United Kingdom (UK) Parliamentary Joint Committee on Human Rights which disapproved a Government proposal to lodge an immigration reserve to the Convention. It considered the proposal unnecessary given the Convention gave no additional rights to migrants enter the UK, nor had power to compel on migration matters. A reserve, may however, give Government inordinate migration controls while conflating disability and public health risks.17

7.22 Several submissions, such as from Queensland Advocacy Incorporated (QAI), called for the withdrawal of the interpretive declaration. Mr Kevin Cocks from QAI stated:

> Withdrawing it would make it a fairer process for people with disabilities, whether they were children, as part of a family, or

14 Migration Law Program, Australian National University College of Law, *Submission 59*, p. 4.

15 Castan Centre for Human Rights Law and Rethinking Mental Health Laws Federation Fellowship, Faculty of Law, Monash University, Melbourne, *Submission 36*, p. 16.

16 Professor Ron McCallum AO, *Committee Hansard*, Sydney, 12 November 2010, p. 12.

17 Australian Federation of Disability Organisations, *Submission 6*, pp. 8-9. The United Kingdom later made a reservation asserting the right to apply laws for 'entry into, stay in and departure from the United Kingdom of those who do not have the right under the law of the United Kingdom to enter and remain in the United Kingdom, as it may deem necessary from time to time'. See United Nations Enable—Rights and Dignity of Persons with Disabilities, *Reserves and Declarations*, accessed May 2010 at <http://www.un.org/disabilities/default.asp?id=475>

> adults, as individuals or part of a family. There would be no discrimination, and Article 5 in the CRPD calls for non-discrimination.[18]

7.23 The Australian Capital Territory (ACT) Human Rights Commission claimed the interpretative declaration contradicted Australia's otherwise progressive domestic policy. The Commissioner submitted:

> …given the challenging background of many people who have recently arrived to our country, including those seeking asylum, we suggest it sends the wrong message about Australian society that people with a disability are not valued. To the contrary, health, discrimination and human rights legislative and service regimes that exist around Australia, particularly in the ACT, demonstrate the commitment of our society to inclusiveness. National strategies and action plans on health and disability highlight the importance of liaising with those from a CALD background. To suggest in their very first contact with Australia that people with a disability are not valued contradicts these aims and goals.[19]

7.24 The Cabramatta Community Centre observed:

> We note that Australia sought to exclude the migration health requirement from its obligations under the United Nations Convention on the Rights of Persons with Disabilities, where these requirements are based on legitimate, objective and reasonable criteria, through the declaration that was made upon ratification...[20]

Scope of Australia's obligations under the Disability Convention

7.25 Before considering the significance of the Disability Convention for the current inquiry, it is useful to establish what general obligations are imposed on Australia, and other treaty signatories, under international law.

7.26 While treaty obligations vary, and the debate about the relationship between international and domestic law continues, three practical obligations can be considered to apply:

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18 Mr Kevin Cocks, Queensland Advocacy Inc. (QAI), *Committee Hansard*, Brisbane, 28 January 2010, p. 18 and see QAI *Submission 90.*

19 Australian Capital Territory (ACT) Human Rights Commission, *Submission 76*, p. 3.

20 Cabramatta Community Centre, *Submission 28*, p. 1.

- the Vienna Conventions on the Law of Treaties provides that treaties are governed by international law not domestic law;
- State Parties must ensure their domestic law permits them to meet their treaty obligations; and
- a State Party may not invoke the provisions of its internal law as justification for its failure to perform a treaty.[21]

7.27 While not domestically enforceable, treaties may impose obligations on a State Party to ensure their domestic laws are consistent with, and do not impose obstacles to, compliance. There is thus potential for international treaties to influence the formation and administration of domestic law and to aid its statutory interpretation.[22]

7.28 The Federal Court case *Minister for Immigration and Ethnic Affairs v Teoh* (1995) provided an important test case for this in Australian case law.[23]

7.29 Mr Teoh, a Malaysian national married to an Australian citizen with whom he had children, was refused permanent residency on a drug trafficking charge and was to be deported under the *Migration Act 1958*. In the judgment on the case, the majority determined that there had been a breach of natural justice, as the Immigration Department had failed to invite Teoh to make a submission on whether a deportation order should be made, contrary to its obligations.

7.30 The High Court held by a majority that there was a 'legitimate expectation' that the best of interests of children be a primary consideration based on the *Convention on the Rights of the Child*, which had not had legislative implementation. The *Teoh* case thus established a principle that Government and its agencies will act in accordance with the terms of a treaty, even where those terms had not been incorporated into Australian law.[24]

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21 A State 'cannot plead provisions of its own law or deficiencies in that law' in answer to a claim it is in breach of a treaty obligation. Mark Jennings, Senior Adviser International Trade, 'The Relationship Between Treaties and Domestic Law' Treaties in the Global Environment, Attorney-General's Department, accessed April 2010 at <http://www.dfat.gov.au/treaties /workshops/treaties_global/jennings.html>.

22 JSCOT, *United Nations Convention for the Rights of the Child, 17th Report,* August, 1998, p. 4.

23 *Minister for Immigration and Ethnic Affairs v Teoh* [1995] 183 CLR 273, see JSCOT, *United Nations Convention for the Rights of the Child, 17th Report,* August, 1998, p. 144. Other relevant cases include *Mabo v Queensland (No. 2)* [1992] 175 CLR 1 , *Dietrich v The Queen* [1992] 1777 CLR 292.

24 'The Relationship Between Treaties and Domestic Law' Treaties in the Global Environment accessed April 2010 at <http://www.dfat.gov.au/treaties/workshops/treaties_global/ jennings.html> .

The health requirement and international obligations

7.31 The Committee's inquiry found that there was substantial concern from some submitters regarding the interaction of Australia's domestic legislation is and its international obligations regarding migration policy.

7.32 The chief concern was that the *Migration Act 1958* (Cth) is exempt from the provisions of the *Disability Discrimination Act 1992* (Cth) (DDA). Many submitters considered that this puts Australia at odds with its international obligations to ensure domestic legislation is free from discriminatory provisions.[25]

7.33 Many submitters raised perceived inconsistencies between the Health Requirement and the Disability Convention. In particular, it was held that the Health Requirement is at odds with the certain articles of the Disability Convention, namely 4, 5 and 18. Briefly:

- **Article 4** which provides fundamental protections against discrimination in obliging signatories (State Parties) to:
  - …undertake to ensure and to adopt all appropriate legislative, administrative and other measures for the implementation of the rights recognized in the present Convention;
  - …take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities.[26]
- **Article 5** which provides fundamental protections for Equality and Non-Discrimination, requiring that State Parties shall:
  - recognise that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law; and
  - prohibit all discrimination on the basis of disability and guarantee persons with disabilities equal and effective legal protection against discrimination on all grounds.[27]
- **Article 18**, guarantees liberty of movement and nationality, including 'the freedom to choose residency and nationality on an equal basis with others' including by ensuring that persons with disabilities:

25 See citations later in this chapter.

26 United Nations Convention on the Rights of Persons with a Disability(Art. 4. 1(a) & (b)).

27 Information in this section from *United Nations Enable*, 'Convention on the Rights of Persons with Disabilities' accessed March 2010 at <http://www.un.org/disabilities/default.asp?id=259> and see Professor Ron McCallum and Professor Mary Crock, *Submission 31*, Attachment 2, Background Operation of the CRPD.

- Have the right to acquire and change a nationality and are not deprived of their nationality arbitrarily or on the basis of disability;
- Are not deprived, on the basis of disability, of their ability to obtain, possess and utilize documentation of their nationality or other documentation of identification, or to utilize relevant processes such as immigration proceedings, that may be needed to facilitate exercise of the right to liberty of movement;
- Are free to leave any country, including their own;
- Are not deprived, arbitrarily or on the basis of disability, of the right to enter their own country.[28]

7.34 However, in relation to the Disability Convention, the United Nations Human Rights Committee *General Comment 18: Non-Discrimination* also provides that:

> …not every differentiation of treatment will constitute discrimination, if the criteria for such differentiation are reasonable and objective and if the aim is to achieve a purpose which is legitimate under the covenant.[29]

7.35 This is known as the 'proportionality test'. The Law Institute of Victoria advised that the proportionality test recognises that human rights are not absolute and may be subject to 'reasonable and justifiable limitations'. In the context of the Health Requirement, the proportionality test would require:

> …balancing the right to discriminate against people with a disability with requirements to protect Australia against health risks, excessive public expenditure and access to services'.[30]

Views in relation to obligations under the Disability Convention

7.36 The Australian Federation of Disability Organisations (AFDO) asserted that Australia's migration treatment of people with a disability does not comply with key clauses in the UN Convention including the General Obligation to repeal legislation[31], requirements for respect, non-discrimination and equality of opportunity[32], and for freedom of

28 *United Nations Convention on the Rights of Persons with a Disability* Articles 18(a), (b) (c) & (d) respectively.

29 New South Wales Young Lawyers Human Rights Committee, *Submission 32*, p. [6].

30 Law Institute of Victoria, *Submission 88.1*, p. 4.

31 *United Nations Convention on the Rights of Persons with a Disability* Article 4 (1)(b).

32 *United Nations Convention on the Rights of Persons with a Disability* Article 3.

movement.[33] AFDO also advised that consultations over the National Disability Strategy revealed that the migration treatment of people with disability was a major concern.[34]

7.37 Many submissions cited the cases of Drs Moeller and Abdi and Mr Kayani as exemplars of the failure to provide equal and fair treatment for people with disability under the current migration health requirement, in contravention of Articles 5 and 18.[35] Others spoke from personal experience about discrimination under the current health arrangements.

7.38 Cynthia Sierra Muir wrote about her struggle to keep her sister Carmen, her legal ward, from being sent back to Spain. As discussed earlier, Carmen had no family in Spain but was refused permanent Australian residency because of her intellectual impairment.[36]

7.39 Mrs Muir maintained that Australia's ratification of the Disability Convention should ensure her sister's access to health services without discrimination (Article 25), and her right to free movement (Article 18). In particular, Article 18 implied that:

> As a disabled person, Carmen has the right:
>
> - To decide where she lives and to move about the same as everyone else.
> - To belong to a country (be a citizen) and not have that taken away because she is disabled.
> - To have papers, like passports, that other people have.
> - To leave any country including her own.[37]

7.40 Some legal experts also supported the view that Article 18 demands equal treatment of people with a disability under migration law.[38] However, it was also noted that issues raised over the provision were not resolvable at Convention consultations.[39]

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33 *United Nations Convention on the Rights of Persons with a Disability* Article 18.

34 Australian Federation of Disability Organisations (AFDO), *Submission 6*, pp. 3 and 4.

35 Federation of Disability Organisations (AFDO) *Submission 6;* Multicultural Development Association, *Submission 20*, pp. 7–8; Mary Ann Gourlay, *Submission 25*, pp. 20-21; Ethnic Disability Advocacy Centre Inc, *Submission 42*, pp. 4–5; LIV *Submission 88:1*, p. 3; Queensland Centre for Intellectual and Development Disability, *Submission 85*, p. [2]; Mr Graeme Innes, AHRC, *Committee Hansard* 12 November 2010, p. 4

36 Mrs Cynthia Muir, *Submission 3*, p. 1.

37 Mrs Cynthia Muir, *Submission 3*, p. 3.

38 NSW Disability Discrimination Legal Centre (DDLC), *Submission 55*, p. 4.

39 Professor Jan Gothard, Down Syndrome WA, *Committee Hansard*, Melbourne, 18 February 2010, p. 46.

7.41 The Committee sought clarification from the Law Institute of Victoria in relation to Article 18:

> The LIV notes that international law does not confer on non-citizens a general right to enter a foreign country and Article 18 of the UN Disabilities Convention does not confer any such right. A country is therefore entitled to refuse entry to non-citizens on the basis of legitimate, objective and reasonable criteria.[40]

7.42 In applying the proportionality test, however, LIV did not think the migration criteria compatible with Article 5 in that the health criteria are applied in a blanket way, and not balanced proportionately against the right to equal treatment.[41]

7.43 On this basis, the Migration Law Program ANU College of Law submission maintained that 'legitimate, objective and reasonable' criteria must comply with all 'principles of inclusion and equality', including freedom of movement:

> To the extent that government uses health criteria to 'pick and choose' those who should be allowed to enter Australia on the basis of the perceived severity of their disability and the perceived health costs flowing from it, such a course of action would be clearly discriminatory and in breach of the freedom of movement guaranteed in article 18 of the Convention.[42]

7.44 In its submission, the National Ethnic Disability Alliance (NEDA) cited comprehensive legal advice prepared by Dr Ben Saul of the University of Sydney. Dr Saul believes that the current migration arrangements fail to meet equal protection obligations under the Disability Convention.[43]

7.45 In his evaluation Dr Saul applied various tests to determine consistency between obligations under the Disability Convention and the Migration Act exemption under s 52 of the *Disability Discrimination Act 1992.* The focus of this assessment was primarily, but not exclusively, the migration Health Requirement.[44]

7.46 Consideration in particular was given to obligations under Disability Convention Articles 4, 5 and 18. It was the opinion of Dr Saul that Article

40 Law Institute of Victoria, *Supplementary Submission 88.1*, p. 3.

41 Law Institute of Victoria, *Submission 88:1*, p. 5.

42 Migration Law Program, Australian National University College of Law, *Submission 36*, p. 4.

43 National Ethnic Disability Alliance, *Submission 1*, p. [2].

44 National Ethnic Disability Alliance, *Submission 1: 1*, Legal advice from Dr Ben Saul, Director, Sydney Centre for International Law, Sydney University, 15 May 2008.

18 in itself does not guarantee freedom of movement given Government priorities to safeguard public health.[45] However, as Article 5 compels a state party to 'prohibit discrimination in law or practice in any field regulated and protected by public authorities':

> …even where permission to enter a foreign country is not recognised as a human right (which might be fatal to protection under article 4), where a State chooses to legislate to provide for the entry and stay of non-citizens, such laws (including health requirements as in the Migration Regulations 1994) must comply with the non-discrimination requirements of article 5.[46]

7.47 Dr Saul's assessment also identified potential for both direct and indirect discrimination under Australia's health requirement under Article 5, so that:

- *Direct* discrimination may arise where additional medical tests or evidentiary requirements are specifically imposed on disabled persons once they have been identified as disabled through the health screening process. There may thus be differential treatment compared with other visa applicants…
- *Indirect* discrimination may potentially arise where [Migration] Act sets standards of health requirements which the disabled do not or cannot meet.[47]

7.48 Finally, the 'proportionality test 'was applied to both the Australian and Canadian migration health requirements. The conclusion was that Canada had a far stronger *prima face* case for 'justified differentiation' under Article 5. In particular :

> Failure to take into account the benefits as well as the costs of admitting people with a disability may cast doubt on whether protection of the health system alone is a sufficiently reasonable and objective policy to justify differential treatment on the basis of disability.[48]

7.49 A number of submissions suggested that Australia's position was discriminatory under the Disability Convention. Castan Centre for Human Rights Law and Rethinking Mental Health Laws Federation Fellowship stated:

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45 Dr Saul also notes that a draft containing requirements for equal rights to 'enter and migrate to a country other than state of origin' was not accepted during Disability Convention consultations. National Ethnic Disability Alliance *Submission 1:1*, p. 3 and see ref. in Ms Mary Ann Gourlay, *Submission 25*, p. 36.

46 National Ethnic Disability Alliance ,*Submission 1.1*, Legal advice from Dr Ben Saul, [p. 3].

47 National Ethnic Disability Alliance, *Submission 1:1*, Legal advice from Dr Ben Saul, pp. [3; 4].

48 National Ethnic Disability Alliance, *Submission 1:1*, pp. 6–8.

> A provision that differentiates applicants based on whether they have a disease or condition is a distinction on the basis of disability. It impairs those visa applicants who have disabilities from obtaining immigration status on an equal basis with others, as they have to meet additional criteria that are inherently hard to meet for a majority of people with long-term impairments. According to the *CRPD* this constitutes discrimination.[49]

7.50 Ethnic Disability Advocacy Centre identified indirect discrimination as the consequence of the costing measures:

> Indirect discrimination against refugees and migrants with disability occurs because the threshold of the health test is set too low to adequately balance the interests of non discrimination against people with disability with the preservation of scarce health resources. Thus, in some cases the health assessment may lead to discrimination that is not proportionate to the policy objective of preserving health resources for all Australians.[50]

7.51 Mr Graeme Innes, Disability Discrimination and Race Discrimination Commissioner, argued that 'legitimate reasonable and objective' migration criteria must include a more sophisticated costs benefits analysis.[51]He stated at hearings:

> Obviously, the cost of a disability is not an irrelevant consideration when it comes to migration and to many other matters. The real issue is the balancing process between the costs and the benefits.[52]

7.52 Professor Mary Crock accepted that migration laws must in some respects be discriminatory to ensure Australia's best interests. However she considered that the failure to distinguish between disease and disability discriminates between people in an 'unequal way', and thus fails the 'reasonable and proportionate' test.[53]

7.53 Given Australia has a developed framework which prohibits discrimination under Australian law in the *Disability Discrimination Act 1992 (DDA),* the Committee next evaluates the effect of the migration

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49 Castan Centre for Human Rights Law and Rethinking Mental Health Laws Federation Fellowship, Faculty of Law, Monash University, Melbourne, *Submission 36*, p. 23.

50 Ethnic Disability Advocacy Centre Inc., *Submission 42*, p. 5.

51 Mr Graeme Innes, Australian Human Rights Commission, *Committee Hansard,* Sydney, 12 November 2010, p. 3.

52 Mr Graeme Innes, Australian Human Rights Commission, *Committee Hansard,* Sydney, 12 November 20010, p. 22.

53 Professor Mary Crock, *Committee Hansard,* Sydney, *12 November 2010*, p. 13.

exemption for the treatment of people with a disability under the Health Requirement.

The Migration Exemption

7.54 As outlined in Chapter 2, the DDA makes disability discrimination unlawful and aims to promote equal opportunity and access for all people with disabilities within Australia.[54]

7.55 Part 2, Division 5 of the DDA currently provides for a number of exemptions to the Act including for defence peace keeping purposes, superannuation and insurance and, at s 48, on the basis of infectious diseases to protect public health.[55]

7.56 However, s 52 also exempts the application of the DDA to Migration law and regulations so that:

> Divisions 1, 2 and 2A do not:
>
> (a) affect discriminatory provisions in:
>
> (i) the *Migration Act 1958*; or
>
> (ii) a legislative instrument made under that Act; or
>
> (b) render unlawful anything that is permitted or required to be done by that Act or instrument.

7.57 Professor Jan Gothard of Down Syndrome Western Australia was among the many[56] who argued that it is time for change:

> Race-based discrimination was removed from Australian legislative and migration practice in 1975 with the passage of the Racial Discrimination Act, but the passage of the Disability Discrimination Act (DDA) in 1992 did not have the same impact for people with disability: clause 52 of the DDA explicitly acknowledges the 'discriminatory provisions' of the Migration Act of 1958 but states that no section of the DDA shall apply to the Migration Act or to those who administer it. While Australia has rejected discrimination on the basis of race in all areas of law and

54 Australian Human Rights Commission, Disability Rights, accessed May 2010 at <http://www.hreoc.gov.au/disability_rights/>

55 *Disability Discrimination Act 1992* (Cth).

56 Professor Patricia Harris, *Submission 2*, p. 4, Mary Ann Gourlay *Submission 25*, pp. 9–10; Blind Citizens Australia, *Submission 44*, p. 11; Robert Duncan McCrae, *Submission 94*, p. 1.

> policy, in the arena of migration people with disability are still subject to the same attitudes prevalent in 1901.[57]

7.58 In addition, Mr Frank Hall-Bentick of the AFDO commented:

> ...we are concerned that the terms of reference do not examine the exemption of the Migration Act from the Disability Discrimination Act. We are concerned these terms of reference only seek to tweak these discriminatory, unjust migration procedures by adding further complex assessment procedures rather than challenging and removing these discriminatory rules and regulations.[58]

7.59 Similarly, the United Nations High Commissioner for Refugees (UNHCR) described the effect of the migration exemption as follows:

> The health requirement is inherently discriminatory in its effect and is only legalized, to that extent, by section 52 of the Disability Discrimination Act 1992.[59]

7.60 The Ethnic Disability Advocacy Centre noted:

> As a consequence of the Migration Act (1958) being exempted from the Disability Discrimination Act (1992), refugees and migrants with disability and their families are not offered the same protection from discrimination that apply to other areas of Australian law.[60]

7.61 The Federation of Ethnic Communities' Councils of Australia (FECCA) considered that application of the *Disability Discrimination Act 1992* to the *Migration Act 1958* would remove this potential for discrimination:

> It is an anomaly that immigration law is not currently subject to the DDA. Historically disabilities have been considered with health requirements to protect the community from transmittable diseases. It is time to break this nexus. Health regulations should not single out people with disability and refuse them visas or place different requirements on them. Clearly it is time to ensure that immigration law conforms to Australia's obligations under international conventions including the Disability Convention. We need to look at the way society treats a person with disability

57 Down Syndrome WA, *Submission 57*, p. 3.

58 Mr Frank Hall-Bentick, Australian Federation of Disability Organisations, *Committee Hansard*, Melbourne, 18 February 2010, p. 42.

59 United Nations High Commissioner for Refugees (UNHCR), Regional Office for Australia, New Zealand, Papua New Guinea and the Pacific, *Submission 82*, p. 6.

60 Ethnic Disability Advocacy Centre Inc. *Submission 42*, p. [3].

> including under its visa requirements to maintain their legitimate human rights.[61]

7.62 Mrs Maria Gillman, whose well qualified and blind sister was rejected on the basis of her 'health' condition, stated:

> I wish to make it clear that we did not consider for one moment that Una might not meet the health requirements, as she was a healthy person with no known medical condition. Naively, we did not think that her blindness could be an obstacle to her application, as Australia had enacted the Disability Discrimination Act in 1992.[62]

7.63 The Royal Australasian College of Physicians (RACP) remarked on the contradiction between Australia's international commitments and domestic policy in the following terms:

> The exemption of the Migration Act from the DDA promotes the two-tiered value system afforded to people with disability living in Australia on the one hand, and potential migrants with disability on the other.[63]

7.64 The RACP saw there was room for the Migration Exemption to be 'reformulated, to remove the potential for any direct or indirect discrimination against migrants with disability'.[64]

Views on possible reform of the migration exemption

7.65 The Committee sought views on the impact of removing the migration exemption from the *Disability Discrimination Act 1958* (Cth). The Committee was particularly interested in how this may increase application numbers, possible litigation and Australia's sovereign capacity to determine who enters Australia. Views were also sought on appropriate ways to manage Australia's health resources if changes were made.

7.66 Mr Brandon Ah Tong Pereira, Vision Australia, commented that:

> Let us be absolutely clear: to discriminate in immigration solely on the basis of disability contravenes the moral standards of fairness that underpin international human rights norms and, by admission, is at odds with international law. This assertion remains, regardless of the perceived justification under the

61 Federation of Ethnic Communities' Councils of Australia, *Submission 24*, pp. 8, 9.

62 Mrs Maria Gillman, *Committee Hansard*, Melbourne, 18 February 2010, p. 27.

63 Royal Australasian College of Physicians, *Submission 80*, p. 7.

64 Royal Australasian College of Physicians, *Submission 80*, pp. 7; 12.

> vanguard of 'public interest'—that is, the idea of needing to minimise public health and safety risks, contain public health expenditure and maintain access to health and community services for Australian residents[65]

7.67 Dr Rhonda Galbally of the National People with Disabilities and Carer Council responded to questions as to whether the removal of the exemption would distort demand for places in Australia. She noted that a more liberal approach in the past had not produced that result:

> We have gradually seen a change over time where the interpretations of the law have become different over the last two decades. We have never seen a flood to Australia. We have seen genuine families applying to come here or people in refugee situations where they happen to have a family member with a disability or who declare, and there will be families who do not declare them as things have become harsher and harsher… [66]

7.68 Mrs Catherine McAlpine of Down Syndrome Victoria suggested that the removal of the DDA would simplify migration processes:

> The Disability Discrimination Act just means that people cannot be discriminated against because of their disability, so all the other criteria apply. You asked the question: what if it was a family reunion? It is the same thing. We are not just talking about skilled migrants. We are saying that if it is a family reunion and you meet every other requirement, then there should be no discrimination on disability. If it is a refugee and you meet the refugee requirements, you should not be discriminated against. So to a certain extent it is just very simple: if the disability act applies, you cannot discriminate on those grounds.[67]

7.69 Professor Jan Gothard agreed, observing that the DDA makes clear the distinction between discriminating against people with a disability, irrespective of their skills or assets, and population policy.[68] She stated:

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65 Mr Brandon Ah Tong Pereira, Vision Australia, *Committee Hansard*, Melbourne, 18 February 2010, pp. 49–50.

66 Dr Rhonda Galbally, National People with Disabilities and Carer Council, *Committee Hansard*, Melbourne, 18 February 2010, p. 6.

67 Mrs Catherine McAlpine, Down Syndrome Victoria, *Committee Hansard*, Melbourne, 18 February 2010, pp. 60-61; see also Mr Frank Hall-Bentick, Australian Federation of Disability Organisations, *Committee Hansard*, Melbourne, 18 February 2010, p. 58.

68 Professor Jan Gothard, Down Syndrome WA (Western Australia), *Committee Hansard*, Melbourne, 18 February 2010, pp. 53–54.

> If a person is a professional person, if they are well qualified and if, as an individual, they have the skills Australia needs, then I do not see why their disability should be a bar.[69]

7.70 However, a key issue for the Committee is clarity in the application of legislation and its regulation. This provides transparency and certainty for applicants and also avoids potentially time consuming and costly litigation as a means of determining outcomes.

7.71 Professors Mary Crock and Ron McCallum AO, respectively experts in migration and law, did not see that a more generous approach would cause an appreciable increase in litigation. Professor Crock stated:

> There will be litigation. Whenever there is a rule change, people litigate to see what the boundaries of the rules are. It is inevitable. There is litigation at the moment that goes on in this area. It is not entirely settled. So I do not think that it is going to open the floodgates to litigation. It is, on the other hand, going to take a lot of pressure off the minister. That is what it is going to do and it is better to have litigation where you can actually see how the rules are operating and it is transparent than to have everything happening behind a closed door. [70]

7.72 Professor Ron McCallum concluded:

> I think the main group that would benefit are families that have a disabled member. We are not going to see a flood of disabled people from around the world applying as independent migrants without any job prospects or family members here.[71]

7.73 At hearings in Sydney, Mr Graeme Innes, Disability Discrimination and Race Discrimination Commissioner, commented further on the impact of removing the exemption:

> I think that if the exemption were completely removed it would mean that the government was, if you like, giving away its capacity to make decisions as to who is granted visas to come to Australia because, if the act were to apply without any restriction, such grants would need to be on a non-discriminatory basis unless

69 Professor Jan Gothard, Down Syndrome WA, *Committee Hansard*, Melbourne, 18 February 2010, p. 57.

70 Professor Mary Crock, *Committee Hansard*, Sydney, 12 November 2009, p. 21.

71 Professor Ron McCallum AO, *Committee Hansard*, Sydney, 12 November 2009, p. 21.

> the government was able to demonstrate unjustifiable hardship in making such a decision.[72]

Committee Comment

7.74 In this report the Committee has set out a template for reform of the current migration arrangements which will provide a more appropriate and just approach for the migration assessment for people with a disability across the visa streams. The Committee believes this model for reform will also better reflect our international obligations and domestic policy on disability.

7.75 However, a body of submitters argued that a more fundamental review was required and that Australia's overarching anti-discrimination framework, the DDA, should apply to migration law.

7.76 The Committee notes that removal of the exemption would not deactivate provisions in the DDA which allow for discretion to protect against infectious disease:

> This Part does not render it unlawful for a person to discriminate against another person on the ground of the other person's disability if:
>
> - the person's disability is an infectious disease; and
> - the discrimination is reasonably necessary to protect public health.[73]

7.77 As discussed earlier, Dr Saul's legal advice confirms that international law also allows for provisions that prohibit migration to contain health risks. This would suggest that even if the migration exemption was removed, Australia retains the right to continue to exercise discretion in considering health conditions that might pose a threat to the community. Regardless of the DDA exemption, Australia's obligations under the Disability Convention are subject to application of the interpretive declaration.

7.78 The Committee considers that improved domestic administration of migration assessment procedure is a more appropriate and just means to proceed. The Committee considers that the removal of the migration exemption from the DDA may result in increased litigation.

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72 Mr Graeme Innes, Australian Human Rights Commission, *Committee Hansard*, Sydney, 12 November 2009, p. 7.

73 *Disability Discrimination Act 1992* (Cth) s 48.

7.79 Therefore the Committee concludes that the recommendations presented here will enable a more compassionate assessment of mitigating factors and a more progressive accounting of both possible costs and contributions of an individual visa applicant and their families, particularly in relation to a person with a disability.

7.80 The Committee also welcomes the Government's progression of the National Disability Strategy and the recent announcement that it will amalgamate all anti-discrimination law into one piece of legislation, with a view to promoting social inclusion.[74] Given this, the Committee considers that a review of the DDA and its impact on people with a disability is timely.

7.81 The Committee also recommends that, as part of a recommended review of the DDA, the Australian Government review the legal implications of removing the exemption of the *Migration Act 1958* (Cth). This review should take into account the Committee's recommended changes to the migration treatment of people with a disability, and consult with relevant government and non government bodies over any proposed amendments to the DDA exemption.

Recommendation 18

The Committee recommends that as part of its proposal to amalgamate Australian discrimination law, the Australian Government review the *Disability Discrimination Act 1992* (Cth) with particular reference to the section 52 migration exemption, to determine its legal implications for migration administration and conduct expert consultations on its impact on people with a disability.

Michael Danby MP

Chair

June 2010

74 On 21 April 2010 the Attorney-General the Hon. Robert McClelland MP and the Minister for Finance and Deregulation the Hon. Lindsay Tanner MP announced that the current Commonwealth *Racial Discrimination Act 1975*, *Disability Discrimination Act 1992*, *Age Discrimination Act 2004* and *Sex Discrimination Act 1984* would be consolidated into one Act. See: 'Reform of Anti-Discrimination Legislation', *Joint Media Release,* Attorney-General's Department, accessed May 2010 at<http://www.ag.gov.au/www/ministers/mcclelland.nsf/Page/MediaReleases_2010_ SecondQuarter_21April2010-ReformofAnti Discrimination Legislation>.

Appendix A: List of submissions to the inquiry

1	National Ethnic Disability Alliance
1.1	National Ethnic Disability Alliance SUPPLEMENTARY
2	Professor Patricia Harris
3	Mrs Cynthia Muir
4	Name Withheld
5	Queensland Nurses' Union
6	Australian Federation of Disability Organisations
7	Dr Susan Harris Rimmer and Dr Kristin Natalier
8	Disability Services Commission
9	Tasmanian Government
10	Haemophilia Foundation Australia
11	Australian Lawyers for Human Rights
12	Name Withheld
13	Confidential
14	Mr Dermot Hogan
15	Physical Disability Australia
16	Deafness Forum of Australia
17	Queensland Parents for People with a Disability Inc.

18	Mr J.P Tempest
19	Ms Gillian Palmer
20	Multicultural Development Association
21	Deaf Australia Inc.
22	Mrs Kerry-Anne Inglis
23	Action on Disability within Ethnic Communities (ADEC)
24	Federation of Ethnic Communities' Councils of Australia
25	Ms Mary Ann Gourlay
26	Vicdeaf
27	Name Withheld
28	Cabramatta Community Centre
29	Name Withheld
30	Immigration Advice and Rights Centre Inc.
31	Professor Mary Crock and Professor Ronald Clive McCallum AO
32	New South Wales Young Lawyers Human Rights Committee
33	Australian Catholic Bishops Conference
34	The Migration Institute of Australia
35	Down Syndrome Victoria
36	Castan Centre for Human Rights Law and Rethinking Mental Health Laws Federation Fellowship
37	Vision Australia
38	Dr Brian Donovan
39	Australian Tertiary Education Network on Disability
40	AMPARO Advocacy Inc
41	Down Syndrome New South Wales
42	Ethnic Disability Advocacy Centre
43	Cerebral Palsy League
44	Blind Citizens Australia
45	National Council on Intellectual Disability

46	Human Rights Council of Australia Inc.
47	Australian Federation of Disability Organisations and others
48	Uniting Justice in Australia
49	Confidential
50	Ms Nicolette Szymanska
51	The Ethnic Communities Council of Queensland Ltd
52	Left Right Think-Tank
53	Multicultural Mental Health Australia
54	Human Rights Law Resource Centre Ltd
55	New South Wales Disability Discrimination Legal Centre Inc
56	Freehillls
57	Down Syndrome WA
58	Australian Human Rights Commission
59	Australian National University College of Law
60	Ms Lauren Swift
61	Ms Lydia Campbell
62	Ms Kione Johnson
63	Ms Chantelle Perpic
64	Name Withheld
65	Mr Raheel Ahmed
66	Department of Immigration and Citizenship
66.1	Department of Immigration and Citizenship SUPPLEMENTARY
66.2	Department of Immigration and Citizenship SUPPLEMENTARY
67	National Association of People Living with HIV/Aids
68	Australian Federation of AIDS Organisations Inc
69	HIV/AIDS Legal Centre Inc
70	Positive Life New South Wales

71	Department of Families, Housing, Community Services and Indigenous Affairs
71.1	Department of Families, Housing, Community Services and Indigenous Affairs SUPPLEMENTARY
72	Carers New South Wales
73	Mr Richard Anderson
74	Ms Sharon Ford
75	The Royal Society for the Blind (South Australia)
76	Australian Capital Territory Human Rights Commission
77	North Queensland Multicultural Health Network Disability
78	Confidential
79	Disability Discrimination Legal Service Inc
80	Royal Australasian College of Physicians
81	Name Withheld
82	United Nations High Commissioner for Refugees
83	Disability Studies and Research Centre, University of New South Wales
84	National Welfare Rights Network
85	Queensland Centre for Intellectual and Developmental Disability, University of Queensland
86	High Commission of Canada
87	Public Interest Advocacy Centre Ltd and Service for the Treatment and Rehabilitation of Torture and Trauma Survivors
88	Law Institute of Victoria
88.1	Law Institute of Victoria SUPPLEMENTARY
89	Multicultural Disability Advocacy Association of New South Wales
90	Queensland Advocacy Incorporated
91	Child Safety Commissioner of Victoria
92	Department of Health and Ageing

93	Ms Una Thysse
94	Mr Robert Duncan McRae
95	Disability Advisory Committee, City of Yarra
96	New South Wales Government
97	Department of Education, Employment and Work Place Relations
98	Clothier Anderson and Associates
99	Dr D McKenzie
100	Confidential
101	Council of Australian Postgraduate Associations
102	Wavelength International Pty Ltd
103	Dr Fiona Downes
104	Deafness Foundation Victoria
105	Refugee Council of Australia
106	Ms Jasmin Reinartz
107	Professor Susan Hayes
108	Name Withheld
109	Mr Mark Dreyfus MP
110	Mr Don Randall JP MP
111	New Zealand Department of Labour
112	Mr Bill Shorten MP, Parliamentary Secretary for Disabilities and Children's Services
113	National Ethnic Disability Alliance, Australian Federation of Disability Organisations, People with Disability Australia, Disability Resources Centre, Federation of Ethnic Communities' Councils of Australia

Appendix B: List of public hearings

Thursday, 12 November 2009 - Sydney

Individuals

Professor Mary Crock

Ms Kione Johnson

Ms Adama Kamara

Professor Ronald Clive McCallum AO

Australian Federation of AIDS Organisations Inc

Ms Linda Athalia Forbes, Policy Analyst

Australian Human Rights Commission

Mr Graeme Innes, Human Rights Commissioner and Disability Discrimination Commissioner

Mr David Mason, Manager, Strategic Policy Team

Cabramatta Community Centre

Ms Ricci Ulrike Tobetha Bartels, Executive Officer

Mrs Yamamah Khodr-Agha, Manager Complex Cases, Fairfield Migrant Resource Centre

Down Syndrome NSW

Mrs Jill O'Connor

HIV/AIDS Legal Centre Inc

Mr Iain Stewart Brady, Solicitor

Lachlan Riches, President, HALC Management Committee

Migration Institute of Australia

Ms Maureen Horder, Chief Executive Officer

Ms Rachel Magill, Professional Support

Multicultural Disability Advocacy Association of NSW

Ms Susan Laguna

National Ethnic Disability Alliance

Mr Dinesh Wadiwel, Executive Officer

The Migration Institute of Australia

Mr Brian Kelleher, Professional Development Manager

Wednesday, 18 November 2009 - Canberra

Australian Rights for Human Lawyers

Dr Susan Harris Rimmer, President

Wednesday, 25 November 2009 - Canberra

Department of Families, Housing, Community Services and Indigenous Affairs

Ms Helen Bedford, Branch Manager

Ms Frances Davies, Group Manager

Mr Philip Moufarrige

Thursday, 28 January 2010 - Brisbane

Individuals

Mrs Cynthia Muir

Mr James Muir

Amparo Advocacy Inc

Ms Maureen Teresa Fordcye, Coordinator

Cerebral Palsy League

Dr Gabrielle Rose, Senior Policy Advisor

Mrs Josie Russell, Board Executive Officer

Deaf Australia Inc.

Ms Karen Margaret Lloyd, Executive Officer

Ethnic Communities Council of Queensland

Mr Andrew Bartlett, Advocacy and Policy Advisor

Ms Lalita Lakshmi, Advocacy Program Coordinator

Multicultural Development Association

Ms Kerrin Benson, Chief Executive Officer

Ms Karen Lee, Executive Manager, Government and Community Advocacy Team

Mr Aiah Thomas, Coordinator, Christmas Island

QLD Nurses Union

Ms Beth Mohle, Assistant Secretary

Queensland Advocacy Incorporated

Mr Kevin Cocks, Executive Director

Mr Robert Duncan McRae, President

Queensland Centre for Intellectual and Developmental Disability, University of Queensland

Ms Miriam Taylor

Queensland Nurses' Union

Dr Liz Todhunter, Research and Policy Officer

Queensland Parents for People with a Disability Inc.

Mr Phil Tomkinson, Member

Refugee and Immigration Legal Service

Ms Marg Le Sueur, Principal Solicitor

Thursday, 18 February 2010 - Melbourne

Individuals

Dr Brian Donovan

Ms Sharon Ford

Ms Maria Gillman

Mr Ashley Greeves

Action on Disability within Ethnic Communities (ADEC)

Ms Licia Kokocinski, Executive Director

Australian Federation of Disability Organisations

Ms Lesley Hall, Chief Executive Officer

Mr Frank Hall-Bentick, Board Executive Member

Blind Citizens Australia

Ms Robyn Gaile, Executive Officer

Clothier Anderson and Associates

Ms Stephanie Jane Booker, Lawyer

Department of Families, Housing, Community Services and Indigenous Affairs

Dr Rhonda Galbally, Chairperson, National People with Disabilities Carer Council

Down Syndrome Victoria

Ms Kirsten Deane, President

Ms Catherine McAlpine, Executive Officer

Down Syndrome WA

Dr Janice Gothard, Migration Spokesperson

Haemophilia Foundation Australia

Ms Sharon Caris, Executive Director

Law Institute of Victoria

Ms Joanne Knight, Chairperson, Administrative Law and Human Rights Section

Mr Peter Papadopoulos, Member, Migration Law Committee

Transcultural Mental Health Access Programme

Mrs Shehani De Silva, Coordinator

Vicdeaf

Mr Graeme Kelly, Chief Executive Officer

Vision Australia

Mr Brandon Ah Tong-Pereira, Policy Officer

Ms Renee Williamson, National Advocacy Manager

Wednesday, 24 February 2010 - Canberra

Department of Immigration and Citizenship

Dr Paul Douglas, Chief Medical Officer

Mr Matt Kennedy, Assistant Secretary, Family and Health Policy

Mr Peter Vardos, First Assistant Secretary, Migration and Visa Policy

Wednesday, 10 March 2010 - Canberra

Refugee Council of Australia

Mr Paul Power, Chief Executive Officer

Wednesday, 17 March 2010 - Canberra

Department of Immigration and Citizenship

Dr Paul Douglas, Chief Medical Officer

Mr Nicolas Torkington, Acting Assistant Secretary, Family and Health Policy

Appendix C: Migration Regulations 1994 —*Schedule 4,* Part1

Public Interest Criteria 4005 (standard)

The applicant:

(a) is free from tuberculosis; and

(b) is free from a disease or condition that is, or may result in the applicant being, a threat to public health in Australia or a danger to the Australian community; and

(c) is not a person who has a disease or condition to which the following subparagraphs apply:

(i) the disease or condition is such that a person who has it would be likely to:

(A) require health care or community services; or

(B) meet the medical criteria for the provision of a community service; during the period of the applicant's proposed stay in Australia;

(ii) provision of the health care or community services relating to the disease or condition would be likely to:

(A) result in a significant cost to the Australian community in the areas of health care and community services; or

(B) prejudice the access of an Australian citizen or permanent resident to health care or community services;

regardless of whether the health care or community services will actually be used in connection with the applicant; and

(d) if the applicant is a person from whom a Medical Officer of the Commonwealth has requested a signed undertaking to present himself or herself to a health authority in the State or Territory of intended residence in Australia for a follow-up medical assessment, the applicant has provided such an undertaking.

Public Interest Criteria 4006A (employer sponsored waiver)

(1) The applicant:

(a) is free from tuberculosis; and

(b) is free from a disease or condition that is, or may result in the applicant being, a threat to public health in Australia or a danger to the Australian community; and

(c) is not a person who has a disease or condition to which the following subparagraphs apply:

(iii) the disease or condition is such that a person who has it would be likely to:

(A) require health care or community services; or

(B) meet the medical criteria for the provision of a community service; during the period of the applicant's proposed stay in Australia;

(iv) provision of the health care or community services relating to the disease or condition would be likely to:

(C) result in a significant cost to the Australian community in the areas of health care and community services; or

(D) prejudice the access of an Australian citizen or permanent resident to health care or community services;

regardless of whether the health care or community services will actually be used in connection with the applicant; and

(d) if the applicant is a person from whom a Medical Officer of the Commonwealth has requested a signed undertaking to present himself or herself to a health authority in the State or Territory of intended residence in Australia for a follow-up medical assessment, the applicant has provided such an undertaking.

(2) The Minister may waive the requirements of paragraph(1) (c) if the relevant nominator has given the Minister a written undertaking that the relevant

nominator will meet all costs related to the disease or condition that causes the applicant to fail to meet the requirements of that paragraph.

(3) In subclause (2), ***relevant nominator*** means an approved sponsor who:

(a) has lodged a nomination in relation to a primary applicant; or

(b) has included an applicant who is a member of the family unit of a primary applicant in a nomination for the primary applicant; or

(c) has agreed in writing for an applicant who is a member of the family unit of a primary applicant to be a secondary sponsored person in relation to the approved sponsor.

Public Interest Criteria 4007 (waiver on consideration of offsets)

(1) The applicant:

(e) is free from tuberculosis; and

(f) is free from a disease or condition that is, or may result in the applicant being, a threat to public health in Australia or a danger to the Australian community; and

(g) is not a person who has a disease or condition to which the following subparagraphs apply:

(v) the disease or condition is such that a person who has it would be likely to:

(A) require health care or community services; or

(B) meet the medical criteria for the provision of a community service; during the period of the applicant's proposed stay in Australia;

(vi) provision of the health care or community services relating to the disease or condition would be likely to:

(A) result in a significant cost to the Australian community in the areas of health care and community services; or

(B) prejudice the access of an Australian citizen or permanent resident to health care or community services;

regardless of whether the health care or community services will actually be used in connection with the applicant; and

(h) if the applicant is a person from whom a Medical Officer of the Commonwealth has requested a signed undertaking to present himself or herself to a health authority in the State or Territory of intended residence in Australia for a follow-up medical assessment, the applicant has provided such an undertaking.

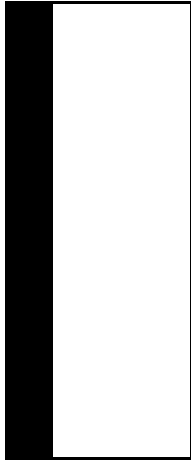
(2) The Minister may waive the requirements of paragraph if:

(a) the applicant satisfies all other criteria for the grant of the visa applied for; and

(b) the Minister is satisfied that the granting of the visa would be unlikely to result in:

(ii) undue cost to the Australian community; or

(ii) undue prejudice to the access to health care or community services of an Australian citizen or permanent resident.



Additional comments by Senator Sue Boyce and Senator Sarah Hanson-Young

Dismantling the Deficit Model

Introduction

1.1 We would like to thank the many people who demonstrated their deep concerns for potential migrants and refugees with a disability, and their families, by making submissions to this Inquiry and appearing as witnesses. As the transcripts and case studies demonstrate many of the stories are harrowing and reveal deep hurt and injustice.

1.2 We would like to thank our fellow Committee members and the Committee secretariat for their unfailing sensitivity in dealing with this complex and troubling issue. We acknowledge that the recommendations made in *Enabling Australia: An Inquiry into the Migration Treatment of Disability* would, if accepted by the Government, lead to real and positive changes for people with a disability, and for families that include a person with a disability, wanting to make their homes in Australia.

1.3 However, we are of the view that the Inquiry provided sufficient evidence to warrant going further than Recommendation 18 to achieve a truly non-discriminatory, and economically and socially beneficial, approach to migration treatment of disability.

Further recommendations

Recommendation A: We recommend that the Government remove the exemption of the Migration Act 1958 from the Disability Discrimination Act 1992.

Recommendation B: In the event that Recommendation A is not accepted, we recommend that the Government acknowledge that rejecting temporary visa holders as permanent visa holders solely on the basis of the birth of a child with a disability is discriminatory and develop protocols to address this.

Migration Treatment of Disability—History

1.4 As outlined in *Enabling Australia*, especially in the discussion preceding Recommendation 4, pp 58, numerous witnesses criticised the confusion within current Australian migration law of disease and disability.

1.5 The laws underpinning Australia's migration treatment of disability and of mental health conditions continue to be based on the outmoded 'Medical Model' which views all disability as a deficit requiring cure, not the 'Social Model' which acknowledges that social attitudes and the physical environment contribute significantly to the ability of people with a disability or a mental health condition to contribute.

1.6 The United Nations Convention on the Rights of People with a Disability, to which Australia was an early signatory, is firmly based in the 'Social Model' approach to disability.

1.7 The president of the Australian Lawyers for Human Rights, Dr Susan Harris Rimmer, gave the following comparison of the earlier Medical Model of disability and the current Social Model:

> The medical model is often called the deficit model. It basically says that a person is defined as not having certain attributes of an able bodied person. So if someone is deaf it means that they do not have the hearing of someone who has 100 per cent hearing. Someone who is blind is opposed to someone who has 20/20 vision. So in some ways it is factual, objective criteria. If someone cannot see that means they are blind. The social model will say: yes, but most of their struggles in life will not come from the fact that they are vision impaired; they will come from the fact that people look at them, see that they are vision impaired and treat them as if they are stupid, for example, or cannot hold down a job or cannot be a father or a mother or—

> **Senator BOYCE**—Or not build buildings that are easy for them to access.
>
> **Dr Harris Rimmer** —Exactly. Or they will not be able to participate in the workforce because of a range of those impediments caused by people not thinking about blind people when they are designing the building. So, there is this blend of objective criteria that are based on the physical attribute of the person and also the social attitudes that are placed in their road. Some of the obstacles are objective but some are created by society. The social model says that Australia, as far as it can under the disability convention, should try to dismantle as many as it can of those obstacles that are constructed by society—that are not innate. Just because a person is blind, it does not mean that they cannot become a professor of law and head up a UN human rights committee if they are given the right opportunities. Our job is to try to dismantle as many of those socially constructed attitudes and obstacles to full participation as we can. That is what the social model would say. The opposite would be to simply say, 'You're blind; therefore you can't do certain things.' I do not think the medical model is very good. People would usually call it the deficit model: you are always judged by what you lack, which in this case is sight.
>
> **Senator BOYCE**—And the current health requirement of our legislation is based on that deficit model?
>
> **Dr Harris Rimmer**—Yes: 'You will only ever be a burden economically; we don't see you in any other term[1]

1.8 Australian Human Rights Commissioner and Disability Discrimination Commissioner, Mr Graeme Innes AM, described the application of the models to his own disability:

> ....The initial recommendation in my Public Service career—too many years ago for me to think about now—was that I should not be made a permanent public servant due to my disability. That recommendation was not followed—thankfully, I hope people would feel—and as a result I have managed to make a bit of a career in the Public Service since then.
>
> **Senator BOYCE**—Mr Innes, I would like your views on the fact that we seem to talk about disability as a disease or condition…

1 Dr Susan Harris Rimmer, Australian Lawyers for Human Rights, *Committee Hansard*, Canberra, 18 November 2010 p. 7.

> **Mr Innes**—I agree with you, and that is the reason that I spoke quite strongly about broadening the criteria so that medical criteria are just a part of the decision-making process. We could characterise disability in a non-medical or non-health way, which would achieve the sorts of objectives that I think you and I would share. The Convention on the Rights of Persons with Disabilities has gone a long way to try to move us away from that medical construct or medical model. I can only adopt the thrust of the convention in that regard, in that it looks at disability as being an impairment whereby the limitations to disability are caused by, in many cases, the barriers which society constructs. To take my disability as an example: I am limited in my enjoyment of movies at the cinema because they are not audio described. A person who is deaf is limited in their enjoyment of movies at the cinema because they are not captioned. So it is not the disability which is the cause of the problem but rather the way that society has constructed itself to only cater to a certain proportion of society—in the same way as, if this building had steps and not a ramp, it would not be catering to all society. So, yes, I think we could better characterise it, and that could be done as part of the drafting for the legitimate, reasonable and objective criteria test that we have talked about. [2]

Removing the Disability Discrimination ACT 1992 CTH Exemption

1.9 Given the damaging and erratic outcomes of attempting to use the existing health-based criteria to assess the economic benefit of an intending migrant with a disability to Australia, especially a child, the Committee sought to discover "on-balance" criteria that would include the social and emotional contributions that a migrant and/or migrant family might make in the future.

1.10 Both Mr Innes and Professor Ron McCallum AO, Professor of Labour Law and former Dean of Law in the Faculty of Law of the University of Sydney and current Chair of the United Nations Committee on the Rights of Persons with Disabilities, noted that if they were intending migrants, rather than Australian-born, it is highly probable they would have been refused because of their sight disabilities. (Note: Professor McCallum appeared in a personal capacity.)

2 Mr Graeme Innes AM, Australian Human Rights Commissioner and Disability Discrimination Commissioner, *Committee Hansard*, Sydney, 12 November 2009, p. 7.

1.11 The rejection in 2009 of Dr Siyat Hillow Abdi (see Case Study 6.4, *Enabling Australia*), who was the first blind person to be registered as a teacher in South Australia, suggests they are correct in that view.

1.12 We contend that these examples alone should be sufficient to cause the Government to rethink the current *Disability Discrimination ACT 1992 CTH* (DDA) exemption applying to migration law.

1.13 Whilst numerous witnesses stated it would be possible to identify, adapt or develop actuarial tables to assess the social and emotional benefit, as well as the economic benefit, to Australia of a migrant with a disability, no suitable table was identified by the Committee.

1.14 A number of witnesses warned of the shortcomings of existing tables.

> **Dr Rose**—I would just like to pick up on that assessment issue. You are opening up a Pandora's Box. There are a number of assessment instruments that operate within disability specific areas. There are also internationally renowned classifications. One I have already mentioned is the GMFCS, which is the Gross Motor Function Classification System. But if you have an applicant who is deaf then it will not be applicable. So it is a Pandora's Box, and you need to tread very carefully through that minefield in terms of assessment. One strategy could be that if the child is identified as, for example, having cerebral palsy then you could enlist the expertise and experience of the experts that provide services for cerebral palsy to do a further assessment to make sure that it is tailor-made for that particular disability. But then you get into specifics where sometimes the disability is not identified. Sometimes it is a poly-disability and there are elements of autism, Asperger's and something else. It is not specific or there is just a developmental delay. Doctors will not provide a diagnosis, usually, in the first 24 months of a child's life. They are given the diagnosis of developmental delay and not necessarily a label that gets attached to that at such an early age. So be careful with the assessment issue. [3]

1.15 The many witnesses who suggested that the *Disability Discrimination ACT 1992 CTH* (DDA) exemption currently applying to migration be removed, or significantly relaxed, did so on one or more of the five general grounds listed below:

1.16 The current exemption meant Australia was contravening its international obligations particularly in regard to the United Nations Convention on the

3 Dr Gabrielle Rose, Cerebral Palsy League, *Committee Hansard*, Brisbane 28 January 2010, p. 22.

Rights of Persons with a Disability (UNCRPD). The Migration Law Program, Australian National University College of Law stated:

> To the extent that government uses health criteria to 'pick and choose' those who would be allowed to enter Australia on the basis of the perceived severity of their disability and the perceived health costs flowing from it, such a course of action would be clearly discriminatory and in breach of the freedom of movement guaranteed in article 18 of the Convention.[4]

1.17 The current health-based criteria can put the lives of refugees at risk and/or can place inhumane burdens on families who might be forced to choose between saving most members' lives and leaving a family member with a disability behind.

1.18 The Multicultural Development Association explained:

> Most visa assessments are not undertaken at refugee camps but in the closest metropolitan city… What this means is that people are hiding in cities where they may be further discriminated against, or at risk of injury or death because of their ethnicity or disability. … This is especially dangerous for single women, children, the elderly or those with disability or health conditions that are vulnerable targets. [5]

1.19 Dr Susan Harris Rimmer, Australian Lawyers for Human Rights, said:

> If you are making someone choose between saving their life and staying with their child, often the family will make the decision that the mother will stay because the mother is not the target of the persecution but the father is, and the father will leave. Australia is one of the few countries that forces people to take that sword of Damocles sort of decision.[6]

1.20 The requirement that Medical Officer of the Commonwealth (MOC) assess costs based on migrants with a disability using all available health and community services in Australia ignores the emotional, and subsequently financial, costs associated with splitting families; ignores cultural attitudes to family obligations and caring; and ignores the financial resources of some families.

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4 Migration Law Program, Australian National University, College of Law, *Submission 59*, p. 5.

5 The Multicultural Development Association, *Submission 20*, p. 4.

6 Dr Susan Harris Rimmer, Australian Lawyers for Human Rights, *Committee Hansard*, Canberra 18 November 2009 p. 12.

1.21 Ms Benson from the Multicultural Development Association said:

> I think settlement would be less resource intensive if people were able to reunify with their families.[7]

1.22 The Public Interest Advocacy Centre and NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors stated:

> In many cases, the MOC cost assessment is based on the assumption that an applicant with a disease or condition would access all available health and community services. This assumption however ignores the fact that in many cases strong family and cultural ties mean that applicants with a disease or condition would be more likely to be cared for by a family member and less likely to be put into care. [8]

1.23 In the case of the 'one fails, all fail' rule, Australia is depriving itself of untold talent and significant economic contributions. See Case Study 6.3, Case Study 5, and Case Study 6, *Enabling Australia*, as examples.

1.24 It is impossible to assess, or currently even place a value on, some of the contributions that a person with a disability, given a supportive environment, might make to Australia. *Enabling Australia* contains numerous case studies of adults with a disability whose abilities were underestimated or improved and have subsequently made significant contributions. See Case Study 6.4

1.25 This view was shared by the specialist medical organisation, the Royal Australasian College of Physicians, which stated:

> The Royal Australasian College of Physicians (RACP) believes that people with disabilities 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.[9]

1.26 This is even more so in the case of children with a disability. Whilst we do not believe the system should laud 'super migrants' over 'ordinary migrants', there are numerous examples in *Enabling Australia* of children who have grown up to make outstanding economic and/or social contributions to their communities. See the accounts of Ms Sharon Ford's

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7 Ms Kerrin Benson, Multicultural Development Association, *Committee Hansard*, Brisbane, 28 January 2010, p. 36.

8 The Public Interest Advocacy Centre and NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors, *Submission 87*, p. 10.

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

daughter with Down syndrome (see Case Study 6.3) and of Mr Abebe Fekadu, who is a paraplegic, in *Enabling Australia*, p 49.

1.27 Ms Maureen Fordyce, from AMAPRO Advocacy Inc stated:

> It is ludicrous that the current system tries to predict. With one individual, a young child, they predicted he would never be able to walk or talk or do many of the things that he is currently doing, like running and speaking. The idea that you can look at a young child and try to predict how they will develop based on the medical model is completely flawed and needs to change.[10]

1.28 Opposition to, or concern about, completely removing the exemption of migration law from the provisions of the DDA was most often based around the Public Interest Criteria (PICs), which address the possibility of 'undue cost to the Australian community' and 'undue prejudice to the access to health care or community services of an Australian citizen or permanent resident'. See Migration Regulations 1994 summary, *Enabling Australia*, pp. 11-12.

1.29 However a number of witnesses queried the motivation of this opposition. Ms Karen Lloyd, the executive officer of Deaf Australia Inc. commented:

> I would like to ask the question about the whole thing—about the Migration Act and the assessment of those people with disabilities and with ill health: what are we trying to protect Australia from? Are we trying to protect Australia from illnesses that are contagious, like they do at Customs, where you cannot bring in fruit or wood that carries disease? Are we trying to do that with people or are we trying to protect Australia from the fact that if we do not understand it, we do not like it? I think that is a question that needs to be addressed.[11]

1.30 It seems to us that concerns about cost, about depriving Australians of access to services and about excessive litigation are versions of the view that removing the exemption would open the floodgates to migrants with a disability.

1.31 One witness, Dr Gabrielle Rose, of the Cerebral Palsy League, described this view as: 'the flavour of this discussion: the unspoken thing'.[12]

1.32 In regards to the likelihood of increased litigation, Professor Mary Crock, an immigration law expert, commented:

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10 Ms Maureen Fordyce, AMPARO Advocacy Inc, *Committee Hansard*, Brisbane 28 January 2010, p. 22.

11 Ms Karen Lloyd, Deaf Australia Inc, *Committee Hansard*, Brisbane 28 January 2010, p. 22.

12 Dr Gabrielle Rose, Cerebral Palsy League, *Committee Hansard*, Brisbane 28 January 2010, p. 24.

> The idea that you can actually use regulations to get lawyers out of the migration business has always been a total mystery to me. That is what we do. You cannot regulate people out. I have for many years tried to say, 'Just stop with the legislation already if you want to get the lawyers out.' There will be litigation. Whenever there is a rule change, people litigate to see what the boundaries of the rules are. It is inevitable. There is litigation at the moment that goes on in this area. It is not entirely settled. So I do not think that it is going to open the floodgates to litigation. It is, on the other hand, going to take a lot of pressure off the minister. That is what it is going to do and it is better to have litigation where you can actually see how the rules are operating and it is transparent than to have everything happening behind a closed door. I have been saying for years that I think it is totally offensive that I have to have a relationship with Minister X or Minister Y in order to get a result for a client. That is just wrong. You should have a system that operates with transparency and if it means that a few people go to a tribunal or to a court then so be it. That is much better than going through the senators' entrance at Parliament House.[13]

1.33 In any case, her husband, Professor McCallum, who was instrumental in the development of the United Nations Convention on the Rights of Person with Disabilities, operational in Australia from 2008, stated:

> I have no doubt that if our migration rules remain as they are someone will bring a complaint under the optional protocol to the (UN) committee on which I sit. I can say this because I would, quite properly, be debarred from sitting on any complaint that came from Australia. I have seen instances, particularly, of families with disabled members who feel hurt and undone by the rigidity of these non-balancing rules. One of the reasons that we have a convention is to try to change some of these stereotypes. These rules are contrary to the social model in their stereotypical, non-balancing operation.[14]

1.34 The National People with Disabilities Carer Council strongly argued that the Migration Act should not be exempted from disability discrimination law.

1.35 Asked about the potential for this to worsen existing unmet need for Australians with disability, the Council's chairperson, Dr Rhonda Galbally, said:

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13 Professor Mary Crock, *Committee Hansard*, Sydney, 12 November 2009, p. 21.

14 Professor Ron McCallum AO *Committee Hansard*, Sydney, 12 November 2009, p. 22.

> I regard that as a furphy that has been raised in the immigration debates in general—that is, you should not have immigration to Australia because it might affect the working conditions of the current inhabitants. The issues to do with the unmet need of people with disability are being addressed. I think that the government has made a major stand already by commissioning the Productivity Commission analysis of the feasibility of other models for dealing with this in Australia so that we will have sustainable options. The new National Disability Strategy under development is also tackling these issues. The numbers of immigrant people with disabilities that we are speaking about would really be very irrelevant to the massive issue of unmet need that I agree with you does have to be addressed. [15]

1.36 Dr Galbally also stated to any irrational fear that removing migration discrimination against people with disabilities would not, open the floodgates.

> **Dr Galbally**— We have gradually seen a change over time where the interpretations of the law have changed over the last two decades. We have never seen a flood to Australia. We have seen genuine families applying to come here or people in refugee situations where they happen to have a family member with a disability who they declare, and there will be families who do not declare them as things have become harsher and harsher. So I think that it is like the mythology of the yellow hordes flooding down from China argument.

> **Dr Galbally**—It is fear mongering, is my view, like another form of racism. I think it is very dangerous, those sorts of arguments. The data, from my understanding of it, would indicate that there has never been a time in Australian history when families with people with disabilities have flooded into this country. We have had in the past a more liberal interpretation of the position compared with the position we have currently. I just cannot see it as a possibility.[16]

1.37 Other witnesses noted that Australia was just one player in the highly competitive international market for skilled labour and being seen as a disability-friendly nation would assist Australia in attracting individuals

15 Dr Rhonda Galbally, National People with Disabilities Carer Council, *Committee Hansard,* Melbourne, 18 February 2010 p .2.

16 Dr Rhonda Galbally, National People with Disabilities Carer Council, *Committee Hansard,* Melbourne, 18 February 2010 p .6.

and families with valuable skills. Mr Andrew Bartlett, from the Ethnic Communities Council of Queensland, said:

> … it is a simple fact that with regard to the developed world longer term, in certain areas of skills there will be a lot of competition globally. I do not think that is going to change. Like a lot of areas, it serves us well—whether it is on a purely economic competitive basis or on some of those looser general terms of being seen to be more engaging, welcoming and encouraging of diversity—to have more recognition of the wider contributions people make. It gives us extra advantages over countries that do not do that [17]

1.38 We also note the comments of the Committee Chair, Mr Michael Danby, to witnesses at the Committee's Brisbane hearing:

> I notice in your submission… there is a general discussion on the economic and social benefits to Australia of immigration. This is not strictly to do with disability, but I want you to know that we had before this committee some evidence from Access Economics. If you extrapolate that economic modelling to the current level of migration, broken up by category you will find that after the first year even the humanitarian program has a net positive benefit on the tax base. That is unchallenged. I recently had an article published in the Age to that effect, and it was massively attacked by Hansonites and Greens et cetera. But no-one disputed the modelling; no-one was able to cast doubt on it at all. So if you want to look at the net economic benefit of even the humanitarian program of current migration over the next 20 years you can find it on my website. [18]

1.39 In our view, if such a disadvantaged group as those who come to Australia under the humanitarian program make a positive economic contribution after only 12 months, it is just as likely that individuals with a disability, who themselves meet all other relevant criteria or whose family members do, would similarly make a quick and positive contribution.

1.40 Given the weight of testimony to this Inquiry suggesting low costs and high benefits to Australia, we urge the Government to accept our Recommendation A and remove the exemption of the Migration Act 1958 from the Disability Discrimination Act 1992.

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17 Mr Andrew Bartlett, Ethnic Communities Council of Queensland, *Committee Hansard*, Brisbane, 28 January 2010, p. 5.

18 Mr Michael Danby MP, Chair, Joint Standing Committee on Migration, *Committee Hansard*, Brisbane, 28 January 2010, p. 29.

‘A Special Case?’—Children with disability born in Australia to temporary visa holders

1.41 There are a small number of cases each year of couples in Australia holding temporary visas conceiving and giving birth to a child with a disability and subsequently being refused permanent visas, or being advised not to apply for permanent visas, on this ground alone. See example in AMPARO Advocacy Inc, Submission 40, p. 4.

1.42 Mr Graeme Innes said these cases had not been brought to the attention of the Human Rights Commission and the Commission did not have an opinion on them, but conceded that he could certainly ‘see the argument’ [19] for this to be treated as overt discrimination.

1.43 In the same context, Professor Mary Crock told the Committee:

> 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.[20]

1.44 Given the strength of the grapevine within the disability sector, Mr Andrew Bartlett’s comments regarding signals sent to all individuals and families in Australia are particularly apposite.

> (The) wider issue of the signals that are sent when a family is knocked back because they have a child with a particular disability or a health condition is one that should not be ignored. The cost might be able to be quantified in dollars and cents in the way we can regarding health treatment but if we have families knocked back, as we have seen in some of the more high profile cases such as … Dr Moeller with a child with Down syndrome, and the example from the previous government … that got a lot of profile regarding a child who had autism. It is not just trauma for that family, it is not just an impediment to their ability to settle more steadily, it is not just an extra unnecessary burden with excessive activity in the migration process or the administration of it, it also sends a signal to every single family around Australia who may

19 Mr Graeme Innes, Human Rights Commission, *Committee Hansard*, Sydney, 12 November 2009 p. 9.

20 Professor Mary Crock, *Committee Hansard*, Sydney, 12 November 2009, p. 20

> have a member with autism or Down syndrome that somehow or other they are a drain on society. We really need to emphasise, whether it is through our multicultural framework or our disability policy framework, that everybody has the capacity to contribute positively to the community and we should be looking at every opportunity to strengthen that signal.[21]

1.45 We would urge the Government to accept our **Recommendation A**. But, in the event, that the Government rejects this suggestion, we believe that **Recommendation B** should be favourably considered along with the 18 recommendations in *Enabling Australia*.

Senator Sue Boyce
June 2010

Senator Sarah Hanson-Young
June 2010

21 Mr Andrew Bartlett, Ethnic Communities Council of Queensland, *Committee Hansard*, Brisbane, 28 January 2010, p. 3