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Official Committee Hansard

JOINT STANDING COMMITTEE ON MIGRATION

Reference: Migration treatment of disability

WEDNESDAY, 18 NOVEMBER 2009

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JOINT STANDING
COMMITTEE ON MIGRATION
Wednesday, 18 November 2009

Members: Mr Danby (*Chair*), Mrs Vale (*Deputy Chair*), Senators Bilyk, Boyce, Hanson-Young and McEwen and Mrs D'Ath, Mr Georgiou, Dr Stone and Mr Zappia

Members in attendance: Senator Boyce and Mr Danby, Mrs D'Ath, Dr Stone, Mrs Vale and Mr Zappia

Terms of reference for the inquiry:

To inquire into and report on:

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.

WITNESSES

HARRIS RIMMER, Dr Susan Gail, President, Australian Lawyers for Human Rights 1

Committee met at 12.14 pm**HARRIS RIMMER, Dr Susan Gail, President, Australian Lawyers for Human Rights**

CHAIR (Mr Danby)—I declare open the public inquiry into our migration treatment of disability in Australia. Following our successful hearing in Sydney last week, we welcome the Australian Lawyers for Human Rights. The committee does not require witnesses to give evidence under oath, but I remind you that the hearing is a legal proceeding of the parliament. I welcome you to the inquiry. Would you like to make some introductory remarks?

Dr Harris Rimmer—I would, thank you, but I will keep them very brief. It is my very great pleasure to give evidence today to the committee. I believe that this hearing is going to be an historic one for the purposes of Australian citizenship history and also of migration law. These are issues that have been bubbling away in the background, often on the margins of public discourse, for many years—particularly the issue of disability and the issue of the health requirement as it relates to the refugee and humanitarian visa category. So I am very pleased that the government has called the committee at this time to consider this issue and I am very heartened by the range and number of submissions that the committee has received and the depth of knowledge that the committee has received.

From a selfish point of view, as a researcher it is wonderful because finally things are on the public record that were very difficult to find—data and the way that the legislation works in practice and all those issues, which previously one has had to rely on things like Australian National Audit Office reports in order to get. We have also had some incredibly useful remarks from the Department of Immigration and Citizenship. They are what I am going to focus on in my opening remarks.

However, I will say generally that I am also very interested in the unanimity of the submissions on the major points. So many of the submissions have brought to the committee's attention issues like: the 'one fails, all fails' issue; the fact that the waiver does not apply to all visa categories, which is problematic; the fact that the medical officer of the Commonwealth's determination is so determinative and so difficult to have reviewed and how it limits the discretion of all the other actors within the department—even the minister—when they are making their determinations; the fact that a cost-benefit analysis in this instance is really only about cost, once we look at the way that the test is administered; and the fact that the health requirement is built around infectious disease and does not translate well to issues of disability. That last is a point that is coming through quite clearly: that infectious disease control is a completely separate issue in terms of the way that you should regulate it than the issue of disability.

The other point on which many people are unanimous is that our notions about disability as an issue have changed so much in the last 20 years—for the better, I believe—in terms of considering people with a disability as rights holders, as full citizens and as being able to participate in society and that we should encourage them to participate in society. This is where I think that on one hand our social policy and our development policy have gone in leaps and bounds and yet our migration framework does not necessarily reflect those changes in social attitudes. That is often the way. The migration program is often the last to take on board more progressive social ideas, because it applies to aliens, not us. With that, I would like to turn to the

department's submission, because I have now had the benefit of looking at it and I have a few things to say about it.

CHAIR—This is about the department of immigration's submission?

Dr Harris Rimmer—That is right—submission No. 66. There were three points that I pulled out of it that I would like to start with before we move on to questions. The first was that the department has put a lot of work into the comparative systems of other countries, which is incredibly useful for these purposes and is one of the terms of reference of the inquiry. They lay out the US, Canada, New Zealand and the UK as comparative migrant taking countries. I want to place a little bit of a caveat on that for the committee's reference. The department is absolutely right in saying that all migrant receiving countries have a health framework in which they consider infectious disease control, and it is generally all built around tuberculosis.

But other countries do not treat disability in the same way as our migration system. I am not sure that that comes through strongly enough in the department's submission. The US and the UK do not treat disability in the same way that we do. New Zealand does. New Zealand is more transparent, actually. Their legislation says, 'If you are under 21 and you have these types of disability—if you are blind, if you are deaf, if you are wheelchair ridden—you are going to be over our threshold.' They are even more explicit than our regime. But the US, the UK and Canada do not have the same attitude to disability as we do. I wanted to make that clear.

If you look at non migrant receiving countries—traditionally defined, so I am talking now about European countries, which have quite different concepts of migration than we do; they are not looking at migrants as a source of economic benefit or labour, generally speaking—they have made deep changes to the way that they consider their refugee and humanitarian programs. So Norway, for example, when it is considering its refugee and humanitarian intake, stresses that 10 per cent of that intake should be of people with disabilities, because that is the representation of people with disabilities in the Norwegian demographic. They have quite a different way of perceiving these issues. The Japanese have quite a different attitude to age, for example, than we do. They are much happier to take aged parents than we are.

Countries have different ways of conceiving migration, so I think we have to keep interrogating the idea—the concept—that we are completely normal and the same as other countries, because we are not. We deal with disability in a particular way that is unique to Australia. Having said that, I say that New Zealand may be a little bit worse.

The second point is that the department, in the appendix on page 43, says that it is estimated that more than \$70 million in health and community services costs would have resulted if these visas had been granted. When they list that 1,586 visas have been cancelled or not given on the basis of the health requirement, they claim that that has netted a benefit to the Australian economy of \$70 million that would otherwise have been spent. We have to be very cautious of statements like that. For a start, the ANAO report has told us that medical costs are hard to quantify.

Second, 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.

I will get to the point that they received advice that the convention is based on legitimate, objective and reasonable criteria later on. I understand that that was quite an issue in the Sydney hearings. But on page 27, in the conclusion the department says that—

CHAIR—Sorry, what page is that?

Dr Harris Rimmer—Page 27. The department says that they think that it might be time to ‘fine tune’ the health requirements. So they make that allowance. But they say that this fine tuning will have to be carefully done to ensure that it does not introduce other inequities, including a reduction in services to Australians and others with an entitlement to access Australia’s health and community services. In many press releases around the health requirements, previous immigration ministers, particularly Minister Ruddock, made the statement that basically a strict application of the health requirement results in more services and money for Australians with a disability. I do not think that that causation can be proved. In my view, valuing people with a disability will have impacts domestically as well as internationally, but we do not have any data one way or another. So I think that that is a statement for which there is no evidence at this point. You could say that if we value people with a disability in the migration process that we might get better and more useful services for Australians with a disability, because we would be sending the message that people with disabilities are an integral part of our society. So that does not necessarily follow. You could bring the level of services for both Australians with a disability and migrants with a disability up, and not at the expense of each other. That is a false dichotomy, in my view. Having hit you with all of that, I shall pause for questions.

CHAIR—Thank you for your presentation and your submission.

Mrs VALE—When we talk about measuring a person’s value or contribution or social value, how do you suggest that we should actually look at that. Often I think that any economic measure of the person’s contribution is obviously the easiest that a bureaucrat can articulate. How would you suggest that we could value a person’s social contribution or their human value to their new society? Could you give us some guidelines?

Dr Harris Rimmer—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. Often their cost to the medical system can be quantified even though the ANAO has shown us that that actually has a few holes in it. 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.

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 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.

Mrs VALE—And translating it into the visa criteria.

Dr Harris Rimmer—Yes. There are ways you could do it. For example, a lot of social policy now quantifies the impact or the contribution of carers. You will know that in other committees—other House of Representatives committees—they have done lots of work on carers' responsibilities and how much they actually contribute to the Australian economy in terms of qualitative as well as quantitative outcomes. So, caring for aged people, for people for disabilities and for small children can be costed.

One of the things our health requirement does not do is cost the value of a carer, for example. They are seen as a burden as opposed to a potential benefit to the community. They do not cost the issue of people with a disability, with the right services, participating in the economy. But they also do not cost what happens if that person—the primary visa applicant in many cases; say, your Dr Moeller—does not get his visa. What is the cost to the Australian economy if Dr Moeller does not get his visa because of his son? We do not do any of that 'what if' kind of costing either.

Mrs VALE—We do not do any comparison.

Dr Harris Rimmer—We do not do any comparison of different types of outcomes. Now we are trying to quantify wellbeing, which is hard—but that can be done as well—the wellbeing of keeping a family together, for instance, or the wellbeing to a community of having that member of the family valued and able to be brought to Australia. That is another type of measurement. Our point in the submission is that some things are just good things to do because they are ethical and they are compliant with human rights. There is a cost to Australia to be seen as being noncompliant with its human rights obligations—a cost in foreign affairs terms, a cost in terms of our Security Council bid and a cost in terms of our international and regional reputation. We do not do any of that costing. So there are all kinds of ways to measure value as opposed to cost and I think that we could come up with some creative and interesting ways of doing that if we change the way we think about the issue.

Mrs VALE—We will have to change those paradigms very carefully, wouldn't we, because the things that you are suggesting are very indirect values—very indirect costs, if you like—but they can also be very subjective. So in your submission we would value any more clear and transparent guidelines which could be really clear indicators for public servants making those decisions.

Dr Harris Rimmer—Yes, although the indicators we have are still very value laden. So, for example, we are using a health matrix which is all about tuberculosis. If we used, say, diabetes or obesity instead of TB as the proxy for our health matrix, we would have a whole different set of issues around the health requirement. TB generally is seen as a proxy for the developing world because TB is still most prevalent in developing countries. 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.

Mrs VALE—The difference with tuberculosis being, though, that it is infectious; the other diseases that you articulated are—

Dr Harris Rimmer—But disability is not infectious.

Mrs VALE—No, it is not, but neither are, generally, diabetes or obesity—

Dr Harris Rimmer—No, but they all have costs. Infectious disease is not the only criteria.

Mrs VALE—So maybe we need to be very clear on the different circumstances.

Dr Harris Rimmer—Indeed, and most countries say—and I think it is completely legitimate—that the health requirement is necessary to deal with communicable diseases. I do not think anybody argues with that, but that is not everything that the health requirement does. Our health requirement also has the ‘significant cost’ test, and that is where we get into trouble. If we were really looking at significant costs to the health system objectively, we would be looking at those lifestyle related diseases, but we do not, because they are our diseases as well.

CHAIR—Even if we were not to change the matrix—and I note you are critical of the terms of reference of this inquiry because of their focus on economic cost-benefit—and we simply took into consideration what you said earlier about the economic cost of not allowing in, under the skilled migration program, a skilled person who is coming with a disabled person, at least we would be advanced from where we were.

Dr Harris Rimmer—Yes, that is right. We could do it incrementally. We could make the waiver applicable to all visa categories and think about those categories where economic benefit to Australia really is important, like the skilled visa category. There is an argument there. You could take into account the cost-benefit analysis of not allowing that skilled person to come in, for example. But that paradigm of economic benefit to Australia is not correct when thinking about the refugee and humanitarian visas. We are not bringing in those people because of their possible economic benefit to Australia; we are bringing them in because of our obligations under various human rights and refugee conventions, and we are doing it voluntarily. It is inappropriate to add the economic benefit model to those categories, and other countries do not do that. When it comes to infectious disease control, that is completely different. All refugees should be checked for infectious disease.

CHAIR—We have evidence from Access Economics that shows that people who come in under the humanitarian program do have an economic benefit to Australia—

Dr Harris Rimmer—Yes, they do; I agree.

CHAIR—So maybe we should apply the cost-benefit analysis to everyone, but not just that. That is my point. I take your point about that not being the only thing that should be in the judgement about people but, even if we were to just accept the economic costs, even with the humanitarian program, we would be in advance of where we are now.

Dr Harris Rimmer—I think we would, but I also think we need to be creative about cost. I just feel like so much of our society is defined in terms of economics. Everybody wants to talk about economic issues. But that is not what is important to all Australians all the time, and we know that. Australians do not just vote on economic issues. That is the No. 1 thing, but it is not all they care about, and the migration program should not be all about that. The Snowy River scheme may have been of enormous economic benefit to Australia, but it was not just about economics. The Snowy Mountains scheme has a symbolic nation-building aspect in our history. We have to think about some of the more qualitative issues, even though they are hard.

Mrs D'ATH—I just wanted to take you specifically to your comments on page 14, where it states:

... 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.

But you acknowledge that there is a lack of data. You say 'many' in that submission but what knowledge do you have that that in fact is occurring?

Dr Harris Rimmer—We only really have anecdotal evidence. I saw that there was some data in the IARC submission. I think there were a couple of case studies in there. Most of the immediate knowledge I have of the issue was gained by working in UNHCR so I cannot actually use any of that knowledge on the public record but it certainly happens. People have to choose whether the head of the household—the father usually—saves his life or does not save his life and stays in the country with his family. It is a horrible decision we are forcing people to make. It is not because they do not love their children as much—which was unfortunately the comment I got from a lot of people when I put this point into an editorial on *On Line Opinion*. I got comments saying, 'Well, they just don't love their children.' This is why I say that sometimes that model is inappropriate to put on the refugee category, because they are not choosing to leave their country of origin; they are forced for reasons of persecution to leave their country of origin.

So 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. But as to how many that happens to, I do not know. The only people who could tell you are in the department of immigration. And I am not sure they will. I am not sure that they keep those statistics.

Certainly, in my personal experience there would be around six or seven cases where I saw that happen. Obviously Mr Kayani is a classic example. You have heard a lot about his case, I would assume, in the hearings. Kayani is a specific case because he was here and then applied for his family to reunite with him. What we do not know is how many people leave their country and just leave their family behind. We know a little bit about that because we know a lot of the Afghan boat people tried to get their families to come after them but were prevented by temporary protection visas—and there were something like a couple of hundred of those boats. We do not know how many of those would not have been able to come because of the health requirement.

Senator BOYCE—I hope that you might be able to explain for us the difference between the medical model and the social model of disability. In evidence we have bumped up against this a number of times but I do not think we have ever had it spelt out.

Dr Harris Rimmer—It is a tricky one. I am not surprised that people have had trouble—

Senator BOYCE—People have told us that certain attitudes were characterised as being under the medical model and that the social model would be better. So what I am trying to do is—

Dr Harris Rimmer—Figure out exactly what that means?

Senator BOYCE—Well, I know what it means but I would like it on the record.

Dr Harris Rimmer—Sure. 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 terms.'

CHAIR—If the health requirement was waived so that visa applicants could make a personal financial undertaking to cover the costs, would that be an advance?

Dr Harris Rimmer—It would, but it would still favour people from countries where they could afford to pay. It would be a great step up—it would help your Dr Moellers—but it is not going to help your Mr Kayanis.

Senator BOYCE—Or Lowys.

Dr Harris Rimmer—Or Lowys. So it will be tricky. I think that would be very palatable to the Australian public, but I do not think it is actually going to eventually stop some of the hardship of the current system.

Dr STONE—You asked a question that interested me, Dr Harris Rimmer. In your submission, there is reference to the fact that, because children with disabilities are not perceived as having an economic value, they have no independent agency in the migration process, so their visa application will always be attached to their parents. Part of the argument about eliminating pure disability from the migration stream is the perception of a finite resource in terms of assisting a person needing all the resources of someone with a very substantial intellectual or physical disability. Therefore, is the ALHR interested in some sort of threshold agreement like we have for aged parents, for example, where we say that people may bring in their aged parent as long as they have a commitment to not have them on welfare or Medicare for so many years? Are you rejecting that on the basis that parents with a child with a terribly expensive condition requiring ongoing, perhaps 24/7, care would only be eligible if they were affluent enough to say, 'Not a problem; we will privately insure and provide all the care the child needs so it won't be a cost for your health service or health system'? A poorer family in that situation could not bring the child out.

Dr Harris Rimmer—That is in fact the way it works in the US and the UK, although they are not specific. They basically say that people with a disability, as long as they do not harm others, are fine but, because so much of their medical care is privatised, there are very stringent private health insurance requirements. The department has never liked that idea, because they find it very hard to enforce once people are here. They do not like the aged-parent undertaking either, generally, because they find it very hard to enforce the undertakings once people are here. I think it has merit for the skilled program but it is inappropriate for certain other categories. If we applied the waiver, for example, in some of the categories where it does not currently exist, it might be that sponsorship would work in the skilled migration categories. That would be one way of at least lessening public fear about the program. I am not sure that the health insurance thing would cover it, but there could at least be some sort of bond or undertaking or something

like that. But I know the department will say that that never works and, 'We don't like it at all.' I know that when I have raised—

CHAIR—How does it work in the UK and the US and why do they—

Dr Harris Rimmer—Because no one can get health care unless they are privately insured. There is no other option over there. We have an option here where if you turn up at a hospital and need care you have to be given it, even if you are not a citizen. That can lead to issues.

CHAIR—But in the UK they have the National Health Scheme.

Dr Harris Rimmer—They do. They do not really have a skilled migration visa category as we do. In fact, they have just introduced a points system based on our points system. It is very interesting. I think that they are going to start coming—

CHAIR—Reverse colonialism.

Dr Harris Rimmer—Yes, actually, I guess it is. I thought it quite fun at the time. European migration is very weird: they have never had this concept of migration for labour, the way we do. In New Zealand, immigration is in the Department of Labour.

Dr STONE—It is historic then.

Dr Harris Rimmer—It is historic, yes. We frame all of our migration policies under that rubric. Other systems, particularly in Europe, do not. They have not quite got the same attitude; it is usually more family reunion related. Generally they are relying on the fact that the UK citizen who is the standing surety will assist. But, again, that usually requires that you have an anchor person—that someone will have the bond. If we are saying 'one fails, all fail', you cannot even have that particular system in place because you cannot get the person with the job offer to come and then anchor for the rest. We do not even have that concept 'one fails, all fail' in our system.

Dr STONE—Given that if you are a sponsored refugee the health test is waived, can you give an idea of how many of our refugee intake are sponsored and how many are not?

Dr Harris Rimmer—The refugee intake, who are all UNHCR referred, is more than 6,000. The sponsored refugees are a large percentage of the humanitarian program. It changes per year but I think this year we had something like 12,000 or 14,000.

Dr STONE—Sponsored?

Dr Harris Rimmer—No, total. And of those I would think—

Dr STONE—I want the sponsored proportion, who therefore have the health assessment waived.

Dr Harris Rimmer—The waiver is not applied automatically to refugee and humanitarian visas. You can apply for a waiver in all those visa categories, but it is not automatic that you will

get it. At the back of the department's report there is a list of refugee and humanitarian visa applicants who failed the health requirement and for whom the waiver was not exercised. You would think that that would be the very category in which the waiver is always exercised. That is not the case. Even in the 'women at risk' category three failed, on the current data, and quite a lot of refugees from Africa fail because of HIV. They turn out to be one of the largest cases in the department of immigration's criteria. I was not surprised by that but it is a bit depressing. But that is an excellent question. I could ask the department to get that answer for us. People who are sponsored tend to have an easier time of the process and slightly better integration outcomes. I will take it on notice.

CHAIR—I would like to ask a couple of specific things that follow on from Dr Stone's questions. How do you think we should deal with families seeking to enter Australia if one member of the family does not meet the health requirement? And do you have specific changes to the health requirement that you would recommend in order to acknowledge the special position of children with disabilities?

Dr Harris Rimmer—Yes. In the case of families where one member has a disability, even if they are the primary applicant, I think that there is a different set of considerations for the department, which we currently do not have. These cases should be activating some sort of concept of the right to family reunion and the right to family life—some sort of presumption that we want to keep families together if can. That is not the way they are currently treated under our Migration Act. It might be taken into account at ministerial level but it might not, and we will never know. Generally speaking, there is an additional human rights obligation in cases that involve families.

Where the person with a disability is a child, there is an added human rights obligation under the Convention on the Rights of the Child. We should act and be making decisions in regards to the best interests of that child. Often, that will mean taking into account what the position of that child would be in their country of origin vis-a-vis here. It would be tempting to say that you are always going to be better off in Australia, but that might not always be the case. It would depend on where the person is from and so forth. But that is an added layer of obligation. It does not determine the outcome of those cases; it is just another set of considerations that the decision maker should be thinking about. Currently, the minister does do that in relation to section 417 cases under the Migration Act. Under that, the minister's brief is to look at issues like the best interests of a child and the right to a family life. That currently exists under our discretionary framework.

CHAIR—But the decision maker below the minister does not take that into consideration.

Dr Harris Rimmer—No.

CHAIR—Even if we were to take the lower threshold of the economic benefit of the other participants of the family or in the case of a child of principal applicants who have applied to come here? So there is no cost-benefit—

Dr Harris Rimmer—No. The submission by Ms Mary Ann Gourlay was very interesting when it came to the way carers—

CHAIR—Who is she?

Dr Harris Rimmer—She made submission No. 25. She is from the University of Technology Sydney by the looks of it. She wrote a very good submission. One of the things that she talks about is how the value of carers is completely dismissed in our current system. It is often mothers, women, who have no economic value under our particular system because they are not in the public economy and so we just dismiss them out of hand. I thought that that was a pretty good point.

CHAIR—You are not talking about paid carers; you are talking about family members who are carers of either older people or children.

Dr Harris Rimmer—Yes. And often they are the people who will allow the primary salaried person to do their job. Dr—

CHAIR—You cannot run a small business if you have to be at home looking after the kids.

Dr Harris Rimmer—That is right.

Mrs VALE—I have the same problem with how the system values mothers and housewives, whether a carer is in that capacity or not. What a wonderful contribution mother and housewives do in culturing a society. Yet there is no value placed on that. So it is a similar thing to what you are saying.

Dr Harris Rimmer—Absolutely. If we take a very prosaic point, 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.

Mrs VALE—They are a team.

Dr Harris Rimmer—If we do not take that into consideration, we really make those types of highly skilled and valuable migrants very angry, which in fact we have done. There is a public relations cost.

CHAIR—We had submissions in Sydney with high profile IT executives who just made the decision not to come, because their Down syndrome child—

Dr Harris Rimmer—Yes. I hear that all over the place. 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. That is not what my argument rests on, because I care about the Frank Lowys of the world but I also care about the Kayanis of the world. But it is something that the Australian government should

consider. We have never done economic modelling on who we are losing. But I certainly know that we lose a lot of academics.

Senator BOYCE—Following up on that—and it was not my question—are you aware of any economic modelling around the value of an intact family, so to speak?

Dr Harris Rimmer—There was considerable economic modelling done around the *Time for action* report, which was undertaken by the National Council on Domestic Violence very recently. The Australian government asked an expert council and either Treasury or the Productivity Commission to cost violence.

Senator BOYCE—So there might be some way that we could look at that.

Dr Harris Rimmer—There might be something. The Productivity Commission did quite a lot of work on the disability issue. All their economic modelling was saying, ‘We could really make more money out of these people if we tried harder.’ That was the general message.

Senator BOYCE—We had some evidence in Sydney suggesting that we should have a quota system for the number of people with disability who could come to Australia. The concept did not exactly thrill me at the time. You were mentioning earlier that Norway had a 10 per cent quota.

Dr Harris Rimmer—Yes.

Senator BOYCE—Can you give us any more information about how that works?

Dr Harris Rimmer—It is only for the refugee and humanitarian program. They have a quota to ensure gender equality because it is very important in the Norwegian political framework. We have a quota system, the women at risk system, as part of our refugee and humanitarian program. It is similar to that, except it is much broader. They aim for 50 per cent of the program to comprise women and 10 per cent to comprise people with disability. New Zealand has 20 set places for refugees with HIV—it is small but it is there. Japan has a certain quota, in its very small refugee program, for people over 60. It is interesting because migration programs reflect a society’s values generally, so you tend to find out about a society by the way they construct their migration program.

Mrs VALE—Doesn’t it also reflect the demographic of the home society?

Dr Harris Rimmer—Very much, yes, but it is also a value thing. The Japanese society values aged parents in a way that our society maybe should but does not. There are value judgements there. There are problems with quotas. We never seem to be able to fill our women at risk program, which is very counterintuitive.

Senator BOYCE—That is interesting.

Dr Harris Rimmer—I know. It is not as if there are not enough women at risk out there, but they seem hard to identify.

Mr ZAPPIA—Dr Harris Rimmer, I hear your argument in respect of trying to place a value on a person with a disability. My question to you is: would you not then apply that same argument to any person who wanted to come to Australia and, if so, how do you then construct an immigration policy?

Dr Harris Rimmer—I see what you mean. Once we become more qualitative—once we say, for example, that a refugee today might be the Frank Lowy of the future—

Mr ZAPPIA—Absolutely.

Dr Harris Rimmer—we are crystal-ball gazing. So how do we have something for right now that is fair, objective and transparent and that the department can handle? I am often critical of the department but they have a very difficult job. They have to be even-handed and apply the same standards in many different posts all over the world. So the question is: how do we do it without every department of immigration official collapsing in a screaming heap at the end of every business day? Partly I think that the PAMs have to be re-written so that immigration officials feel that they are directed to take certain things into account that they currently cannot and they feel less constrained in using their own common sense. 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.

CHAIR—Dr Harris Rimmer, thank you very much for that perfectly timed conclusion to your evidence.

Resolved (on motion by **Senator Boyce**, seconded by **Dr Stone**):

That this committee authorises publication of the transcript of the evidence given before it at public hearing this day.

Committee adjourned at 12.58 pm