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HIV/AIDS Legal Centre Incorporated (NSW) ABN 39 045 530 926

Ref: JSCM Review

5 November 2009

Joint Standing Committee on Migration
Attention: Anne Engwerda-Smith
Australian Parliament House

VIA EMAIL

Dear Ms. Engwerda-Smith,

JSCM Review into the migration treatment of disability

Find attached our submissions to the Joint Standing Committee on Migration review into the migration treatment of disability.

We have been authorised by the Gay and Lesbian Immigration Task Force (GLITF) to indicate their general agreement with these submissions. GLITF associates itself with these submissions generally. Information on GLITF can be obtain via their website at: http://www.glitf.org.au/

We thank you for your indulgence in granting us extended time in which to make these submissions. We look forward to the opportunity to providing further oral evidence to the Committee at the hearing in Sydney. If you have any questions in relation to this letter, please do not hesitate to contact us.

Yours sincerely,

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Submissions on reform of Australia's Migration Regulations regarding the Health Criteria and Health Waiver, specifically addressing the impact upon people living with HIV/AIDS

Submissions by Brady, Principal Solicitor of the HIV/AIDS Legal Centre
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Overview of Submissions

These submissions assert a core position that the health criteria should be dropped as a bar to making a successful visa application. The principles of the numerous international conventions and treaties which Australia has ratified, and best practice public health policy do not merit the imposition of discriminatory health criteria against applicants with HIV or with other disabilities.

In the alternative, this submission provides a number of measures which may be adopted to modify the current health criteria and health waiver system. These reforms would be aimed at lessening the negative impacts of the current system and improving its fairness and compliance with Australia's International Treaty obligations.

Suggested key reforms are:

- Remove the health criteria (excepting public health risk issues) for all humanitarian visas;
- Extend the health waiver to all economic stream visas (skilled and employment based visas);
- Stipulate primary and secondary considerations to be taken into account in the health waiver: primary consideration to be conformance to Australia's International treaty obligations; secondary considerations to be other compassionate/economic circumstances;
- Remove the dollar value costing from the MOC opinion and costing advice;
- Alternatively make the costing based on the added health costs for an applicant due to their HIV condition or other disability; equalizing for those costs that might be expected of a person of like sex, age and general health without HIV or other disability;
- The MOC opinion should be made by a specialist in the disability or condition the applicant (or relevant secondary applicant) has;
- Adopt 'buy in' provisions for all migrants to have them contribute to the general welfare and healthcare system differentially to defray costs associated with migration.

HIV/AIDS Legal Centre: Background

The HIV/AIDS Legal Centre (HALC) was established in 1992, evolving from the Australian Federation of AIDS Organisations (AFAO) and the then AIDS Council of NSW (ACON) Legal Working Party, and has since then been a Specialist Community Legal Centre (CLC) funded by the State and Federal Governments. In recent years the funding portion of the State has increased, due to limitations on funding CPI increases to CLCs from the Federal Government. Last year the NSW State's Public Purpose Fund approved an ongoing increase to the Centre's funding to increase the level of services to the core target groups identified in State and Federal HIV Strategies.

HALC is a small legal centre located in the ACON building on Commonwealth St. in Sydney. The Centre enjoys the generous support of ACON in provision of office space, telephone, mail, and general accommodations at token rent. HALC would not exist without the support of ACON. The Centre employs three solicitors, two being migration agents, and has a part-time Coordinator. HALC relies heavily on volunteer workers to provide the advice and/or casework it delivers to over 300 HIV positive persons each year. HALC also receives generous assistance from practitioners in private practice with a wide range of practice areas where HIV/AIDS may be of relevance including immigration lawyers/agents.

HALC in the HIV enabling environment

The work of HALC is an essential part of creating the 'enabling environment': an environment best allowing HIV positive people to live well and free from fear and risk of harm due to their HIV status, and for engendering freedoms and empowerment among the community, including those at most risk of contracting HIV, to reduce the incidence of HIV infection. The 'enabling environment' approach is a critical part of the Federal and NSW State HIV strategies, which reflect best practice and a world leading response to the HIV epidemic since the 1980's.

HALC's work in Immigration

By providing HIV specialised legal information, education, advice and representation, HALC is able to practically engender and pursue the protection of human rights for HIV positive people. As the International Guidelines on HIV/AIDS and Human Rights, produced by the Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS notes:

> *'The key human rights principles which are essential to effective State responses to HIV are to be found in existing international instruments, such as the Universal Declaration of Human Rights the International Covenants on Economic, Social and Cultural Rights and on Civil and Political Rights, the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination against Women, the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and the Convention on the Rights of the Child....'*[1]

The principal rights implicated in the current immigration health criteria enshrined in Australian law are the right to non-discrimination and equal treatment under the law, the right to marry and found a family, and the right to freedom of movement.

The International Guidelines on HIV/AIDS and Human Rights states:

'7. RIGHT TO LIBERTY OF MOVEMENT

[1] United Nations High Commissioner for Human Rights and the Joint United Nations Program of HIV/AIDS

The right to liberty of movement encompasses the rights of everyone lawfully within a territory of a State to liberty of movement within that State and the freedom to choose his/ her residence, as well as the rights of nationals to enter and leave their own country. Similarly, an alien lawfully within a State can only be expelled by a legal decision with due process protection.

127. There is no public health rationale for restricting liberty of movement or choice of residence on the grounds of HIV status. According to current international health regulations, the only disease which requires a certificate for international travel is yellow fever.[2] *Therefore, any restrictions on these rights based on suspected or real HIV status alone, including HIV screening of international travellers, are discriminatory and cannot be justified by public health concerns.*

128. Where States prohibit people living with HIV from longer- term residency due to concerns about economic costs, States should not single out HIV/AIDS, as opposed to comparable conditions, for such treatment and should establish that such costs would indeed be incurred in the case of the individual alien seeking residency. In considering entry applications, humanitarian concerns, such as family reunification and the need for asylum, should outweigh economic considerations.'

HALC has, for many years promoted the right to liberty of movement by directly providing advice and representation to HIV positive persons and their families in relation to immigration matters. While principally and originally focussed on interdependent and spouse visas – loosely termed, the family formation visas – in recent years HALC has provided assistance and representation in skilled stream visa applications, including subclass 457 (temporary business – employer sponsored) visas, and with other skilled applications for which there is currently no health waiver. HALC has through its practice of migration law built a solid range of experience with the issues and problems created by the current health criteria and regulations.

Stress the Immigration Process Causes Upon the Applicant/Sponsor

Partner visa (*formerly known as Interdependent and Spouse visas*) applicants have been the core of HALC's work in migration. We have first hand experience and awareness of the significant stress the migration health process puts on relationships and the applicants/sponsors involved. Where the HIV condition is known from the start, there is added stress and uncertainty in such applications.

Applicants tell of feeling stigmatised from the start of the process. They are well aware of being treated differently and less favourably due to their HIV status. They report feeling unwanted and worth-less.

[2] WHO International Health Regulations (1969).

Case Study 1

HALC assisted at the end of one partner visa application with a client from a Mediterranean island with a dubious human rights reputation, whom Lachlan Riches President of HALC and a Partner at Taylor and Scott had assisted at earlier stages of the Application. The initial Departmental application was unsuccessful, as was review at the Migration Review Tribunal and subsequent review at the Federal Magistrates Court. The applicant was finally successful, gaining a Ministerial discretion to grant permanent residency in the public interest (Migration Act 1958, *Section 351*). However the process took around 10 years from the initial application. The applicant had worked through most of the process, and was a highly valued supervising/managing employee of a cleaning contractor. He lost work rights for over a year whilst awaiting the Minister's intervention. During that year, the applicant described his increasing depression and anxiety as he waited for an outcome. His relationship with his partner was significantly damaged during this period. He described waiting each day for 3.00pm when the mail arrived. He was waiting for word of his Ministerial submissions, his last hope for grant of a visa, to be able to continue his relationship and live in Australia, rather than return to secrecy and fear of persecution for his sexuality in his home country. He described how the whole process left him deeply psychologically and emotionally scarred. The client was re-employed by his former employer upon getting his visa. The relationship did not survive.

Such responses to the stress of uncertainty and fear of refusal over prolonged periods are not uncommon. A more extreme example came, again, via one of Lachlan Riches' clients. His client, having waited for the Department to determine his interdependent application health waiver for around five years, abandoned his HIV treatment in despair. His health declined, and he died of an HIV related condition, upon which time the Department, which had just a few weeks before the applicant died sought further information on the circumstances, advised that it would close its file on the matter a few days after becoming aware of the death of the applicant. The applicant had a business in Australia with several employees, which went into disarray when he died.

Case Study 2

We assisted an HIV positive sponsor and his HIV negative partner with a partner visa. The couple had limited means, as the sponsor had had limited work due to his fluctuating health condition. The applicant was from a European nation and worked as a fairly low paid community sector worker. The limited means of the couple was a potential issue in the application. The sponsor had attempted to live in the European country with his partner, but encountered recurring health problems due to his condition and prevalent poor winter conditions. The couple were effectively forced to move here for the sponsor's health. The health criteria did not play a part in this application. While the applicant's partnership in Australia would no doubt be a boon to the health and outlook of the sponsor and would be likely to reduce his health costs and improve his health outcomes, as well as provide unpaid/uncosted support for the sponsor at no expense to

the Australian community, none of this benefit to the community is taken into account in the migration process as it was not the applicant who was HIV positive.

The process is no less traumatic and stressful for those couples who discover that the applicant partner is HIV positive only through the health check for the visa. Such couples have to deal with a new diagnosis and the attendant emotional and relationship stresses that involves; but also they are thrown into confusion and deep uncertainty as their application process and chances of success are suddenly and radically changed.

Case Study 3

Our clients, based in regional Australia received a positive diagnosis for the secondary applicant, the primary applicant's partner, through the health examination process. They were applying for a second subclass 457 visa. Being from Southern Africa they had either not been tested or had tested negative to HIV previously in the health examination for the first visa. The employer/sponsor for the original subclass 457 visa, a private healthcare provider, had refused to assist with the health undertaking that would be required in the renewal of the 457, currently a condition for a waiver under par. 4006A of Schedule 4 of the Migration Regulations. They moved from Sydney to regional Australia to take up employment with a public healthcare organisation, in the hope of getting the health undertaking from that employer. The process was complicated by a change of the DIAC case officer. There was confusion on the part of the public health employer as to who in the organisation had the authority to decide whether to provide the health undertaking. The process was prolonged and it exacerbated the shock of diagnosis for the couple. Their relationship was almost ended by the time the health undertaking was finally approved. The couple were able to rebuild their relationship once the stress of the migration process was concluded.

Whilst some relationships can survive the gruelling process sometimes combined with a new diagnosis, many relationships do not.

Case Study 4

Another client in regional Australia was working under a subclass 457 visa. She had tested HIV negative in her Southern African country of origin. While here she formed a relationship with an Australian citizen. She applied for an independent skilled visa, and was diagnosed HIV+ through the health process. The diagnosis shock lead to her burying her head in the sand and letting her migration process slide. Her migration agent in regional Australia had no experience at health issues. She withdrew the independent skilled application – there being no health waiver for that visa. She and her partner decided to apply for a spouse visa. There was some tension in the relationship due to the diagnosis and the stress of the migration process. The Australian partner was believed to be HIV negative. Unfortunately before a partner visa application could be lodged, the

relationship ended. Due to some confusion the skilled application had been refused after it was formally withdrawn. Our client was 'off-visa' (commonly termed, unlawfully within Australian territory) for some months before a protection visa was finally lodged. The protection visa was granted based on HIV status stigma and persecution of returnees to her country of origin.

Case Study 5

Another client from Southern Africa working under a subclass 457 visa moved to regional Australia to an employer which would be more likely to provide a health undertaking for a new subclass 457 visa, when the original visa expired and the person was diagnosed as being HIV positive. Again, the private healthcare provider in the city would not approve a health undertaking on a new 457 for the applicant, although they recognised her as a valued employee. The case officer for DIAC was new and did not get a handle on the health waiver process for 457 visas. The employer, a State health department have taken a prolonged time to decide on whether to agree to a health undertaking. The health department employer has indicated that they will make the undertaking, but have taken some months to finalise the process. The nomination expired in this time and now must be renewed by the employer. A new case officer has been assigned to the application, and it seems like starting from scratch.

The applicant's partner left the country prior to the application and had to withdraw. His mother was dying in their country of origin. The applicant and her daughter moved to regional Australia to proceed with the process. As the process drew on the partner lost faith that they could succeed, or that he could return. The relationship almost broke down. Our client was in regional Australia with her child, and without her husband. Over 7 months of uncertainty about whether the waiver would be granted have been taking a heavy toll of stress and anxiety. The near breakdown of the couple's relationship has been largely due to the migration health waiver process and the stress involved. The application remains afoot. The couple are in contact again and looking for ways to get the husband back onshore. Throughout her time in Australia, the applicant has contributed much valued service to the community.

Case Study 6

Other clients also from Southern Africa were on subclass 457 visas. A family with two teenage kids, both parents have skills in high demand. They applied for an independent skilled visa and were both diagnosed as HIV+ in the health examination. They had tested negative in their country of origin prior to coming to Australia. They had a private migration agent who stressed them about the process in order to pressure them to pay more money. They came to our service when their 457 had expired and they were on a bridging visa for the independent skilled visa. They had to decide on continuing with the independent skilled visa knowing it would fail, in order to eventually get to the Minister for a discretionary compassionate grounds visa grant. The alternative was to withdraw that application and lodge a protection visa. They had some protection claims. At that

time if they lodged a protection visa application they would lose work rights. With a family to support, they would have great difficulty in staying well and healthy pending the Minister's consideration of their matter, which can routinely take a year or more. They decided to continue in the independent skills process. They lodged at the MRT and over a year out they have not received a hearing date. The couple initially had great stress over the uncertainty of the process. Fear of returning to their country of origin was very high. Added to this stress their children do not know of their parents' HIV status. Such secrecy within families is not unusual in our experience.

This family decided to go through the process and seek the Minister's exercise of discretion to grant a visa to stay. While this approach was risky, the alternative of making a protection visa application was both uncertain and would bring immediate hardship. The parent would have lost work rights while the application was processed. Added to this, the protection visa process has a historically high risk of refusal, and bears a stigma that many working migrant are reticent to accept. These applicants would have been accepted for the independent skills visa (on either partner's skills) but for their HIV status.

Lessons from the case studies

The case studies show the current process creates significant and sometimes overwhelming stress for many applicants. In all cases the applicants would have been successful and quickly finalised, but for the presence of HIV and the need for the health waiver. The process puts greatest stress on the applicants who are most likely to suffer deleterious affects from such stress.

The process is complicated. For both the 457 health undertaking, and the health waiver for permanent visas we have dealt with DIAC case officers, private migration agents/lawyers, clients, and employers who are baffled by the process. Working with health waivers routinely, we consider the process fairly straight forward. We are regularly surprised and dismayed by the confusion, fear and error the HIV based health waiver engenders among others in the process. This again increases the stress inherent in the current system.

While our recent experience in the health waivers has been positive, we know that in the recent past more arbitrary and harsh outcomes were routinely experienced. The process is itself stigmatising. Applicants know they are treated differently and less favourably due to their HIV status. Among applicants from countries where HIV stigma is probably higher and more critical than in Australia, this process exacerbates the stigma and fear.

SUBMISSIONS

A. *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.*

The current health criteria provisions are discriminatory. While in theory all applicants are tested according to the same health criteria provisions, only those with an identified health issue or a disability fail the health criteria and are, by that criteria alone, refused a visa. For those visas with a health criteria waiver, only those with an identified health issue or disability are required to make further submissions and sometimes they or their sponsor and others close to them must give undertakings and meet extra qualifying requirements.

Australia's migration health regulation typifies the very essence of discrimination. There is no question that the discrimination is lawful. It is stipulated by regulation, required by enactment, and empowered under the constitution. However it is nonetheless discrimination, and unless carefully calibrated to necessity, underpinned by a principled rationale and mediated by fairness, it will not live up to the best aspirations of the Australian policy and our obligations under International law and International treaties and conventions we have voluntarily ratified or signed (*Australia's international treaty obligations*[3]).

Apart from the question of whether such discrimination is necessary or desirable in the Australian context, there is a question of the principled rationale underlying it. What is really being assessed and screened under the current health criteria and health test? Certainly the obvious and easily identified conditions are being screened. HIV is perhaps the largest single disease/disability condition easily tested for and identified for assessment under the health criteria. Notably fairly obvious conditions such as Downs Syndrome, paraplegia or advanced liver disease will also be caught under the current test.

What of smoking? Smoking is one of the single most expensive health issues in advanced economies such as Australia, and yet will not be adverted to under the current health criteria. What of obesity, or diabetes? Anecdotally, we understand that morbidly obese applicants may have an issue and fail the health criteria; it is not a certain outcome and is a fairly recent addition to the conditions which may cause an application to fail. We know of at least one application where the applicant with diabetes requiring ongoing medication by pills and insulin injections was passed on the health criteria by the Medical Officer of the Commonwealth.

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[3] Australia's Current Treaty obligations applicable to these submissions include but are not limited to the Convention on the Rights of the Child, the Universal Declaration of Human Rights, the Convention on Economic, Social and Political Rights, the Convention on the Rights of Persons with Disabilities, and The Refugee Convention.

What of applicants with a genetic predisposition or familial history of cancer? What of applicants with a predisposition for Parkinson's disease or early onset dementia? What of applicants liable to CJD? All such applicants, with no indication of these conditions at the time of medical assessment, will pass the current health criteria. Clearly the criteria does not screen for all applicants likely to incur significant health costs to Australia, even where tests and assessments of such likelihood of significant costs are calculable.

The current health criteria and health assessment by the Medical Officer of the Commonwealth or relevant panel doctor is not a 'value free' assessment of likely health costs. It is blind to some identifiable potential significant health costs, and sensitive to others. Notably it is now, and has been historically, sensitive to HIV as a potential health cost. It is ordinarily a test sensitive to stigmatised, unordinary, and socially less acceptable conditions and disabilities. Those health conditions less readily identified [genetic/familial predispositions], more socially accepted [obesity, smoking] are unlikely to fail under the health criteria, despite the clear statistical evidence of the healthcare and community service costs they attract.

So, do we really want to apply such a test? The argument for the current criteria rests on a practical understanding that the testing will be an appropriate, practical application of contemporary medical knowledge and testing capabilities and medico-social expectations. Where there are easily, readily identified likely health and community costs to Australia raised by an application for migration entry, why not take that into account, even if it doesn't identify all likely health costs?

A clear and ethically principled alternative to this approach would be to abandon the imposition of any health criteria at all, bar those relating to public health threats. While there is much to be said for aspiring to this goal, we frankly feel it is unlikely to be adopted by the present Parliament in the current economic and social context.

However the current position can also reasonably be mediated by adoption of fair, practically calibrated and principled criteria to assess the merits of applicants posing such identified costs. Given the failings identified in the current schema, adoption of a fair, practically calibrated and principled approach will require a corollary change in the availability of the health waiver for visa categories.

Visas with health waiver applicable

In respect of humanitarian based applications there is no reasonable rationale for applying a balance of economic costs and benefits. The health waiver should be automatic (or the all but the public safety aspect of the health criteria should be dropped) for all humanitarian based visa applications.

Currently offshore non-sponsored humanitarian visas have no waiver, offshore sponsored humanitarian visas have a waiver, and onshore refugee visas have effectively no health criteria. The current schema in respect of humanitarian visas is irrational and does not conform with the aspirations of the refugee convention, and other humanitarian and rights based conventions and treaties to which Australia is signatory or has ratified.

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.

Case Study 7

Our client, a West African who came to Australia as a refugee sought to sponsor his uncle and uncle's immediate family, brother and brother's immediate family, and sister and sister's immediate family, on Global Special Humanitarian visa subclass 202. During the application process, already a long process especially for offshore humanitarian visa applications, two significant events occurred; the sponsor's sister, a woman in her late twenties, died from causes unknown requiring her young son to be adopted by his uncle, and two out of a total of 13 applicants discovered that they were HIV positive.

Discovering that their HIV positive status had a possible detrimental effect upon the application the two HIV positive applicants said that they would withdraw from the application in the hope that the rest of their family could go on to live better lives. They were then informed of the 'one fails all fail' policy. At this point the applicants' Australian sponsor then contacted us for assistance.

A significant amount of stress has been caused to the two positive applicants, one of whom is a teenage boy, upon learning of their positive status, along with learning that their status may impact upon the livelihood of their family. Additionally a significant amount of stress has been caused to the family in Australia who are all torture victims, out of fear for their family in West Africa.

The sponsor has indicated to us that prior to the health checks, positive indications had been given by the case officer in the humanitarian section of the Australian Embassy in Pretoria. We have made submissions on behalf of the applicants, but a decision is still pending. These applications were made in early 2007.

Adopting the principled approach to the health criteria would not stop at applying the waiver to just humanitarian type visas. It would allow the waiver to all visa categories equally. Once we identify consistent, principled and rational measures by which to assess applicant's circumstances for the grant of a health waiver, why would we not apply these to all visa categories equally? Consistent and values based criteria applied to all visa applicants would best conform the visa assessment system to Australia's international treaty obligations and our values.

Where we have available a set of criteria and measures by which applicants can be fairly and rationally assessed on merits, including economic and social benefits to Australia and individual circumstances those should logically be applied to all visa categories as they would best exercise Australia's values and aspirations for human rights. It would provide a consistent and seamless system for assessing all visas. It would simplify and increase efficiency of the migration process. It would rationalise and ameliorate inequities in the discriminatory aspects of current scheme.

B. *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.*

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.

The value of family contribution needs to be able to be taken to account where there is one or more disabled person in a family. By allowing the health waiver for economic stream visas, the 'one out all out' rule would cease to produce unsatisfactory results such as those in the case of Dr Bernhard Moeller and family. While some members of an applicant family may represent a likely significant cost, others may represent a significant contribution. Why shouldn't the other family members on the application be able to be taken in the balance?

Case Study 8

When making an application for a visa subclass 457 an applicant's spouse discovered that they were HIV positive. The applicant and their spouse were then advised in their home country that they would be unsuccessful in the application if the spouse remained on the application as a member of the family unit.

Listening to this advice the applicant and their spouse then discussed the matter and decided that the applicant should continue with the application and go to Australia along with their two children. Coming from a developing country they believed this to be the way to a better future for their two little girls. The applicant was informed by someone in their home country that after working on a 457 visa for some time they would then be able to apply for an independent skilled visa and then sponsor their spouse shortly thereafter to come to Australia. After lodging the independent skilled visa they were then informed of the 'one fails all fail' policy, and withdrew the application. The applicant then sought our advices where we confirmed the 'one fails all fail' policy.

We indicated to the applicant that they would be able to add their spouse to the 457 visa but would have to approach the employer to obtain a health undertaking. The applicant discussed this with their employer; however, the employer is not willing to give any such undertaking. Unfortunately, the applicant and their employer are located in NSW and therefore at the current time they cannot apply for an Employer Nominated Scheme visa. We informed the applicant that they should make enquiries into obtaining employment in one of the participating states for the ENS.

The applicant and children have now been separated from their spouse and parent for five years, with only occasional and short visits.

Beyond the mere economic considerations in assessing the contribution, there is also the more nebulous concept of the social contribution a disabled applicant and their family may make. Such contributions range widely from subtle contributions to the multi-cultural fabric of Australian society, to the embodiment of the highest aspirations of Australia as a compassionate and inclusive society. Operationally, the practice of including such considerations in the health criteria balance could reflect Australia's move toward fulfilment of the aspirational content of the international human rights treaties and covenants which it has ratified. In *Bui v Minister for Immigration & Multicultural Affairs* their honours French, North and Merkel JJ stated:

> *"47 The evaluative judgment whether the cost to the Australian community or prejudice to others, if the visa is granted, is "undue" may import consideration of compassionate or other circumstances.* ***It may be to Australia's benefit in moral or other terms to admit a person even though it could be anticipated that such a person will make some significant call upon health and community services.*** *There may be circumstances of a "compelling" character, not included in the "compassionate" category that mandate such an outcome. But over and above the consideration of the likelihood that cost or prejudice will be "undue" there is the discretionary element of the ministerial waiver. And within that discretion compassionate circumstances or the more widely expressed "compelling circumstances" may properly have a part to play."*[4] ***[emphasis added]***

While the current provisions allow for such considerations to be taken into account, the practice has produced widely varying results. First, as stated, lack of the waiver provisions for the bulk of economic stream visas (until recently, with the effective extension of the waiver to 856 – Employer Nomination Scheme visas (State Sponsored)) has restricted the scope for such considerations to be given weight. Applying the waiver provisions to all (or at least more) of the economic or skilled stream visas will ameliorate this problem. Second, the practice of balancing the consideration has varied widely and arbitrarily over time.

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[4] French, North and Merkel JJ at 47 in *Bui v Minister for Immigration & Multicultural Affairs* [1999] FCA 118.

Political considerations and generally a 'culture' engendered in the Department by the 'Minister' at any given time have greatly impacted on the practical application of the current provisions. While the provisions allow for compassionate and compelling circumstances to be given weight: at various times past there has been significantly less weight given to such considerations by delegates and the Department generally. In our experience, it was routinely stated by practitioners in the field up to mid 2006, that an applicant should not expect to be successful at the delegate level, but that they may be successful if a strong application was reviewed at the Migration Review Tribunal. The overall advice was that health waivers were very chancy and hard to get.

Some of the broader considerations that might properly be considered in the health waiver equation go far beyond the individual applicant. For instance, there is a general benefit to be gained from HIV migrants in de-stigmatising HIV generally in the community. Many HIV+ migrants become engaged in HIV focussed and other community organisations and incrementally their engagements help to decrease fear and stigma associated with HIV in the broader community and their own ethnic communities. Such engagements provide subtle and valuable social support mechanisms for HIV+ residents from their own and other culturally and linguistically diverse backgrounds, as well as for other HIV+ citizens.

Further to this, many of our migration clients are regionally and rurally located. Their addition to the diversity and cultural fabric of rural and regional Australia may properly be considered as being a benefit to Australia. The economic contribution they make regionally and the skills they bring with them have a differential benefit in regional Australia. Conversely, their impact on services will, in the vast majority of cases, be minimal, as the services are already provided for quite small numbers of existing rural and regional HIV+ citizens. A small increase in patients using such services is likely to increase efficiency of existing service provision rather than require new service provision.

The current regulations and policy guidance are silent on detailed broad considerations such as these. While they allow scope for such considerations to be given weight there is no guidance as to weighting. When (particularly in the past) such issues are not given much weight by Departmental officers, there was no error, as the guidance given under the regulations are so broad as to allow such latitude. As our submissions below indicate, reference to Australia's international treaty obligations may provide more guidance in relation to particularly the humanitarian aspects of an application. Increased guidance on broader social, cultural and economic considerations may be provided by more explicit wording in the policy advice (PAMS PIC).

C. *Report on the impact on funding for, and availability of, community services for people with a disability moving to Australia either temporarily or permanently.*

Undoubtedly a person with a disability, such as HIV, is likely to incur health care and community services costs. All citizens are likely to do so at times throughout their lives. Not all persons with a disability will need to use a greater range of services than ordinary, however some will.

The current system requires the MOC to estimate the likely lifetime costs of a person with a disability to Australia. In doing this, the MOC is not assessing the particular applicant, rather a generic exemplar with the same form and type of condition as the applicant. It is not an individualised estimate used to make the assessment, but a generalised costing for persons with that condition and similar severity or otherwise.

For HIV positive applicants, as for applicants with other disabilities, this generalised estimate of likely costs may be quite inappropriate to their particular circumstances, and likely outcome. There is a wide margin of appreciation for the concept of 'same form and type of condition' as employed by the MOC. It is by no means a very exact or in depth consideration of the severity and other particularities of the applicant's condition. It is a broad brush estimation that is used.

The notes of guidance for Medical Officers of the Commonwealth issued by Health Services Australia for assessment and reporting on HIV positive applicants is clear on this point. Under Chapter 5, Financial Considerations the HSA states:

5. Financial considerations

5.1 ***The cost of treating individual patients with HIV/AIDS has not been well-studied in Australia. Given the rapid development of new therapies, older papers*** [25] ***provide no useful insights into the present cost of managing patients with HIV/AIDS.*** *Although the cost of illness has been studied widely in developing countries, only a limited number of recent publications exist for OECD countries. A recent, retrospective cohort study of 280 persons in the United States estimated the average cost to the US government and/or to insurers was $US20 114 a year (approximately $A25 800 at the-then exchange rate of 0.78 cents).* [26] *Independent predictors of cost were CD4+ T-cell counts, Medicaid eligibility and behavioural comorbidities.* ***This association with costs replicated the findings of an earlier US study reporting hospitalisation rates in 2000 – 2001 were significantly higher among patients with greater immunosuppression****; women; black persons; patients who acquired HIV infection by way of drug use; those of 50-or-more years of age; and those with Medicaid or Medicare cover.* [27] *Mean annual outpatient visits decreased significantly between 2000 and 2002, from 6.06 to 5.66 visits per person per year.*

5.2 ***Slightly more than 10 000 of the approximately 15 000 people living with HIV in Australia currently are taking antiretroviral drugs and most of those individuals require only regular check-ups and monitoring****, either*

in specialised general practices or in hospital outpatient departments, every three to six months.[28,29]

5.3 ***A minority of persons living with HIV require admission to hospital for treatment,*** *mostly for the management of AIDS-defining illnesses, including opportunistic infections and lymphoma as well as comorbidities including liver disease and substance dependency.*[5] ***[emphasis added]***

Further, the current scheme is doubly discriminatory as it purports to measure the HIV+ applicant (or other disability the applicant has) against their lifetime costs as if all other applicants do not come with lifetime medical costs. In this way it assesses them unfairly against an assumed zero lifetime medical cost, rather than a reasonable estimate cost for someone of a similar age and other characteristics but without HIV.

We submit that it would be better for the dollar costing to be abandoned altogether. The dollar costing, as indicated by the HSA 'notes of guidance' is not well supported by evidence and is therefore somewhat speculative. It also works on aggregated broad based historical data, generating an estimate for a generic person with the same form or type of condition in a broad sense and is not specific or greatly particularised to the actual condition and best prognosis for the individual applicant.

Mitigating the costs impact

Beyond these core arguments of approach, there are some supplementary arguments to be considered. While the bulk of any lifetime costs estimate is likely to consist of drug treatment costs, these have reduced in cost slightly over time. They may reasonably be expected to reduce in cost as patents expire and new drugs become available.

In terms of other HIV specialised services drawn upon by HIV+ migrants, these services are already provided for the resident HIV+ population, and as part of Australia's National and State strategies for management and prevention of HIV. There is unlikely to be a significant increased burden on such services with the addition of migrant HIV+ persons, rather to some extent an economy of scale will allow the services to reach greater efficiency.

Under the recommendations made in these submissions, applicants with a disability coming in under the skilled stream would have to meet all other criteria for the visa: they would have to be skilled and able to work for the foreseeable term. Such applicants would reasonably be contributing to the economy for a considerable period. The criteria already select out many disabled migrants, in the sense that they would never meet the standard criteria. In this way, the changes to the system we are proposing do not seek to make reasonable accommodations different to the standard criteria, instead they merely level the field to allow disabled applicants a chance in the right circumstances.

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[5] Notes for Guidance for Medical Officers of the Commonwealth of Australia, Financial implications and consideration of prejudice to access for services associated with infection with human immunodeficiency virus and acquired immune deficiency syndrome (HIV/AIDS), 9 July 2008 at page 24.

Other possible approaches should also be considered. One approach is to reconsider the recent migrant restrictions/cost of entry provisions. This approach has been applied to the migration system to attract skilled migrants to rural and regional Australia, encouraging or requiring that migrants stay in the rural or regional location for some period after migration rather than just relocating to the cities once they have permanency. A restriction similarly applies to spouse visas, requiring the relationship to continue for at least two years after the temporary visa application before permanency can be granted. There are of course current restrictions on Centrelink (welfare) benefits access for migrants. 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.

We propose this type of 'buy-in' provision to mitigate estimated costs of the migrant in the cases of the skilled/economic stream visa applications. Such 'buy-in' provisions would have no place in cases where the basis for the grant of the visa was on strong compassionate grounds, for example where the applicant and/or sponsor is unable to work or is receiving Social Security benefits We strongly support the bipartisan adopted public policy in Australia that all people in Australia should have the benefit of basic universal healthcare coverage under Medicare.

The underlying arguments founding the current health criteria restrictions are twofold essentially. First, it is a means of controlling perceived 'floodgates' of applicants trying to come to Australia for the opportunity for good free services afforded under our universal welfare/Medicare scheme. Second, it puts a brake on the number of people migrating to Australia who would get the benefit of our universal welfare/Medicare coverage without having contributed to the economy and cost of the scheme. The rationales are necessarily linked. Both are addressed in the submissions above.

D. Report on how the balance between costs and benefits might be determined and the appropriate criteria for making a decision based on that assessment.

A scheme to properly assess the economic and social contribution of migration applicants with a disability would include many of the considerations detailed in the current policy directions (PAMS 3). It would appropriately seek to consider the particular skills and attributes of the applicant and their potential contribution to the Australian economy and society. It would take into account the role and potential of their sponsor or family or other significant persons involved with the application. It would consider the applicant and others potential loss to the Australian community should they be refused a visa.

Such a scheme would also appropriately consider the broader picture of the applicant's circumstances in relation to Australia's international treaty obligations. These would include (without limitation) the Convention on the Rights of the Child, the Universal Declaration of Human Rights, the Convention on Economic, Social and Political Rights, the Convention on the Rights of Persons with Disabilities, The Refugee Convention.

Guidance could be included in the PAMS to indicate that the aspirations under the Conventions should be given significant weight as primary considerations in determining an application and the grant of a health waiver. Further, guidance could direct that the various conventions be considered even where the applicant has not cited the convention, but where on the face of the evidence there is a reasonable claim or reference to a convention ground for granting the waiver.

Case Study 9

An applicant from East Africa and her Australian husband were taking steps to organize an application for a spouse visa application, however feeling unwell prior to the application she underwent medical tests and discovered that she was pregnant and also HIV positive. Realising that her HIV status would complicate the visa application process the couple became concerned for their unborn child due to infant mortality rates in East Africa.

The couple then approached us for assistance and we assisted them in obtaining a medical treatment visa so that the applicant could come to Australia to give birth to the baby and avoid the child contracting HIV during birth. Whilst this medical treatment visa was granted, an 8503 restriction was placed upon this visa. Adhering to the 8503 restriction the applicant returned to Africa where she has since lodged a spouse visa application.

The applicant's Australian husband could not accompany her back to East Africa as he has to work to support the family and could not obtain paid work in the Applicant's home country. Since the applicant's return to her home country to await the decision on the spouse visa application, her young son, an Australian baby, has become ill. Whilst the baby does not, by western standards, have any serious illness, in a developing country with limited access to medical treatments, the situation may have gone pear shaped. The applicant and her Australian child are still waiting in Africa not just for a decision but for the letter from the MOC giving a costing so that a request for a health waiver can be made.

Had there not been such high restrictions upon immigration of HIV positive people it would have been reasonable for the applicant to have lodged her spouse visa application when pregnant and this to have been granted prior to giving birth. As it is, the family has had to separate to await a decision, and the health of the Australian baby is in jeopardy. When the issue of the baby's health was put to the case officer, his reply was that the baby accompanying his mother, back to East Africa to make an application and await a decision, was a 'lifestyle choice'.

Consideration of Australia's international treaty obligations would leave appropriate leeway for discretion on the part of delegates and other decision makers, while providing more clear guidance for the exercise of the discretion in conformity with Australia's values and aspirations. This approach has recently been adopted in the new Ministerial Direction No. 41 in respect to s501 cancellations or visa refusals on 'not of good character' grounds. Those new directions provide a model which may now readily be adapted to the health waiver provisions for essentially the same compelling rationale: Australia does and should seek to best meet its international obligations and the highest aspirations of fairness and justice in the operation of its immigration system.

Case Study 10

Following the death of her mother, a HIV positive child was left in an orphanage with no family in her home country in South East Asia. The child's uncle, now an Australian citizen, and his Australian wife sought to bring the child to Australia so they could care for her. The child's only family was in Australia however, none were classified as immediate enough to allow for a sole remaining relative visa.

The child's uncle and aunt looked into adopting their niece, however it was not possible under the local laws and therefore 'a full and permanent adoption' could not be proved sufficiently for immigration purposes under the local laws. The couple then looked to making an orphan relative visa application; however no health waiver is available.

A further measure to clarify the decision process would be to no longer require or allow a dollar value costing by the MOC of the value of social and health services expected to be used by the applicant. The current system requires the Medical Officer of the Commonwealth to give a dollar estimate for the likely lifetime (or visa period) costs of the health and community service the applicant will incur (*estimated lifetime costs*). Basic problems inherent in this system are that the MOC is not a specialist practitioner for the various conditions and disabilities they are required to give report on. They will rely on a report by a specialist practitioner in the condition or disability where available. There will always be a margin of appreciation and interpretation in their understanding of the specialist report and incorporation into their own assessment and estimate.

Further, the MOC is not a specialist health economist trained and specialising in health cost estimates and analysis. The task of estimating an applicant's lifetime medical costs would always be a complicated, specialised task requiring expert analysis and knowledge. In the best of circumstances such an estimate would draw on as detailed health and medical history of the applicant as possible. The current system by contrast relies on scant and basic health information about the applicant and more heavily relies upon sometimes outdated cohort or population data in respect of limited health issues.

For example in respect of HIV positive applicants, the estimate of $250,000 lifetime costs has long been the norm. This estimate from the MOC has varied little from applicant to applicant despite the varied personal circumstance and health histories of the applicants. A newly diagnosed applicant, not on treatment (HAART – AntiRetroviral Therapy) will

oftentimes attract the same cost estimate as an applicant who has been on treatment for many years. In this way the current system seems to provide individualised assessments, but is in fact geared toward a cohort or population based estimate of outcomes. While this may provide 'swings and roundabouts', over estimating the lifetime costs for some applicants while underestimating costs for others, it does not provide the individualised assessment it purports to provide. In this sense it is irrational to its stated purpose of assessing the individual circumstances of the applicant and properly assessing the costs and benefits of that applicant.

Case Study 11

A spousal visa applicant tested positive for a rare strain of HIV-2, which strong evidence indicated that she had contracted from her Australian husband. When undergoing the medical tests for immigration purposes the MOC gave the same estimated costing for likely costs as if she had HIV 1.

However, her doctor indicated that she had shown an excellent immune response to the HIV-2 virus, and her doctor was optimistic that she may be a 'super controller' or 'elite suppressor' whose immune system keeps the virus at bay without drug therapy intervention.

The trajectory of HIV 2 disease progression is very different, and preferable, to that of HIV 1 which is commonly found in Australian and other western populations. This means that treatment is not likely to be required until many years after infection, if at all. In regard to the applicant's need for treatment the doctor stated that 'it is unlikely that she will require antiretroviral therapy for the next 20 years or so, given the relatively benign course of HIV 2.' If treatment is required 'HIV 2 responds well to some of the same drug therapies used for HIV 1.'

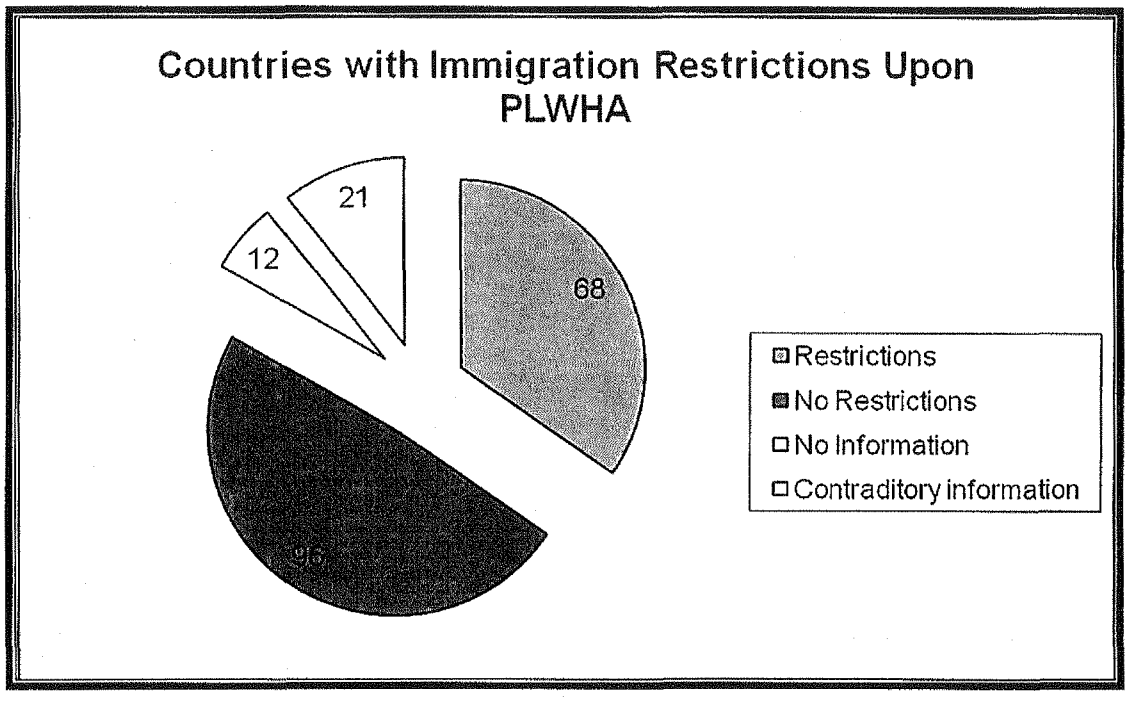
Having a specialist MOC would likely have resulted in the calculation of a significantly reduced life time costing. The strain of the virus was never considered by the MOC despite indication that no treatment would be needed for the next 20 years, which is a significantly different trajectory to that of a person of a similar age, sex and background with HIV-1.

Furthermore, the monetary estimate is incommensurate with social and cultural benefits and difficult to assess against convention and treaty based obligations and rights. Where as currently occurs, as dollar figure for the estimated lifetime costs is given, this cannot fairly and properly be balanced against usually uncosted, and often literally incalculable, economic and social benefits the applicant may claim to bring to Australia.

E. Report on a comparative analysis of similar migrant receiving countries.

Australia is out of step with the Countries it would compare itself with. Australia's current policies are comparable to countries such as Singapore, Iran, Jordan and Malaysia. Our policies nearly mirror New Zealand's health migration policy.

The majority of States in the international community do not have any restrictions upon HIV positive people seeking to reside or holiday in their country. As indicated, included in these countries that do not have any restrictions upon PLWHA are countries which Australia would typically wish to be associated with including the United Kingdom and many States in the European Union.[6]



From these 96 countries without restrictions, 31 are members of the EU.[7]

With respect to the countries that do have restrictions and some a total ban on travel and residency for HIV positive people, a United Nations *'Press Conference on Issues of Exclusion Against People Living with HIV, Marginalized At-Risk Populations'* notes that;

> *"10 of the current 15 members of the Security Council had HIV-related travel restrictions and three of its permanent members -- China, the Russian Federation and the United States -- had a total ban on the entry of people living with HIV. The Republic of Korea, home*

[6] Deutsche AIDS-Hlife *'Travel and Residence Regulations for People with HIV/AIDS'* 2008/2009
[7] Ibid

of United Nations Secretary-General Ban Ki-moon, was among the 13 countries worldwide which completely barred people with HIV."[8]

As has been noted Australia does not have a complete ban on travel and migration for HIV positive people; the regulations as they currently stand are similar to that of such countries as New Zealand, Singapore, Iran, Jordan and Malaysia, just to name a few.[9]

New Zealand's Migration Regulations are almost the same of our own. New Zealand's Immigration Operations Manual includes HIV as a condition that is 'a danger to public health' and 'could be significant cost to the community'.[10] The majority of New Zealand's regulations and operational manual with respect to health were last updated in November 2005.[11] There is nothing to indicate that New Zealand is moving towards removal of restrictions to HIV positive people, despite calls from across the globe to do so.

The United Nations has beseeched States to remove restrictions on travel and migration for PLWHA, openly indicating that such policies are discriminatory.

> *"There is no evidence that travel restrictions related to HIV in any way limit its further spread," he said, stressing that, on the contrary, such restrictions frequently caused people to refrain from testing for HIV, stop taking their medication, and enhanced the discrimination faced by people living with the disease. "The only medical, moral and common-sense response would be for countries to immediately and unconditionally remove or revoke all current travel restrictions related to HIV."*[12]

The United States of America has answered the request by the United Nations to remove travel and residency restrictions. As of 4 January 2010 HIV positive people will not face any restrictions provided that nothing of significance surfaces during the 45 day public commentary period. Until this time the USA had a total ban on travel and residency to HIV positive people. The CDC Docket on the matter states:

> *"the U.S. Department of Health and Human Services (HHS), is amending its regulations to remove "Human Immunodeficiency Virus (HIV) infection" from the definition of communicable disease of public health significance and remove references to "HIV" from the scope of examinations for aliens.*

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[8] United Nations '*Press Conference on Issues of Exclusion Against People Living with HIV, Marginalized At-Risk Populations*' 11 June 2008 accessed at http://www.un.org/News/briefings/docs/2008/080611_HIV.doc.htm

[9] Deutsche AIDS-Hlife *'Travel and Residence Regulations for People with HIV/AIDS'* 2008/2009

[10] We note that Australia does not and never has taken the position that HIV is a public health risk in respect of migration or entry purposes, contrasting with the New Zealand provisions.

[11] Immigration New Zealand – *Operations Manual*, A5 – Health Requirements effective from 28/11/2005 accessed at: http://www.immigration.govt.nz/opsmanual/index.htm

[12] United Nations '*Press Conference on Issues of Exclusion Against People Living with HIV, Marginalized At-Risk Populations*' 11 June 2008 accessed at http://www.un.org/News/briefings/docs/2008/080611_HIV.doc.htm

> *Prior to this final rule, aliens with HIV infection were considered to have a communicable disease of public health significance and were thus inadmissible to the United States per the Immigration and Nationality Act (INA). While HIV infection is a serious health condition, it is not a communicable disease that is a significant public health risk for introduction, transmission, and spread to the U.S. population through casual contact. As a result of this final rule, aliens will no longer be inadmissible into the United States based solely on the ground they are infected with HIV, and they will not be required to undergo HIV testing as part of the required medical examination for U.S. immigration."*[13]

This ban that the US has had in place since 1987 and codified into US legislation in 1993, has been removed, recognizing that the previous regulations:

> *"a) stigmatizes and discriminates against HIV-infected people, which include battered women and children; the lesbian, gay, bisexual and transgender (LGBT) community; or other vulnerable or already stigmatized populations; b) separates loved ones; c) denies U.S. businesses and research institutions access to talented workers; d) bars students and tourists from accessing opportunities and supporting our economy; and/or e) violates human rights by denying or interfering with the rights to life, freedom of movement, privacy, liberty and work. While HHS/CDC acknowledges these assertions, its mission is to protect public health and base decisions upon solid scientific and medical grounds. Therefore, there is no public health benefit for retaining this government-imposed barrier."*[14]

At signing a new HIV/AIDS Treatment Extension Act into law, President Obama stated:

> *"Twenty-two years ago, in a decision rooted in fear rather than fact, the United States instituted a travel ban on entry into the country for people living with HIV/AIDS. Now, we talk about reducing the stigma of this disease -- yet we've treated a visitor living with it as a threat. We lead the world when it comes to helping stem the AIDS pandemic -- yet we are one of only a dozen countries that still bar people from HIV from entering our own country."*[15]

Of the problems with the restrictions identified by the US CDC review, the Australian Regulations and waiver provisions address 'possible separation of loved ones', and

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[13] Department of Health and Human Services, Centers of Disease Control and Prevention Docket No. CDC-2009-0003 RIN 0920-AA26 *'Medical Examination of Aliens – Removal of Human Immunodeficiency Virus (HIV) infection from Definition of Communicable Disease of Public Health Significance'* 22 October 2009

[14] Ibid

[15] *Signing of the Ryan White HIV/AIDS Treatment Extension Act of 2009*, President Obama, Diplomatic Reception Room, 30 October 2009, accessed at: http://www.advocate.com/News/Daily_News/2009/10/30/Obama_Lifts_the_HIV_Travel_Ban/

currently has only limited scope to recognize 'talented workers'. The majority of concerns the United States' recognized in recommending reform of its outdated regulations are still live issues in Australia's current health criteria provisions.

The United Nations has given indication that they will continue to advocate for HIV positive people and request that member States remove discriminatory immigration policies;

> *Asked if there was a role for the United Nations to play in ending discriminatory policies against migrants with HIV, Mr. Heath said that, by taking a stand on the issue, the Organization could help level the playing field. "Across the globe, we need people to be able to move freely and work where they need to work. We need to usher in legislation that takes HIV out of the equation."*[16]

With the liberalization of the HIV health ban by the USA, such restrictions are being properly seen as historical artefacts left over from the early days of 'contagion fear' that permeated the response of some countries to the onset of the HIV epidemic.

We submit that HIV immigration restrictions will increasingly been seen as an outdated throwback to darker times, practiced only by parochial backwaters and nearly emerged quasi-democratic nation states with dubious human rights practices. We submit that the health criteria regulations be amended to require consideration of Australia's international obligations under conventions and treaties to which Australia is signatory or which Australia has ratified. Such health regulations aught to require consideration of the applicants' (both primary and secondary) and sponsor's circumstances in relation to Australia's international treaty obligations.

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[16] United Nations '*Press Conference on Issues of Exclusion Against People Living with HIV, Marginalized At-Risk Populations*' 11 June 2008 accessed at http://www.un.org/News/briefings/docs/2008/080611_HIV.doc.htm