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Joint Standing Committee on Migration
Parliament House
Canberra ACT 2600
Via email: jscm@aph.gov.au

18 October 2009

Dear Secretary

Submission to the inquiry into the migration treatment of disability

Please find attached a recent article by Kristin Natalier and Susan Harris Rimmer. The article is called '**Counting the cost: the social construction and human rights conceptualisation of the disabled child migrant through Australia's migration processes**'.

We argue that the current 'cost' of a disabled child under the migration programme is not as objective as it seems, but in fact constructed on a range of prejudices and assumptions about citizenship.

Dr Kristin Natalier is a lecturer in the School of Sociology and Social Work, University of Tasmania. Dr Susan Harris Rimmer is a Research Fellow in the Centre for International Governance and Justice, RegNet, College of the Asia-Pacific, ANU.

Recommendation

That the Committee recommend to the Australian Government that the health requirement should be reformed to make its operation conform to Australia's international human rights obligations.

We would be pleased to discuss these issues further with the Committee if required.

Yours sincerely,

Dr Susan Harris Rimmer
Centre for International Governance and Justice, RegNet, ANU

Counting the cost: the social construction and human rights conceptualisation of the disabled child migrant through Australia's migration processes

Abstract

Children living with a disability who seek to migrate to Australia are currently subject to the health requirement, which exclude applicants on the basis of their cost to Australia's health systems. While seemingly subject to objective processes of quantification, these children are in fact incorporated into a set of structures that order belonging and citizenship in classed, raced and ableist terms. In so doing, migration systems construct a static and disempowering social category, that of the disabled child migrant. This paper explores this construction within technical and administrative processes; it then goes on to explore the possibility of an alternative, human rights based approach. The paper concludes that for people living with a disability to become visible and to claim worthiness, capacity and advocacy in this system as opposed to silent, helpless burdens, human rights discourse itself will require transformation.

Key words: Disability, migration, children, citizenship, quantification

Introduction

Fears centered on disability, ethnicity and citizenship are a constitutive theme of Australia's contested and imagined national identity. Ethnicity and ability, as separate and intersecting structures, were the basis of excluding people from the nation state (Meekosha 2006). This exclusion was – and is – informed by the desire for the economic and demographic growth, so that desired citizens were genetically, morally and physically strong. The acceptance of particular categories of migrants and their full inclusion into the nation was based on conformity to an ideal, that of, 'the good citizen embodied as male, white, active, fit and able, in complete contrast to the unvalued, inactive, disabled other'; indeed, 'The concept of a disabled citizen could be described as a contradiction in terms' (Meekosha and Dowse 1997, 50).

The initial framework for assessing potential citizens was referenced to medical models of biological superiority, which were presented as a rational basis for decisions (Meekosha 2006). While the language has changed, rationality, now referenced to economics and medicine, is presented as the continuing basis of migration decisions. But Soldatic and Fiske (2009:298) claim 'the primacy of 'rational decision-making' remains unexamined and unchallenged'; this paper begins that challenge.

The paper is guided by two questions: How do Australia's migration systems construct children living with a disability?; and can rights discourses offer an alternative claim to inclusion? It applies a critical inter-categorical analysis (McCall 2005) to the 'health requirement' with Australia's migration processes, which specifies that a person applying for residency must be free from any disease or condition that constitutes a threat to public health or the community or is likely to require health care or community services. The paper argues that quantification is a core process by which the disabled migrant child is constructed as a static and disempowering social category. This process mirrors the weakness of the international human rights system to allow disabled non-citizen children to claim non-discrimination rights from the destination state.

This discussion centers on the construction of children within these processes because to date, children have been marginalised in legal and conceptual analysis of migration (eg Jakubowicz and Meekosha 2002, Meekosha and Dowse 1997). And yet, children living with a disability are particularly disadvantaged under the current system. Conceptually, the construction of Western childhood positions children precariously within migration processes and the protections promised in human rights discourse.

Australia's health requirement: creating the disabled migrant child

On its face, Australia's migration system no longer explicitly excludes on the basis of ethnicity or ability. At present, when people apply to reside in Australia, they must meet the 'health requirement', which requires the applicant must be free from any disease or condition that creates a threat to public health or the Australian community, is likely to require health or community services, and would likely result in a significant cost to the community or limit access of citizens or permanent residents to health care or community services.¹ These provisions are justified as protecting the public health and safety of the Australian community, containing public expenditure on health and community services and ensuring the priority of Australian residents in access to those services (DIAC 2009).

While not explicitly discriminatory the health requirement is referenced to ethnicity and medical authority as mutually reinforcing structures of exclusion. After an initial written application, a health matrix, based on tuberculosis (TB) rates in the country of origin is used to assess the risk of an applicant. A Medical Officer of the Commonwealth (MOC) assesses those living in 'high risk' countries –primarily countries in the developing world – for disease and physical impairment. If a physical impairment is identified, the opinion is taken as correct (DIAC 2009). In so doing, disability is conceptualised in medical rather than social terms, with no reference to the self-identification of the person.

On its face, medical diagnosis imposes a rational and scientific structure on migration processes. But the emphasis on TB, a disease more commonly found in developing countries acts as a filter, so that ethnicity still informs the assessment identification of acceptable migrants. In contrast, 'lifestyle' diseases, more commonly found amongst people in the developed countries, require significant resources but are not used to screen people into the health matrix. But disability, ethnicity and age are linked so that those being drawn into the health matrix are more likely to be identified as living with a physical disability: 80% of people with disabilities live in developing countries; and children constitute about a quarter of all disabled people (UN Enable 2006).

Quantification buttresses the identification and exclusion of people living with a disability.

Quantification is the increasingly common and expected process of translating the characteristics of any social phenomenon into numbers. The resultant data are afforded a high degree of authority: they are understood as the outcome standardized and universalised rules that are a defence against the biases of decision makers less relevant (Espeland and Nelson 1998). A MOC finding of physical impairment triggers quantification, and the transformation of impairment into disability as the MOC

¹ The process is specified in three key documents: *Migration Act 1958 (Cth)* s60(1); *Migration Regulations 1994 (Cth)* reg. 2.25A; Department of Immigration and Citizenship, *Procedures Advice Manual 3* (14/04/2009) Sch4/4005-4007 – The Health Requirement [4].

makes an economic assessment of the cost of any condition, referenced to actuarial tables. Refusal of a visa occurs when a person is diagnosed with a condition that would impose a 'significant cost' in treatment. This is currently defined any costs over a threshold value of \$21,000 over five years to treat; (calculations are referenced to annual per capita health and welfare expenditure for Australians).

Actuarial tables are an example par excellence of the rationality and standardization (Simon 1988). However, the use of actuarial tables in this process reflects the symbolic nature of quantification. Following Carruthers and Espeland (1991), we argue symbols of rationality and may function to legitimate particular decisions even when the decision making process is de-coupled from technique. This is evident in two characteristics of actuarial tables: the quality of the data used and the sole focus on the costs of disability.

On the first point, the Australian National Audit Office has highlight deficiencies the actuarial tables, finding them to incorporate costings that are incomplete and out-of-date, and with an ad hoc rather than systematic inclusion of items and services (ANAO 2007:23). On the second point, the relationship of children living with a disability to markets is confined to a consumer within health and community care markets. Further, these markets are reified. The costs of care are presented as the result of the needs of particular categories of disability; there is no space within the process for an acknowledgement that health care is the outcome of intersecting institutions, cultural expectations and the structural position of individuals.

The discretionary waiver of the health requirement under some circumstances may mitigate the implications of quantification. In certain sub-classes of visas, an applicant who has failed the health requirements may be able to apply for a waiver to be exercised by the Minister or his or her delegate. Consideration is to be given to the potential for an applicant's health to deteriorate, their need for medical and community care, educational and occupational services, the charge on public funds and prejudice to access, the availability of any private care and support, whether minor children will be affected, location of family members and sponsors, and compassionate or humanitarian considerations. These considerations are still referenced to the quantification: if the estimated health expenditure will exceed the 'undue cost' of \$200 000 or when there will be substantial prejudice to citizens' access, the discretion to exercise the health waiver is in effect withdrawn. In these considerations, the importance of quantification processes is seemingly marginalised.

Despite the promise of discretion, barriers to residency are not removed and the social category of the disabled child migrant is not re-conceptualised. Quantification remains a barrier, with the threshold of \$200 000 effectively pricing many children out of the waiver. The points of reference continue to reflect a deficit model of disability, in its emphasis on costs rather than productive labour. The expectation of on-going dependency is explicit in the focus on the availability of private care and support. This positions applicants in relationships of dependency within the private sphere – there is no conceptual space for disabled people to inhabit public sphere. Thus, the disabled migrant child is dependent and familialised.

The use and relevance of the waiver are structured by ethnicity and class. Consideration of the waiver is not automatic, and people must pay specialists to argue the case. Further, the emphasis on family care of a disabled person benefits applicants who have qualifications, financial resources and earning capacities, that is, those from middle or upper class backgrounds. Class position also intersects with ethnicity – those without the necessary resources are more likely to be moving from developing countries (NEDA 2009). Thus, the most vulnerable – people with limited resources and opportunities, and particularly refugees – are the least likely to be granted the protections and opportunities available in Australia.

Australia's migration systems impact upon children and adults living with a disability. But they have unique implications for how children are conceptualised as a social category, and their material life chances. Disability is seen as an individual deficit, rather than the outcome of social processes and power relationships (Goggin and Newell 2005). Defining child applicants with reference to costs reflects and reinforces a conceptualisation of disability as a deficit and as largely unproductive. Able-bodied children are presumed to be in the process of developing (intellectually, physically, emotionally) into productive citizens (Prout 2005), but this expectation is denied to children living with a disability, whose potential engagement in the labour market is denied (cf. AIHW 2008), as are any present or future contributions to the social good (Gothard 1998). Denying the possibility of productivity in turn denies an independent future. The provisions within the waiver power clearly conceive of children living with a disability as appropriately dependent upon their family and removed from the public realm.

This model places children in a particularly precarious position. Empirically, they face greater barriers to residency when costs are calculated over a lifetime. Further, the health requirement is designed so that it 'one fails, all fail' – children may be left behind to allow other family members to migrate (particularly in refugee cases, where the decision is more markedly forced and options

limited). This limits the child's (and their family's) emotional, physical and social well being (NEDA undated). These disadvantages are also structured by ethnicity: children from developing countries are more likely to be screened in to the health matrix, and more likely to be living with a disability, compared to children from developed countries. Thus, the workings of the migration system impact most negatively upon a group who stands in particular need of the protections and opportunities that may be available in Australia.

Intersectional human rights analysis: liberation and chain

Human rights could provide a source of counter-argument to the current imagining of the disabled migrant child under Australian migration policy. The most ratified human rights instrument is the *Convention of the Rights of the Child*. One of the other most fundamental and agreed human rights is the right to family life and family unity, even for non-citizens, set out in the *International Covenant on Economic Social and Cultural Rights*. Additionally, Australia is a signatory to the *1951 Refugee Convention* and although there is no specific requirement to provide family reunion to refugees, there is a wealth of 'soft' law.² Finally, the health requirement is prima facie contrary to the social model of disability as reflected in the *Convention on the Rights of Persons With Disabilities* (the *Disability Convention*) which emphasises the holistic contribution of a person which a disability, their inherent equality and their human worth beyond an economic assessment of the cost of their disability. Moreover, human rights can potentially provide an alternative methodology and framework to assess the worth of disabled non-citizen children, one that emphasises personal narrative and individual worth on the grounds of innate dignity and equality of that individual, impervious to market ideology and technical citizenship (Weissbrodt 2008).

Instead, disabled migrant children sit at an intersection of human rights 'black spots', within frameworks which correspond to the social construction of disabled migrant children, set out above. Children have been marginalised even in academic rights analyses of disability and migration. Migration, then, is the last bastion of sovereignty, heavily linked to the labour market (Dauvergne 2008) and exercised largely within the Executive power. The negation of the rights of aliens is endemic and structural. There is no right to migrate and even such rights as are bestowed by the 1951 Refugee Convention or the new UN Migrant Workers Convention are narrowly prescribed and restrictively applied. Where challenged, there is little recourse to the courts or parliament. The Australian Government's right to legislate in regards to aliens and govern over matters of immigration is constitutionally protected.³

² See further UNHCR EXCOM Conclusions 9(XXVII)-1977; 24 (XXXII) – 1981 and 88(L)-1999.

³ *Commonwealth Constitution*, s51(xix), s51(xxvii); *Robtelmes v Brennan* (1906) 4 CLR 395, 400.

In terms of disability rights, advocates argue that therefore even those people living with a disability who have full technical citizenship of a state endure a state of invisibility and ‘defective’ citizenship. Thus, the Health Requirement is by nature discriminatory, but such discrimination is explicitly legalised by section 52 of the *Disability Discrimination Act 1992 (Cth)*; Australia has signed but also entered a broad reservation to the *Disability Convention*, which states that the Convention does not impact on the health requirement.

The weakness in the human rights framework around disability and migration can be explained by quantification logic. With declining birth rates, most first world countries now need migrants if only to help them maintain their national living standards and to provide services and care for the aging population - and thus the competition described by Dauvergne as ‘the pursuit of the best and the brightest’ (2008: 12), an expectation that is referenced to ableist definitions of labour market contributions. Margaret Somers (2008: 1) warns that the growing authority of the market is distorting the non-contractualism of citizenship; that rights, inclusion and moral worth are increasingly dependent on contractual market value. Accordingly, non-citizens are arguing for ‘the right to have rights’.

Martha Minow suggests that rights rhetoric is often interpreted as offering two separate tracks – one track to freedoms and civil rights, granted to those who are identified as autonomous, rational and capable of making independent decisions; and a second track to protection and social provision. The benefits provided by the second track, often come at the price of exclusion and disempowerment for those labeled dependent, incompetent and irrational (Minow 1995) – the characterisation of children living with a disability.

Conclusion

Children subject to Australia’s migration decisions about the health are subject to the control and planning of society and nature through quantification with its implications of rational and ‘scientific’ knowledge. Denying residency to children living with a disability is rooted in technical and administrative processes, but these are not objective – they are explicitly and latently structured by class, ethnicity, ability and age. These intersect within the migration system to create a static and disempowering social category: the disabled migrant child. We propose in the alternative a human rights discourse that allows non-citizen children with a disability to become visible and to claim worthiness, capacity and advocacy in this system as opposed to silent, helpless burdens but human rights discourse itself will require transformation.

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