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Set out below are our submissions to the Joint Standing Committee on Migration *Inquiry into the migration treatment of disability*.

1. Overview

1.1 About the Immigration Advice and Rights Centre

IARC is a community legal centre in New South Wales specialising in the provision of advice, assistance, education, training, and law and policy reform in immigration law. IARC provides free and independent advice to approximately 3,000 people each year and many more attend our education seminars annually. IARC also produces *The Immigration Kit* (a practical guide for immigration advisers), the *Immigration News* (a quarterly publication), client information sheets and conducts education/information seminars for members of the public. Our clients are low or nil income earners, frequently with other disadvantages including disability, low level English language skills, past torture and trauma experiences and domestic violence victims.

IARC was established in 1986 and since that time has developed a high level of specialist expertise in the area of immigration law. We have also gained considerable experience of the administrative and review processes applicable to Australia's immigration law.

1.2 General overview

IARC is appreciative of the opportunity to be heard in relation to the migration treatment of persons with a disability. We believe that there are a number of serious issues requiring consideration, as discussed below. We recognise that the Department of Immigration and Citizenship (**DIAC**) has recently made some attempts at revising the health criteria under Australia's migration system. For example, on 28 March 2009 a new health matrix and revised version of the health PAM for temporary visa applicants was released. Nevertheless we believe that there remain significant concerns about the impact of the health criteria on persons with disabilities. To address these concerns we would respectfully submit that fundamental changes to the current system are required.

One of main concerns with the current immigration system, as reflected in a number of the arguments set out below, is that it eliminates the voice of persons with a disability. For example:

- the absence of a health waiver provision removes their ability to put forward arguments as to why they should be granted a visa to Australia
- the sole focus of the costs to the community removes their ability to articulate their value and the potential contributions that they would bring to the Australian community, and
- the "one fails, all fails" test renders irrelevant the persons' stated intentions on whether they even want to come to Australia.

As a recent study by NEDA of persons with a disability found[1]:

> 4. The ability to [have] a voice and be heard is a key component of feeling included. Linking social inclusion with human rights frameworks and support for advocacy provides a direction for giving people opportunities to be heard.

The Australian immigration system's treatment of disabilities needs to be overhauled in order to give recognition to the rights of persons with a disability and to ensure that Australia complies with its obligation under the Convention on the Rights of Persons with Disabilities (**CRPD**) to adopt appropriate measures to foster respect for their rights and dignity, combat stereotypes, prejudices and harmful practices relating to people with disability; and promote awareness of their capabilities and contributions.

2. IARC's concerns regarding the migration treatment of disability

2.1 Provision for health waiver

As outlined below, IARC has a number of concerns in relation to the migration treatment of persons with a disability. However, one of the primary and most obvious ones is the lack of waiver provisions for some subclasses of visa.

For example, within the family stream[2], a waiver provision exists for the following subclasses: 100, 309, 801 and 820 (Partner), 101 and 802 (Child), 102 (Adoption), 110, 310, 814 and 826 (Interdependency), 300 (Prospective Marriage), 445 (Dependent Child) and 461 (NZ Citizen Family Relationship Temporary). It does **not** exist for subclasses such as 115 and 835 (Remaining Relative), 116 and 836 (Carer), 117 and 837 (Orphan Relative), 103 (Parent), 804 (Aged Parent), 143 and 173 (Contributory Parent), 864 and 884 (Contributory Aged Parent) or 114 and 838 (Aged Dependent Relative).[3]

[1] NEDA (2009) *This is my Home – Belonging, Disability and Diversity* available at http://www.neda.org.au/files/this_is_my_home_august_2009_final.pdf
[2] IARC does not provide advice in relation to the economic stream of migration and therefore limits its comments in this submission to those areas of immigration law in which we have relevant expertise.
[3] There is a health waiver available for applicants for parent visas who have been granted a Substituted 676 Tourist visa following the Minister's intervention in their case but this is a very small proportion of parent visa applications.

We fail to see the justification for such a blanket exclusion for some visa subclasses for all persons who fail to pass the health test, regardless of the circumstances of their case. This inflexibility will invariably lead to inhumane, unjust and discriminatory decisions being reached. By contrast, the provision of a health waiver for all visa subclasses will still enable the Government to maintain control over entry of persons to Australia who may pose a health risk or may prejudice access by Australians to health and community services while permitting informed, compassionate consideration of all relevant facts and circumstances for each individual application.

The inflexibility of the current health test for some visa subclasses encourages the creation of artificial pathways or circumstances in order to achieve a particular immigration outcome. Set out below is an example of a case in which IARC acted in relation to a Carer visa application where there was no health waiver available.

Casestudy:
IARC acted in relation to a carer visa application which took nine years to be granted. Despite very clear carer needs of the sponsor there were a number of legal obstacles put in his way. The final one of these was that the sponsor's mother (applicant's wife) failed the health test. The applicant was in Australia and his wife was in their home country (and therefore was not an applicant). She had originally planned to come to Australia with her husband to take care of their son but when it was realised that her health issues would prevent this the couple made the decision that the care of their son in Australia was more important then them staying together and therefore the father traveled to Australia alone to look after their son. The Department indicated that they were considering refusing the application on the grounds that a member of the family unit failed the health test.

The application was eventually successful on the basis that the husband and wife had separated and therefore she no longer formed part of the applicant's family unit. While this was factually correct by the time of decision (ie 9 years after the application had been lodged) it was only correct because the Australian health test had forced the permanent separation of the couple and the breakdown of the family relationship.

If they had not separated their son (an Australian citizen) would not have had the care he desperately required and would have in fact cost the Australian community significantly more as a result of his reliance of community services and support, which his father now provides instead. This was hardly a humane outcome for the family, nor was it consistent with Australia's obligations under various international treaties (eg the ICCPR) in relation to protection of the family unit.

The lack of a health waiver may also discourage applicants from seeking treatment and/or testing for serious health problems because they are frightened that it could jeopardize their chances of getting a visa or have other negative consequences if they are diagnosed with a disease or condition.

Historically we understand that the health waiver was provided only for visas with sufficient ties to Australia (eg partner and child visas) while those who sought to immigrate independently, or with the support of a more distant relative, did not have a waiver available to them. As set out in Form 1071i the health criteria is justified as necessary to:

- minimise public health and safety risks to the Australian community;
- contain public expenditure on health and community services, including Australian social security benefits, allowances and pensions; or
- maintain access of Australian residents to health and community services.[4]

The focus on family stream visas for health waivers seems counterintuitive if the policy rationale behind the health test is to minimize the cost to the Australian community, as those who are migrating under the economic stream are more likely to bring a greater economic benefit to Australia.

Recommendation 1: IARC recommends that <u>all</u> visa subclasses include a relevant health waiver for applicants and members of their family unit who are required to satisfy the health test.

2.2 Balancing of costs and contributions

The second major concern that IARC has with the current immigration system is the mathematical equation used to assess whether a person will be a "significant cost" to the Australian community. This fails to:

- take into account the benefits that applicants can bring to Australia
- appropriately calculate the costs to the Australian community, and
- consider the costs to the individual and the Australian community of the person not being granted a visa.

<u>Benefits to Australia</u>

The current calculations for the health test focus solely on the costs to the community of a particular person being granted a visa to Australia. However, such costs need to be weighed against the potential contributions and benefits that the person can also bring. Currently there is no provision for such benefits to offset the costs, even where it is mathematically obvious that the overall benefit to Australia would be positive.

There are many examples of cases where it is clear that the contribution of an applicant to the Australian community can economically be proven to be many times greater than the costs that would be borne in relation to their disability or

[4] Form 1071i *Health requirement for permanent entry to Australia* available at www.immi.gov.au

condition. Nevertheless they will still be refused. One of the most widely publicized is that of Dr Abdi (eg http://www.abc.net.au/news/stories/2009/05/12/2567851.htm) who would bring great benefit to Australia as the holder of a PhD, an inspirational leader as the first blind teacher, highly respected within his profession (as demonstrated by an offer for a senior position in South Australian government) but still had difficulty getting a visa because of his disability.

As set out in the NEDA 2008 report *Refugees and Migrants with Disability and the United Nations Convention on the Rights of Persons with Disabilities*:

> NEDA is concerned that current law and policies affecting refugees and migrants with disability undermine fundamental rights. These policies arguably send the perverse message that people with disability present an overwhelming burden to Australian resources, and that people with disability are not capable of making a positive contribution to social and economic life.[5]

In most other areas the Australian government recognises the contribution that persons with a disability can make to society. As Brendan O'Connor (the former Minister for Employment Participation) stated:

> People with a disability or mental illness have an enormous amount to contribute and we need to tap into underutilised groups in our community to boost our nation's capacity.[6]

This sentiment was echoed by Attorney- General McClelland on the passage of the *Disability Discrimination and Other Human Rights Legislation Amendment Bill 2008* through Parliament, when he stated:

> These reforms will contribute to ensuring that our laws continue to promote greater equality, equal opportunity and a fair go for people with disabilities.[7]

The Government's approach on disability issues, as represented by such statements, is consistent with Australia's international obligations. Article 8 of the Convention on the Rights of Persons with Disabilities (**CRPD**) requires State Parties to undertake to adopt immediate, effective and appropriate measures to: raise awareness regarding people with disability; foster respect for their rights and dignity, combat stereotypes, prejudices and harmful practices relating to people with disability; and promote awareness of their capabilities and contributions.

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[5] available at http://www.neda.org.au/files/refugees_and_migrants_with_disability_and_un_crpd_july_2008_final_2.pdf

[6] O'Connor, B. (4 April 2008) *Minister OConnor congratulates Disability Services Australia* available at http://www.deewr.gov.au/Ministers/OConnor/Media/Releases/Pages/Article_081022_150515.aspx

[7] McClelland, R. & Shorten, B. (25 June 2009) *Further Measures To Improve Disability Rights* available at http://www.attorneygeneral.gov.au/www/ministers/RobertMc.nsf/Page/MediaReleases_2009_SecondQuarter_25June2009-FurtherMeasurestoImproveDisabilityRights

The recognition by the Government of the contributions that individuals with disabilities can make to society, and the Government's commitment to facilitating their involvement in society is incongruous with the singular focus of the health requirement on the costs that potential immigrants with disabilities represent to the Australia community, without taking into account the benefits and contributions they can make. We would also respectfully submit that it puts the Australian government in breach of its obligations under the CRPD as it creates stereotypes and prejudices while eliminating any recognition of their capabilities and potential contributions.

While we recognise that there is some danger in trying to put a dollar figure on the potential benefits that a person may bring to Australia, this danger is greatly outweighed by the disempowering injustice of the current sole focus on the costs of such applicants.

Recommendation 2: IARC recommends that provision be made for the inclusion of the benefits that a person with a disability or condition can bring to Australia so that such benefits can be counterbalanced against any assessment of costs to the community of such a person being granted a visa to Australia.

Calculating the costs of granting the visa

The current calculation of costs in relation to a particular individual is flawed in a number of critical ways. First, the reduction of whether a person passes the health test to a mathematical formula about "significant costs" creates a façade of objectivity. In fact the calculation of such costs is not objective. There is, and always will be, a subjective element in the calculation of what costs to include, what the prognosis is, what treatment is "required" and what conditions/illness should be considered. This is not an objective, scientific process, as is implied by the use of a mathematical formula.

In the case of *X v MIMIA* [2005] FCA 429 the court considered the circumstances in which an applicant pays for, and self-administers, their own medication. This case exemplifies the difficulty in interpreting the current legislative provisions in calculating what is a "significant cost". The court gave a detailed analysis of whether medication paid for by the applicant would constitute "*a significant cost to the Australian community in the area of health care and community services*". It found that:

> ... I am satisfied that on a wide or ordinary construction, the term "health care" in subpara 4005(c)(i) imports an element of personal attention or activity by a provider of health care. The term is not apt to extend to the mere provision of prescription medication that is self-administered. ...The costs of the anti-retroviral medication a hypothetical HIV sufferer would be likely to require therefore cannot be taken into account in assessing whether the provision of "health care" would be likely to result in a significant cost to the Australian community. ...

An example of a means to address this can be found in Canadian immigration law (an explanation of which is set out in the legal advice provided by Dr Ben Saul in the National Ethnic Disability Alliance's submission to the Committee). Canadian immigration law contains similar provisions as in Australia, with some important distinctions that provide additional protections not allowed for in Australia. Under s38(1) of the *Immigration and Refugee Protection Act 2001* (Canada) a foreign national is inadmissible on health grounds if their health condition: (a) is likely to be a danger to public health; (b) is likely to be a danger to public safety; or (c) might reasonably be expected to cause excessive demand on health or social services. This formulation provides two advantages. Firstly, requiring that the condition must cause "excessive demands" rather than just result in "significant costs," provides for a more substantial consideration of the potential costs to the community Secondly, it acknowledges the necessarily high level of subjectivity required of the decision maker in assessing the myriad factors involved in determining whether a disease or condition results in "excessive demands". Further, it is also interesting to note that the Canadian health assessment requires two or more concurring medical opinions – again a recognition of the subjective nature of the assessment.

A second serious concern with the current formula used to assess costs is that the health criteria does not require consideration of the particular applicant's circumstances. In *Robinson v MIMIA* (2005) 148 FCR 182 the court found that PIC 4005 requires the MOC to "ascertain the form or level of condition suffered by the applicant in question and then apply the statutory criteria by reference to a hypothetical person who suffers from that form or level of the condition." This was supported in *JP1 & Ors v Minister for Immigration & Anor* [2008] FMCA 970 (22 August 2008) where the judge noted that "there is no requirement to consider other details of a particular applicant's circumstances. The legislation is not cast in terms of the particular applicant's circumstances. It is cast in terms of what 'a person' who has the disease or condition suffered by the applicant would be likely to need".

Casestudy:
The example provided in the paper *'Discrimination and Immigration: An Australian (Bad) Example*" by Sharon Ford and Jan Gothard (paper presented at the 8th World Down Syndrome Congress, Singapore, April 2004) provides an insight into the personal experience of a family applying to migrate to Australia with a child with Down Syndrome. This highlights the lack of individual consideration that is given to applicants with a disability and the broad assumptions made based on that disability rather than their individual circumstances. This is available at http://www.dsav.asn.au/Topics/immigration.html

An important aspect of making an assessment based on the individual's actual individual circumstances includes an assessment of the likelihood that the applicant will actually access particular services as opposed to just their potential

eligibility for those services. DIAC's current approach to this issue is reflected in the PAMS which state:

> **56.4 Actual use of services is irrelevant**
>
> In determining whether an applicant's condition is likely to result in significant costs or prejudice access, MOCs are unable to take into account whether the applicant will actually use the identified health care or community services. They must assess the likelihood of an applicant's condition resulting in a need for health care or community services without regard to the applicant's personal circumstances or any claims by the applicant that they do not intend to use the identified care or services. Essentially, MOCs give a costing assessment based on a hypothetical person with the same severity of health condition.
>
> This is because there is no way such intentions can be legally enforced once permanent residency is obtained. For example, an applicant's medical or financial or marital circumstances may change, resulting in a reappraisal of their need not to use the care or services, or some applicants may simply change their mind regarding services once residence is achieved and the full level of costs is realised.

IARC has seen many clients facing issues with passing the health test where families and applicants are willing to provide guarantees that they will bear all costs associated with any medical expenses, including taking out appropriate health insurance to cover major treatments. Obviously this is not a practical solution for the Australian government as they cannot impose restrictions on permanent residents, which cannot also be imposed on Australian citizens (as those permanent residents will be able to become citizens after a number of years in Australia). However, consideration needs to be given to making some allowances for cases where an individual will not be accessing services although they may be eligible to do so.

A third flaw with the current calculation of costs is the breadth of what can be included in " community services" for the purposes of the calculations. For example, this can include job retraining which would be an expense for many migrants entering Australia who are unable to work in their previous field of expertise (eg due to lack of recognition of their qualifications or language difficulties) yet these migrants are not prevented from entering merely because society will incur this expense as a result of them being granted a visa. This is of particular concern given the relatively low threshold of what is considered to be a significant cost (ie $21,000 over five years for a permanent visa application).

In order to prevent discrimination against persons with a disability we believe that the definition of "community services" should be narrowed when used to calculate costs for the health test. This should not include existing community services that are provided in order to facilitate access to, and participation in, the community by persons with a disability.

Recommendation 3: IARC recommends that the method of calculating the costs to the community be revised to acknowledge the subjective nature of the

calculation, narrow its scope and tailor the calculation to the specific circumstances of the individual.

Recommendation 4: IARC recommends that the method of calculating the costs of "community services" exclude use of existing community services provided to facilitate access to, and participation in, the community by persons with a disability.

Calculating the costs of NOT granting the visa

Any mathematical formula for accurately assessing the cost to the Australian community of a particular individual being granted a visa needs to also take into account the costs of not granting the visa. This should include the cost to the individual as well as the costs to their family and the broader community. A good discussion of some of the social costs and benefits to the broader community resulting from migration can be found in *Social Costs and Benefits of Migration in Australia*, which states that:

> Many of the social costs and benefits of migration to Australia are either unquantifiable, or not measured[8]

In calculating the costs of not granting the visa, all hidden and societal costs need to be taken into account. For example, the costs of isolation, disempowerment, possible loss of work, focus and motivation of both the applicant (who may already be in Australia), as well as their family members in Australia should be considered. Where families are split up, it reduces the ability of the person in Australia to contribute and integrate because their energy and focus is on the family member (or members) that remain overseas – this is especially pronounced where it is a family member who is disabled or ill and requiring care. This loss of productivity is a significant cost to the Australian community and should not be ignored in the equation.

We would respectfully submit that in some cases the human costs of not granting the visa will far outweigh the cost of granting a visa to an individual with a health or disability issue.

Casestudy:
In 2001 an Australian citizen from Pakistan poured petrol over himself and set himself alight in front of Parliament House in Canberra. He died as a result. He had waited six years for a visa to bring his family to Australia, including his daughter who has a disability. He had arrived in Australia in 1995 on a visitor visa and had then applied and been granted refugee status. He had tried to reunite with his family since 1995, but all his efforts had come to nothing, largely because DIMIA considered that his daughter would be 'too much of a drain on

[8] Kerry Carrington, Alison McIntosh and Jim Walmsley (2007) *Social costs and benefits of migration in Australia* available at www.immi.gov.au

the health system'. It was assumed that, because she had a disability, she would cost the community over $750,000 (*News Limited, 4/4/01*).[9]

In calculating these costs of not granting the visa, account must also be given to the losses that Australia would suffer in not allowing the family members of the person with a disability to migrate either. This is discussed further in section 2.3 below, and is exemplified by the recent case of Dr Moeller where the benefits to the Australian community of the skills of the applicant far outweighed the costs that would be borne by the community in granting a visa to his daughter with down syndrome.[10]

Recommendation 5: IARC recommends that the costs of not granting the visa be included in the calculation of whether there will be a net cost to the community if the visa is granted.

2.3 One fail all fails test

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

The UNHCR has raised particular concerns with the impact that this rule has in humanitarian cases where the applicants are particularly desperate to obtain a visa to Australia. In such cases the person with the disability can be blamed for a poor immigration outcome. In a presentation attended by IARC the UNHCR provided examples of children or wives being abandoned when it was discovered that they have a health issue that may result in a visa to Australia being refused. Indeed they have even had extreme cases where a person commits suicide because they believe that their family cannot be granted protection in Australia while they have a family member who is ill. IARC would respectfully submit that the human and familial costs of such a policy are too great with no corresponding policy justification.

This test also means that the assessment that is done excludes from Australia the whole family who may make significant contributions to society, well above the costs that would be borne by the one member with the health or disability issue. This undermines the aims and economic effectiveness of the Australian

[9] Example quoted from the *Joint Submission tot eh Seante Inquiry into the administration and operation of the Migration Act 1958 – NEDA and MDAA* available at www.mdaa.org.au/archive/05/mdaa-sima.doc
[10] DIAC media release (30 October 2008) *Doctor's family has review options* available at www.immi.gov.au

immigration system (eg the economic stream which aims to attract appropriate skills and expertise in areas of demand). The Dr Moeller case referred to above clearly demonstrated this.

Casestudy:
IARC acted in relation to a partner visa application where the applicant had a severely disabled child. There were no plans for the child to migrate to Australia, and arguably the child would not even have been physically capable of making the journey to Australia. The mother and father of the child had separated and the child lived with the father who cared for her with the support of his extended family. The mother came to Australia, remarried and applied for a partner visa. Her partner visa application was refused by the Department on the grounds that she had a member of her family unit who failed the health test. While her application for review at the MRT was being processed the child died. Thus the case was successfully remitted and her visa was granted. This creates a difficult situation for the mother where the death of her child becomes a positive immigration outcome for her.

Recommendation 6: IARC recommends that the "one fails, all fails" rule be abandoned and the health criteria only apply to applicants for a visa to Australia.

2.4 Compulsory HIV testing

Our understanding is that most countries do not have mandatory HIV testing. For example, the United States has the largest humanitarian program and it is currently proposing to cease HIV testing. While we have no particular expertise in evaluating HIV testing we understand that this is because statistics have shown that mandatory HIV testing has no impact on decreasing the rate of infection.

In contrast, the negative impact of compulsory HIV testing can be great. Humanitarian agencies and resources are overstretched. We understand that the UNHCR's view is that currently there is simply not the resources, expertise and infrastructure to provide appropriate support and counseling to support mandatory HIV testing. To have compulsory HIV testing in countries where there is no appropriate counseling and support if the test shows a positive result, is irresponsible and dangerous.

Our extensive experience has shown that many applicants for a visa are completely bewildered by the entire immigration process. They have no understanding of what they are required to do or why, but merely follow instructions to the best of their ability. Therefore, when they are told to attend a doctor's surgery for a medical examination they will attend. They have no knowledge that they are going to be tested for HIV and therefore the psychological effect of a positive result can be devastatingly unexpected. This is on top of the fact that it will also be likely to exclude them and their family from a visa to Australia (which in humanitarian visa cases they are particularly

desperate to be granted). Without appropriate counselling and support for such applicants, they are highly vulnerable and at great risk of depression, self harm and suicide.

This impact is particularly concerning given that Australian immigration laws require HIV testing for everyone aged 16 years and over. Therefore children may be diagnosed with HIV without understanding what they are being tested for and without being adequately prepared for the possibility of a positive result.

Recommendation 7: IARC recommends that compulsory HIV testing be abandoned.

2.5 Lack of review

In IARC's opinion there is very limited opportunity for any meaningful opportunity to appeal a negative decision by a Medical Officer of the Commonwealth (**MOC**). While a person who fails the health test is provided with an opportunity to comment in relation to the opinion of the MOC, in most cases this is meaningless where there is no health waiver provision. In a few cases additional information may be provided in response to this, which is then given to the MOC for them to reconsider their opinion. In IARC's experience this reconsideration will in most cases not result in a change of the opinion formed by the MOC.

In some cases it may be possible to lodge an appeal with the Migration Review Tribunal (**MRT**), but not in all cases. There is no right of appeal for a humanitarian visa application, which is refused on health grounds. In addition, review rights are often of limited utility because of the delay, expense, language difficulties and other barriers that make the process difficult, and for some impossible.

Even if an appeal to the MRT is lodged, it is very difficult to challenge the reasonableness of the opinion of the MOC, even where the expertise of the MOC or the Review MOC (**RMOC**) is questionable (see 2.7 below). The fact that the opinion of the RMOC is binding on the MRT and cannot be challenged, even with expert medical testimony makes it very difficult to succeed.

In addition, we note that where applicant is in a country where there is only one panel doctor (see 2.7 below) it is difficult for them to obtain an independent second opinion when appealing the decision.

We note that in the past the Government has claimed that Ministerial intervention powers could be used to correct an unjust outcome.[11] Any reliance on Ministerial intervention powers as a systematic mechanism of ensuring a humane and just outcome is unsatisfactory due to the non-compellable, non-reviewable nature of

[11] See for example, the Department's response in the Dr Moeller case - DIAC media release (30 October 2008) *Doctor's family has review options* available at www.immi.gov.au

such decisions, the lengthy and uncertain process and the lack of transparency in any conclusion reached by the Minister. While Ministerial intervention can be effective in isolated cases, it often only arises as a result of media coverage and/or community support. For those who are unable to clearly articulate their compassionate claims (eg due to language barriers, social isolation or as a direct consequence of their disability) the result is not always so positive.

Recommendation 8: IARC recommends that a health waiver be included for all visa subclasses to enable a more meaningful review that takes account of all the circumstances of the individual.

Recommendation 9: IARC recommends that an appeal process be implemented to allow an appeal to be made to at least two appropriately qualified specialists who must reach a consensus on the health of the individual, before the person fails the health test.

2.6 Lack of transparency

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

The Australian National Audit Office's (**ANAO**) report *Administration of the Health Requirement of the Migration Act 1958*[12] was highly critical of the lack of transparency surrounding the health criteria under Australian immigration law. The report found that:

> "While DIAC included some infectious diseases of global significance within this criterion, the reasons or a firm basis for doing so was often unresolved and undocumented. DIAC did not follow a systematic process for incorporating new or emerging health risks into its guidelines and risk management framework. This weakened DIAC's ability to develop responsive and soundly based migration guidelines and procedures, and to ensure that its guidelines aligned with other national public health policies." (p19)

> "In particular, the health criterion indicating 'threat to public health', which must be met by applicants in order to be granted a visa was not defined in DIAC's guidelines. Guidelines did not clearly explain which diseases constituted a public health threat under the health requirement. In addition, some costings for MOCs to determine 'significant costs' were incomplete or out of date, and there was no systematic decision process for inclusion of items (or services) on DIAC's significant 'prejudice to access' list. Consequently, DIAC was not providing a sound basis for MOCs to make consistent decisions on 'prejudice of access'."(p23)

[12] Australian National Audit Office (2007) *Administration of the Health Requirement of the Migration Act 1958* available at www.anao.gov.au

The audit raised the issue that lack of definitions or inconsistent definitions across DIACs documentation could lead to a narrower interpretation of the Public Interest Criteria than is intended by the legislation, and possible inequitable application of the health requirement. What exactly constitutes a threat to public health for immigration purposes under the health requirement is not clear from policies as they stand. For example, an applicant must be 'free from TB,' but this does not distinguish between active and inactive TB. Nevertheless individuals with inactive TB are allowed entry into Australia (we note that in the PAMS it states that in policy references to tuberculosis, it is to be interpreted as "active turberculosis," but this is not set out in the legislation itself). This lack of clarity puts potential applicants in an uncertain position as to whether their health issues will be caught by the health requirement.

Another issue considered by the audit was how causing 'prejudice to the access' to Australian health care and community services is a reason why someone may fail the health requirement. Under current policy the following limited examples are provided of what conditions would be considered under the prejudice to access criteria:

- organ transplants are considered to be an example of extensive prejudice to access as there are far more potential recipients than donors
- substantial prejudice to access occurs where facilities are in high demand, waiting lists are common, choice of persons for treatment may be exercised and the consequences of failure to obtain treatment may seriously disadvantage an individual by causing premature death, unnecessary pain or suffering, or loss of quality of life. Services which may result in substantial prejudice to access include:
    - dialysis
    - blood/plasma products, including coagulation factors and immunogobulins
    - fresh blood or blood components for people with rare blood groups
    - intravenous immunoglobin products
    - knee and hip joint replacement
    - radiotherapy for the treatment of malignancy
    - interferon treatment for chronic active hepatitis or
    - nursing home or residential care placement.

However, the ANAO was critical of how DIAC's prejudice to access list is compiled. The list is not explainable by any policy or criteria, the ANAO found little documentation of procedure, the list was not regularly reviewed, and guidelines for costing for many items on the list were not fully developed. Given the importance of the health criteria to the visa application process, there should be considered procedures and policies in the compilation of the prejudice to access list and associated costs, both for effective decision-making and transparency and certainty for applicants.

Recommendation 10: IARC recommends that further information be made publicly available on:

- the average cost calculations for specified disabilities or conditions
- what diseases or conditions are considered to prejudice access by Australians to health care and services, and

- information on how these lists are calculated.

This lack of transparency continues in relation to the opinion provided by the MOC which generally provides very little guidance in relation to exactly how their opinion was formed. The provision of more detailed reasons and explanations would enable a more meaningful response from applicants and would enable them to address those issues more pointedly in any application for review by a RMOC.

Recommendation 10: IARC recommends legislative provisions be implemented specifying what detailed information must clearly be set out in the opinion of a MOC.

2.7 Quality of decision making

The assessment of the health criteria was one of the first areas relating to immigration that was privatised. A review should be conducted of this outsourcing arrangement to see whether this has resulted in a reduction of the quality and/or expertise of the doctors making these assessments – particularly in relation to the use of panel doctors outside Australia.

The ANAO's report *Administration of the Health Requirement of the Migration Act 1958*[13] provided a review of some of the arrangements with the use of panel doctors and noted potential issues with the quality of those approved. It stated:

> However, documentation submitted to DIAC to support the approval of panel doctors did not meet DIAC's own standards. A small ANAO sample identified deficiencies in 50 per cent of approved panel doctor applications examined, including: illegible copies, non-certified documents, documents not translated, and photographs too unclear for identity purposes.

IARC has particular concerns about those countries where there is only one panel doctor appointed. For example, a review in October 2009 of the publicly available list on the DIAC website showed the following countries only had one panel doctor listed: Afghanistan, Algeria, Armenia, Azerbaijan, Bahrain, Belarus, Botswana, Burkina Faso, Cambodia, Cameroon, Congo, Cuba, Djibouti, Estonia, French Guyana, Gambia, Georgia, Guatemala, Guyana, Jamaica, Kiribati, Mauritania, Mongolia, Morocco, Mozambique, Nicaragua, Panama, Paraguay, Sudan, Swaziland, Suriname, Trinidad & Tobago and Tunisia.

In some of the countries that only have one panel doctor, it may be due to limits in medical services available in the country. However, for many of the countries on the list, such as Cuba or Estonia, it is doubtful that more doctors for the panel could not be found.

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[13] Australian National Audit Office (2007) *Administration of the Health Requirement of the Migration Act 1958* available at www.anao.gov.au

For those applying from a country with only one panel doctor, this may create serious obstacles. It is common to have a difference of opinion between medical professionals, and if an applicant would like to have their medical results reviewed, they will not be able to, as there is only one panel doctor in their country. We recognise that the PAMS state that:

> In countries where there are no (or limited) panel doctors, the department may accept an examination from a non-panel doctor where it is considered to be fair and reasonable to do so, and the HOC agree.

However, in our experience acceptance of a medical opinion of a non-panel doctor is rare.

Another area of concern is whether appropriate specialists are being used to make the assessments. The assessments by the MOC are binding and there is no independent review process. This is particularly concerning given that the MOC may not have the relevant expertise to be making the assessments that they are making – for example, it requires very specialized knowledge and expertise to be able to make assessments and forecast the prognosis, treatment or effects of a particular disability or condition. Only a specialist should be able to do this.

Recommendation 11: IARC recommends that a review be conducted of the outsourcing arrangements for health care assessments.

Recommendation 12: IARC recommends that in all countries more than one panel doctor should be appointed.

2.8 Exclusion from the Disability Discrimination Act

The Australian Government has always ensured that its treatment of people with a disability cannot be considered to be discrimination under domestic law. Section 52 of the *Disability Discrimination Act* 1992 (Cth) (**DDA**) contains an exemption for the *Migration Act* and *Regulations*. It states:

> **52 Migration**
> Divisions 1, 2 and 2A do not:
> (a) affect discriminatory provisions in:
> (i) the Migration Act 1958; or
> (ii) a legislative instrument made under that Act; or
> (b) render unlawful anything that is permitted or required to be done by that Act or instrument.

On 18 July 2008 Australia ratified the United Nations Convention on the Rights of Persons with Disabilities (**CRPD**). However, when it did so it specifically excluded the effect of the CRPD on migration laws. In the context of its ratification of the CRPD the Australian government issued an interpretive declaration stating:

> Australia recognises the rights of persons with disability to liberty of movement, to freedom to choose their residence and to a nationality, on an equal basis with others. Australia further declares its understanding that the Convention does not create a right for a person to enter or remain in a country of which he or she is not a national, nor impact on Australia's health requirements for non-nationals seeking to enter or remain in Australia, where these requirements are based on legitimate, objective and reasonable criteria.

IARC has had the benefit of reading the report provided by NEDA entitled *Refugees and Migrants with Disability and the United Nations Convention on the Rights of Persons with Disabilities*[14]. IARC supports the concerns raised in that report and the conclusions reached as follows (their emphasis):

> At its best, law offers protections that safeguard rights and promote freedom and participation. At its worst, law and policy can support alienation, exclusion and discrimination.
>
> It is acknowledged that migration policies must carefully balance a range of factors, including the need to safeguard community resources and promote social and economic sustainability. Similarly, provision of welfare entitlements must also be weighed to create incentives for productivity and employment and protect against unplanned expenditure from the public purse.
>
> However, NEDA is concerned that current law and policies affecting refugees and migrants with disability undermine fundamental rights. These policies arguably send the perverse message that people with disability present an overwhelming burden to Australian resources, and that people with disability are not capable of making a positive contribution to social and economic life.
>
> The United Nations Convention on the Rights of Persons with Disabilities (UN CRPD) provides an important opportunity to address areas of Australian law where there are inconsistencies with fundamental rights for people with disability, agreed to by the international community as a whole.
>
> This report highlights areas of significant inconsistency between the obligations under the UN CRPD and areas of migration and social security policy affecting refugees and migrants with disability.
>
> **NEDA strongly recommends the Australian Government commit to law reform, in the areas of migration and social security policy affecting refugees and migrants with disability, as part of the implementation plan for UN CRPD.**
>
> It is NEDA's hope that the Australian Government will constructively use UN CRPD as a guiding instrument towards progressive reforms that improve the lives, the rights and the wellbeing of people with disability. NEDA believes that positive reforms in line with UN CRPD will go some way towards demonstrating an Australian commitment to safeguarding the fundamental rights of people with disability.

2.9 Impact on children

The impact of the health criteria can be particularly profound on young children with a disability. These children are more likely to fail the health test as the cost

[14] NEDA (2008) *Refugees and Migrants with Disability and the United Nations Convention on the Rights of Persons with Disabilities* which can be found at http://www.neda.org.au/page/refugees_and_migrants_with_disability.html

of their disability will be assessed across their lifetime (eg under policy this will include the costs of special education), making it more likely to exceed the minimum monetary threshold set as to what is a "significant cost" to the community.

As discussed in 2.5 above, this can lead to the child being blamed for a poor immigration outcome (or feeling responsible themselves for the poor immigration outcome) and even being abandoned by the family. This is a result that is particularly concerning given Australia's obligations under the Convention on the Rights of the Child.

Casestudy:
A family from Asia applied to migrate to Australia. One of the younger children has a physical disability and DIMIA (as it was then known) indicated that the whole family would be refused a visa because she did not meet the health criteria. The family was in a dilemma and eventually decided to make the move to Australia, leaving the child in the care of relatives, and hoping to sort out her visa once they had arrived and settled in.

After a long separation from her family resulting from the lengthy immigration process, the young girl developed feelings of inferiority and very low self-esteem. She felt abandoned by her parents and attempted suicide. When she finally arrived in Australia some years later she was very temperamental and aggressive towards her siblings. The family felt distraught about having to leave her behind and is now struggling to deal with the consequences. [15]

2.10 Other impacts on Australian citizens and residents

IARC also has concerns about the impact of Australia's migration laws on Australian permanent residents and citizens with a disability. Sponsors with disabilities applying for family stream visas (eg partner visas) are highly likely to be asked to provide an assurance of support in order for the applicant to be granted a visa. If they are unable to find anyone to provide this assurance then the application will be refused and the family will have to remain separated. This then impacts on the costs that the Australian community must bear since the Australian permanent resident or citizen will turn to community services to obtain the support which otherwise would have been provided by the family member.

Given the financial burden of a disability, the likely corresponding reduction in income and the possible social isolation as a result of the disability, it is common that sponsors with a disability are unable to themselves provide an assurance of support and often have no-one within their support network who is able or willing to do so.

[15] Example quoted from the *Joint Submission tot eh Seante Inquiry into the administration and operation of the Migration Act 1958 – NEDA and MDAA* available at www.mdaa.org.au/archive/05/mdaa-sima.doc

Casestudy:
IARC acted for a client who had a severe stroke which left him unable to work. He was a permanent resident of Australia. Following the stroke he applied for his wife and children to come to Australia. Due to his reliance on Centrelink, a discretionary assurance of support (**AOS**) was requested. He had no support network or other family in Australia and was unable to find anyone willing and able to provide the AOS. Despite a submission asking that the request for the AOS be withdrawn, it was not. After an extended period of time the application was refused. This actually resulted in greater costs to the Australian community as the client was not able to obtain the care from his wife and children and therefore had to rely on publicly funded support services.

Recommendation 13: IARC recommends that consideration be given to the impact of the assurance of support system on sponsors who have a disability. DIAC policy should address such cases and provide guidance to caseofficers on how to appropriately deal with them.

3. Conclusions

IARC greatly appreciates the Government's initiative in establishing this review into the migration treatment of persons with a disability and IARC's ability to provide some feedback to the Committee on behalf of its vulnerable clients.

As outlined above, there are a number of areas in which the current migration system requires review and amendment to ensure that all persons with disabilities are treated humanely, justly and in a manner which respects their human rights, dignity and the positive contributions that they and their families make to the Australian community. We look forward to the Committee's conclusions and recommendations in this complex and difficult area.

Regards

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