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Committee Secretary
Joint Standing Committee on Migration
Department of the House of Representatives
Parliament House
CANBERRA ACT 2600

Email: jscm@aph.gov.au

Dear Secretary,

Inquiry into the migration treatment of disability

Dear Committee Secretary,

Thank you for the opportunity to make a submission to your inquiry into the migration treatment of disability. Our submission is based on our research and experience in migration law, policy and practice.

In the submission we first discuss general principles that inform our approach to the issue. We identify flaws in the current operation of the health requirement, and propose three models for reform. In light of that analysis we make four recommendations for reform.

We are happy to provide further details for the Committee if requested, including providing evidence at any public hearing the Committee may be holding.

Yours sincerely,

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Introduction

1. We welcome the government's commitment to undertake an inquiry into the health requirement in migration law and its impact on persons with disabilities. We are a group of academics, migration agents and students affiliated with the ANU College of Law and its Migration Law Program with expertise and experience relevant to the Committee's inquiry. Our submission also reflects and draws on the vast collected experience of the teachers within the ANU College of Law's Migration Law Program who are also practising migration agents with extensive, practical experience of the migration health requirement.

2. It is timely to review the health requirement due to developments in the last twenty years. At various periods in history, cholera, tuberculosis and leprosy have been feared diseases but advances in medical science have made them less threatening. Similarly, there have been advances in evidence gathering from medical experts. Australia is also competing with other developed countries for skilled migrants and we need to be confident that the health requirement is not a blunt instrument being unfairly applied. Despite this need for an overhaul of the health requirement regime, this submission confines its scope to reform proposals for modifying or removing the health requirement for people with disability.

Summary of Recommendations

3. In summary, we recommend the following steps be taken to reform the health requirement with regard to visa applicants and their families with disability.
   (a) That greater consideration be given to Australia's international obligations towards people with disability.
   (b) That reform of the role to be performed by the Medical Officer of the Commonwealth in relation to the health requirement be explored, including the possibility of making their opinion reviewable by an appropriate merits review tribunal.
   (c) That universalising the health waiver across all the visa categories be considered in relation to the health assessment of people with disability, while (i) encouraging a wide community debate about what should be a legitimate, objective and reasonable migration decision for migrants with disability and (ii) improving training and resources for primary decision-makers.
   (d) That a progressive development towards the exclusion of disability from the health requirement be embraced as one of the community objectives in the wider context of overall health care reforms.

General Principles

Non-Discrimination

4. We are guided in our views by core principles underpinning international human rights law, key amongst which are the relevant principles of equality, fairness, legality, inclusion, respect for human dignity, non-discrimination and family unity. These are reflected in human rights treaties to which Australia is a party, including most recently the Convention on the Rights of Persons with Disabilities (hereinafter Disability Convention). Article 1 of the Disability Convention sets out the purpose as follows:

   > The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

5. Article 3 of the Disability Convention enunciates the basic principles governing the way in which people with disability are to be treated, stating that:

> *The principles of the present Convention shall be:*
> *(a) Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;*
> *(b) Non-discrimination;*
> *(c) Full and effective participation and inclusion in society;*
> *(d) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;*
> *(e) Equality of opportunity;*
> *(f) Accessibility;*
> *(g) Equality between men and women;*
> *(h) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.*

6. The Disability Convention has introduced a paradigm shift in both the approach to and definition of disability, emphasising the international community's commitment to viewing persons with disability as capable of claiming a range of rights and making decisions for their lives based on their free and informed consent, as well as being active members of society. In this sense, people with disabilities should not be primarily considered as a burden on society, but as active and contributing members. This is underpinned by the principles of *participation* and *inclusion* reflected in specific obligations throughout the Convention.

7. Our approach to the health requirement in the Migration Regulations should be seen in this light, consistent with the understanding that disability is a construction which, as the Preamble to the Disability Convention notes, 'results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders full and effective participation in society on an equal basis with others.'[1]

8. As a party to the Disability Convention, Australia is obliged (under the general obligation in article 4, amongst other provisions) to consider the extent to which its legislative and regulatory regimes may currently discriminate against and exclude people with a disability from taking up their rights to be active members of society. It is thus incumbent upon a State Party to consider the extent to which its laws, policies and practices directly or indirectly contribute to the construction of disability by creating impediments to effective and equal participation in society. The health requirement, which potentially excludes people with a disability from entering Australia, should be considered in this context.

9. It is our opinion that the health requirement in migration law as it currently operates falls foul of both the spirit and the letter of the Disability Convention. It can contribute to the negative construction of disability by creating and reinforcing attitudinal barriers to the participation in Australian society of migrants who might otherwise have legitimate grounds for entering under Australia's migration program by effectively equating a person's overall worth with a fiscal bottom line. Equally importantly, it also allows for potential interference with the right of family unity.

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[1] Rather than provide a definition of disability, the Convention indicates who are persons with disabilities, and emphasises the dynamic and evolving nature of the concept.

10. We recognise that Australia declared its understanding on ratification of the Disability Convention that it '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.'[2] It is our understanding that this is to be considered an interpretive declaration and not a reservation to those articles protecting the equal rights of persons with disability to liberty of movement, to freedom to choose their residence and to a nationality, which the declaration otherwise confirms. As such, it is not to be considered a "catch-all" protection for any policy relating to immigration against the full application of the rights recognised by the Convention. In any case, the declaration must be read consistently with the object and purpose of the Convention,[3] and does not detract from the clear and positive obligation on Australia under article 18 to recognise 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*.

11. In light of the above, 'legitimate, objective and reasonable' criteria should be read consistently with the principles of inclusion and equality underpinning the Disability Convention. To the extent that government uses health criteria to 'pick and choose' those who should be allowed to enter Australia on the basis of the perceived severity of their disability and the perceived health costs flowing from it, such a course of action would be clearly discriminatory and in breach of the freedom of movement guaranteed in article 18 of the Convention. Nor can these criteria disproportionately interfere with other core rights and obligations contained in the Convention and elsewhere, not least of which is the right to respect for private and family life guaranteed by articles 22 and 23.

Family Unity

12. To the extent that the current health criteria apply to those applying for a visa under the family migration program, it potentially infringes on the principle of family unity. That the family is the fundamental unit of society, entitled to respect and protection, is recognised in almost every human rights treaty and declaration.[4] The Preamble to the Disability Convention states:

> (x) Convinced that the family is the natural and fundamental group unit of society and is entitled to protection by society and the State, and that persons with disabilities and their family members should receive the necessary protection and assistance to enable families to contribute towards the full and equal enjoyment of the rights of persons with disabilities, ...

13. Respect for privacy and for home and family life is expressly guaranteed in articles 22 and 23. Consistent with recognition of the family as the fundamental group unit of society entitled to protection, these provisions can be read as providing a right to family unity in the migration program. Health criteria which can lead to the exclusion of a person with disability from being able to exercise

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[2] Australia's Declaration on Ratification of the Convention, available at: http://www.un.org/disabilities/default.asp?id=475.

[3] Vienna Convention on the Law of Treaties 1969, articles 18 and 19 on reservations, which also applies to interpretive declaration. See, *Belilos v Switzerland* .[1988] ECHR 4.

[4] See, eg, preamble and article 16(3) of the *Universal Declaration of Human Rights*, article 23(1) of the *International Covenant on Civil and Political Rights* and article 10 of the *International Covenant on Economic, Social and Cultural Rights*.

this right of family unity can not be justified, and should be removed from the legislative regime.

14. While there is no specific provision on family unity in the 1951 Refugee Convention and its 1967 Protocol, the right to family unity is widely recognised in other international human rights law, which applies to refugees as it does to all others. In addition, Executive Committee Conclusions Nos. 1, 9, 24, 84, 85, and 88, each reaffirms States' obligations to take measures which respect family unity and family reunion.[5]

15. From a more pragmatic perspective, family reunion is clearly integral to a refugee's ability to be able to resettle effectively and provide the maximum contribution to their new country. Many refugee settlement agencies report of the difficulty many refugees have in fully rebuilding their lives until they know their families are also safe. Australia has one of the largest refugee resettlement programs in the world and it is our own interests to ensure that resettlement is as effective as possible by reducing barriers to family reunion.[6] While the waivable health criterion 4007 applies to refugee and humanitarian visas, refusals of visas in this situation do occur. Having a relative refused entry because of disability can be particularly distressing for a refugee if that disability is a direct or indirect result of the same persecution which caused the refugee to flee.

16. We therefore urge the Committee in making its recommendations to consider a reformulation of the health criteria to ensure consistency with the purposes of the Disability Convention, and to avoid reinforcing historical and societal impediments facing people with disability seeking equal access to human rights and participation in society.

17. The assumptions about 'cost' and 'accessibility' that currently dominate the health criteria as they appear in Schedule 4 of the Migration Regulations 1994 need to be modified to fully reflect the content and intent of the Disability Convention.

18. It is our experience that the current system results in injustices, expense and inefficiency. The cost of medical tests along with visa applications can be substantial, and applicants can be left waiting for a long time, especially if their application ends up being one relying on ministerial discretion.

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

Resort To Ministerial Discretion

20. Because there is no health waver available under Public Interest Criterion 4005, a migration agent is frequently put in a position where they have to advise a client to submit a visa application which they know is likely to fail, with a view to eventually putting their case to the Minister to exercise his or her personal discretion to grant a visa. The 'safety-valve' of the Minister's discretionary powers is there to redress the compassionate and humanitarian circumstances of

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[5] See Erika Feller, Volker Turk, and Frances Nicholson (eds), *Refugee Protection in International Law* (Cambridge University Press, 2003), Chapter 19.2, para. 3.

[6] Under the current health requirement, PIC 4007 applies to offshore humanitarian visa applicants. See, Migration Regulations 1994, Schedule 2, cl 200.226, 200.323, 201.226, 201.323, 202.227, 202.323, 203.226, 203.323, 204.226, 204.323.

individual cases that fall between the cracks of the rigid codified system of visa criteria, including the unwaivable health criterion 4005. Resort to personal appeals to the Minister has obvious disadvantages including the lack of certainty of the outcome, the delay in waiting for an uncertain outcome, and perhaps most damaging to the welfare of the family and the community. Since a decision of a Tribunal is a prerequisite to the Minister's personal discretionary powers being activated, there is also the added costs burden of additional appeals to the Migration Review Tribunal.

21. The inefficiencies inherent in the current system of ministerial discretion, where the Minister cannot act until after a primary decision and then a merits review have been completed, are well documented, as has the opaque nature of the reasoning behind any use of the discretion. The report of the Senate Select Committee on Ministerial Discretion in Migration Matters, tabled in March 2004, and the report in January 2008 by Elizabeth Proust into the use of Ministerial powers under the Migration Act,[7] both provide clear arguments why the use of the Ministerial discretion power should be curtailed, with such discretion to be delegated to departmental decision makers where possible.

22. Because of the opaque nature of the use of the Ministerial discretion powers under the Migration Act, and the fact that the use of the discretion is non-compellable and non-appealable, migration agents are currently put in a position where they have to advise clients on whether or not they should 'take a punt' on their chances with ministerial discretion. Given the costs involved to visa applicants it can be a very expensive punt with odds that are difficult to calculate.

23. We submit that the health requirement, in its current form, is inefficient and costly in its application, and can result in unfair outcomes. Reform will necessitate revaluating the purpose of the health requirement, in light of both Australia's domestic needs and its international obligations towards people with disability. It will require reassessing the health requirement's application in order to create a more efficient and fairer system for persons with disability and their families seeking to migrate to Australia.

Flaws in the Current Model

24. The current operation of the health requirement has significant flaws. We note in particular:

- The absence of a health waiver in Public Interest Criterion (PIC) 4005 of the Migration Regulations 1994 means that the health requirement can lead to the exclusion of a person solely on the basis of their health status, which in certain instances will include their disability. The absence of any discretion in such instances is incompatible with Australia's obligation to ensure that any impediment to the equal enjoyment of freedom of movement is only imposed on grounds that are legitimate, objective and reasonable. The failure to provide an avenue for considering other factors – humanitarian, financial, familial, societal etc – cannot be considered reasonable in these circumstances.
- The framing and exercise of the health waiver in PIC 4007 unreasonably preferences economic considerations above all others.

[7] Elizabeth Proust, "Report to the Minister for Immigration and Citizenship on the Appropriate Use of Ministerial Powers under the Migration and Citizenship Acts and Migration Regulations", 31 Jan 2008, available at: http://www.minister.immi.gov.au/media/media-releases/2008/proust-report.pdf.

- The 'safety net' of Ministerial discretion is inconsistent with good administrative practices, is time consuming and costly for all parties, and results in unnecessary insecurity and uncertainty for people with disability in the migration system[8].

Options for Reform

We consider there to be three potential reform options:

First Model: Reform of MOC decision-making

25. The first medical assessment that visa applicants and their family receive may well be the first hurdle to the assessment of the applicants' satisfaction of the health requirement. It is a legislative requirement that visa applicants and their family have their medical conditions examined by a Medical Officer of the Commonwealth (MOC), and the Minister is required to take the opinion of the MOC to be correct.[9] Although an opinion of the MOC about medical costs and whether the condition prejudices Australians' access to health care or community services can be reviewed by another MOC, they are not adequately resourced to provide reviews of their own opinions at the level demanded by the public of bodies such as the Migration Review Tribunal.

26. At the moment, the MOC's opinion with regard to the health requirement is confined to the assessment of the potential cost and accessibility against the demands from Australians in the same diagnostic category, regardless of whether the health care or community services will actually be used.[10] However consideration might need to be given to those cases where a balancing of factors – such as value to the community of the applicant due to their skills, or value to the employer because of the nature of their skill – warrant further consideration of satisfaction of the health criteria. This can be achieved by expanding the role of the MOC to make a medical assessment in the overall context of the applicant's personal and social circumstances.

27. Such a change to the role of MOC will lead to a similar health assessment model that has been implemented in Canada, where medical officers form a view about medical admissibility of a visa applicant,[11] taking into account not only their medical condition but also non-medical factors such as the availability or cost of publicly funded health and social services along with the willingness and ability of the applicant or his or her family to pay for the cost of private support.

28. The Canadian experience shows, as illustrated by the Canadian Supreme Court decision in *Hilewitz v Canada (Minister of Citizenship and Immigration)*,[12] that medical officers may make a generic assessment based on the classification of the impairment rather than on its particular manifestation in relation to a given individual, resulting in an automatic exclusion for all individuals with a particular disability.[13] Should this reform option be pursued, therefore, it is essential to

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[8] For further arguments on the efficiency, transparency and integrity benefits of reducing the use of ministerial discretion, see the submission by Andrew Bartlett (Submission 13) to the Senate Legal and Constitutional Affairs Legislation Committee inquiry into the Migration Amendment (Complementary Protection) Bill 2009.

[9] Migration Regulations 1994 (Cth), reg 2.25A.

[10] Migration Regulations 1994 (Cth), Schedule 4, 4005(c).

[11] Immigration and Refugee Protection Act, SC 2001, c. 27 (Canada), s 38(1)(c).

[12] [2005] SCJ No 58.

[13] Ibid, paras. 55-56.

ensure that the health assessment be subject to review by a merits review tribunal, including the hearing of expert evidence through the method of hot tubbing which allows presentation of concurrent expert opinion.[14]

Second Model: Universalising the waiver to all visa subclasses

29. Currently, a visa application will be refused if an applicant or a member of their family does not meet the health requirement and a health waiver is unavailable in application of Public Interest Criteria 4005 in Schedule 4 of the Migration Regulations.[15] As clarified in *Robinson v MIMIA*,[16] the health assessment in terms of required treatment and costs likely to incur for the treatment should be made on a case-by-case basis.[17] However, it is questionable to what extent due regard has been given by each decision-maker to individual circumstances or the specific degree of condition.[18] As long as decision-makers are required to take the opinion of the MOC to be correct, there is little scope for them to take into account the visa applicant's broader personal circumstances.

30. One approach to reform would be to provide a health waiver in all circumstances, including those migrating under skilled and business migration streams. This would allow decision-makers to weigh up the individual circumstances of the applicants and their family at an early stage and in a way consistent with Australia's declared understanding of its obligations towards persons with disability. A waiver of the health requirement at the first stage of a visa application could alleviate the complicated and stressful procedure that families with disability would otherwise have to be put through.

31. If the health waiver was expanded to all visa categories it would give the primary decision maker greater flexibility and discretion at the original stage of decision making. Each decision-maker would be able to consider mitigating factors on a case-by-case basis as outlined in Procedures Advice Manual 3. While this flexibility should facilitate original decision-makers making more reasonable decisions weighing up the particular circumstances of the family and the impact that a family member with disability may have on public health, there is also a concern that it may well result in inconsistent decision-making, giving some visa applicants an unfair or flawed decision.

32. The fairness and legitimacy of health decisions also depends on which factors are to be taken into account and how much weight is to be given to each factor. Under the current health waiver scheme, in determining whether the costs are 'undue', the delegate can weigh the health costs against mitigating factors such as:

- the merits of the case (i.e. compassionate and/or compelling circumstances)
- qualifications and employment prospects of the applicant in Australia;
- established links in Australia including community and economic ties;
- assets and income; and
- availability of care and support from family members or other bodies.[19]

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[14] For details regarding 'hot-tubbing' see the paper by Hon Justice Garry Downes AM 'Concurrent Expert Evidence in the Administrative Appeals Tribunal: The New South Wales Experience', presented at the Australasian Conference of Planning and Environment Courts and Tribunals, Hobart 27 February 2004.

[15] Migration Act 1958 (Cth), s 65; Migration Regulations 1994 (Cth), Sch 4, 4005..

[16] (2005) 148 FCR 182.

[17] Ibid, para. 56.

[18] See, eg, *X (Kapambwe) v MIMIA* [2005] FCA 429.

[19] Procedures Advice Manual 3, Sch 4.4005-4007.97.3.

If too much weight was given to the amount of personal resources by way of covering the potential costs for medical treatment and social services, people migrating from wealthy countries or wealthy families would be necessarily favoured against those migrating from developing countries or non-wealthy families, even if the latter group of people could potentially make a significant contribution to the Australian community. A wide community discussion will be required in this context to consider what might be the community values that should form the basis for making legitimate, objective and reasonable health assessments.

33. The primary decision-maker's health assessment can also be tainted by heuristics. The study of heuristics shows that individual decision making and judgement is often driven by heuristic-based reasoning rather than evidence based rational choice. Reliance on heuristics can lead to bias and undermine social policy outcomes intended by legislators. Decision-makers with many decisions to make and a complex matrix of regulations to apply, face the inherent difficulty of deciding how to weigh costs against benefits to the community. Their ability to make legitimate, objective, and reasonable decisions will depend on their training and access to quality resources. Should this reform option be pursued, the way in which decision-makers weigh up different factors must be closely monitored and reviewed on a regular basis.

Third Model: Exclusion of a consideration of disability from the health requirement

34. The third, and perhaps the most progressive reform option, is to exclude disability from medical condition for the purpose of the health requirement. The health requirement can only maintain its legitimacy if it encapsulates the social model of disability as reflected in the Disability Convention. The social model recognises the inherent equality of persons with a disability and their human value beyond an economic assessment of the cost of that disability. It considers people with disability as equals, not as objects of paternalism or charity.[20] When put in practice, the social model of disability supports a shift towards greater consideration by primary decision-makers of personal factors, rather than the potential costs to the community.

35. In fact, many countries including the United Kingdom and the United States have no restrictions on or discrimination against people with disability unless they pose a threat to others.[21] There is no reason why Australia cannot follow suit by removing the impediment imposed by the current health criteria on visa grant to applicants with disability.

36. However, the question of cost will inevitably arise with this proposal. Any legislation which relates to health walks a tight-rope, balancing the needs of the Commonwealth and the States. While the Commonwealth is in charge of migration and can implement the policies it requires, any changes to the health requirement have implications for the State-run public healthcare systems and social services. Unless adequate health care reform is achieved and implemented among the Federal Government, the States and the Territories, this reform option may not be favoured by policy-makers.

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[20] Diane Driedger, *The Last Civil Rights Movement: Disabled Peoples International* (Hurst & Company, 1989) 28.

[21] See, eg, US Immigration and Nationality Act, 8 USC 1182, s 212(a)(1).

Recommendations

37. In the light of the above considerations we recommend the following steps be taken to reform the health requirement with regard to visa applicants and their families with disability.
    (a) That greater consideration be given to Australia's international obligations towards people with disability.
    (b) That reform of the role to be performed by the Medical Officer of the Commonwealth in relation to the health requirement be explored, including the possibility of making their opinion reviewable by an appropriate merits review tribunal.
    (c) That universalising the health waiver across all the visa categories be considered in relation to the health assessment of people with disability, while (i) encouraging a wide community debate about what should be a legitimate, objective and reasonable migration decision for migrants with disability, and (ii) improving training and resources for primary decision-makers.
    (d) That a progressive development towards the exclusion of disability from the health assessment be embraced as one of the community objectives in the wider context of overall health care reforms.