Submission No 31

SUBMISSION TO THE JOINT STANDING COMMITTEE ON MIGRATION INQUIRY INTO THE MIGRATION TREATMENT OF DISABILITY

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I Terms of Reference

In this submission and in the attachments prepared by five of our students we will make some preliminary points about the operation of the health rules in immigration law and policy and then address in turn each of the terms of reference

II The Health Rules and Disability

The operation of the health rules in migration law is explained in the extract from Professor Crock's forthcoming book at **Attachment 1.** The most significant features of the regulations are that the rules:

1 are plainly discriminatory in their operation;
2 make no distinction between disease and disability;
3 operate to exclude ***all members*** of a family group where one family member has a disability that makes that person excludable;
4 involve no process for decision makers to undertake a cost-benefit analysis of persons with disabilities; and
5 force decision makers to assume or deem that the existence of nominated diseases or disabilities *will result* in certain costs, leaving decision makers with little or no scope to exercise choice or discretion.

III Should the balance between the economic and social benefits of the entry and stay of an individual with a disability, and the costs and use of services by that individual, be a factor in a visa decision?

The simple answer to this question is found in the **obligations Australia assumed** on signing and ratifying the **UN Convention on the Rights of Persons with Disabilities (CRPD)**

An outline of the key features of the CPRD is appended at **Attachment 2.** In the context of the present inquiry, the most significant and innovative feature of the Convention is that it adopts what is called a "social model" of disability. This means that the Convention acknowledges as central truth the fact that it is often **societal attitudes** that define a person as "disabled" rather than any physical attributes they may have. The Convention represents a signature departure from the "medical model" whereby a person's physical or psychological features have been used as a determinant of disability.

Upon signing and ratifying both the Convention and Protocol, Australia has undertaken to adopt the "social model" and to abandon the "medical" model of disability. This is a central aspect of the Convention for two reasons. First, because the medical model focuses on what a person cannot do, it operates without regard to the barriers posed by societal attitude. Second, the medical model itself perpetuates and encourages the creation and maintenance of social barriers.

There are few examples more stark of the "medical" approach to disability than Australia's health rules in immigration. The government's awareness of the dissonance between the

CRPD and the health rules is apparent in the declaration made upon ratification of the Convention and in the exemption of most aspects of the *Disability Discrimination Act* from the operation of the migration legislation.[1] That declaration provides:

> 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.[2]

The most important aspect of the CRPD is that it prohibits state parties from **discriminating** against persons with disabilities. Although it does not broach the delicate subject of movement across borders (the freedom of movement provision relates to movement within a state only), it binds state parties to make **reasonable accommodation** for persons with disabilities. It is acceptable for Australia to weigh issues of national interest in any decision involving the admission or stay of a non-citizen. However, it is not acceptable to discriminate against persons with disabilities solely on the basis of those disabilities. In our view a regime that fails to acknowledge the benefits a disabled person might bring to Australia breaches both the non-discrimination and reasonable accommodation principles of the CRPD. In our view, the health rules in immigration need to be changed so as to allow for the *holistic assessment* of individuals applying to migrate to Australia, whereby any **negative aspects** of their disability are **weighed against the benefits** that they or their family may bring to the country. On these points see the submission of Ms **Lauren Swift** at **Attachment 3.**

As well as placing Australia in breach of its non-discrimination obligations under the CRPD, the current health rules reflect an out-moded view of disability. Their continued operation will **impede attempts to effect change in community attitudes** towards disability and will affect social cohesion. The rules perpetuate a view that migration to Australia involves all **take** and no **give** on the part of the Austrailan community: migrants must be *perfect* in mind and body and *job ready* in terms of their skill. This vision of migration is unhealthy as it denies the element of mutuality that must exist for migration to be successful. Moreover it means that migrants to Australia **lack the diversity** that exists within a natural population. The health rules compromise the humanity of Australia's migration laws in ways that ultimately operate to the detriment of the community.

In fact, the operation of the current health rules in immigration places Australia in breach of a range of international human rights instruments. Many of those immediately affected are **children.** The rules break up families by either encouraging migrants to abandon and/or hide the existence of disabled children or by forcing the mothers of such children to stay behind, leaving the husband to face life without family in Australia. In this respect Australia's laws sit uneasily with the UN Convention on the Rights of the Child and with the International

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1 See s 52 *Disability Discrimination Act*

2 To date, there have been no objections to this Declaration. (UNEnable: *Declarations and Reservations*)

Covenant of Civil and Political Rights, in particular with the right that convention enshrines to the enjoyment of *family life*. A more detailed exploration of the relationship between the CRPD and other human rights instruments is provided by **Ms Lydia Campbell** at **Attachment 4**

IV The options to properly assess the economic and social contribution of people with a disability and their families seeking to migrate.

As the brief overview of the recent history of the immigration health rules in Attachment 1 demonstrates, the present regime has become harsher and harsher in its operation over the years. It is not clear that the policy change has ever been based on hard scientific data about the need to restrict the admission of all persons with disabilities. Rather, the changes seem to have had more of an ideological than statistisical basis.

Return to a balancing of interests test

The best option for returning the regime to one that is not overtly discriminatory towards persons with disabilities is to amend the regulations to allow immigration officials, including merits review bodies, to **weigh the costs** that might be associated with the admission of an individual with disabilities **against the benefits** that might flow from admitting the individual and his or her family. Medical doctors could retain the function of determining the disease or condition affecting the applicant. Immigration officials would then be empowered to consider a range of other factors in making the decision whether or not to grant a visa.

It is a nonsense to say that this cannot be done or that it would result in an inordinate number of immigration appeals. The health rules have never generated a great deal of case law. More generous immigration health rules in other countries (see below) have not lead to an avalanche of cases in those countries.

V Comment on how the balance between costs and benefits might be determined and criteria for making a decision on that assessment.

It should not be difficult for government to articulate criteria for balancing benefit and burden in cases involving prospective migrants living with a disability. The fact that the Minister is able to do this in individual cases should be proof enough that a balancing test can be created.

The test should start by including in any assessment all members of a family unit. Hence, when the negative factors are compiled (these are already the subject of sophisticated computations), these should be weighed against total gains from a family group. If it is possible to estimate what a person is likely to cost a society, it must be possible to estimate also the likely contributions that a person might make. Actuarial assessments are made routinely in the life insurance business. Given the parameters for the selection of the skilled migrants who currently dominate Australia's migration program, factors to consider would be easy to identify. They would include: age; occupation; career trajectories; and relationships - to take into account the value of keeping a family unit together for mutual support and advancement. In the latter respect, any balancing test should acknowledge the role that a disabled person plays as a focus and often as a point of cohesion within a family unit.

We offer by way of example a young South African man who survived a shooting accident that left him serious disabled. See Case Study of **Mr Ryan Dekker Attachment 5**. This young man has managed to carve out an independent, drug-free existence where his professional skills earn him enough points to easily surpass the requisite mark in the

independent skilled (points tested) category. He has been denied a visa because of his disability. The visa class in question attracts the generic health test that provides no discretion in decision makers to waive the rules. No credit is given to the man's genius and quite awe-inspiring determination and ability to persevere against all of the odds. Australia is a poorer place for excluding such a man. While we have suggested that a more appropriate course for the young man would be to come as a sponsored (and therefore at least partially supported) skilled migrant (ie under the ENS), the health rules as currently modelled would still pose an impossible barrier for him.

VI The impact on funding for, and availability of, community services for people with a disability moving to Australia temporarily or permanently.

Australia's generosity as an immigration nation has declined markedly in recent decade. This term of reference asks by implication whether Australia can afford to be more generous to its migrants. The simple and obvious answer is: of course it can. The question is not one of capacity but of priorities and political will. If Australia is able to continue spending billions running detention centres on Christmas Island and in Indonesia, then it can afford to fund services within Australia to assist in the settlement of newly arrived migrants.

In relation to temporary visa holders, the question of access to community services is answered at least in part by the stipulation that most temporary migrants are obliged to hold private health insurance. Again, if a cost-benefit approach is taken, the demographics of the temporary skilled program suggests that the country stands to gain much more than it would lose by relaxing the health rules.

Acknowledging that the largest group excluded by the current health rules are persons living with HIV/AIDS, we commend to the committee the analysis that has been made of the situation of these persons by both the Australian Federation of AIDS organisations and by Ms **Kione Johnson** (see **Attachment 6**).

VII A comparative analysis of similar migrant receiving countries.

We commend to the committee the analysis that has been made of the situation of persons living with HIV/AIDs by both the Australian Federation of AIDS organisations; by Ms **Lydia Campbell** (see **Attachment 4**); Ms **Kione Johnson** (see Attachment 6) and Ms **Chantelle Perpic** (see **Attachment 7**). The available information suggests that Australia's health rules are considerably more restrictive than those of the countries seen as traditional comparators: Canada and the United Kingdom, but that most countries see this as an area where discretion should be available to allow admission, especially in cases involving family members.

ATTACHMENT 1

The following material is taken from Chapter 6 of the forthcoming text written by Mary Crock and Laurie Berg, ***Immigration and Refugee Law in Australia*** (Sydney: Federation Press, 2010):

Screening the health of non-citizens coming into the country has always been a matter of high priority for federal governments. On the one hand, health testing is seen as essential to safeguard the wellbeing of the Australian population. Poor control of "health concern non-citizens" is seen rightly as a potential public relations disaster and a threat to community confidence in the immigration program. From other points of view, however, the processes put in place have been criticised as overly complicated, demanding and time consuming, particularly for shorter-term visitors and business entrants.[3] Questions have been raised also about the restrictive views taken of people with disabilities. As explained below, no distinction is drawn between disability and disease for the purposes of the health rules. In many situations, if an applicant would be eligible to receive a Commonwealth government disability pension, this will operate as a bar to the grant of a visa. Although a special inquiry into the health rules was made in 1992, it was not until late in 1995 that significant changes were made to the criteria and procedures used in screening the health of non-citizens coming to Australia.[4] In the intervening years the trend has been towards increasing rigidity in the operation of the rules.

The present Regulations require applicants in all visa classes except diplomatic or short-term medical treatment categories to meet specified health criteria. The tests imposed on applicants vary according to the class of visa sought and the nature and length of the non-citizen's proposed stay in Australia. Some applicants are required to do no more than furnish a statutory declaration that he or she is free of certain diseases and conditions. Other non-citizens can be required to submit to a chest x-ray; or a full medical examination carried out by medical practitioners under the auspices of relevant health authorities.

Traditionally, the immigration authorities have taken quite a relaxed approach to the health processing of temporary residents and short-term visitors. There is now a presumption - for some a requirement[5] - that these people will take out private health insurance or meet any health care costs incurred during their stay in the country. Temporary residents are no longer eligible for medicare or other health-related benefits. Provided that they do not propose to work in health sensitive industries; that they do not fall into classes of individuals known to present health risks; and are in general good health, most applicants for temporary visas are not required to undergo a full health assessment.[6] The safeguard, for

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3 See Committee of Inquiry into the Temporary Entry of Business People and Highly Skilled Specialists (1995) (the Roach Report) at para 4.50-4.58.

4 see JSCMR above n 57.

5 For example, non-citizens entering Australia under an employer nomination may have some of the health requirements waived if the employer gives the Minister a written undertaking to meet all of the costs associated with a disease or condition that would otherwise cause the applicant to fail to meet the health requirements: see Sch 4 cl 4006A.

6 Under reg 2.25A(1), the Minister may proceed without seeking a medical opinion in respect of an applicant for a temporary visa where there is no information known to immigration authorities from the application *or otherwise* (emphasis added) that suggests that the applicant may not meet the health criteria. The inclusion of the words "or otherwise" expand the ambit of the Department's health inquiry mandate which was limited formerly to the information contained on an application form. As well as allowing officials to take into account information supplied by members of the public, the change could allow the use of statistical data on matters of health and the spread of

the government, is that where an applicant fails to disclose matters relevant to the assessment of health (or character), he or she becomes liable to cancellation of the visa issued as the result of the false or misleading information provided.[7]

In practice, applicants for temporary visas permitting a stay or three months or less are usually not subjected to health testing unless they meet the policy descriptor of being of "special significance". Persons targeted for health testing irrespective of length of stay are persons deemed to be of high risk because of their exposure to "blood-borne contact" (such as medical workers, tattooists, sex workers and intravenous drug users) or because of the vulnerability of the people and places they are likely to visit (such as child care centres and preschools). Older persons and parents seeking to visit for more than 6 months are also fall into this category, as do pregnant women and persons with known or suspected health conditions .[8]

In spite of the provision in the Regulations for fast track screening, in practice all applicants for permanent residence continue to have their health monitored very closely before being granted a visa. At present, no countries were gazetted for the purposes of reg 2.25A(1), which meant that all applicants for permanent residence were required to undergo full health checks. It is in the context of these cases that most controversy has occurred over the content and administration of the health tests. The health criteria that apply to migrants to Australia fall into three broad groupings. The first is the general test set out in Sch 4, item 4005 of the Regulations which applies to all applicants for permanent or provisional visas[9] with the exception of partner, child, interdependent and certain humanitarian visas. The second test (in Sch 4, item 4006A) is applied to temporary visa applicants (subclasses 457 (Business long stay) and 418 (Educational)) and creates limited exceptions in cases where health insurers and sponsoring employers guarantee to cover the health costs of temporary visa holders who would otherwise fail to meet the health criteria. The third test (in Sch 4, item 4007) visas allows for the waiver of the health rules in limited circumstances for certain close family, business and humanitarian visa applicants.[10]

A common feature of all of the health rules is the requirement that visa applicants are required to be free from tuberculosis or from a disease or condition which represents a threat to public health in Australia. Persons who have suffered from tuberculosis can be required to sign an undertaking that they will present for regular health testing after their admission into Australia. The tests also operate on their face to exclude people with a "disease or condition" that "would be likely to": (a) require health care or community services or meet the *medical* requirements for the provision of a community service; and (b) prejudice the access of Australians to health care or community services or result in a "significant cost" to the Australian community in the area of health care or community

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disease from different parts of the world. The fact that the government may be moving towards the use of more epidemiological data in health assessments is supported by the provision in reg 2.25A(1) for the fast tracking of applicants for permanent visas who come from "gazetted" countries and who present no "known" health risk.

7 See *Migration Act* 1958, ss 109 and 116.

8 See generally, DIAC *Form 1163i – Health requirement for temporary entry to Australia.*

9 A provisional visa is a temporary visa that is a precondition for the eventual grant of a permanent residence visa.

10 The health waiver applies to partner visas; all child visas; refugee and humanitarian visas granted overseas; temporary humanitarian visas, and close ties, business skills (permanent) and New Zealand Citizen family relationships visas.

services (irrespective of whether an applicant would access such services in practice).[11] There is no discretion in the Minister (or the MRT) to waive the requirements of the item 4005 test. The concession made in item 4007 for close family, business and humanitarian visa applicants is that the issues of "significant cost" and "prejudice to the Australian community" can be overlooked as long as the potential costs or use of community services and prejudice are not *"undue"*. Where one member of a family group fails the assessment, the whole group will be denied visas.[12]

The outsourcing of medical assessments has lead to a rather complex and fractured system from the perspective of the migrant. The immigration department has maintained a section charged with the formulation and implementation of health policy (in conjunction with other relevant federal and state departments). The process of assessing a person's health status is carried out by the "Health Assessment Service" (HAS) for persons outside of Australia and by "Health Services Australia" (HAS) for persons in the country. Medical practitioners appointed by HAS are referred to as "Approved Medical Practitioners" (AMPs) while general medical staff are referred to as "Medical Advisors". In addition, reg 1.03 of the Migration Regulations provides that "Medical Officers of the Commonwealth" (MOCs) are doctors appointed by the Minister under reg 1.16AA to give their opinion on whether individual applicants meet the health requirement. MOCs also appear to be referred to as "Panel Doctors". The operation of the HAS and HAS are supervised by what appear to be a roving team known as "Global Medical Directors" (GMDs) who are responsible for auditing and supervising the panel doctors. In addition, both the HAS and HAS operate an internal appeal system whereby "Review Medical Officers of the Commonwealth"(RMOCs) undertake a medical review of adverse assessments made by MOCs.[13]

The issues that have generated most litigation are those relating to the charcterisation of a disease or condition; the determination of what will constitute a significant cost; and when an applicant will be considered to "access" community services so as to prejudice Australian users of those services. There is also case law on the question of what will constitute "undue" cost or prejudice for the purpose of the health waiver. Each of these matters will be considered in turn.

The tribunal (the IRT and now the MRT) is given power to review visa refusals, but no authority to question the health assessments carried out by the government's medical officers, the CMOs. The CMO's opinion constitutes a separate decision by a person not acting as a delegate of the Minister.[14] These officers were required to assess the health status of the applicants, but they would also proffer advice on the likely cost burden the applicant would place on the Australian community.

Identifying a disease or condition

In early cases where fresh evidence became available to the Tribunal suggesting improvements in the applicant's health after the initial assessment, some IRT members would attempt to negotiate a reassessment of the applicant by the medical officer, with

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11 Until 1 November 1995, a further restriction was placed on the admission of people suffering from a disease or condition of an hereditary nature that might affect the health status of children born to them in Australia: see former items 4006 and 4008.

12 See *Migration Act* 1958, s 140.

13 See Department of Immigration *PAM3*, ch 6.

14 See, for example, *Re Nelson* (IRT 28, 9 November 1990), *Re Papaioannou* (IRT 113, 19 April 1991), and *Re Dusa* (IRT 285, 29 August 1991).

varied degrees of success.[15] Other devices were used by the IRT to avoid negative medical assessments in cases where the Tribunal took the view that justice favoured the grant of a visa. While it could not question the opinion formed by the medical officer, the Tribunal took the view that it could determine the factual question of whether or not an applicant suffered from a "disease or condition" for the purposes of the Act.

In *Re Berman*[16], the Tribunal dissected the medical opinion furnished and concluded that the relevant officer had left scope for a finding that the applicant no longer suffered from a disease or condition. The IRT considered the time that had elapsed since the first assessment; opinions of other doctors; and the continuing good health of the applicant. It concluded that the risk of re-occurrence of Mrs Berman's disease was not real or serious or substantial. This finding, taken together with the fact that she did not presently suffer from the disease, meant that she was free from that disease. In reaching this conclusion, the Tribunal adopted a two stage inquiry. The first required the making of an immediate diagnosis of the applicant's situation, with a finding that the disease or condition existed being conclusive of the inquiry. If no disease or condition could be detected, a second stage of inquiry ensued to establish the likelihood of the disease or condition occurring or re-occurring within a reasonable time frame. The Tribunal noted that this approach was necessary because some diseases or conditions are incipient or inchoate, so that an applicant may not show obvious or demonstrable symptoms at a given date. If the second stage inquiry established that the applicant was not at risk, it followed that she or he was 'free from' the disease or condition specified.

In *Re Nguyen*[17] the Tribunal examined the medical officer's assessment of a young Vietnamese woman who, as the result of her premature birth, had lower than average intelligence. The Tribunal once again intervened on the ground that the applicant did not have a "disease or condition" that could activate the health concern provisions. On the basis of literature submitted to it, the IRT drew a distinction between what the medical officer assessed as "borderline intellectual functioning" and "mental retardation". It held that while the latter state could be considered a "condition", the former could not. Similar reasoning was used in *Re Henry*[18] to admit a woman whose legs were paralysed as a result of childhood poliomyelitis, who was wrongly assessed as a person suffering from systemic paraplegia.[19]

Interestingly, in the decade or more that has passed since cases like *Re Berman*[20] were decided, the Federal Court in rare cases has continued to find some wriggle room in the straight jacket of the health assessment system. As in earlier cases, dispute has arisen over the characterisation of an individual suffering from a condition that manifests in a wide variety of forms, with varying impacts on the individual's need for assistance. A number of the cases have involved families with a child suffering from a form of mental disability such as Downs Syndrome. In cases such as *Minister for Immigration v Seligman*[21] it is evident

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15 See, for example, *Re Papaioannou* (IRT 113, 19 April 1991); *Re Cruz* (IRT 1411, 6 November 1992); *Re Ratley* (IRT 924, 21 May 1992); *Re Rosenauer* (IRT 945, 28 May 1992); and *Re Alakoc* (IRT 194, 28 June 1991).

16 IRT 3937, 6 July 1994

17 IRT 5667, 30 June 1995

18 IRT 4935, 22 February 1995

19 see also *Re Nance* (IRT 5065, 21 April 1995) where a Romanian orphan was wrongly assessed as intellectually as well as physically disabled.

20 IRT 3937, 6 July 1994

21 (1999) 85 FCR 115 ('*Seligman*'). See [66].

that the child (or young person) in question is both a cherished member of the family and unlikely to be a burden on the community because of both the talents of the child and the degree of family support.

In *Seligman*[22] the Federal Court held that the focus of the consideration will be whether the Medical Officer's opinion is "of a kind authorised by the regulations". If an opinion "travels beyond the limits of what is authorised, then to act upon it as though it is binding is to act upon a wrong view of the law and to err in the interpretation of the law or its application, a ground of review for which s 476 of the Act provides".[23] The Court observed[24] that Regulation 2.25A(3) requires the Minister to take the relevant opinion to be "correct" where:

(1) What is provided is an opinion;

(2) The opinion is that of the Medical Officer of the Commonwealth who provides it;

(3) The opinion is the opinion of the Medical Officer "on a matter referred to in sub-reg (1) or (2)"; and

(4) The opinion addresses satisfaction of the requirements at the time of the Minister's decision.

Later cases adopting the approach outlined in *Seligman* suggest that the opinion of a Medical Officer will be difficult to challenge. In *Blair v MIMA,*[25] for instance, Carr J acknowledged that the court was entitled to consider the Medical Officer's opinion, but rejected the applicant's claims that the Medical Officer had failed to exercise his jurisdiction, or that the opinion was vitiated by legal error. In that instance the Medical Officer had formed an opinion that a secondary applicant for a subcl 151 Former Resident visa with Downs Syndrome and a mild intellectual disability would require ongoing assisted schooling

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22 *Seligman* (1999] 85 FCR 115 at [66].

23 Note that the challenge in *Seligman* went to the substantive validity of the regulation in question rather than to the exercise of the discretion in that case. In that case what was then reg 2.25B of the *Migration Regulations* was held to be ultra vires and invalid (but severable). It was purportedly made pursuant to s 505 of the *Migration Act*, which authorises the making of regulations providing that the Minister is to get a specified person to give an opinion on a specified matter. However the Court noted [at 54] that reg 2.25A directed the Medical Officer to consider some things and not others in the formation of his or her opinion as to whether the disease or condition would be likely to result in a significant cost to the Australian community in the areas of health or community services. Namely, it required the Medical Officer to disregard the applicant's prospective use of such services – an assessment which the Court held was required by Item 4005(c). At the time of the decision, Sch 4, cl 4005 provided that the health criterion will be satisfied if the applicant or person concerned ...:

(c) is not a person who has a disease or condition that, during the applicant's proposed period of stay in Australia would be likely to:

(i) result in a significant cost to the Australian community in the areas of health care or community services; or

(ii) prejudice the access of an Australian citizen or permanent resident to health care or community services.")

Therefore the regulation was held to be both "internally inconsistent because what it requires the Medical Officer to do is inconsistent with the language of the criterion which it imports", and "beyond the power conferred by s 505 because the limitation it imposes upon that opinion means it does not address the relevant criterion". Following the decision of *Seligman*, Reg 2.25B was repealed: SR 199 No 81. However cl 4005 was also amended, to incorporate the wording and effect of this former regulation. Challenges to the validity of this newly worded clause have been unsuccessful. See further below.

24 See *Seligman* (1999) 85 FCR 115 at [48] and [49].

25 [2001] FCA 1014 (31 July 2001).

and speech therapy, and would be eligible for long term income support in the future at significant cost to the Australian community. This opinion was then relied upon by the MRT, which affirmed the decision to refuse the visa. Dismissing the appeal, Carr J held that the applicant had not proved on the balance of probabilities that the Officer had ignored additional material; purported to make adverse findings on that material; or formed his opinion in an arbitrary and capricious manner so as to amount to an actual or constructive failure to form an opinion. These issues were dealt with "assuming but without so deciding that the Opinion is subject to judicial review". Carr J also added that in his view, the Medical Officer was not under any obligation to provide reasons why he rejected (if he did so) any expert medical evidence proffered. The other grounds of appeal based on legal error on the part of the Tribunal were not successful either.[26]

The more recent case of *Robinson v Minister for Immigration and Multicultural and Indigenous Affairs*[27] involved a young boy presenting as the son of a subclass 855 (Labour Agreement (Residence) visa applicant. The boy suffered from a mild form of Downs' Syndrome but was assessed nonetheless by the MOC and RMOC as an individual who would be likely to require special education and other assistance during his lifetime. This meant that he was assessed as a person whose admission would result in significant cost to the Australian community. Siopis J ruled that the MRT had committed a jurisdictional error by relying on the determination by an RMOC. His Honour held that the medical assessments were unlawful because the officers had failed to determine the exact form or level of the boy's impairment, relying instead on a blanket determination that anyone with Downs syndrome would fail to meet the health test.

Robinson's case is a reminder of past controversies in what was then the IRT over when an individual could be considered "likely to prejudice access to health care" of any Australian citizen or permanent resident. Two approaches emerged. One view was that all the circumstances of an individual should be considered in determining the impact that person would have on scarce community resources, but taking into account also the benefits that person might bring to the country. The alternative approach was to focus less on the subjective circumstances of the applicant than on the general burden posed by an individual with the disease or condition of the applicant, weighed against the demands made by other individuals in Australia in the same diagnostic category as the applicant. In the early days the IRT (precursor of the MRT) appears to have favoured the view that any burden on the community should be balanced against the benefits that might accrue through the admission of an applicant and of his or her family unit as a whole. This approach was echoed in the recommendations of the Health Rules Report (at para 4.41) but does not seem to have been followed by some medical officers. For example, in *Re Lu* (IRT 207, 12 July 1991) a negative assessment was made of an adopted child rendered blind by her premature birth on the basis of the cost to the Australian community. On the basis of evidence provided of the technological aids that are now available to enable blind persons to participate fully in social and professional life in Australia, the IRT rejected the assessment made and invoked the Minister's power to waive the health criteria. In spite of the contrary recommendations made in the Health Rules report, the changes made in November 1995 and maintained ever since did not adopt anything like a balancing approach

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26 *Bui v Minister for Immigration and Multicultural Affairs* (1999) 85 FCR 134; *Imad v Minister for Immigration* [2001] FCA 1011 (26 July 2001); and *Inguanti v Minister for Immigration* [2001] FCA 1046 (3 August 2001), discussed below.

27 (2005) 148 FCR 182 ('*Robinson*').

in the area of health assessments. As noted earlier, the Regulations in Sch 4, item 4005 now require a medical officer to assess the potential cost and other burdens that would flow from admitting an applicant *without regard to whether that person will use the services* involved. The officer is required to focus not on the actual burden that is likely to be imposed by a person (given his or her private resources), but the burden that would be posed by a person in the applicant's diagnostic category.

In *Imad v Minister for Immigration*,[28] Heerey J dismissed the applicant's claim that cl 4005 was invalid because it was "incapable of meaning or application". At [13]-[14], His Honour articulated the test set out in cl 4005(c) as follows:

> The criterion in cl 4005(c) requires the applicant to be not a person who has a disease or condition of a kind described in paragraphs (i) and (ii). The "person" referred to in (i) is not the applicant but a hypothetical person who suffers from the disease or condition which the applicant has. The criterion requires assessment as to whether or not a disease or condition is such that it would be likely to require health care or community services and that provision of health care or community services would result in a significant cost to the Australian community. The assessment of the likelihood of health care or community services is a qualification or characterisation of the kind of disease or condition in question, just like saying `this is a surgical procedure which usually requires general anaesthetic'. It is not a prediction of whether the particular applicant will, in fact, require health care or community services at significant cost to the Australian community."

Heerey J commented that this converse task (inquiring into the financial circumstances of a particular applicant or any family members of friends or other sources of financial assistance) would be an inappropriate task for a medical officer. He therefore held that the MRT had not erred in failing to take into account the capacity of the applicant's family to pay for her medical expenses; this 'objective' test was specifically mandated by cl 4005. This approach was also followed in *Inguanti v Minister for Immigration*[29] although it has clearly been modified by the ruling in *Robinson,* discussed earlier.

Certainly, the application of this test in the manner suggested by the court in *Imad* has delivered some very unsatisfactory outcomes. In *Inguanti*, the visa applicant (Mr Urso) was a Italian-born American citizen whose application for a preferential family visa was denied on the basis that he failed to meet the health criteria set out in cl 4005. The medical officer found that the Mr Urso's intellectual disability was sufficiently severe to prevent him from living independently (he needed regular supervision and assistance with daily activities); that Mr Urso would meet the eligibility criteria for Government supported accommodation and special programs for people with disabilities, and was likely to require nursing home care in the foreseeable future. He therefore concluded the applicant was "a person who has a disease or condition that during the applicant's proposed period of stay in Australia, would be likely to result in a significant cost to the Australian community in the area of community services and prejudice access to services in short supply". Schedule 4 item 4005 rendered it irrelevant that Mr Urso and his sister had each inherited A$414,500 from their mother's estate; that Mr Urso held A$420,000 in a trust account; that he received pension and union payments each month; and that his sister had a large family in Australia who would always house and care for him.

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28 [2001] FCA 1011 (26 July 2001).

29 [2001] FCA 1046 (3 August 2001).

Paradoxically, the decision was set aside by Heerey J on the grounds that the Medical Officer had treated the question as being "whether Mr Urso's condition, as distinct from a condition of that nature suffered by a hypothetical person, would be likely to result in a significant cost to the Australian community" (by assessing his personal eligibility for Government supported accommodation and special programs). However perhaps realising the unsatisfactory results of this approach, Heerey J concluded by stating that "[w]hatever the outcome of any further proceedings, I must say that this is a very strong case for compassionate consideration under s 351".

The ameliorative ruling by Siopis J in *Robinson's* case notwithstanding, there is little doubt that these provisions do continue to make it difficult for both medical officers and the MRT to make positive recommendations in the cases where applicants suffer from a disease or condition that would see Australians in a similar state of health receiving some form of government assistance or using community resources.

Significant cost and health care

The recent history of the health rules in Australia suggests that the process has indeed become increasingly mechanistic. The relevant policy guidelines state that the MOC's cost assessment must cover either the visa period (for temporary visas) or a period of 5 years for permanent resident applicants (3 years for those aged 70, phased in from 68). The guidelines no longer provide a monetary estimate.[30] However, practitioners have been advised that the unofficial rule of thumb is that "significant cost" will be shown where it can be estimated with reasonable certainty that a person will require treatment costing more than $20,000 over five years (or a pro-rata equivalent for elderly applicants).[31]

Because the rules operate on theoretical costs rather than what a person will actually consume, it has become virtually impossible for individuals with serious diseases and conditions such as HIV-AIDS to obtain visas permitting long-term stay in Australia. Although Finkelstein J found in one case that a self-funded visitor who was HIV positive would not be a burden on the Australian community,[32] the judge was overruled on appeal. The Full Federal Court in *Minister for Immigration v X*[33] ruled that the RMOC had committed no error in law by simply adding together the cost of antiretroviral treatments and the monthly monitoring costs. The Court found that the law required consideration of the cost of the drug regimen even though the treatments were both paid for by the applicant and self administered. The judges ruled that Finkelstein J was in error in supposing that because health care "imports an element of personal attention or activity by a provider of health care", self administered treatment cannot be considered as health care.

Access to community services

The rigidity of the health rules is perhaps most apparent in the reference made to an applicant meeting the medical criteria for the provision of a "community service". The phrase "community service" has been interpreted broadly to include supported accommodation, home and community care and the payment of income support. In *Seligman,*[34] the Federal Court emphasised the words "in the areas of", and was guided by

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30 Until 1 July 2001 "significant cost" was defined in PAM3 as 50% above the average per capita health care and community services costs for Australians. See Migration Practice Essentials Pty Ltd *Health Criteria* June 2006, 23.

31 See Migration Practice Essentials, *ibid.*

32 See *X v Minister for Immigration and Multicultural and Indigenous Affairs* [2005] FCA 429 (15 April 2005).

33 *Minister for Immigration and Multicultural and Indigenous Affairs v X* (2005) 146 FCR 408.

34 See *Minister for Immigration v Seligman* (1999) 85 FCR 115.

dictionary definitions of the word "service". On this basis, it was held that "community services" could encompass the provision of a disability related government pension. This was reiterated in *Bui v Minister for Immigration & Multicultural Affairs*,[35] where the Federal Court stated that the activities covered "do not exclude the provision of financial benefit or other support involving a cost" [at para 35], but could extend to "special training and financial support" referred to by the Medical Officer in his assessment. To avoid doubt, a definition of "community services" has since been inserted in reg 1.03 of the Regulations, stating that the term includes the provision of an Australian social security benefit, allowance or pension.

More importantly, the phrase "Community service" links the health rules to s 94 of the *Social Security Act* 1991 (Cth) which sets out the criteria for the grant of a disability support pension. It should be noted in this context that only the *medical criteria* for the grant of such pensions are relevant. To be eligible for a disability support pension an individual must suffer from a physical, intellectual or psychiatric impairment that rates at least 20 points on what are known as the "Impairment Tables". In addition he or she must have a continuing inability to work. The Impairment Tables are scheduled to the *Social Security Act* and operate to grade the levels of impairments for different diseases and conditions. As a matter of practicality, most people who achieve an impairment rating of 20 or more would probably find it difficult to convince anyone that they would be able to sustain full time work (at least 30 hours per week) at award wages or above for a period of at least two years – without requiring excessive leave or work absences. However, these are matters of fact that can be the subject of submissions. The Impairment Tables provide a link between immigration and social security that makes it easier to designate monetary values to particular illnesses or disabilities insofar as eligibility for a pension of some kind imputes a federal government payment of designated amounts (in addition to any other expenditure on medicines or community services.

Undue cost and undue prejudice

In practical terms, the IRT's power to question the assessment of medical officers in matters concerning cost and burdens on the community appears to be limited to those visa classes in which it is possible to waive the health requirements. In addition to the immediate family and humanitarian visas, waiver is available in respect of certain employment related visas.[36] In these cases, the regulations require the applicant's employer to sign an undertaking in respect of an applicant's potential health costs for the duration of his or her stay in Australia. Pursuant to Item 4007(2), the requirements of par 4007(1)(c) may be waived if the Minister is satisfied that the granting of the visa would be unlikely to result in:

(i) Undue cost to the Australian community; or

(ii) Undue prejudice to the access to health or community services of an Australian citizen or permanent resident.

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35 (1999) 85 FCR 134.

36 Schedule 4 item 4007 applies to the following subclasses: 100 Spouse; 101 Child; 102 Adoption; 110 Interdependency; 151 (Former residence – defence service personnel); 200 Refugee; 201 In Country Special Humanitarian; 202 Global Special Humanitarian; 203 Emergency Rescue; 204 Woman at Risk; 300 Prospective Marriage; 309 Spouse; 310 Interdependency; 449 Humanitarian (Temporary); 445 Dependent Child; 447 Secondary Movement Offshore Entry (Temporary); 449 Humanitarian Stay; 451 Secondary Movement Relocation (Temporary); 461 New Zealand Citizen Family Relationship (Temporary); 787 Witness Protection (Trafficking) (Temporary); 801 Spouse; 802 Child; 814 Interdependency; 820 Spouse; 826 Interdependency; 832 Close ties; 852 Witness Protection (Trafficking) (Permanent); and 890-893 Business Skills.

The interpretation of these provisions was also considered by the Federal Court in *Bui*. In that case, the applicant had received a letter which stated that the Minister had "the power to waive the criterion where the Minister is satisfied that compassionate or compelling circumstances justify waiver of the criteria", and invited him to provide reasons for waiver on these grounds. While both the trial judge and the Full Court on appeal noted that these terms are not explicit in 4007(2), it was held that they are broad considerations which "may properly have a part to play" in the exercise of the discretion. The Full Court added that there was nothing in the exchange of correspondence or the record of the ministerial decision to indicate that the delegate took any unduly restrictive approach to the exercise of the waiver.

The ground of appeal based on the Medical Officer's opinion was also unsuccessful. The Medical Officer had presented a document entitled 'Waiver Opinion', in which he stated, "In my opinion, the likely cost to the Australian community of health care or community services is $420,000 (in financial support)". No basis for this estimate was offered. While the Court accepted that the officer went beyond his statutory function in doing so (the document was said to have "no more legal status than any other piece of gratuitous advice that might be proffered to the decision-maker"), there was nothing in the materials to indicate that the Minister's delegate regarded himself as bound by that opinion. With respect to the "questionable estimate of the cost which the applicant would impose on the community", (which had apparently been relied upon by the delegate of the in his decision to refuse the applicant's visa), the Court stated that this " may be criticised" and raised "concerns about the quality of the decision making process" [43]. However it held that these matters in themselves did not indicate error of law or procedure infecting the decision of the delegate in such a way that it would be reviewable.

The government's policy documents provide detail on what might constitute "extensive" or "substantial" prejudice in access to services, focusing on situations where facilities or procedures are in high demand and where Australians are required to wait for considerable periods of time before gaining access to the service. Compelling circumstances and the factors that should be taken into account are also addressed in PAM3. Although not legally binding these are interesting as they underscore the fact that the public interest criteria are designed to assess the likely financial and social impact that an individual might have on the community. The guidelines discount the strength of emotional ties:

> For example, the genuineness of the relationship between the applicant and the sponsor is not sufficient reason to waive the health requirements for a Partner case".[37]

While they state that "reasonable weight" is to be given to humanitarian circumstances, they also advocate that consideration be given to "the immigration history of the sponsor, including compliance to date with immigration requirements and any undertakings". How such matters relate to the health status of an applicant is not explained.

The toughness in the approach taken under the coalition government emerged forcefully in 2001 with the self immolation outside of Parliament House in Canberra and eventual death of one Shahraz Kiane. Mr Kiane was an asylum seeker who was granted a protection visa as a refugee in 1997. He tried for four and a half years to sponsor his family to join him in Australia under the "split family" provisions of a 202 Global Special Humanitarian visa. He was denied on the basis that his youngest daughter had cerebral palsy and so would be

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[37] See PAM3, Ch 90, [90.3]: "Compelling Circumstances".

eligible for a disability pension, thus representing an undue cost for the Australian community. The man's relatives in Australia offered to tender to the government the amount of the costs assessed by the CMO: all to no avail. Notwithstanding a scathing report by the Ombudsman following the man's death,[38] the government maintained its position and the family were not visaed to come to Australia from Pakistan.

[38] See Commonwealth Ombudsman *Report on the Investigation into a Complaint about the Processing and Refusal of a Subclass 202 (Split Family) Humanitarian Visa Application*, August 2001, available online at: www.comb.gov.au/commonwealth/publish.nsf/AttachmentsByTitle/reports_2001_dima_visa.pdf/$FILE/DIMA-Kiane-aug01.pdf.

ATTACHMENT 2: BACKGROUND ON THE OPERATION OF THE CRPD

Paper prepared by Professor Ron McCallum

On 13 December 2006, the General Assembly of the United Nations adopted the CRPD, and it was open for signing on 30 March 2007.[2] The CRPD came into force on 3 May 2008 after 20 nations had ratified it. The General Assembly also adopted an Optional Protocol to the CRPD which enables persons who have suffered discrimination etc to complain to the Monitoring Committee, once they have failed to obtain redress under the laws of their nations. Australia ratified the CRPD on 16 July 2008, and it became operative in our nation on 17 August 2008. Australia ratified the Optional Protocol on *n August 2009.
The first sentence of Article 1 of the CRPD sets forth the purpose of this convention in the following words. It says:

> 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.

Focusing on one of the biggest challenges, namely prejudices held against persons with disabilities, the CRPD adopts what has become known as the "social model" of disability. To understand what is meant by the social model, it is necessary to comprehend the history of how disabilities have been perceived in societies, and especially in Australia. Let me briefly go back to the beginning of the 20th Century in 1900, when disabilities were mainly perceived as a medical problem which medicine might or might not be able to cure. What was more, persons with disabilities had to be pitied, they were deemed unable to take care of themselves and were therefore graciously provided with welfare based support but rarely were they given the opportunity to find ways to empower themselves and lead a life in society's mainstream. By the 1960s and 1970s, the Australian Government had overlaid on the medical model a carer's model whereby social welfare and other programs sought to care for the needs of persons with disabilities.

However, the social model sees persons with disabilities as persons in our own right, and sees our barriers to achieving our full place in society as lying in the paternal attitudes and practices of society. The social model seeks to lift these attitudinal barriers to enable persons with disabilities to enjoy all of the rights and obligations granted to persons without disabilities.

The social model is enshrined in the CRPD in the final sentence of Article 1. This sentence sets forth an open-ended definition of "disability", however, it must be read in conjunction with paragraph E of the CRPD's preamble. The final sentence of Article 1 says that, "Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others." Paragraph E of the preamble recognises

> ... that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others.

The importance of overcoming the social barriers that exclude persons with disabilities cannot be overstated. The CRPD does a fine job in trying to address the significance of society's need to overcome deep-held prejudices. Not only does it contemplate awareness-raising with respect to we people with disabilities, but it gives us for the first time in a core human rights treaty, a set of general principles. These general principles need to be taken into

account when implementing human rights, particularly for persons with disabilities. These principles are set out in Article 3 of the CRPD and I shall discuss three key principles.
Let me briefly sketch the architecture of the CRPD in the following paragraphs. The CRPD is the latest Convention of the United Nations, and in fact it is the first Convention which has been adopted this Century.

Article 4 of the CRPD sets forth the obligations which this Convention places upon ratifying states. Paragraph 1 of Article 4 requires countries to take measures to ensure that all of the rights of the CRPD are bestowed on people with disabilities. The second paragraph of Article 4 is concerned with the implementation of the CRPD in the area of social, economic and cultural rights. It exhorts nations with economic capacity to cooperate with other countries to implement these rights throughout all of the ratifying nations. Paragraph 3 of Article 4 obliges states parties to consult and to cooperate with disabled organisations in the implementation of CRPD laws and programs. The fourth paragraph of article 4 is a savings clause, making it clear that the CRPD should not be read to derogate from any existing legal rights of persons with disabilities. Lastly, the final paragraph of Article 4, paragraph 5, makes it clear that the CRPD applies throughout federal nations like Australia.
Article 5 of the CRPD is headed "Equality and Non-Discrimination", and it can be thought of as embodying the essence of the CRPD. The first two paragraphs of Article 5 say:

> 1. States Parties recognise that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law.
> 2. States Parties shall prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds.

The expression "discrimination on the basis of disability" is defined in Article 2 to mean:

> any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation.

"Reasonable accommodation" is a term of art, and it is defined in Article 2 to mean:

> necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.

Articles 6 and 7 recognise that women and children with disabilities usually suffer extra burdens than do we men with disabilities. Article 8 of the CRPD is headed "Awareness Raising". It obliges governments to establish programs to make people aware of persons with disabilities and of our capacities and our roles in society. Finally, Article 9 requires states parties to take measures to enable persons with disabilities to access the physical environment with respect to transport and access to information etc.

Articles 10 to 23 and Article 29 of the CRPD guarantee what may be best described as civil and political rights. They should be read in their entirety to comprehend their detail, however, in short form, these articles guarantee the right to life; to protection in situations of risk and humanitarian emergencies; to equal protection before the law including legal capacity and access to justice; to liberty and security of the person; to freedom from torture or degrading treatment; to freedom from exploitation, violence or abuse; to protection of

personal integrity; to liberty of movement and nationality; to be able to live independently and in the community; to personal mobility including to mobility aids; to freedom of expression and opinion, including access to information; to respect for privacy; to the rights to marry, to parent children and to participate in family life; and to participate in political life.

Articles 24 to 28 and 30 of the CRPD set forth social, economic and cultural rights. Again, they should be read in full, but in essence they cover the right to education; to health care, including sexual and reproductive care and information; to habilitation and to rehabilitation; to work and to employment, including equal pay for work of equal value; to an adequate standard of living and to social protection; and to participation in cultural activities, recreation, leisure and sport.

The following articles of the CRPD deal with implementation of this Convention by the countries who have ratified it. Article 31 requires countries to collect statistics on disability matters which are necessary in the establishment of national programs to implement the CRPD.

Article 32 obliges states parties to engage in international cooperation and to support countries in implementing the CRPD. After all, in relation to the social and economic rights to education, to health, etc, the states parties vary in their economic capacities with respect to the time frames in which they will be able to implement all of the rights guaranteed by the CRPD. Article 32 is an important article of the Convention, especially for developing countries. It is an article that Australia takes seriously in its role as an international aid donor. The new Australian Government has given strong emphasis to disability as a priority for the Australian aid program, as an important way to increase social participation for all in developing countries. The Government has committed to playing a leadership role in supporting people with disabilities in the Asia Pacific region. Australia is providing $45 million over two years to develop an avoidable blindness program, and the development of a comprehensive disability strategy to guide Australia's international development assistance program. The new strategy has three core outcomes - to improve the quality of life for people with disabilities, to reduce preventable impairments, and effective international leadership on disability and development.[4]

Article 33 is an important provision. Its first paragraph obliges governments to "designate one or more focal points within government for matters relating to the implementation of the present Convention". Paragraph 2 requires governments to establish independent mechanisms for monitoring the implementation of the CRPD, and paragraph 3 mandates that persons with disabilities and disabilities organisations are involved in these monitoring arrangements. Australia is developing a national disability policy, and in September 2008 the Australian Government established the National People with Disabilities and Carer's Council, NPDCC, of which I am honoured to be a member.

Article 34 establishes a United Nations monitoring committee, and under Article 35 state parties are required to report to this committee on the implementation of the CRPD. It is now timely to turn to this monitoring committee and to its election in which I participated.