

**SUBMISSION TO THE JOINT STANDING COMMITTEE ON MIGRATION
INQUIRY INTO THE MIGRATION TREATMENT OF DISABILITY
Professor Ron McCallum AO and
Professor Mary Crock**

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 Australian 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

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 statistical 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 requirement⁵ - 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

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 of 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 visas⁹ 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

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 led 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 characterisation 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

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

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 observed²⁴ 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

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

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.

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

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.

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 Shahrzad 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

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](http://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.

ATTACHMENT 3

Disability and Australian Migration Law: In Contravention of the Convention?

By Lauren Swift

A family excluded from a country because the young son has Down's syndrome and a man setting himself on fire in desperation ...

Both of these situations have been borne out of Australia's migration policy. In a country that prides itself on equality and a 'fair go', the health requirements for people applying for visas to enter and remain in Australia discriminate against people with a disability and their families. In light of the introduction of the UN Convention on the Rights of Persons with Disabilities, a renewed examination of Australia's handling of visa applications is now in order.

An analysis of the current legislation shows that Australia has exempted the *Migration Act 1958* and any legislative instruments made under that Act from its disability discrimination legislation. Further scrutiny reveals that if Australia really wants to implement and abide by the objectives of the Convention then its health criteria for visa applicants will need to be amended. Australia cannot claim to be upholding the Convention when it is on an international stage denying a right to freedom of mobility and equality on the basis of disability. A shift in attitude in the way people with a disability are viewed and treated will be necessary in order to move away from the categorising of people as a 'cost or burden to the community' but to see the positive attributes and benefits they can bring. This shift is paramount because at present Australia is in contravention of the Convention.

The Convention

In July 2008, the Australian Government ratified the UN Convention on the Rights of Persons with Disabilities (the Convention). The Convention contains principles largely focussed on non-discrimination, equality and the human rights of people with a disability. Article 1 defines disability as including "those who have long-term physical, mental, intellectual or sensory impairments". Article 2 defines discrimination on the basis of disability as "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..." The Australian Government has now also signed and ratified the Optional Protocol, allowing individual complaints for breaches of the treaty to be made to the Committee on the Rights of People with Disabilities. This is an important avenue for redress, which can be accessed once all national remedies have been exhausted and "permits international scrutiny of our laws and practices".³⁹

Article 18 of the Convention refers to liberty of movement and nationality by recognising the "rights of persons with disabilities to liberty of movement, to freedom to choose their residence and to a nationality, on an equal basis with others". However, Australia has sought exemption from Article 18 through a declaration on the basis of its migration laws. When signing the Convention, Australia stated that the Convention does not

³⁹ Robert McClelland (Attorney-General), *Speech to the Disability and Age Discrimination Law Reform Summit*. Sydney, 30 July 2009.

create a general right of entering and remaining in Australia nor does it impact on Australia's health requirements for non-nationals seeking entrance to Australia.⁴⁰ This raises the question of whether this declaration is inconsistent with the principles of the Convention. Furthermore, it highlights Australia's continued view of migration law as separate from the rest of domestic law, and requiring certain practice that may be classified as discriminatory. Are Australia's migration laws and case law therefore in contravention of the Convention?

Disability Discrimination Law

In 1992, Australia passed the *Disability Discrimination Act*. It defines discrimination, at section 5, as treating or proposing to treat the aggrieved person because of their disability less favourably than they would treat a person without the disability. This includes not only direct but also indirect discrimination, which can occur when a condition that is applied to everyone has an unfair effect on a particular group or person with a disability.⁴¹ The objects of the Act highlight the importance of ensuring that people with a disability have the same rights to equality before the law as everyone else. Section 29 purports to make it unlawful for any Commonwealth law, program or administrator to "discriminate against another person on the ground of the other person's disability". However, according to the Act at section 52, Australia's migration program is subject to certain exceptions in terms of disability discrimination. This section states that Divisions 1 (discrimination in work), 2 (discrimination in other areas) and 2A (disability standards) do not:

- (a) *affect discriminatory provisions in:*
 - i. *the Migration Act 1958; or*
 - ii. *a legislative instrument made under that Act; or*
- (b) *render unlawful anything that is permitted or required to be done that Act or instrument.*

Australia has implemented domestic legislation firmly against disability discrimination, yet the exemption in terms of migration law appears to be flagrantly contrary to the objectives.

Migration Law

The *Migration Act 1958* (Cth) regulates the entrance and presence of non-citizens in Australia. Along with the regulations, it provides for all the visa categories and the application criteria, which include passing health and character tests as part of the public interest criteria.⁴² The applicant is assessed by a medical practitioner appointed by the minister / Commonwealth (MOC). If the applicant satisfies the relevant criteria, depending upon their visa class, and the Department of Immigration and Citizenship (DIAC) is satisfied the rest of the application is valid, then a visa is granted.⁴³ If the application is refused on health grounds, then the applicant has the right to have the decision reviewed by the Migration Review Tribunal (MRT).⁴⁴

All applicants for permanent or provisional visas are required to satisfy item 4005 in Schedule 4 of the Regulations (with some concession for certain visas). The health requirements are satisfied if the applicant:

- *is free from tuberculosis; and*

⁴⁰ Cynthia Banham, 'Australia to sign UN Disability protocol' *The Age* (30 July 2009).

⁴¹ *Disability Discrimination Act 1992* s6.

⁴² Robert Guthrie and Elizabeth Waldeck, 'Disability and Immigration in Australia' (2007) 83 *Precedent* 33.

⁴³ *Migration Act 1958* s65.

⁴⁴ Robert Guthrie and Elizabeth Waldeck, 'Disability and Immigration in Australia' (2007) 83 *Precedent* 33.

- *does not suffer from a disease or condition that is or may result in the applicant being a threat to the Australian health system or public; and*
- *does not suffer from a disease or condition that is such that a person who has it would likely to:*
 - *require health care or community services, the provision of which would be likely to result in a significant cost to the Australian community, or*
 - *prejudice the access of an Australian citizen or permanent resident, regardless of whether the healthcare or community services will actually be used in connection with the applicant.*⁴⁵

In *Inguanti v Minister for Immigration and Multicultural Affairs*⁴⁶ the question was whether 4005 of the regulations was illogical and therefore invalid. It was argued that it was unreasonable to assess the likely costs regardless of whether the applicant would actually use these services.⁴⁷ Heerey J dismissed this claim and said it was reasonable to assess the condition and the seriousness in terms of future possible expenses. He also said it was unreasonable for the MOC to be required to assess the financial circumstances of a particular applicant.⁴⁸ This is an important point as it was raised in circumstances of an Italian-born American citizen with an intellectual disability. His condition was assessed as severe enough to render him eligible for government assistance, programs and possibly a nursing home, and therefore a ‘significant cost to the community’. The MOC as per 4005 considered it irrelevant that the applicant and his family which cared for him had sufficient funds so as not to be a ‘burden’.

Heerey J applied the same sort of reasoning in *Imad v Minister for Immigration and Multicultural Affairs*⁴⁹ where he clarified the test for applying the 4005 criteria. He said the ‘person’ referred to was not the applicant but a hypothetical person who suffered from the same disease or condition. By applying this objective test, it may be argued that people with a disability such as the applicant in *Inguanti* are unfairly treated, as it is on the basis of their disability that they are excluded. Article 2 of the Convention specifically identifies exclusion on the basis of disability as discrimination. By also not taking into account financial means, there is no way an applicant can overcome the hurdle of proving there will be no resulting burden on the state. This is an assumption not made for people without a disability.

Medical Assessment and Significant Cost

The implementation of the health criteria is largely focussed on how the MOC assess the applicant. This means that any implementation of the Convention will have to review the processes in this assessment regime. Determining what is actually a disease or condition under the criteria is contentious. There has been some leeway in past cases where the MRT has intervened and not activated the health provisions, such as in *Re Nguyen*.⁵⁰ In this case, the Tribunal found the MOC had wrongly diagnosed her and that the distinction in

⁴⁵ *Migration Regulations 1994*, Schedule 4, 4005.

⁴⁶ [2001] FCA 1046.

⁴⁷ Robert Guthrie and Elizabeth Waldeck, ‘Disability and Immigration in Australia’ (2007) 83 *Precedent* 33.

⁴⁸ *Inguanti v Minister for Immigration and Multicultural Affairs* [2001] FCA 1046.

⁴⁹ [2001] FCA 1011.

⁵⁰ (IRT 5667, 30 June 1995).

classification was important to her assessment, resulting in her not being found to suffer from a disease or condition.⁵¹

The case of *Robinson v Minister for Immigration and Multicultural and Indigenous Affairs*⁵² concerned the young son, David, of a visa applicant.⁵³ David suffered from a mild form of Down's syndrome and was assessed as not meeting the health criteria because he would incur a significant cost to the Australian community. In the Federal Court, it was ruled that the medical assessments were unlawful because rather than determining David's precise level of Down's syndrome, the MOC had just applied a general test that anyone with Down's syndrome would be a burden and therefore not qualify for a visa. Ultimately it took six years for the Robinson family to secure a resolution to their case,⁵⁴ highlighting the difficult process facing a person or a family member with a disability and receiving an unfavourable health assessment.

A further difficulty is assessing what actually is a 'significant cost to the community'. This task is placed in the hands of the MOC which is guided by average annual per capita health and welfare expenditure.⁵⁵ *Seligman v Minister for Immigration and Multicultural Affairs*⁵⁶ is an example where there was a dispute over the cost to the community of the 22 year old son, Gregory, of the Seligman family. Gregory had borderline intellectual functioning and despite his circumstances of support from his family, an employment offer and positive specialist reports, the family visa was refused based on the perceived cost to the community. The case was decided in favour of the Seligman's as the MOC was found to have applied the wrong criteria, and should have considered the actual likelihood of significant cost requiring appropriate evidence.

Significant cost is especially difficult for HIV and AIDS sufferers who are assumed to need significant treatment and services. In *X v Minister for Immigration and Multicultural Affairs*⁵⁷ counsel for the applicant argued that he was infected with HIV but was

“a healthy man on combination treatment for which he pays and will continue to pay while he is the holder of a temporary residence visa...the costs...borne by the Australian healthcare system for the period of the visa he seeks, that being a period of only four years... is a totally insignificant cost...”⁵⁸

However, the court on appeal followed *Inguanti* and agreed that 4005 required a focus on a hypothetical person who suffers from HIV, not the general condition of the applicant. The court found that merely adding the cost of antiretroviral treatments and monthly monitoring costs was acceptable and not in error of law. When looking at the purpose of the Convention to “promote, protect and ensure the full and equal enjoyment of all human rights”⁵⁹ by persons with disabilities, it is difficult to reconcile the principles in situations such as these. When decisions are made about whether a person should be allowed to enter the country by

⁵¹ See also *Re Henry* (IRT 4935, 22 February 1995).

⁵² (2005) 148 FCR 182.

⁵³ Subclass 855 (Labour Agreement) visa.

⁵⁴ Jan Gothard and Charlie Fox, 'Consign disability discrimination to the bin', *The Australian* (17 November 2008).

⁵⁵ Robert Guthrie and Elizabeth Waldeck, 'Disability and Immigration in Australia' (2007) 83 *Precedent* 33.

⁵⁶ (1999) 85 FCR 115.

⁵⁷ [2005] FCA 429.

⁵⁸ *X v Minister for Immigration and Multicultural Affairs* [2005] FCA 429 at 11.

⁵⁹ *UN Convention on the Rights of Persons with Disabilities*, article 1.

categorising worth in relation to health and judging that illness or disability is a ‘cost’ to the community, then that is hardly promoting the “respect for their inherent dignity.”⁶⁰

The meaning of ‘community service’ within the cost criteria of 4005 has also needed clarification. In *Seligman* the court emphasised the words ‘in the areas of’ and took a broad application. The regulations now state that it includes the provision of an Australian social security benefit, allowance or pension.⁶¹ This requirement also links to s94 of the *Social Security Act 1991* (Cth), outlining the criteria necessary for a disability support pension. It is interesting that while it is this criterion in the disability support pension that can help determine the health assessment of a person, this very same pension has a ten year waiting period. So while a person may be assessed according to it, access to it will be restricted. Furthermore, carers of newly arrived people with a disability also have to wait ten years before they can access income support.⁶² This could be argued as interfering with an adequate standard of living and to social protection under the Convention article 28 and the right to health under article 25. It may also be contrary to article 15 of the Convention in regard to inhuman and degrading treatment provisions, violating human rights.⁶³

Humanitarian Visas

A highly controversial case involved an asylum seeker, Sharaz Kiane, who was granted a protection visa as a refugee. He then attempted to bring his family into Australia under the ‘split family’ provisions.⁶⁴ His wife’s visa was denied on the basis that his daughter had cerebral palsy and thus would be a significant cost to the community. As this humanitarian application was made offshore, the merits of the application and health criteria were applied to the whole family as a single unit. Therefore, because the daughter had failed the health assessment, the whole family under the same visa was denied. After four and a half years of trying to sponsor his family and gain them entrance to Australia, Mr Kiane in desperation set fire to himself outside of Parliament House and died from his injuries.⁶⁵

In this case, the difference between applying onshore and applying offshore in relation to protection visas is significant. If Mr Kiane’s family had been onshore then the health requirement would not have been a criterion because “Australia has an obligation to provide protection to persons, irrespective of their health status, who have been found to engage Australia’s protection obligations onshore.”⁶⁶ It therefore seems strange that where one family member has activated the protection provisions, the rest of the family is denied based on a disability, not to mention their geography. Once again, this contravenes article 18 of the Convention as well as article 5 relating to equality and non-discrimination.

⁶⁰ Ibid.

⁶¹ *Migration Regulations 1994* 1.03.

⁶² The Multicultural Disability Advocacy Association of NSW and The National Ethnic Disability Alliance, ‘*Joint Submission to the Senate Inquiry into the Administration and Operation of the Migration Act 1958*’ (2005).

⁶³ Australian Federation of AIDS Organisations Inc, ‘United Nations Convention on the Rights of Persons with Disabilities’ *Briefing Paper* (22 August 2008).

⁶⁴ Subclass 202 (Global Special Humanitarian) visa.

⁶⁵ 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).

⁶⁶ Id at 3.

The recent case of Bernard Moeller, the German Doctor, who was refused permanent residency because he had a son with Down's syndrome, attracted much publicity.⁶⁷ It was claimed by DIAC that the treatment of Mr Moeller's family was not discriminatory because it applied the same treatment to everyone.⁶⁸ However, as the Convention recognises, people with a disability face difficulties "which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others." So when they are already coming from a position of disadvantage, applying the same criteria does not create equality. While the health criterion applies to all, the impact is felt only on those with a disability for reasons they can not change as "impairment is a fact of life".⁶⁹ Furthermore, while DIAC has claimed it was not discriminatory, the *Disability Discrimination Act* clearly recognises that it is by providing an exemption for migration as discussed earlier. If it was not discriminatory, it would not need an exemption and would fall into line with the Disability Act.

Social Attitudes

An issue of equality may be raised when looking at assurances of support, which are sometimes discretionary, but also sometimes mandatory.⁷⁰ These are maintenance guarantees that must be accepted by the Minister and involve the lodgement of bonds and the upfront payment of a health services charge.⁷¹ This places people who can access funds in a better position than those who cannot, perhaps revealing a level of inequality through a reliance on finances. The philosophy behind this focus on financial support, along with the health requirements and potential cost to the community, is that of national interest and undue burden on the community. The question could be asked: is it in the national interest to keep out individuals who could bring skills and qualities needed because that person or a family member has a disability? Moreover, is disability such a bad thing? There has been debate over people *choosing* disability, such as a deaf couple wanting to use pre-implantation genetic diagnosis to choose a deaf child.⁷²

The Joint Standing Committee on Migration Regulations recommended that there should be a balanced approach between the benefits an individual could bring and the assessment of burden to the community.⁷³ The Convention also marks "a paradigm shift by utilising a social model of disability".⁷⁴ This looks at disability as an evolving concept between those with impairments and the social / environmental factors that affect them. Parliamentary Secretary for International Development Assistance, Bob McMullan, has highlighted how in light of the Convention it is important to shift the attitudes of the Australian people in regard to how people with a disability are viewed and treated.⁷⁵ He has stated that Australia is developing a National Disability Strategy to implement the

⁶⁷ Cynthia Banham, 'Australia to sign UN Disability protocol' *The Age* (30 July 2009).

⁶⁸ Jan Gothard and Charlie Fox, 'Consign disability discrimination to the bin', *The Australian* (17 November 2008).

⁶⁹ Mr Bill Shorten, 'Implementing and Monitoring the Convention on the Rights of Persons with Disabilities (CRPD) in the Australian Social and Legal Context – Keynote Address' Parliament House (20/08/2008)

⁷⁰ *Migration Regulations 1994* 2.7.

⁷¹ *Id* at 2.39 and 5.41.

⁷² Isabel Karpin, 'Choosing Disability: Preimplantation Genetic Diagnosis and Negative Enhancement' (2007) 15 *Journal of Law and Medicine* 89.

⁷³ Joint Standing Committee on Migration Regulations

⁷⁴ Australian Federation of AIDS Organisations Inc, 'United Nations Convention on the Rights of Persons with Disabilities' *Briefing Paper* (22 August 2008).

⁷⁵ Bob McMullan, 'Second Conference on the States Parties to the Convention on the Rights of Persons with Disabilities' (3 September 2009).

Convention. This should include a review of the migration legislation, as at present it is not in line with the Convention.

Conclusion

Australia has implemented disability discrimination legislation on a federal level as evident in the *Disability Discrimination Act 1992*. The act aims to eliminate discrimination to ensure equality and the protection of fundamental rights.⁷⁶ However, section 52 of the Act provides certain exemptions for migration laws, revealing that discrimination is present and regarded as acceptable in this area. This discrimination manifests itself largely in the public interest criteria, specifically the health conditions, for people wishing to enter and remain in Australia. The introduction of the *UN Convention on the Rights of Persons with Disabilities* has provided a renewed focus on these issues.

In light of the Convention and its purpose and provisions, an examination of the Australian process of health screening reveals that discrimination is inherent in the system. By requiring applicants to submit to health criteria, applied on an objective basis, to determine if any illness or disability will be a financial ‘cost’ to the community, puts people with a disability on an unequal footing against those who are not disabled. This specifically violates article 18 of the Convention by restricting a person’s liberty of movement for reasons of disability. The Australian cases also reveal a tendency to devalue the contribution of a person with a disability by only seeing a *possible* financial taxpayer burden and discriminating on the basis of a child having, for instance, Down’s syndrome. A repositioning of the social and political attitudes of how people and their families with a disability are viewed should coincide with an effort to implement the Convention in relation to migration.

The migration laws should be changed to conform with the Convention by:

- Removing section 52 from the *Disability Discrimination Act 1992* and
- Changing the health assessment criteria under Schedule 4 of the Regulations so that people with a disability are not assessed according to the cost to the community. It should not be used to restrict people with a disability but rather a greater emphasis should be placed on the benefit brought to the community, therefore acknowledging that disability is not a criterion for exclusion.

Such changes to the legislation alongside efforts to educate the community on disability and changing social attitudes are vitally important – both in themselves, and also because Australia is in Contravention of the Convention.

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⁷⁶ *Disability Discrimination Act 1992* (Cth), objects.

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ATTACHMENT 4

IMMIGRATION HEALTH RULES AND DISABILITY: SUBMISSION LYDIA CAMPBELL

INTRODUCTION

The United Nations Convention on the Rights of Persons with Disabilities (hereafter the “UNCRPD”) came into force on 13 December 2006.⁷⁷ It promises an innovative approach to the treatment of persons with disabilities with respect to their general human rights, and those specifically pertaining to the freedom of movement.

This paper seeks to address the extent to which the UNCRPD obliges State parties to facilitate the full enjoyment of those rights articulated therein. It does this by comparative reference to antecedent international legal instruments which impact upon the rights of persons with disabilities including the International Covenant on Civil and Political Rights (hereafter the “ICCPR”), the Convention against Torture and other Cruel, Inhuman or Degrading Treatment (hereafter the “CAT”) and the Convention on the Status of Refugees (hereafter the “Refugees Convention”).

Part One analyses the extent to which antecedent international legal instruments adequately respected and supported the rights of persons with disabilities generally and with respect to migration. Part Two evaluates the potential of the UNCRPD to facilitate the full enjoyment of the rights of persons with disabilities in light of the findings of Part 1.

PART I. THE INTERNATIONAL LEGAL FRAMEWORK

The Domestic Model vs. the International Model

In order to appreciate the extent to which persons with disabilities have been supported under the previous international legal framework, it is essential to summarise the extent to which State domestic legislation and policy has been unaccommodating and discriminatory toward peoples with disabilities. For the most part, State domestic law and policy reflects a preoccupation or trend in State legislation and policy to adopt the “medical model” of disability.⁷⁸ According to Quinn and Degener, this model “...focuses on persons’ medical traits such as their specific impairments ... [having] the effect of locating the “problem” of disability within the person”.⁷⁹

In the context of migration, this results in the adoption of stringent laws and policies which emphasise the concerns surrounding an individual’s disability. Common law countries such as the United States of America, New Zealand, Canada and Australia in their adoption of the medical model of disability, have devised legislation and policy which acts to the exclusion of persons with a disability. Each of these States provides for exclusion of entry on the grounds of medical inadmissibility where the Applicant is likely to be either a threat to public health and safety or impose significant costs on domestic health and community

⁷⁷ United Nations Enable, *Convention on the Rights of Persons with Disabilities*,

<<http://www.un.org/disabilities/default.asp?navid=12&pid=150>> accessed 15 October 2009.

⁷⁸ Quinn, Gerard and Degener, Theresia, ‘Chapter 1 – The Moral Authority for Change: Human Rights Values and the Worldwide Process of Disability Reform’ in *Human Rights and Disability: The Current Use and Future Potential of United Nations Human Rights Instruments in the Context of Disability*, (New York and Geneva: 2002) at 14.

⁷⁹ Ibid.

services.⁸⁰ Thus, domestic legislative and policy trends in key common law countries are constructed very much in terms of the disabled person's economic utility⁸¹ and not by reference to their fundamental human rights.

Comprising of binding international treaties, non-binding treaties, customary international law and a number of regional treaties⁸² the international legal framework mitigates the often stringent and discriminatory domestic legal framework of nation states. Contrary to State domestic law, the international legal framework adopts the "human rights model" of disability which:

...focuses on the inherent dignity of the human being and subsequently, but only if necessary, on the person's medical characteristics. It places the individual centrestage in all decisions affecting him/her and, most importantly, locates the main "problem" outside the person and in society.⁸³

This section seeks to highlight areas of international law which have an impact upon the migration rights of people with disabilities by conferral of both universal and specific rights. A detailed analysis of all international human rights instruments is beyond the scope of this paper. Three of the key instruments which have particular relevance to disabled peoples will be examined – the ICCPR, the CAT and the Refugees Convention.

The International Covenant on Civil and Political Rights

Entering into force on 23 March 1976, the rights contained in the ICCPR can be categorised as follows: "...(a) rights that refer to human existence, (b) liberty rights, (c) associational rights and (d) political rights."⁸⁴ Like a number of key human rights instruments, the ICCPR does not make *specific* reference to the rights of persons with disabilities. Nonetheless, the rights of disabled peoples are supported in a number of more generalised, or "universal"

⁸⁰ See Section 212 of the *Immigration and Nationality Act 1952*, <<http://www.uscis.gov/portal/site/uscis/menuitem.f6da51a2342135be7e9d7a10e0dc91a0/?vgnextoid=fa7e539dc4bed010VgnVCM1000000ecd190aRCRD&vgnnextchannel=fa7e539dc4bed010VgnVCM1000000ecd190aRCRD&CH=act>>, accessed 30 September 2009, *Immigration New Zealand, Immigration New Zealand Operational Manual: Administration*, <<http://www.immigration.govt.nz/NR/rdonlyres/607ED409-0193-46A1-B3FF-8496DCB2FAC7/0/Administration.pdf>> accessed 30 September 2009, *Immigration and Refugee Protection Act, S.C 2001*, s 38(1), s 38(2)(a-d), <<http://www.iijcan.org/en/ca/laws/stat/sc-2001-c-27/latest/sc-2001-c-27.html>>, accessed 30 September 2009 and *Migration Act 1958 (Cth)*, <http://www.austlii.edu.au/au/legis/cth/consol_act/ma1958118/> accessed 30 September 2009, *Migration Regulations 1999*, <http://www.austlii.edu.au/au/legis/cth/consol_reg/mr1994227/> and Department of Immigration and Citizenship, *Fact Sheet 22: The Health Requirement*, <<http://www.immi.gov.au/media/fact-sheets/22health.htm>> accessed 15 October 2009.

⁸¹ Quinn, Gerard and Degener, Theresia, Chapter 1 – The Moral Authority for Change: Human Rights Values and the Worldwide Process of Disability Reform' in *Human Rights and Disability: The Current Use and Future Potential of United Nations Human Rights Instruments in the Context of Disability*, (New York and Geneva: 2002) at 14.

⁸² For an extensive list please see United Nations Office of the High Commissioner for Human Rights, *International Law*, <<http://www2.ohchr.org/english/law>> accessed 15 October 2009,

⁸³ Quinn, Gerard and Degener, Theresia, Chapter 1 – The Moral Authority for Change: Human Rights Values and the Worldwide Process of Disability Reform' in *Human Rights and Disability: The Current Use and Future Potential of United Nations Human Rights Instruments in the Context of Disability*, (New York and Geneva: 2002) at 14.

⁸⁴ Quinn, Gerard & Degener, Theresia, Chapter 4: "Disability and Freedom: The International Covenant on Civil and Political Rights" in *Human Rights and Disability: The Current Use and Future Potential of the United Nations human rights instruments in the context of disability*, (New York and Geneva: United Nations 2002) at 54.

provisions. For example, the Preamble of the ICCPR makes reference to the “recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family”.⁸⁵ Further, the rights of peoples with a disability are covered generally by Articles 2 and 26 which constitute the Convention’s non-discrimination provisions.⁸⁶ Article 2 provides that each State party to the Covenant is to ensure to all individuals within its territory and subject to its jurisdiction all rights contained in the ICCPR without distinction as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status and is to take all reasonable steps to facilitate the realisation of these rights at a domestic level.⁸⁷ Though this provision clearly stipulates an obligation on behalf of States to ensure rights as enshrined in the Covenant to all peoples including those with a disability, it contains a clear qualification that such rights are to be realised for persons *within the territory and subject to the jurisdiction* of the State in question. Such a provision is of little benefit to potential migrants.

According to Quinn and Degener, Article 26 of the ICCPR is broader in its application and encompasses peoples with disabilities by the term “other status”.⁸⁸ Article 26 states that:

All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.⁸⁹

Despite the broad scope of the ICCPR it does not explicitly provide rights in the context of migration. The ICCPR does contain a term with respect to freedom of movement by way of Article 12(1). However, Article 12 is qualified by the requirement of lawful residence in a State (problematic particularly in the context of refugees and asylum seekers) and that this provision may be restricted in its application where it is necessary to protect “...public health or morals or the rights and freedoms of others”.⁹⁰ According to Joseph et al., the ICCPR therefore fails to guarantee a right to residency.⁹¹ General comments of the Human Rights Committee have affirmed this interpretation of Article 12, however, the Committee does highlight circumstances in which this interpretation will not be justified⁹²:

⁸⁵ The United Nations, *International Covenant on Civil and Political Rights*, Preamble, <<http://www.ohchr.org/english/law/ccpr.htm>> accessed 12 October 2009.

⁸⁶ Quinn, Gerard & Degener, Theresia, Chapter 4: “Disability and Freedom: The International Covenant on Civil and Political Rights” in *Human Rights and Disability: The Current Use and Future Potential of the United Nations human rights instruments in the context of disability*, (New York and Geneva: United Nations 2002) at 54.

⁸⁷ United Nations, *International Covenant on Civil and Political Rights*, Article 2, <<http://www2.ohchr.org/english/law/ccpr.htm>> accessed 12 October 2009.

⁸⁸ Quinn, Gerard & Degener, Theresia, Chapter 4: “Disability and Freedom: The International Covenant on Civil and Political Rights” in *Human Rights and Disability: The Current Use and Future Potential of the United Nations human rights instruments in the context of disability*, (New York and Geneva: United Nations 2002) at 59.

⁸⁹ The United Nations, *International Covenant on Civil and Political Rights*, Article 26, <<http://www2.ohchr.org/english/law/ccpr.htm>>, accessed 12 October 2009.

⁹⁰ Id at Article 12(1) and (2).

⁹¹ Joseph, Sarah, Schultz, Jenny, Castan, Melissa, *The International Covenant on Civil and Political Rights: Cases, Materials and Commentary*, (United States: Oxford University Press, 2000) at 246.

⁹² Ibid.

The Covenant does not recognize the right of aliens to enter or reside in the territory of a State party. It is in principle a matter for the State to decide who it will admit to its territory. However, in certain circumstances, an alien may enjoy the protection of the Covenant even in relation to entry or residence, for example, when considerations of non-discrimination, prohibition of inhuman treatment and respect for family life arise.⁹³

Such circumstances do, however, remain subject to conditions relating to the consent of States for entry.⁹⁴ Thus, while ICCPR contains provisions of universal relevance applicable to disabled peoples, the only and specific provision relating to movement is both qualified and restrictive in its application.

Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

The CAT prohibits the use of torture and other cruel, inhuman or degrading treatment or punishment. The CAT defines torture to include an act causing severe physical or mental pain or suffering, which is intentionally inflicted upon a person for the purposes of confession, punishment, intimidation or coercion.⁹⁵ Such acts are defined to be perpetrated at the design of or at the acquiescence of public authority.⁹⁶ The definition of cruel, inhuman or degrading treatment or punishment, however, is less clear.⁹⁷

The relevance of the CAT in the context of disability rights has significantly increased in light of the findings of the Special Rapporteur of the Human Rights Council which highlights the increased vulnerability of disabled peoples in both the public and private arena, exposing them to significant violence and abuse:

Persons with disabilities are often segregated from society in institutions, including prisons, social care centres, orphanages and mental health institutions. They are deprived of their liberty for long periods of time either against their will or without their free and informed consent. Inside these institutions, persons with disabilities are frequently subjected to unspeakable indignities, neglect, severe forms of restraint and seclusion as well as physical, mental and sexual violence.

....

In the private sphere, persons with disabilities are especially vulnerable to violence and abuse, including sexual abuse, inside the home, at the hands of family members, caregivers, health professionals and members of the community.⁹⁸

Despite clear application to disabled peoples, the CAT is limited in the extent to which disability rights are indeed supported. According to Bourke and Quinn, the CAT is

⁹³ Ibid.

⁹⁴ Ibid.

⁹⁵ The United Nations, *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, Article 1, <<http://www.hrweb.org/legal/cat.html>>, accessed 11 October 2009.

⁹⁶ Ibid.

⁹⁷ Bourke, Christina and Quinn, Gerard, Chapter 6: The Integrity of the Person: The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and disability, in *Human Rights and Disability: The Current Use and Future Potential of the United Nations human rights instruments in the context of disability*, (New York and Geneva: United Nations 2002) at 135.

⁹⁸ United Nations General Assembly, Sixty third Sessions, *Note by the Secretary-General, Torture and Other Cruel, inhuman or degrading treatment or punishment*, 28 July 2008 at 8-9.

limited in a general sense on account of the definition of torture provided in the Convention which covers those acts of torture which are committed only by or at the behest of public authorities. This necessarily restricts the application of the Convention to those peoples with a disability who suffer torture or other cruel treatment at the hands of private individuals. Further, the definition of cruel, inhuman or degrading treatment or punishment has not been adequately defined, again restricting the general application to disabled peoples.⁹⁹

With respect to migration, the CAT articulates the principle of “non-refoulement”, or non-return, of peoples at risk of torture upon return to their country of origin. Article 3 states that:

1. No State Party shall expel, return (refouler) or extradite a person to another State where there are substantial grounds for believing that he would be in danger of being subjected to torture
2. For the purpose of determining whether there are such grounds, the competent authorities shall take into account all relevant considerations including, where applicable, the existence in the State concerned of a consistent pattern of gross, flagrant or mass violations of human rights.

Clearly relevant to disabled asylum seekers and refugees¹⁰⁰, the importance of such a provision should not be underestimated. However, Article 3 is limited in its applicability as it covers only vulnerable individuals who are both seeking asylum on the grounds of disability. It does not apply to those peoples seeking to migrate for the purposes of employment or family reunification and is therefore not broad in its application.

The United Nations Convention Relating to the Status of Refugees

Though not a constituent of the formal international human rights framework¹⁰¹, the Refugees Convention is relevant to peoples with disabilities. The reason here is twofold. It is clearly an instrument dealing specifically with human migration. Further, the scope of people to whom the Convention applies is significant in light of the prevalence of physical and mental health issues in refugee communities.¹⁰² According to the World Health Organisation, between 2.3 and 3.3 million of the world’s displaced persons live with a disability.¹⁰³

Under the Refugee Convention, an individual will be granted refugee status where the State is satisfied that due to “well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion”¹⁰⁴ the

⁹⁹ Bourke, Christina and Quinn, Gerard, Chapter 6: The Integrity of the Person: The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and disability, in *Human Rights and Disability: The Current Use and Future Potential of the United Nations human rights instruments in the context of disability*, (New York and Geneva: United Nations 2002) at 135.

¹⁰⁰ Id at 150.

¹⁰¹ See Office of the United Nations High Commissioner for Human Rights, Migration – International Legal Framework, <<http://www2.ohchr.org/english/issues/migration.taskforce/standards.htm>>, accessed 23 September 2009 and United Nations Enable, Overview of International Legal Frameworks for Disability Legislation, <<http://www.un.org/esa/socdev/enable/disovlf.htm>>, accessed 11 October 2009.

¹⁰² Australian Lawyers for Human Rights, *A Human’s Worth: Putting a Price on Disability in Migration Matters*, <<http://www.alhr.asn.au/activities/2009/06/01/discussion-paper-a-human-s-worth-putting-a-price-on-disability-in-migration-matters.html>> accessed 30 September 2009 at 15.

¹⁰³ United Nations High Commission for Refugees, *People with Disabilities*, <<http://www.unhcr.org/pages/4a0c310c6.html>>, accessed 11 October 2009.

¹⁰⁴ The United Nations, Convention Relating to the Status of Refugees, Article A(1)(2), <<http://www2.ohchr.org/english/law/refugees.htm>> accessed 30 September 2009.

individual is unwilling or unable to return to their country of origin.¹⁰⁵ This definition is, in and of itself, very involved and subject to complex international jurisprudence.¹⁰⁶

The most amenable ground to the circumstances of disabled refugees in “particular social group”. This is understood in international jurisprudence to mean groups identified by an innate or unchangeable characteristic, groups whose members voluntarily associate for reasons so fundamental to their human dignity that they should not be forced to forsake the association or groups innate because of past association.¹⁰⁷ Persons with a disability, if faced with persecution, may invoke the protection of states in accordance with the first head of “particular social group” being groups identified by an innate or unchangeable characteristic. Successful cases have, for example, been recorded in the United States where it has been held that disabled children constitute a “particular social group”.¹⁰⁸

Should the individual in question be able to prove persecution on the basis of their disability, then Article 33 of the Convention will be triggered. Like Article 3 of the CAT, Article 33 of the Convention on Refugees contains the obligation of non-refoulement in which states are prohibited from returning an individual to circumstances where the right to life or freedom would be threatened,¹⁰⁹ supporting the freedom of movement.

Like the ICCPR and the CAT, the Refugee Convention is also limited in its support of the rights of peoples with disabilities. Prima facie, the Convention does not apply to those people voluntarily seeking to migrate. Further, the right to freedom of movement may only be enforced where the individual has proved the requisite level of persecution and on a ground contained in the Convention before the non-refoulement provision may be invoked. Thus, its application is relevant only to those individuals who fear persecution on the grounds of membership in a particular social group, the definition of which is in and of itself, complex.

Evaluation

Prior to the advent of the UNCRPD, it is clear from the above analysis, that the rights of peoples with a disability generally and in the context of migration have been supported in a very piecemeal fashion. While each of the international instruments outlined provide for the universality of human rights, the practical application of these rights to peoples with a disability is far different. The ICCPR provides only for the freedom of movement of persons lawfully within a State and both the CAT and the Refugees Convention must first be triggered by the persecution of the individual in question before the principle of non-refoulement, and hence the unqualified movement of an individual, can be achieved. The current international legal framework therefore lacks the specificity required to adequately support and maintain the migration rights of peoples with disabilities. This sentiment is echoed by the Office of the High Commissioner for Human Rights:

There is no doubt that existing international human rights system was meant to promote and protect ... the rights of persons with disabilities. Sadly, there is also no

¹⁰⁵ Ibid.

¹⁰⁶ See for example Hathaway, James, *The Law of Refugee Status* (Canada: Butterworths Law, 1993) and Shacknove, AE ‘Who is a Refugee?’ 95 *Ethics* (1985).

¹⁰⁷ See La Forrest J in *Canada v Ward* [1993] 2 S.C.R 169 at 103.

¹⁰⁸ Bhabha, Jacqueline, Crock, Mary, *Seeking Asylum Alone: Unaccompanied and Separated Children and Refugee Protection in Australia, the US and the UK* (Annandale: Themis Press, 2007) at 166.

¹⁰⁹ The United Nations, Convention Relating to the Status of Refugees, Article 33 <<http://www2.ohchr.org/english/law/refugees.htm>> accessed 30 September 2009.

doubt that the existing standards and mechanisms [have], in practice, failed to provide adequate protection in the specific case of persons with disabilities the UN human rights treaty bodies, while having considerable potential in this field, [have] been underutilized in advancing the rights of persons with disabilities. It [is] clearly time for the United Nations to remedy this shortcoming.¹¹⁰

PART II. THE UNITED NATIONS CONVENTION ON THE RIGHTS OF PEOPLES WITH DISABILITIES

Adopted by the United Nations General Assembly on 13 December 2006, the UNCRPD and its Optional Protocol is the latest addition to the international human rights framework. Viewing disability as a “pathology of society”¹¹¹ the UNCRPD provides the requisite specificity to facilitate to realisation of the rights of persons with disabilities both generally *and* in the context of migration.

According to the United Nations Department of Economic and Social Affairs, the Office of the United Nations High Commissioner for Human Rights and the Inter-Parliamentary Union, the need for an international human rights document specific to peoples with disabilities was required as a response to the fragmented international legal framework which often saw persons with a disabilities denied their basic rights and freedoms.¹¹² The UNCRPD was devised to complement the existing international framework and in so doing, ensures the basic human rights and ability of persons with a disability to participate, engage and contribute to society in the context of equal opportunity.¹¹³

The scope of the UNCRPD is very broad, encompassing all areas of economic, social, cultural, political and legal life:¹¹⁴

...It calls for non-discriminatory treatment and equality in access to justice during institutionalization, while living independently and in the community, in undertaking administrative tasks, in treatment by the courts and by police, in education, healthcare, in the work-place, in family life, in cultural and sporting activities, and when participating in political and public life It also protects the life, liberty and security of persons with disabilities [and] their freedom of movement...¹¹⁵

The UNCRPD establishes a number of obligations upon State parties which are relevant to the rights of disabled peoples seeking to migrate. Article 4 creates an obligation upon State parties to “...adopt all appropriate legislative, administrative and other measures

¹¹⁰ Office of the High Commissioner for Human Rights, *Lunch-time briefing on “The International Convention on the Rights of Persons with Disabilities”*, 25 September 2006.

¹¹¹ UN General Assembly, *National Legislative Measures Aimed and Strengthening Rights of Persons with Disabilities Focus, As States Parties to Convention Open Session*, 2 September 2009, <<http://www.un.org/News/Press/docs//2009/hr4998.doc.htm>>, accessed 21 September 2009.

¹¹² United Nations Department of Economic and Social Affairs, Office of the United Nations High Commissioner for Human Rights and the Inter-Parliamentary Union, *From Exclusion to Equality: Realizing the Rights of Persons with Disabilities – Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities and its Optional Protocol* (United Nations: Geneva, 2007) at 4.

¹¹³ *Ibid.*

¹¹⁴ *Ibid.*

¹¹⁵ *Id* at 12.

for the implementation of the rights recognised in the [UNCRPD]”¹¹⁶ in addition to abolishing existing laws, regulations and practices which may impede the full enjoyment of the rights articulated by the Convention.¹¹⁷ Further, State parties are obliged to refrain from any act or practice which is contrary to the objectives of the Convention and must facilitate the elimination of discrimination on the basis of disability perpetrated by any person, organisation or private industry.¹¹⁸ States are therefore under an obligation to review, amend or abolish migration legislation and policy which is contrary to the objectives of the UNCRPD. These provisions have clear relevance for those disabled migrants who face restrictive and discriminatory laws and policies in the exercise of their right to freedom of movement.

The UNCRPD also expressly provides for the liberty of movement and of nationality of peoples with a disability. Overcoming the limitations antecedent international instruments, Article 18 of the UNCRPD states that:

1. *States Parties shall recognize the rights of persons with disabilities to liberty of movement, to freedom to choose their residence and to a nationality, on an equal basis with others, including and ensuring that persons with disabilities:*
 - a. *Have the right to acquire and change a nationality and are not deprived of their nationality arbitrarily or on the basis of disability;*
 - b. *Are not deprived, on the basis of disability, of their ability to obtain, possess and utilize documentation of their nationality or other documentation of identification, or to utilize relevant processes such as immigration proceedings, that may be needed to facilitate exercise of the right to liberty of movement.*¹¹⁹ (*Emphasis added*)

Read with the various non-discrimination provisions of the UNCRPD, the effect of this provision is to render State health requirements onerous and discriminatory and behaving as a barrier the full enjoyment of the right of freedom of movement. Despite this, several States, including Australia, have sought to enter declarations or reservations pursuant to Article 18.¹²⁰ Upon ratification, Australia entered a reservation stating that Article 18:

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.¹²¹

Similarly, the United Kingdom expressed a reservation against Article 18 citing the need to retain control over the entry of foreigners across United Kingdom borders.¹²²

Such action is evidence in and of itself that these States clearly recognise the obligations created by the UNCRPD. Further, States are not permitted to make reservations

¹¹⁶ The United Nations, Convention on the Rights of Persons with Disabilities, Article 1(a) <<http://www.un.org/disabilities/default.asp?id=259>> accessed 30 September 2009.

¹¹⁷ Id at Article 1(b),

¹¹⁸ Id at Article 1(d) and 1(e).

¹¹⁹ Id at Article 18.

¹²⁰ United Nations Enable, Declarations and Reservations <<http://www.un.org/disabilities/default.asp?id=475>>, accessed 11 October 2009.

¹²¹ Id.

¹²² House of Lords, House of Commons, Joint Committee on Human Rights, *The UN Convention on the Rights of Persons with Disabilities: First Report of Session 2008-9* at page22.

where the reservation is incompatible with the object and purpose of the treaty in question.¹²³ The reservations of Australia, the United Kingdom and Thailand with respect to their migration laws and policies are in clear breach of the purpose of the UNCRPD being the promotion, protection and assurance of the “...full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities” and the promotion of their inherent dignity.¹²⁴

PART III: STATE MIGRATION LAWS AND THE EXCLUSIONS OF PEOPLES WITH DISABILITIES

In order to appreciate the extent to which persons with disabilities have been supported under the previous international legal framework, it is essential to highlight the extent to which State domestic legislation and policy has been unaccommodating and discriminatory toward peoples with disabilities. This section provides a brief overview of current migration law and policy utilised by common law countries, including The United States of America, New Zealand, Canada and Australia.

As the primary regulator of migration in the United States, the United States Citizenship and Immigration Services¹²⁵ lists among its core the provision of effective customer-oriented immigration benefits and the promotion of flexible and sound immigration policies and programs.¹²⁶ For disabled migrants, the reality of migration to United States is to the contrary.

The United States’ *Immigration and Nationality Act 1952* provides the USCIS the capacity to deny entry to the United States on the ground of medical inadmissibility. Section 212(a)(1)(A) stipulates the ineligibility of an applicant for the provision of a visa on several grounds including the carriage of communicable diseases and where the applicant is determined in accordance with the Regulations to have a physical or mental disorder that may result in the threat to the property, safety or welfare of the alien or others.¹²⁷

This restriction is tempered by Section 212(g). The section provides for a waiver of the health requirements where the Attorney-General is satisfied of a particular familial connection to a United States citizen¹²⁸ or on the application of certain conditions or terms (including a bond), the Attorney-General waives the requirement as an act of discretion.¹²⁹

Similar to the United States, New Zealand’s *Immigration Act 1987* and immigration policy reflect some prima facie exclusionary provisions.¹³⁰ Relevant to both temporary and

¹²³ Article 19, Vienna Convention on the Law of Treaties, <http://untreaty.un.org/ilc/texts/instruments/english/conventions/1_1_1969.pdf>, accessed 11 October 2009.

¹²⁴ Article 1, UNCRPD

¹²⁵ See United States Citizenship and Immigration Services, <<http://www.uscis.gov/portal/site/uscis/menuitem.eb1d4c2a3e5b9ac89243c6a7543f6d1a/?vgnextoid=2af29c7755cb9010VgnVCM10000045f3d6a1RCRD&vgnnextchannel=2af29c7755cb9010VgnVCM10000045f3d6a1RCRD>> accessed 30 September 2009.

¹²⁶ Ibid.

¹²⁷ For complete details, please see Section 212 of the *Immigration and Nationality Act 1952*, available at <<http://www.uscis.gov/portal/site/uscis/menuitem.f6da51a2342135be7e9d7a10e0dc91a0/?vgnextoid=fa7e539dc4bed010VgnVCM1000000ecd190aRCRD&vgnnextchannel=fa7e539dc4bed010VgnVCM1000000ecd190aRCRD&CH=act>>, accessed 30 September 2009.

¹²⁸ Id at, Section 212(g)(1).

¹²⁹ Id at Section 212(g)(2)(A), (B) and (C).

¹³⁰ Immigration New Zealand, *Health Requirements* <<http://www.immigration.govt.nz>> accessed 30 September 2009.

permanent entry into New Zealand is the requirement that the applicant and those accompanying the applicant, have an “acceptable standard of health”¹³¹, interpreted to mean a standard of health that is “...unlikely to be a danger to public health, unlikely to impose significant costs¹³² or demands on New Zealand’s health services or special education services, [and demonstrates an] ability to perform the functions for which [the Applicant] is granted entry.”¹³³ The final requirement is not applicable to people applying for permanent residence on the basis of family sponsorship or refugee status.¹³⁴

New Zealand migration policy also allows for the waiver of these health requirements in limited circumstances. In the context of temporary residence, applicants may be considered for a waiver of the health requirement in circumstances including where the Applicant has applied for a working visa, where the Applicant has applied for refugee status, where they are the partner or dependent child of a New Zealand citizen.¹³⁵ Included in those factors to be taken into account in assessing whether a waiver should be granted includes the degree to which the Applicant would impose significant costs upon the health and special education services of New Zealand and whether the Applicant’s potential contribution to New Zealand will be significant.¹³⁶ This can be particularly problematic where, as the trend has been, States assess the contribution of a disabled person in terms of economic utility.¹³⁷

Applicants for permanent residence to New Zealand face even more stringent criteria if wishing to apply for a medical waiver. Applicants who suffer from certain illnesses will not be granted a medical waiver.¹³⁸ Applicants and their dependents who have recognised as refugees may apply for a health waiver.¹³⁹

Like other common law countries, Canada defines a minimum standard of health required for entry into Canada. Section 38(1) of the *Immigration and Refugee Protection Act S.C 2001* states that a foreign national will be inadmissible for entry to Canada on health grounds where their particular health condition is likely to present a danger to public health, is likely to be a danger to public safety or may be reasonably expected to cause “excessive demand on health or social services”.¹⁴⁰ In the Canadian context, those conditions thought to impose excessive demand include serious incapacity requiring extensive nursing care¹⁴¹, characteristic of a number of disabilities.

However, unlike both United States and New Zealand migration policy, however, the Canadian legislation does not provide for a waiver of the health requirement, but an explicit inapplicability of the health conditions where the Applicant has been determined to “...be a member of the family class” and has been determined to be the spouse, partner or child of a

¹³¹ Ibid.

¹³² Immigration New Zealand, Immigration New Zealand Operational Manual: Administration, <<http://www.immigration.govt.nz/NR/rdonlyres/607ED409-0193-46A1-B3FF-8496DCB2FAC7/0/Administration.pdf>> accessed 30 September 2009.

¹³³ Immigration New Zealand, above n7. See also Immigration New Zealand above n9.

¹³⁴ Immigration New Zealand, above n9.

¹³⁵ Paragraph A4.65, Immigration New Zealand, above n9.

¹³⁶ Paragraph A4.70 of Immigration New Zealand, above n9.

¹³⁷ Quinn, Gerard and Degener, Theresia, *Human Rights and Disability: The Current Use and Future Potential of United Nations Human Rights Instruments in the Context of Disability*, (New York and Geneva: 2002) at 14.

¹³⁸ Specific illnesses include reduced kidney function in need of dialysis within 4 years of medical assessment, pulmonary tuberculosis, severe haemophilia and any physical incapacity which requires full time care. For more information see paragraph A4.60 of Immigration New Zealand, above n9.

¹³⁹ Id at A4.60.

¹⁴⁰ *Immigration and Refugee Protection Act, S.C 2001*, s 38(1) <<http://www.ijcan.org/en/ca/laws/stat/sc-2001-c-27/latest/sc-2001-c-27.html>>, accessed 30 September 2009.

¹⁴¹ Gushulak, Brian, Williams, Linda, “National Immigration Health Policy: Existing Policy, Changing Needs, and Future Directions”, *Canadian Journal of Public Health*, May-June 2004, Vol 95, at 1-28

sponsor, where the Applicant has applied for permanent residency as a Convention refugee or is a protected person.¹⁴² The latter of the criteria for health requirement inapplicability is encouraging insofar as it exempts refugees and protected persons, those people of whom often present the more severe cases of disability.¹⁴³

CONCLUSION

Prior to the advent of the UNCRPD, the rights of disabled peoples both generally and with specific regard to migration, were upheld to varying extents by a complex and fragmented international legal system. The UNCRPD weaves together the fragmented fabric of this system to promote, maintain and support the rights of peoples with a disability in a manner which requires the compliance and respect of States. Further, specific provisions relating to non-discrimination and the unqualified freedom of movement oblige States to amend current exclusionary laws and policies relating to migration. It is by these provisions that the fundamental human rights of persons with a disability will be realised. State co-operation and participation remains vital to the effective implementation of the Convention and it is with a commitment to the encouragement and facilitation of the rights of persons with disabilities that States must move forward.

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¹⁴² *Immigration and Refugee Protection Act, S.C 2001*, s 38(2)(a-d), above at n17.

¹⁴³ Australian Lawyers for Human Rights, *A Human's Worth: Putting a Price on Disability in Migration Matters*, <<http://www.alhr.asn.au/activities/2009/06/01/discussion-paper-a-human-s-worth-putting-a-price-on-disability-in-migration-matters.html>> accessed 15 October 2009.

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ATTACHMENT 5

CASE STUDY: RYAN DEKKER

Dear Professor Crock,

I include all my qualifications, IELTS, Skills Assessments etc.

If the attachment is blocked from my work address I will send it later from home.

Please note I scored 8/9 for the IELTS which gives me extra points. My degree curriculum was also presented in a community language (Afrikaans, which gives me extra points)

In short, I come out of a home with 2 extraordinary parents, whom without and God Almighty I would not have made it. My Dad is a Medical Doctor, who is not in practice anymore but in the management of private hospitals. My Mom owns a guesthouse and a café which she runs with my sister.

I grew up in a loving home, did well at school and went to University like the average or maybe above average teen.

When I was 24 I was in a tragic shooting accident, which left me paralyzed. My injury was incomplete on the C6 vertebrae. I was in ICU for a month and the doctors feared for my life, and I came to know during this period of my life that truly God exists and had His hand on my life. By the grace of God I made it through ICU and was transferred to the spinal ward for another 2 months rehab.

It was very tough emotionally and physically as I was very weak and traumatized.

After my stay in hospital I moved in with my 2 incredible parents, who gave me the opportunity and support to “get on my feet again” in a figurative sense. As a result of the gunshot damage to my spinal cord I experienced tremendous nerve pain in my hands for which we had no answer. I tried everything but only got sporadic relief. I visited a pain specialist who prescribed a combination of 20 pills a day to control the pain. These pills were extremely strong and some were morphine based.

After 5 months at home I was going crazy and started looking for work. Again by the grace of God I managed to secure a position at the Reserve Bank as a junior programmer. It was tough, my mom and dad took me and came to fetch me from work during their busy schedules. I was in pain, very weak and somebody had to catch the lifts for me and help me to empty my urine leg bag. To adjust to a life in a wheelchair was very hard and I faced many challenges at work.

I came to a point after about 3 years where I decided to leave the pills. I couldn't do it all at once, but in faith in my Maker I left them 1 by 1, 2 by 2 and so on, which was very hard and I had to endure excruciating pain for a couple of months. I drowned myself in my work to cope emotionally. I started slow, baby steps and started studying a technical qualification and finished my programming diploma.

I was getting stronger physically and the pain subsided. After 7 years I had been representing employees with disabilities for 2 years, I was very good at my work as I spent most weekends working on my private websites, but I had no independence. I made a decision that I am going to drive again. Most people scoffed at the idea and my parents told me afterwards they did not think I am going to be able to do it, but during the period I was trying to exercise and get strong they did not break my spirit and just supported me.

I got in the help of an occupational therapist and Springbok wheelchair rugby player and started exercising every day to firstly get strong enough to transfer myself and then eventually move to transferring myself in and out of a car. After 4 months I took the picture of my dream car for my situation to the dealer and ordered a brand new pepper white Mini Cooper S Cabriolet Automatic.

When it arrived we had it adapted and I tried to drive. I could not turn, only drive straight. Every time I tried to turn to the right I lost my balance. I exercised every day after work to master this. I took me 4 months to learn to drive safely again and get strong enough to control the steering and mechanisms safely. I renewed my driver's license and started driving to work. I did not want somebody to help me in and out of the car and assemble the wheelchair as it hampered my independence. I then ordered an ultra light titanium chair and with the help of my occupational therapist figured out how to dismantle it and get it in and out of the car (this took few months to master). Last year I drove to the coast, which is a few hundred miles and I drive the freeway to and from work with the utmost confidence.

I became tired of fighting for the rights of the disabled at the Reserve Bank and I was frustrated. At this point of time I had almost 8 years experience gained at the Reserve Bank and almost a year gained at a private ICT Company which I was working at before my injury. I was very good at my work as it was very challenging and I am very technical and I enjoyed it. I applied for a vacancy at an engineering firm and got accepted on my first interview. I worked there for 9 months and then landed a better position at a large insurance company as a Senior Software Developer. I have been working there for 10 months. Every few months I set new goals. I am redesigning my bathroom with special equipment to improve my independence. I can empty my own catheter with very limited finger function. I left all the medication and haven't had the combination for 6 years now. The only thing I drink is a single anti-depressant as I feel it helps me a bit when I get discouraged and lots of Vitamin C. I have never had kidney stones and have not been admitted to hospital in 10 years. I even went bass fishing the other day. It was a bit tedious strapping the rod to my hand and palm but I managed.

I look back over a period of 10 years where in the beginning the doctors gave my parents little hope of me surviving never mind functioning in society again, and I realize that my God is alive, watching over my footsteps and delighting in every step they take.

I have my sights set on a stubborn and hard to get Skilled Independent Australian Visa, but fortunately quitting is not an option.

God bless

Ryan Dekker

Senior Software Developer

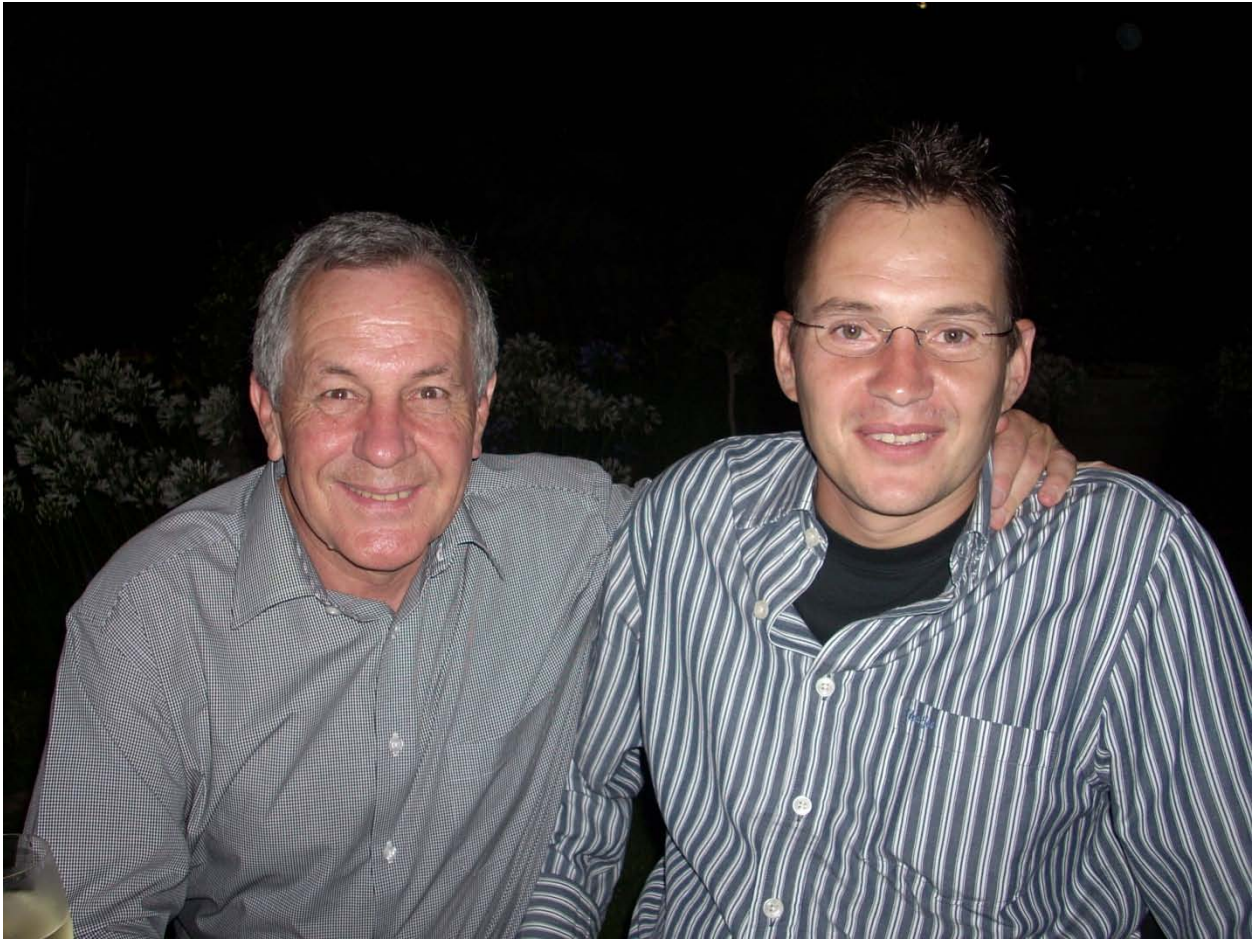
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ATTACHMENT 6

Submission to the Joint Standing Committee on Migration – Inquiry into the Migration Treatment of Disability

Kione Johnson

Immigration law acts to distinguish between the ‘citizen and the stranger’.¹⁴⁴ The immigration health rules preserves the citizen’s right of access to healthcare and community services, and minimises fiscal expenditure on migrants.¹⁴⁵ This submission juxtaposes the Canadian and Australian health criteria to demonstrate that the failure to take the applicant’s personal financial circumstances into account may undermine the economic objectives of skilled migration. I suggest that it is necessary to amend the *Migration Regulations 1994* (Cth)¹⁴⁶ to allow the health criteria to be waived where the applicant can demonstrate that they can provide an economic or social benefit which may mitigate the estimated cost of healthcare or community services. This submission also considers the role of social policy in the discretion to waive the health criteria in family migration cases. It provides a survey of decisions concerning HIV-positive applicants for spouse/interdependency visas to demonstrate how social factors will often override the economic policy objectives underpinning the health criteria. The influence of social factors such as the role of the family and the emotional benefit of a stable relationship suggests that an applicant for a spouse, interdependency or child visa should not be denied entry on the basis that they have a disease or condition, which would be at a ‘significant cost’ to the Australian community.¹⁴⁷

The Australian Immigration Health Rules

The immigration health criteria are designed to minimise Australia’s welfare expenditure and maintain public health standards.¹⁴⁸ The primary health criteria are detailed in reg4005 of the *Regulations*:

The applicant:

- (a) is free from tuberculosis; and
- (b) is free from a disease or condition that is, or may result in the applicant being, a threat to public health in Australia or a danger to the Australian community; and
- (c) is not a person who has a disease or condition to which the following subparagraphs apply:
 - (i) the disease or condition is such that a person who has it would be likely to:
 - (A) require health care or community services; or
 - (B) meet the medical criteria for the provision of a community service; during the period of the applicant’s proposed stay in Australia;

¹⁴⁴ Ireh Iyioha, ‘A Different Picture Through the Looking-Glass: Equality, Liberalism and the Question of Fairness in Canadian Immigration Health Policy’, (2008) 22 *The Georgetown Immigration Law Journal* 621, 622.

¹⁴⁵ Department of Immigration and Citizenship, *Form 1163i: Health Requirement for Temporary Entry to Australia* (2009) Department of Immigration and Citizenship <http://www.immi.gov.au/allforms/pdf/1163i.pdf> at 3 September 2009, 1.

¹⁴⁶ ‘The *Regulations*’.

¹⁴⁷ *Migration Regulations 1994* (Cth), reg 4005(c)(ii)(A).

¹⁴⁸ See LexisNexis *Australian Immigration Law*, vol 2, [20,710].

- (ii) provision of the health care or community services relating to the disease or condition would be likely to:
 - (A) result in a significant cost to the Australian community in the areas of health care and community services; or
 - (B) prejudice the access of an Australian citizen or permanent resident to health care or community services;
 - regardless of whether the health care or community services will actually be used in connection with the applicant.

Reg4005 cannot be waived. A list of visa subclasses required to comply with reg4005 is provided at **Annexure A**.

The immigration health rules are inconsistent with the *Disability Discrimination Act 1992* (Cth), which prevents a person from directly or indirectly treating a person with a disability less favourably than the person would treat another person without the disability in substantially similar circumstances.¹⁴⁹ This inconsistency is avoided as Divisions 1, 2 and 2A of Part 1 of the *Disability Discrimination Act* do not apply to decisions made under the *Migration Act 1958* (Cth).¹⁵⁰ However, the domestic application of the immigration health rules must now be evaluated in conjunction with the Government's international obligations under the *Convention on the Rights of Persons with Disabilities*.¹⁵¹ The Government has asserted that it is unnecessary to abandon the immigration health criteria, declaring 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 remain in Australia, where these requirements are based on legitimate, objective and reasonable criteria.¹⁵²

The Joint Standing Committee on Treaties has indicated that Australia's immigration health procedures conform to the requirements of the *Disability Convention*, as '[t]he processes apply to all applicants...and would not constitute discrimination under international law'.¹⁵³ This submission suggests that the domestic policy objectives could be balanced against Australia's obligations under the *Disability Convention* through the adoption of an objective health assessment, coupled with a case-by-case assessment of the migrant's potential economic and social contribution to Australian society.

Application of the Health Criteria

A visa applicant may be required to attend a medical assessment under s60 of the *Migration Act*. If the Minister is not satisfied that the applicant meets the health criteria, they must

¹⁴⁹ *Disability Discrimination Act 1992* (Cth), ss 5(1), 6.

¹⁵⁰ *Disability Discrimination Act 1992* (Cth), s 52.

¹⁵¹ *Convention on the Rights of Persons with Disabilities* (New York, 30 March 2007) [2008] ATS 12 (entry into force for Australia 16 August 2008) ('*Disability Convention*').

¹⁵² See United Nations, *United Nations Enable: Rights and Dignity of Persons with Disabilities, Declarations and Reservations* United Nations <http://www.un.org/disabilities/default.asp?id=475> at 12 September 2009.

¹⁵³ Joint Standing Committee on Treaties, *National Interest Analysis: United Nations Convention on the Rights of Persons with Disabilities, New York, 13 December 2006* [2008] ATNIA 18, Joint Standing Committee on Treaties http://www.aph.gov.au/house/committee/jsct/4june2008/treaties/disabilities_nia.pdf at 24 September 2009, 15.

decline to grant the visa.¹⁵⁴ In practice, most applicants for temporary visas are not required to undergo a medical assessment unless they are migrating from a country considered 'high risk', or if they plan to enter a classroom, are pregnant and intend to have their child in Australia, or intend to work in the medical profession.¹⁵⁵ However, applicants for permanent visas will generally be required to undergo a medical examination.¹⁵⁶

The Minister 'must seek the opinion of a Medical Officer of the Commonwealth' (MOC) in 'determining whether the visa applicant meets the health criteria'.¹⁵⁷ The distinguishing feature of the Australian health criteria is the fact that the MOC must apply the health criteria objectively, without taking the applicant's ability to personally meet the cost of the health or community services into account.¹⁵⁸ The MOC must determine the 'form or level of condition suffered by the applicant', and then apply the statutory criteria to a 'hypothetical person who suffers from that form or level of the condition'.¹⁵⁹ The applicant will fail the health criteria if a hypothetical person who suffered from that disease or condition would be 'likely to require health care or community services', which would be at a 'significant cost' to the Australian community.¹⁶⁰ The MOC must not attempt to predict the likelihood of the applicant's need for health or community services,¹⁶¹ as it would contradict the express statutory direction to assess the applicant *regardless* of whether the applicant is likely to use those services.¹⁶² This process is justified on the basis that it would be inappropriate to require a MOC to inquire into the individual financial circumstances of every applicant.¹⁶³ However, reg4005 prevents the case officer from considering extraneous factors, including the potential for the applicant to make a social or economic contribution to the Australian community. The decision maker must take the opinion of the MOC as correct.¹⁶⁴ The opinion is excluded from merits review.¹⁶⁵ The applicant may only seek judicial review of the MOC's determination on the ground that it was not of a kind authorised by the *Regulations*.¹⁶⁶ If the applicant could not challenge the MOC's decision, they would be required to apply for the decision to be reviewed by the Migration Review Tribunal, and if the initial decision to refuse the visa was affirmed, apply to the Minister, who can substitute a more favourable decision if they believe it is in the public interest to do so.¹⁶⁷ The Minister is only likely to exercise this power if the applicant can demonstrate 'unique or exceptional circumstances', including threats to their personal safety,¹⁶⁸

¹⁵⁴ *Migration Act 1958* (Cth), s 65(1)(b).

¹⁵⁵ Department of Immigration and Citizenship, above n2, 2.

¹⁵⁶ Department of Immigration and Citizenship, *Form 1071i: Health Requirement for Permanent Entry to Australia* (2009) Department of Immigration and Citizenship <http://www.immi.gov.au/allforms/pdf/1071i.pdf> at 1 September 2009, 1.

¹⁵⁷ *Migration Regulations 1994* (Cth), reg 2.25A(1).

¹⁵⁸ See *JPI v Minister for Immigration and Citizenship* (2008) 22 FLR 37, 48 (Riley FM).

¹⁵⁹ *Robinson v Minister for Immigration and Multicultural Affairs* (2005) 148 FCR 182, 194.

¹⁶⁰ *Imad v Minister for Immigration* [2001] FCA 1011, [13] (Heerey J).

¹⁶¹ *Imad v Minister for Immigration* [2001] FCA 1011, [13] (Heerey J).

¹⁶² See for example *Triandafillidou v Minister for Immigration and Multicultural Affairs* (2004) 181 FLR 302, 312 (Bryant CFM).

¹⁶³ *Imad v Minister for Immigration* [2001] FCA 1011, [14] (Heerey J).

¹⁶⁴ *Migration Regulations 1994* (Cth), reg 2.25A(3).

¹⁶⁵ *Manokian v Minister for Immigration and Multicultural Affairs* (1997) 48 ALD 632, 633.

¹⁶⁶ *Minister for Immigration and Multicultural Affairs v Seligman* (1999) 85 FCR 115, [66].

¹⁶⁷ For example, see *Migration Act 1958* (Cth), s 351(1).

¹⁶⁸ *Migration Series Instruction MSI-386: Guidelines on Ministerial Powers under Sections 345, 351, 391, 417, 454 and 501J of the Migration Act 1958*, issued 14 August 2003, [4.2] ('MSI-368').

considerations of the role of the family unit,¹⁶⁹ the rights of the child,¹⁷⁰ whether refusal would cause considerable hardship to an Australian citizen, or whether the applicant could provide ‘**exceptional** economic, scientific, cultural or other benefit’ to Australia.¹⁷¹

The fiscal cost approach is further entrenched through the Government’s ‘one fails, all fail’ policy.¹⁷² Under the ‘one fails, all fail’ policy, a visa will not be granted unless *all* members of the primary applicant’s family unit¹⁷³ satisfy the health criteria.¹⁷⁴ In many cases, the visa will be denied on the grounds that one of the primary applicant’s children has failed the health criteria.¹⁷⁵ The application of this policy in such circumstances, without allowing for consideration of the family unit’s personal resources, may produce results which come to undermine the purpose of skilled migration. This issue was addressed by the Supreme Court of Canada in *Hilewitz v Minister of Citizenship and Immigration*.¹⁷⁶ The appellants’ visas were denied on the basis that one of their children suffered from an intellectual disability which was likely to ‘cause excessive demands on Canada’s social services’.¹⁷⁷ The Court held that the Department had committed a jurisdictional error by failing to consider the ‘personal circumstances of the families of disabled dependents’.¹⁷⁸ The Court held that the term ‘excessive demand’ is ‘inherently evaluative and comparative’.¹⁷⁹ It would be impossible to determine what demands or costs would be placed on social services without considering the ‘applicant’s ability and intention to pay’.¹⁸⁰ Abella J noted that a purely objective approach, which failed to consider a ‘family’s actual circumstances’, reflected a ‘cookie-cutter methodology’ which defeated the object of the legislation.¹⁸¹

The majority gave considerable weight to the fact that the appellants were applying for permanent residence under the investor and self-employed visa classes.¹⁸² These visas can only be granted if the applicant can prove that they have ‘substantial financial resources’.¹⁸³ In Australia, an applicant for an Investor (Provisional) visa must establish at the time of application that they have assets to a net value of at least \$2,250,000.¹⁸⁴ In addition, the

¹⁶⁹ As recognised in the *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, [1980] ATS 23, art 23.1 (entered into force for Australia on 13 November 1980); Department of Immigration and Citizenship, *MSI-386*, above n25, [4.2].

¹⁷⁰ As recognised in the *Convention on the Rights of the Child*, opened for signature 20 November 1989, [1991] ATS 4, art 3 (entered into force for Australia 16 January 1991); *MSI-386*, above n25, [4.2].

¹⁷¹ *MSI-386*, above n25, [4.2].

¹⁷² See LexisNexis, *Australian Immigration Law*, vol 5, Procedures Advice Manual, PAM3 [P Sch4.4005-4007.75], [75.1] (‘PAM3’).

¹⁷³ Defined in *Migration Regulations 1994* (Cth), reg 1.12.

¹⁷⁴ See PAM3, above n29, [P Sch4.4005-4007.75], [75.1].

¹⁷⁵ Examples include *Robinson v Minister for Immigration and Multicultural Affairs* (2005) 148 FCR 182; *Minister for Immigration and Multicultural Affairs v Seligman* (1999) 85 FCR 115; *Re Imani* [2001] MRTA 439 (5 February 2001); *Re V04/03228* [2005] MRTA 783 (25 July 2005); *Re Sese* [2003] MRTA 8702 (23 December 2003).

¹⁷⁶ [2005] SCJ 58.

¹⁷⁷ *Hilewitz v Minister of Citizenship and Immigration* [2005] SCJ 58, [77] (Deschamps J).

¹⁷⁸ *Hilewitz v Minister of Citizenship and Immigration* [2005] SCJ 58, [40] (Abella J).

¹⁷⁹ *Hilewitz v Minister of Citizenship and Immigration* [2005] SCJ 58, [54] (Abella J).

¹⁸⁰ *Hilewitz v Minister of Citizenship and Immigration* [2005] SCJ 58, [54] (Abella J).

¹⁸¹ *Hilewitz v Minister of Citizenship and Immigration* [2005] SCJ 58, [57] (Abella J).

¹⁸² *Hilewitz v Minister of Citizenship and Immigration* [2005] SCJ 58, [1] (Abella J).

¹⁸³ *Hilewitz v Minister of Citizenship and Immigration* [2005] SCJ 58, [1] (Abella J).

¹⁸⁴ *Migration Regulations 1994* (Cth), Schedule 2, subclass 162, criterion 162.212(3).

applicant is required to have invested at least \$1,500,000 by the time the visa is granted.¹⁸⁵ In this context, the failure to consider the applicant's personal ability to privately cover the costs of the health or community services could produce paradoxical results. As Abella J noted,

It seems to be somewhat incongruous to interpret the legislation in such a way that the very assets that qualify investors and self-employed individuals for admission to Canada can simultaneously be ignored in determining the admissibility of their disabled children.¹⁸⁶

In adopting a solely objective approach, the health criteria may ultimately undermine other immigration policy objectives. In practice, the strict application of the health criteria has ensured that migrants have better short-term health outcomes than the majority of the Australian-born population.¹⁸⁷ However, migrant outcomes are not the same across all visa subclasses. Empirical evidence suggests that applicants in the Family/Parents categories are far more likely to use healthcare services than 'all other migrant categories', as the applicants are generally older.¹⁸⁸ In addition, migrants in the Family/Parents categories are less likely to contribute to Commonwealth funds.¹⁸⁹ However, employer-sponsored migrants are the highest contributors to Commonwealth taxation revenues across all migrant classes.¹⁹⁰ Over time, the disparity in fiscal contributions from employer-sponsored migrants and other skilled stream categories (e.g. independent, student, regional sponsored) narrows, as younger members of the family unit enter the workforce, and the primary applicant's wages increase.¹⁹¹ These potential fiscal benefits are not considered in the application of reg4005. However, in family migration cases where a health waiver is available, the Tribunal often gives considerable weight to the fact that the sponsor's contribution to tax revenue may significantly outweigh the cost of the visa applicant's medical expenses.¹⁹² The Tribunal has also noted that the MOC's estimate as to the likely cost of the disease or condition does not include any benefit which the community may gain as a result of the applicant undertaking paid work in the future.¹⁹³ This submission suggests that reg4005 should be amended to incorporate such considerations into the determination of whether a visa applicant meets the health criteria.¹⁹⁴

¹⁸⁵ *Migration Regulations 1994* (Cth), Schedule 2, subclass 162, criterion 162.222(1).

¹⁸⁶ *Hilewitz v Minister of Citizenship and Immigration* [2005] SCJ 58, [39] (Abella J).

¹⁸⁷ Kerry Carrington, Alison McIntosh and Jim Walmsley, *The Social Costs and Benefits of Migration into Australia* (2007), 36.

¹⁸⁸ Access Economics, *2004 Update of the Migrants' Fiscal Impact Model* (9 July 2004), 12.

¹⁸⁹ Access Economics, *Migrants' Fiscal Impact Model: 2008 Update* (2008), 25.

¹⁹⁰ *Ibid.*, 21.

¹⁹¹ *Ibid.*

¹⁹² For example, see *Re Jantakorn* [2002] MRTA 2494; *Re Abcdeav* [2004] MRT 203, [26]; *Re Abcdef* [2003] MRTA 4207, [42].

¹⁹³ *Re S* [1995] IRTA 6005.

¹⁹⁴ A similar approach has been adopted in Canada, see Citizenship and Immigration Canada, *Operational Bulletin 063B – July 29, 2009* (2009) Citizenship and Immigration Canada <http://www.cic.gc.ca/english/resources/manuals/bulletins/2009/ob063b.asp> at 29 September 2009; Citizenship and Immigration Canada, *Medical Exam Requirements for Permanent Residents* (2002) Citizenship and Immigration Canada <http://www.cic.gc.ca/english/information/medical/medexams-perm.asp> at 20 September 2009.

Recommendation:

The health assessment process under regulation 4005 should be amended as follows:

- (a) The MOC determines whether the applicant meets the criteria;
- (b) If the applicant fails the health criteria, the decision maker should be required to forward a letter outlining the MOC's reasons for determining that the provision of healthcare or community services is likely to result in a significant cost to Australians; and
- (c) The applicant should be given an opportunity to demonstrate any potential social or economic benefits which they may provide to Australian society.

The potential fiscal contributions of the primary and secondary applicants should be a relevant consideration in any challenge to the MOC's assessment.

Application of the Waiver Provisions

The primary health criteria are replicated in regs4006A and 4007. However, regs4006A and 4007 contain a waiver provision, which allows the Minister to waive the health criteria if:

- (a) the applicant otherwise meets all other criteria for the grant of the visa; and
- (b) the grant of the visa would not cause:
 - (i) undue cost to the Australian community; or
 - (i) undue prejudice to the access to health care or community services of an Australian citizen or permanent resident.¹⁹⁵

An overview of the visa subclasses required to satisfy the criteria in regs4006A and 4007 is provided at **Annexure B**. Unlike reg4005, the selection of the subclasses required to satisfy reg4006A is primarily based on economic considerations. Holders of a subclass 457 visa are the second-highest contributors to Commonwealth taxation revenues across all migrant classes.¹⁹⁶ However, applicants entering under a subclass 457 visa are not permitted to access healthcare or pharmaceutical benefits during the term of their stay.¹⁹⁷ Thus, the visa applicant may provide substantial economic benefits to Australia without prejudicing access to healthcare or community services. The Minister may waive the requirements under reg4006A if the visa applicant's employer gives an undertaking that they will meet all relevant costs associated with the disease or condition.¹⁹⁸ In contrast, the power to waive the requirements of reg4007 is generally exercised for humanitarian or compassionate

¹⁹⁵ *Migration Regulations 1994* (Cth), reg 4007(2).

¹⁹⁶ Access Economics, above n46, 32.

¹⁹⁷ *Ibid*, 32.

¹⁹⁸ *Migration Regulations 1994* (Cth), reg 4006A(2).

reasons (particularly if the visa applicant has a close relationship with an Australian citizen).¹⁹⁹

The health criteria cannot be waived if the applicant is found to have tuberculosis.²⁰⁰ Therefore, the only requirement that can be waived by the decision maker or the Tribunal (upon review) is that under paragraph (1)(c) of regs 4006A or 4007.²⁰¹ In addition, the decision maker can only consider exercising the power to waive where the MOC has already determined that the applicant is likely to present a 'significant cost' to Australia in the event that the visa was granted.²⁰² The power to waive is non-compellable.²⁰³ However, government policy stipulates that the decision maker *must* consider exercising the power to waive in a case where the waiver provisions are relevant.²⁰⁴ If the power to waive is to be exercised, the officer is not permitted to disregard, 'dispute or "review" the MOC's opinion'.²⁰⁵

The legislative reference to 'undue cost' or 'undue prejudice' necessarily suggests that the decision maker must engage in a balancing process, where a range of factors are considered.²⁰⁶ The terms 'undue cost' or 'undue prejudice' are not defined in the *Regulations*. 'Undue cost' cannot be paralleled with 'significant cost', as it would 'leave no room for the waiver' provision to operate.²⁰⁷ The cost of the applicant's disease or condition will only be 'undue' if it is 'unjustifiable', extends 'beyond what is warranted', or is 'excessive'.²⁰⁸ This interpretation provides scope for subjective consideration of the applicant's personal circumstances and the potential benefit which they may provide to Australian society. As the Federal Court has noted, '[i]t may be to Australia's benefit in moral or other terms to admit a person even though it could be anticipated that such a person will make some significant call upon health or community services'.²⁰⁹ The waiver provision may be used in order to give effect to broader social policies, including upholding the sanctity of marriage and the potential emotional and economic benefits that a stable relationship may provide to a family unit.²¹⁰

However, Australia is far more stringent than other common law countries. For example, in Canada, a visa cannot be refused on the ground that the applicant 'might reasonably be expected to cause excessive demand on health or social services'²¹¹ if the applicant is a 'spouse, common-law partner or child' of their sponsor.²¹² This is designed to give effect to

¹⁹⁹ Department of Immigration and Citizenship, above n13, 1.

²⁰⁰ *Minister for Immigration and Multicultural Affairs v Seligman* (1999) 85 FCR 115, 127; *Migration Regulations 1994* (Cth), regs 4005(1)(a), 4006A(1)(a), 4007(1)(a).

²⁰¹ *Migration Regulations 1994* (Cth), regs 4006A(2), 4007(2); *Minister for Immigration v Schoeman* [2008] FMCA 671, [32].

²⁰² *Bui v Minister for Immigration and Multicultural Affairs* (1999) 85 FCR 134, 148.

²⁰³ PAM3, above n29, [P Sch4.4005-4007.65], [66.1].

²⁰⁴ *Ibid.*

²⁰⁵ *Ibid.*, [66.2].

²⁰⁶ *Applicant Y v Minister for Immigration and Multicultural Affairs* [2008] FCA 367, [31] (Tamberlin J).

²⁰⁷ *Re Papaioannou* [1991] IRTA 113.

²⁰⁸ *Re Papaioannou* [1991] IRTA 113.

²⁰⁹ *Bui v Minister for Immigration and Multicultural Affairs* (1999) 85 FCR 134, 148.

²¹⁰ *Re Taye* [1995] IRTA 5772.

²¹¹ *Immigration and Refugee Protection Act*, SC 2001, c 27, s 38(1)(c).

²¹² *Immigration and Refugee Protection Act*, SC 2001, c 27, s 38(2)(a).

the policy objective of family unity which underpins these visa classes.²¹³ However, applicants for an Australian spouse, interdependency or child visa will need to demonstrate the existence of ‘compelling circumstances’ before the power to waive the health criteria can be exercised.²¹⁴ Government policy expressly stipulates that the power to waive cannot be exercised solely on the basis that the relationship between the applicant and the sponsor is genuine.²¹⁵ The case officer must consider all the merits of the case, including the costs as estimated by the MOC,²¹⁶ the availability of ‘private care and support’,²¹⁷ and the location of the families of the applicant and sponsor.²¹⁸ However, Tribunal decisions concerning spouse/interdependency applications where the applicant is HIV-positive indicate that the power to waive is frequently exercised. The Tribunal has adopted a balancing process, by which the costs to the community are assessed in conjunction with the ‘harm the applicant’s departure would have on the applicant’s spouse’.²¹⁹

The Australian Government does not treat HIV/AIDS as a public health risk, unlike a disease such as tuberculosis.²²⁰ HIV is assessed on the same basis as ‘any other pre-existing medical condition’.²²¹ However, as HIV may be expensive to treat, it may attract ‘costs well beyond a level considered reasonable for Australian taxpayers to bear’.²²² Tribunal decisions indicate that the cost of HIV/AIDS-related healthcare and community services is estimated at approximately \$250,000 per person.²²³ In practice, this suggests that any visa applicant found to be HIV-positive is likely to fail the health criteria. However, applicants who have a strong personal relationship with their Australian nominator often succeed in having the health requirements waived by the Tribunal. These cases frequently turn on the issue of whether the sponsor could successfully migrate to the visa applicant’s country of origin. For example, in *Re Ra*,²²⁴ the nominator’s criminal record prohibited her from immigrating to the United States. At the time of the Tribunal’s decision, the sponsor and applicant had been married for 7 years.²²⁵ The applicant adduced medical evidence which indicated that his viral load was ‘undetectable’ and that he was unlikely to develop AIDS in the near future.²²⁶ Member Cooke considered that the family would provide considerable contributions to the Australian community over the ‘course of their normal working lives’, which may ‘offset any potential costs occasioned by the visa applicant’s illness’.²²⁷ In addition, the Tribunal attached considerable weight to the impact that a visa refusal would have on the parties’ relationship:

²¹³ Citizenship and Immigration Canada, *IP 8: Spouse or Common-law Partner in Canada Class* (2006) Citizenship and Immigration Canada <http://www.cic.gc.ca/english/resources/manuals/ip/ip08-eng.pdf> at 20 September 2009, 6.

²¹⁴ These examples are provided in PAM3, above n29, [P Sch4.4005-4007.91], [92.3].

²¹⁵ *Ibid.*

²¹⁶ *Ibid.*, [PSch 4.4005-4007.91], [92.2].

²¹⁷ *Ibid.*, [P Sch4.4005-4007.92], [92.5].

²¹⁸ *Ibid.*, [P Sch4.4005-4007.92], [92.6].

²¹⁹ *Re KC* [1998] IRTA 12907.

²²⁰ PAM3, above n29, [P Sch4.4005-4007.42], [42.1].

²²¹ Department of Immigration and Citizenship, above n13, 2.

²²² PAM3, above n29, [P Sch4.4005-4007.42], [42.1].

²²³ For example, see *Re Amanda MacDonald (Member)* [2005] MRTA 103.

²²⁴ *Re Ra* [2001] MRTA 3886.

²²⁵ *Re Ra* [2001] MRTA 3886, [13].

²²⁶ *Re Ra* [2001] MRTA 3886, [13].

²²⁷ *Re Ra* [2001] MRTA 3886, [21].

A failure to grant the visa would not only savage a self evidently viable and continuing 'spouse relationship' but the couple would be double jeopardised by their inability...to live in the visa applicant's country of origin as man and wife.²²⁸

In effect, if the visa were denied, the couple would have been deprived of the opportunity to live as a family unit.²²⁹ However, the fact that the parties' could not maintain their relationship in Australia if the visa were denied is not decisive. For example, in *Re Vali*,²³⁰ the nominator held dual Australian and Swiss citizenship. The parties were residing in Switzerland at the time of the application.²³¹ The Tribunal noted that the parties were able to maintain their relationship if they continued to reside in Switzerland, where they would also have access to a 'high quality medical system'.²³² These factors led the Tribunal to conclude that the grant of the visa would result in undue cost to the Australian community.²³³

Cases such as *Re Ra* demonstrate that the waiver provision will frequently be exercised where:

- (a) the visa applicant is found to be asymptomatic;²³⁴ and
- (b) the parties were likely to be separated in the event the visa was refused.

However, the Tribunal will also consider the prevailing conditions in the applicant's country of origin. In *Re Christian*,²³⁵ the nominator discovered she was HIV-positive when she became pregnant with her first child.²³⁶ The applicant later discovered he was HIV-positive when the parties were living in Singapore.²³⁷ The parties' submissions were summarised as follows:

...the parties' child has lived in Australia since he was three months old and that if the visa applicant was forced to leave Australia then the nominator and the parties' child would be faced with a decision to either remain in Australia without a father and a husband or go to Singapore where they would endure sub-standard medical facilities and where they would lose their strong support networks and cultural ties...due to the tragic circumstances of this case, the parties' child is reasonably likely to lose one or both of his parents before he reaches adulthood and that if the visa applicant has to leave Australia then his son would be precluded from knowing or developing a relationship with him.²³⁸

²²⁸ *Re Ra* [2001] MRTA 3886, [22].

²²⁹ *Re Ra* [2001] MRTA 3886, [20].

²³⁰ [2000] MRTA 3090.

²³¹ *Re Vali* [2000] MRTA 3090, [6].

²³² *Re Vali* [2000] MRTA 3090, [25].

²³³ *Re Vali* [2000] MRTA 3090, [25].

²³⁴ This was mentioned in *Re Ra* [2001] MRTA 3886, [27], see also *Re Taye* [1995] IRTA 5722; *Re FD* [1996] IRTA 8032; *Re Wood* [1998] IRTA 13168.

²³⁵ [2002] MRTA 5266.

²³⁶ *Re Christian* [2002] MRTA 5266, [11].

²³⁷ *Re Christian* [2002] MRTA 5266, [11].

²³⁸ *Re Christian* [2002] MRTA 5266, [41].

In this case, the interests of the child and the inadequacy of medical treatment in the applicant's country of origin were held to constitute compassionate grounds sufficient to waive the health requirements.²³⁹

Recommendation:

Department policy expressly provides that the power to waive cannot be exercised merely on the basis that the relationship between the parties is genuine.²⁴⁰ However, the Tribunal decisions indicate that the 'significant cost' of the healthcare and/or community services required by the migrant will often be outweighed by the social benefits gained through family migration. This submission suggests that these social benefits should be given statutory recognition. In effect, a spouse, child or independency visa should not be denied on the basis that the applicant has a 'disease or condition' which likely to result in a 'significant cost' to the Australian community. This approach would give equal recognition to all visa applicants, eliminating the need to undertaking a balancing of interests in each individual case.

²³⁹ *Re Christian* [2002] MRTA 5266, [42]. The facilities available in the applicant's country of origin were also relevant in cases such as *Re N04/04647* [2006] MRTA 7, [49]-[50].

²⁴⁰ PAM3, above n29, [P Sch4.4005-4007.92], [92.3].

Annexure A

Visa classes required to satisfy regulation 4005

Subclass	Name
103	Parent
105	Skilled – Australian linked
106	Regional-linked
114	Aged Dependent Relative
115	Remaining Relative
116	Carer
117	Orphan Relative
118	Designated Parent
119	Regional Sponsored Migration Scheme
120	Labour Agreement
121	Employer Nomination
124	Distinguished Talent
126	Independent
132	Business Talent
134	Skill Matching
135	State/Territory-nominated Independent
136	Skilled-Independent
137	Skilled – State/Territory-nominated Independent
138	Skilled – Australian-sponsored
139	Skilled – Designated Area-sponsored
143	Contributory Parent (if the applicant was not the holder of a subclass 173 visa or substituted subclass 676 visa at the time of application) ²⁴¹
151	Former Resident (if outside Australia)
160	Business Owner (Provisional)
161	Senior Executive (Provisional)
162	Investor (Provisional)
163	State/Territory Sponsored Business Owner (Provisional)
164	State/Territory Sponsored Senior Executive (Provisional)
165	State/Territory Sponsored Investor (Provisional)
173	Contributory Parent (Temporary)
175	Skilled - Independent
176	Skilled - Sponsored
405	Investor - Retirement
411	Exchange
415	Foreign Government Agency
804	Aged Parent (if the applicant did not hold a substituted subclass 676 visa at the time of application) ²⁴²
835	Remaining Relative
836	Carer
837	Orphan Relative
838	Aged Dependent Relative
845	Established Business in Australia
846	State/Territory Sponsored Regional Established Business in Australia (if the applicant does not reside or propose to reside in a participating State or Territory) ²⁴³
855	Labour Agreement (if the applicant does not reside or propose to reside in a participating State or Territory) ²⁴⁴

²⁴¹ See *Migration Regulations 1994* (Cth), Schedule 2, subclass 143, criterion 143.225.

²⁴² *Migration Regulations 1994* (Cth), Schedule 2, subclass 804, criterion 804.225.

²⁴³ *Migration Regulations 1994* (Cth), Schedule 2, subclass 846, criterion 846.224(c).

²⁴⁴ *Migration Regulations 1994* (Cth), Schedule 2, subclass 855, criterion 855.224(c).

856	Employer Nomination Scheme (if the applicant did not hold a skilled- Independent Regional (Provisional)(Class UX) visa, or; a Subclass 475 (Skilled-Regional Sponsored) visa, or; a Subclass 487 (Skilled-Regional Sponsored visa); or did not reside or propose to reside in a participating State or Territory) ²⁴⁵
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Annexure B

Visa classes required to satisfy regulation 4006A

Subclass	Name
418	Educational
457	Business (Long Stay)

Visa classes required to satisfy regulation 4007²⁴⁶

Subclass	Visa
100	Spouse
101	Child
102	Adoption
110	Interdependency
137	Skilled – State/Territory-nominated independent (certain applicants)
151	Former Resident (if a defence service applicant)
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
415	Foreign Government Agency*
418	Educational*
419	Visiting Academic*
420	Entertainment*
421	Sport*
422	Medical Practitioner*
423	Media and Film Staff*
427	Domestic Worker (Temporary) – Executive*
428	Religious Worker*
442	Occupational Trainee*
445	Dependent Child
447	Secondary Movement Offshore Entry (Temporary)
449	Humanitarian Stay (Temporary)
451	Secondary Movement Relocation (Temporary)
457	Business Entry (Long Stay)*
461	New Zealand Citizen Family Relationship (Temporary)
571	Schools Sector*
572	Vocational Education and Training Sector*
573	Higher Education Sector*
574	Postgraduate Research Sector*
580	Student Guardian*

²⁴⁵ *Migration Regulations 1994* (Cth), Schedule 2, subclass 856, criterion 856.224(a), (b).

²⁴⁶ See PAM3, above n29, [P Sch4.4005-4007.90], [90.4]. Classes marked with a * indicate that the waiver only applies where regulation 2.07AO applies to the applicant.

787	Witness Protection (Trafficking) (Temporary)
801	Spouse
802	Child
804	Aged Parent*
814	Interdependency
820	Spouse
826	Interdependency
837	Orphan Relative
852	Witness Protection (Trafficking) (Permanent)
855	Labour Agreement*
856	Employer Nomination Scheme
857	Regional Sponsored Migration Scheme* (certain standard applicants)
858	Distinguished Talent*
864	Contributory Aged Parent*
884	Contributory Aged Parent (Temporary)*
890-893	Business Skills

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ATTACHMENT 7

THE HEALTH REQUIREMENTS – When the ends do not justify the means

Chantelle Perpic

Over the past century, migrants have been denied entry into Australia under various exclusionary policies. The recent use of a health test reveals a marked shift in immigration law whereby compelling policy objectives are said to legitimate the administration of an otherwise exclusionary test. Upon contrasting Australia's migration framework with that employed in Canada and the UK, we may begin to question whether the constrictive migration laws presently in place are in fact necessary or whether it is time for reform. Ultimately it will be argued that the current migration framework is not proportionate to the ends it seeks to achieve and thus reform is the inevitable option.

1. The structure of the migration framework

The power to subject migrants to health testing as a prerequisite to the grant of a visa is established in s60(1) of the *Migration Act 1968* (Cth) whereby 'the Minister may require the applicant to visit, and be examined by, a specified person, being a person qualified to determine the applicant's health, physical condition or mental condition'. Not all applicants will therefore have to undergo health testing²⁴⁷.

The administration of the health requirements has been outsourced to the Health Assessment Service (HAS)²⁴⁸ and Health Services Australia (HSA)²⁴⁹. Panel doctors, referred to as Medical Officers of the Commonwealth (MOCs), are employed by HAS and HSA and are given the role of determining whether the applicant meets the requisite health requirements under the regulations²⁵⁰. In the event of an appeal, an applicant may apply to have the merits of the case internally reviewed by Review Medical Officers of the Commonwealth (RMOCs).

1.1 The Health Requirements

The regulations firstly establish an absolute prohibition on applicants with tuberculosis (TB) from meeting the criteria for entry²⁵¹. If the applicant does not suffer from TB, the applicant will fail the health test unless the applicant:

- (b) is free from a disease or [condition](#) that is, or may result in the applicant being, a threat to public health [in Australia](#) or a danger to the Australian community²⁵².

Preventing the spread of communicable diseases may be put forth as the basis upon which these health requirements are justified; they seek to peruse a legitimate aim where that aim

²⁴⁷ For who must be assessed refer to: Form 1071i *Health Requirement for Permanent Entry into Australia* or Form 1163i *Health Requirement for Permanent Entry into Australia*.

²⁴⁸ See Procedure Advice Manual 3 (PAM 3), Sch4/4005-4007, section 6.3 for further information about HAS.

²⁴⁹ See PAM 3, Sch4/4005-7, section 6.5 for further information about HSA.

²⁵⁰ *Migration Regulations 1994* reg 1.03.

²⁵¹ *Migration Regulations 1994*, Sch 4 cl 4005(a), 4006A(1)(a), 4007(1)(a).

²⁵² *Migration Regulations 1994*, Sch 4 cl 4005(b), 4006A(1)(b), 4007(1)(b).

lies in preventing infectious disease spreading across borders. However, not all diseases caught by the health rules can be justified on this basis.

The spread of disease is not the only basis upon which a migrant may fail the health test. An economic policy objective has been incorporated into the health regulations producing what is arguably one of the more controversial bases upon which potential migrants may be excluded. One of the grounds upon which an applicant may fail to meet the health requirements is where the:

(ii) provision of the health care or [community services](#) relating to the disease or [condition](#) would be likely to:

(A) result in a significant cost to the Australian community in the areas of health care and [community services](#); or

(B) prejudice the access of an Australian citizen or permanent resident to health care or [community services](#);

regardless of whether the health care or [community services](#) will actually be used in connection with the applicant²⁵³

The idea that an applicant poses a potential burden to the Australian community is a message communicated clearly by the regulations. The objectivity of the test precludes the MOC forming their opinion on what the applicant they are assessing will actually cost the Australian community and whether there are other compelling grounds upon which the visa should be granted²⁵⁴.

Whilst challenges have been made to these regulations on the basis of inconsistency with the rest of the regulations, the Full Court of the Federal Court has upheld its validity²⁵⁵. Since the decision in *Minister for Immigration and Multicultural Affairs v Seligman*²⁵⁶, the regulations have been altered to make clear that the assessment is objective. In *Imad's case*, the validity of the regulations were upheld:

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...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. This meaning is rendered, in my view, clear beyond argument by the concluding words beginning with "regardless"²⁵⁷.

The court went on to discuss the objective underlying the regulation:

14 The intention behind this regulation is understandable, particularly in the light of reg 2.25A. One would expect that a medical officer would be able to assess the nature of a disease or condition and its seriousness in terms of its likely future requirement for health care. On the other hand, one would not expect a medical officer to inquire into the financial circumstances of a particular applicant or any family members or friends or other sources of financial assistance.

The PAM 3 also extrapolates on why a subjective assessment of costs is not permissible:

²⁵³ *Migration Regulations 1994*, Sch 4 cl 4005(c)(ii), 4006A(c)(ii), 4007(c)(ii).

²⁵⁴ *Imad v Minister for Immigration and Multicultural Affairs* [2001] FCA 1011 at 13.

²⁵⁵ *Imad v Minister for Immigration and Multicultural Affairs* [2001] FCA 1011.

²⁵⁶ *Minister for Immigration and Multicultural Affairs v Seligman (Seligman)* [1999] FCA 117

²⁵⁷ *Ibid* at 13.

there is no way such intentions can be legally enforced once residency is obtained...some applicants may simply change their mind regarding services once residence is achieved and the full level of costs is realised²⁵⁸.

The economic policy objective underlying the regulations is evidently focused on the notion that a migrant who suffers from a disease of disability poses a burden on the Australian community regardless of what they have to offer. The inability for a MOC to assess the merits of an applicant's case further constricts any cost benefit analysis being undertaken in the decision to grant a visa.

1.2 Assessing the merits of a case

For the majority of visa applicants²⁵⁹, compassionate considerations cannot be taken into account. This is due to a combination of two factors. Firstly, the limited role MOCs have been ascribed in purely assessing costs precludes compassionate arguments being considered²⁶⁰. Secondly, under reg 2.25A(3), the Minister cannot challenge the findings of a MOC therefore, a finding by a MOC that the applicant poses a 'significant cost' will mean the Minister cannot override this decision and, as a result, the application will fail.

Only in the limited visa classes such as spouse, interdependency and humanitarian visas²⁶¹ can the health requirements be waived thus allowing room for the Minister to consider the merits of an applicant's case thus softening the implications of a MOCs negative findings. However, for the vast majority of visas, failure of the health test means failure to obtain a visa.

Recent decisions of the Migration Review Tribunal reveal the way in which reg 2.25A(3) is being used as a device to effectively tie the hands of the Tribunals in reviewing the merits of a case²⁶². Instead, by relying on reg 2.25A(3), the Tribunal insists that it lacks the legislative authority to consider whether the applicant will fail to meet the health criteria thus the application is dismissed based solely on the MOCs opinion.

A combination of the health requirements and reg 2.25A(3) limit the opportunity for an applicant to seek entry into Australia even if they can put forth strong compassionate arguments. For example in *Re Wade*²⁶³ a 79 year-old women sought entry on a Contributory Parent visa. The applicant, who was living alone in the UK, suffered from 'diabetes mellitus with vascular, kidney and eye complications' so sought entry into Australia to live with her daughter. On the opinion of the MOC, the applicant failed the health test and thus her application was declined.

The applicant's daughter wrote to the Department of Immigration and Citizenship (DIAC) seeking to have the case considered on compassionate grounds. When she was informed by DIAC that the migration regulations prohibit the Department questioning the decision of a MOC or considering the merits of a case under PIC 4005, the applicant wrote a profound and heartfelt statement to the Department:

²⁵⁸ PAM 3, Sch4/4005-7, section 114.5

²⁵⁹ With the exception of visas classes to which *Migration Regulations 1994*, Sch 4 cl 4007 applies.

²⁶⁰ See 1.1.1 of this paper.

²⁶¹ For these visas *Migration Regulations 1994*, Sch 4 cl 4007 applies.

²⁶² See for example: *Re Freeman* (MRTA 1606, 21 August 2009); *Re Savu* (MRTA 1203, 1 July 2009).

²⁶³ *Re Wade* (MRTA 1413, 30 July 2009).

I realise that due to current migration regulations, [the RMO] was unable to consider that my mother would have lived, and been cared for, in my home. She would have top private medical insurance if allowed into Australia. People in my mother's situation will never be able to meet the PIC 4005 (c)(ii)(A)- due to the last paragraph "regardless of whether the health care or community services will actually be used",²⁶⁴.

This case highlights the harsh effect the migration framework may have on applicants. By effectively precluding a subjective assessment to be made as to whether an individual applicant will be a "burden" on the health care system or whether costs can be absorbed by the applicant or a family member, there is no possibility open for applicant to have their individual circumstances considered.

Having briefly outlined the framework in which the health test operates, the next section will analyse the policy objectives said to justify the test. In the final section, these policy objectives and the foregoing discussion of the migration framework will be analysed against overseas migration jurisprudence.

2. The Health Test's policy objectives

The Department of Health and Ageing (DHA) is the body responsible for providing DIAC with 'high-level policy advice',²⁶⁵. The policy objectives, which the health test is said to achieve include:

- to protect the Australian community from public health and safety risks;
- to contain public expenditure on health care and community services; and
- to safeguard the access of Australian citizens and permanent residents to health care and community services in short supply²⁶⁶.

The Longitudinal Survey of Immigrants to Australia (LSIA) is promulgated on the DIAC website as justifying the ongoing application of a rigid health test²⁶⁷. The LSIA was conducted by DIAC between September 1993 and August 1995 with the aim of examining the early years of various aspects of a migrant's life once they had immigrated to Australia. Health was included as an aspect of the study with the results revealing that, of the migrant's surveyed, 9% initially reported poor to fair health with this figure rising to 16% just 3.5 years after migrating²⁶⁸.

According to LSIA, those with poor English skills reported the worst health and those migrants who accessed health services most frequently were 'Humanitarian immigrants had made an average of 2.13 visits and the Preferential Family entrants, 2.06 visits',²⁶⁹.

²⁶⁴ Ibid at 32.

²⁶⁵ PAM 3, Sch4/4005-7, section 6.5

²⁶⁶ See PAM 3, Sch4/4005-7, section 10.1.

²⁶⁷ Department of Immigration and Citizenship (DIAC), 'New settlers have their say - How immigrants fare over the early years of settlement',

<<http://www.immi.gov.au/media/publications/research/overview/newset1.htm>> (accessed 23 September 2009).

²⁶⁸ Ibid.

²⁶⁹ Ibid.

What is implicitly suggested through the study is the need for the ongoing application of the health test to ensure migrants do not burden our health care system. This point is made clear in the executive summary for LSIA where it is stated:

In line with the fact that Humanitarian and Preferential Family visa entrants may be exempted from meeting certain health requirements when they are selected to migrate to Australia, we found that a higher proportion of these two groups (especially the Humanitarian immigrants) compared with the overall average noted fair to poor health²⁷⁰.

An examination of the case law in the next section demonstrates the way in which the policy objectives obstruct the ability for compassionate grounds to be pleaded or for the benefits the applicant will bring to be factored into the decision-making process. Instead, once assessed as posing a burden, the applicant will be denied entry.

2.1 The problem with a policy emphasis on ‘cost’

The decision of *Barwon Health*²⁷¹ illustrates the way in which the regulations, by presuming that migrants are a burden to the health system, fails to allow for a balancing exercise of potential benefits that a migrant may possess.

In *Barwon Health*, the applicants sought entry into Australia on an Employer Nomination Visa. The primary applicant was offered the position of Director of Radiation Oncology at Geelong Hospital and evidence was led that the applicant was urgently needed to fill this position and in doing so would provide his services to the local community²⁷². The visa was declined on the basis of the applicant’s son suffering from autism and moderate mental retardation estimated at costing \$533,000 during the child’s lifetime²⁷³. With waiver not being applicable to the visa class applied for, there was no scope for arguments to be led that the applicant would be providing an invaluable service if granted entry or any other arguments to that effect.

The overriding concern that migrants are burdens on the Australia health care system appears to be a blinding policy objective. Even in cases where the Minister, in his discretion, may waive the health requirements if the applicant does not pose an ‘undue cost’ or ‘undue harm’ to the Australian community²⁷⁴, financial factors are still a real concern for decision-makers. The following cases aptly demonstrate this point.

In the case of *Re Papaioannou*²⁷⁵, the applicant was refused a Spouse visa on the basis that the cost of treating him for chronic renal failure would constitute an ‘undue cost’. Despite waiver being applicable in the present case, and thus a consideration of compassionate grounds being undertaken, the applicant was still denied a visa.

²⁷⁰ Ibid.

²⁷¹ (MRTA 1111, 10 May 2000).

²⁷² Ibid at 11.

²⁷³ Ibid at 7.

²⁷⁴ See *Migration Regulations 1994*, Sch 4 cl 4007.

²⁷⁵ *Re Panagiotis* (IRT V90/00215, 19 April 1991).

The Tribunal member made it clear that he did not arrive at the decision to deny the visa lightly having considered the willingness of the Greek community to absorb some of the applicant's costs²⁷⁶ and the fact that the applicant's wife was a permanent Australian tax payer²⁷⁷. The Tribunal member, in arriving at the decision, appeared compelled to decline the visa due to the inability of the applicant or his wife to absorb any of the costs either in the past or into the future²⁷⁸.

The decision of *Re Kaur*²⁷⁹ also reveals the significant role costs continue to play even in cases where waiver is applied. The presiding tribunal member in *Re Kaur* commented on what will be taken into account in determining whether waiver is applicable to a particular case:

It may be to Australia's benefit in moral or other terms to admit a person even though it could be anticipated that such a person would make some significant call upon health and community services. There may be circumstances of a "compelling" character, not included in the "compassionate" category that mandates such an outcome²⁸⁰.

In *Re Kaur*, similarly to in *Re Papaioannou*, compassionate factors were taken into account including the commitment the applicant's religious community in Australia had shown and also the large support network and family the applicant had in Australia. However, in *Re Kaur* the applicant was able to demonstrate that she would not pose a financial liability to the Australian community. Unlike in *Re Papaioannou*, the applicant in *Re Kaur* was able to show a history of supporting herself financially and also prove that her large Australian family would also contribute financially. In taking into account these factors, the tribunal member waived the health requirements and the applicant was successful in obtaining a Spouse visa despite having failing to meet the medical criteria.

Where waiver is available, and thus compassionate grounds can be taken into consideration, the issue of costs is still given a significant degree of prominence²⁸¹. The case law highlights the way in which, both in cases where waiver is and is not applicable, an assessment of costs is given primacy in determining whether or not to grant an applicant a visa.

Having considered the way in which policy has heavily influenced decision-making in Australia, in the next section this will be contrasted with international jurisprudence. By doing so, it is aimed to reveal the unjustifiably stringent nature of the Australian requirements in comparison to that employed in the UK and Canada.

3. International Migration Law

3.1 Canada's Excessive Demand Criteria

In Canada, the policy objectives mirror those put forth in defence of the Australian health test. Section 38 of the *Immigration and Refugee Protection Act* S.C. 2001 lists the grounds

²⁷⁶ Ibid at 52.

²⁷⁷ Ibid at 51.

²⁷⁸ Ibid at 53.

²⁷⁹ (MRTA 1002, 18 February 2004).

²⁸⁰ Ibid at 53.

²⁸¹ See also *Re Nguyen* (IRT N96/02452, 29 January 1998) for a further illustration of this point.

upon which a migrant may be refused entry based on 'their health condition' including that the applicant:

- (a) is likely to be a danger to public health;
- (b) is likely to be a danger to public safety; or
- (c) might reasonably be expected to cause excessive demand on health or social services.

Section 38 forms the Excessive Demand Criteria²⁸² which has been interpreted in a rather different way to the interpretation given to the health test by Australian courts. In decisions of *Hilewitz* and *de Jong*, the Canadian Courts have made clear that when applying the health test, an individualistic approach must be taken by examining each case on its particular facts. In *Hilewitz* and *de Jong* the courts remarked:

Using contingencies to negate a family's genuine ability and willingness to absorb some of the burdens created by a child's disabilities anchors an applicant's admissibility to conjecture, not reality²⁸³.

In examining the Canadian provisions, commentator Iyioha argues that the policy arguments, whilst superficially attractive, are not plausible. He particularly calls into question the idea that migrants will pose an economic burden to the native population but rather considers the policy objectives as unjustified and discriminatory. As a proposal for reform he suggests a rethinking of migration policy based on a legal, rather than moral argument. He calls for the health test under Canadian law to be revised in light of Canada's international obligations under international instruments such as the ICCPR so as eradicate the discriminatory element inherent in the test.

Whilst Iyioha's challenge to the health criteria is compelling, it is questionable whether the argument for legal rather than moral grounds can translate in the Australian context. This is particularly the case given Australia's lack of commitment to incorporating fully international instruments such as the ICCPR and by maintaining the ability to discriminate on the basis of disability when it comes to migration²⁸⁴.

Where Iyioha's suggestions for reform may be more readily applicable to Australian law include where he suggests that health testing include a cost-benefit analysis. He asserts that if a health test deems migrants to be a cost, an analysis of benefits should also be included. Iyioha argues:

if an individual's economic contribution to the host nation outweighs their use of resources, there is no reason why their healthcare needs should be an issue during the admission process²⁸⁵.

²⁸² Immigration and Refugee Protection Regulations SOR/2002-227, June 11, 2002 (Can.)

²⁸³ *Hilewitz v. Minister of Citizenship and Immigration* and *de Jong v. Minister of Citizenship and Immigration* [2005] 2 S.C.R. 706, 2005 SCC 57 (Can.) at 59.

²⁸⁴ For a discussion of issues in Australia's compliance with international law surrounding disability see: Report 95, Ch 2: Convention on the Rights of Persons with Disabilities, *Joint Standing Committee on Treaties* <<http://www.austlii.edu.au/au/other/jscot/reports/95/>> (accessed 2 September 2009).

²⁸⁵ A Different Picture Through The Looking-Glass: Equality, Liberalism And The Question Of Fairness In Canadian Immigration Health Policy 22 *Geo. Immigr. L.J.* 621 at 635.

In light of this suggestion, we may be inclined to consider a more appropriate approach would be for the law to include a balancing exercise of a migrant's cost and benefit. A cost-benefit analysis would not only look at the burden on the health system the individual may pose, but also the contributions the individual will bring to the country as a result of their unique and personal skills and qualities. In introducing a cost-benefit analysis into the Australian system, decisions such as that in *Barwon Health* (discussed earlier in this paper) would seem more just and fair.

Despite the criticism Iyioha mounts against the health test, we only need to refer back to the ratio in *Hilewitz* and *de Jong* to find that the Canadian provisions allow for more compassion than those in Australia. The difference lies in the ability of the Canadian test to allow for subjective factors unique to the individual to be taken into account whereas the Australian framework explicitly expels such considerations.

3.2 UK health testing

The UK Border Agency, part of the Home Office, controls migration into the UK through medical criteria contained in the Medical Issues (MED)²⁸⁶. In a way the MED is similar to the PAM3 in that it provides the guidelines for determining who requires medical testing, what the testing consists of and other such related issues.

Under MED6, a policy rationale emerges for why medical testing is deemed necessary as part of an immigration program which is similar to that employed in Canada and Australia. Under the MED6, the policy objectives are to ensure migrants do not²⁸⁷:

- endanger the health of other persons in the UK; or
- be unable for medical reasons to support themselves and/or dependants in the UK; or
- require major medical treatment (for which an entry clearance application has not been made).

Where the UK guidelines differ from the PAM 3 is where an outline is given as to when compassionate grounds can be considered as part of an application. The inability of many migrants applying for visas in Australia to have their individual circumstances taken into account is something to which the UK does not share. Under MED10, an entry clearance officer is permitted to consider the applicant's circumstances and, if there are compassionate grounds for granting a visa which outweigh the need for exclusion based on medical grounds, then it is mandated that the Entry Clearance Officer (ECO) refer the matter to the UK Border Agency to determine.

Whilst in the UK, Canada and Australia a similar policy rationale supports the health requirements, the application and form of the provisions remain disparate. Unlike under the Australian migration framework, the UK and the Canadian health requirements allowing for compassionate and unique individual circumstances to be taken into account. From this, we may begin to really question whether the Australia requirements are just too stringent and thus not proportionate to the policy aims they seek to fulfill.

²⁸⁶ For the latest issue (7 August 2008) see: <http://www.ukvisas.gov.uk/en/ecg/medicalissues#20667684> (accessed 22 September 2009).

²⁸⁷ MED6 see: <http://www.ukvisas.gov.uk/en/ecg/medicalissues#20667684>, (accessed 22 September 2009).

An attempt to ascertain whether or not the policy objectives of the health test are proportionate to the health regulations will be likely to be met with little success. The Australian National Audit Office conducted an analysis of the test's application and found that DIAC currently lacks any clear guidelines to effectively measure whether or not it is meeting the policy aims behind the health test. Therefore, as part of ANAO's recommendations, they have suggested that DIAC set up procedures to assess, monitor and report on its performance in this area²⁸⁸. When DIAC implements these recommendations, then we may better assess the health requirement's proportionality to the policy objectives.

4. What can we learn from the UK and Canada?

Both the UK and Canada employ health criteria as a way of screening applicants for entry into the country. These countries, like Australia, also have similar policy objectives, which are said to justify the exclusion of migrants who fail to meet the requisite criteria. Where the major point of divergence is when it comes to analysing the way in which compassionate considerations are allowed to factor into the decision making process. Whilst the Australian jurisprudence reveals there is very little weight (if any) attached to the merits of an applicant's case, in Canada and the UK it is mandated that factors beyond health are taken into account when determining whether or not to grant a visa.

In order to lessen the harsh impact of the current law, it is suggested that Australia reform its policy and laws as a whole to allow decision-makers to consider factors beyond the medical. The MOC can give their opinion as to the potential cost of the applicant's condition but there opinion should be only one factor in the matrix of considerations. The cost an applicant's condition potentially poses to the Australian community should at least be weighed against the benefits an applicant poses to come up with a cost benefit analysis.

5. Beyond the medical: room to consider the individual's circumstances?

The health requirement has become a way of excluding migrants from entering Australia. Whilst employing an exclusionary policy, as part of the migration framework, is nothing new, what is innovative about the health requirements is the strong policy basis put forth as justifying the test's application. Through this paper, it has sought to be argued, that the law currently assumes an applicant will pose a cost to the Australia community and thus, for most visa classes, precludes a consideration of compassionate factors or benefits an applicant may possess. Furthermore, it has been argued that the policy rationale behind the health requirements is not proportionate to the aims they seek to achieve. As a result, reform should take place and the migration framework of the UK and Canada provides a useful starting point.

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²⁸⁸ Audit Report No. 37, 2006-2007, Administration Of The Health Requirement Of The Migration Act 1958, Table 30.1.8.

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