STARTTS

Valuing people with disability in Australia's migration program

Joint Submission to the Federal Parliamentary Joint Standing Committee on Migration's Inquiry into the Migration Treatment of People with Disability

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1. Introduction

1.1 The Public Interest Advocacy Centre

The Public Interest Advocacy Centre (PIAC) is an independent, non-profit law and policy organisation that works for a fair, just and democratic society, empowering citizens, consumers and communities by taking strategic action on public interest issues.

PIAC identifies public interest issues and, where possible and appropriate, works co-operatively with other organisations to advocate for individuals and groups affected. PIAC seeks to:

- expose and redress unjust or unsafe practices, deficient laws or policies;
- promote accountable, transparent and responsive government;
- encourage, influence and inform public debate on issues affecting legal and democratic rights;
- promote the development of law that reflects the public interest;
- develop and assist community organisations with a public interest focus to pursue the interests of the communities they represent;
- develop models to respond to unmet legal need; and
- maintain an effective and sustainable organisation.

Established in July 1982 as an initiative of the Law Foundation of New South Wales, with support from the NSW Legal Aid Commission, PIAC was the first, and remains the only broadly based public interest legal centre in Australia. Financial support for PIAC comes primarily from the NSW Public Purpose Fund and the Commonwealth and State Community Legal Services Program. PIAC also receives funding from Industry and Investment NSW for its work on utilities, and from Allens Arthur Robinson for its Indigenous Justice Program. PIAC also generates income from project and case grants, seminars, consultancy fees, donations and recovery of costs in legal actions.

1.2 PIAC's work on migration and disability

PIAC has a long history of advising, representing and advocating in migration matters. Between 2002 and 2004, PIAC was the solicitor on the record in eleven *habeas corpus* applications for the release of immigration detainees from detention. Following the decision of the High Court in *Al-Kateb v Godwin* [2004] HCA 37, PIAC—along with a number of other advocacy groups across Australia—was instrumental in helping to persuade Federal Members of Parliament that the indefinite detention of immigration detainees awaiting removal was no longer tenable. This resulted in changes being made to the immigration detention regime that saw all of PIAC's, as well as other detainees in a similar situation, released on bridging visas.

In *Minister for Immigration and Multicultural and Indigenous Affairs v B and B* [2004] HCA 20, PIAC acted for Amnesty International Australia in a successful application for leave to file written submissions as *amicus curiae* ('friend of the court'). This case sought to establish that the Family Court had jurisdiction over children in immigration detention, including the power to release them from detention.

PIAC has also acted for clients whose visas have been cancelled under section 501(2) of the *Migration Act 1958* (Cth) (for committing minor criminal offences), for clients seeking bridging visas, and for unaccompanied minors in relation to their protection visa applications.

PIAC has also provided submissions to a number of inquiries relating to migration matters. These include the Senate Legal and Constitutional Committee Inquiry into the provisions of the Migration Legislation Amendment (Identification and Authentification) Bill 2003[1], the People's Inquiry into Immigration Detention[2] and, more recently, the Joint Standing Committee on Migration's Inquiry into Immigration Detention in Australia.[3]

PIAC has been a long-term advocate for better human rights protections for people with disabilities. PIAC's work in this area has included conducting test-case litigation under both Federal and NSW anti-discrimination legislation[4], proposing amendments to both substantive and procedural aspects of anti-discrimination law[5] and responding to new and amending anti-discrimination legislation.[6]

1.3 The NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors

The NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) is a state-wide Affiliated Health Organisation, a not-for-profit company registered with the Australian Securities and Investments Commission (ASIC) and a registered Public Benevolent Institution with the Australian Taxation Office (ATO). STARTTS's mission is to develop and implement ways to facilitate the healing process of survivors of torture and refugee trauma, and to assist and resource individuals and organisations that work with them to provide appropriate, effective and culturally sensitive services. STARTTS's clients are survivors of torture and trauma in the context of organised violence and state terrorism who have settled in Australia. The majority have arrived through the Australian Refugee and Humanitarian Program.

STARTTS's service provision philosophy is based on recognising the socio-political, cultural and human rights context of the traumatic experiences undergone by torture and trauma survivors, and the complex interaction between the effects of the traumatic experiences and subsequent stresses associated with the exile, migration and resettlement processes, in the context of the individual and their own make-up and life experience. Particular emphasis is placed on a holistic client centred approach that recognises and addresses the importance of language, cultural, religious and socio-political issues to overcome access barriers and increase the effectiveness of both community development and clinical interventions.

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1 Public Interest Advocacy Centre, *Inquiry into the Provisions of the Migration Legislation Amendment (Identification and Authentification) Bill 2003* (2003).

2 Anne Mainsbridge and Laura Thomas, *Immigration Detention in Australia: the Loss of Decency and Humanity: Submission to the People's Inquiry into Immigration Detention* (2006) Public Interest Advocacy Centre <http://www.piac.asn.au/publications/pubs/sub200706_20060720.html> at 21 October 2009.

3 Anne Mainsbridge and Laura Thomas, *Towards Humanity and Decency: Submission to the Joint Standing Committee on Migration's Inquiry into Immigration Detention in Australia* (2008) Public Interest Advocacy Centre <http://www.piac.asn.au/publications/pubs/sub2008072_20080729.html> at 21 October 2009.

4 *Hills Grammar School v Human Rights & Equal Opportunity Commission* [2000] FCA 658; *Maguire v Sydney Organising Committee of the Olympic Games* [2000] HREOC H99/115 (Unreported, Commissioner William Carter, 24 August 2000).

5 Simon Moran, *Submission to the Review of the* Disability Discrimination Act 1993 *by the Productivity Commission* (2003) Public Interest Advocacy Centre <http://www.piac.asn.au/publications/pubs/ddasub_20030723.html> at 21 October 2009; Robin Banks, *Implementing the Productivity Commission Review of the Disability Discrimination Act: Submission to the Senate Legal and Constitutional Affairs Committee Inquiry into the Disability Discrimination and Other Human Rights Legislation Amendment Bill* (2009 Public Interest Advocacy Centre <http://www.piac.asn.au/publications/pubs/sub120109_20090112.html> at 21 October 2009.

6 Anne Mainsbridge, *Submission to the Senate Legal and Constitutional Committee on the Disability Discrimination Amendment Bill 2003* (2004) Public Interest Advocacy Centre <http://www.piac.asn.au/publications/pubs/DDA_20040510.html> at 21 October 2009.

Based on this philosophy, STARTTS provides a broad range of services including assessment; counselling for all age groups; psychiatric assessment and interventions; family therapy; group interventions; assistance to overcome vocational and non-vocational barriers to employment; bodywork such as massage, physiotherapy, acupuncture and pain management groups; support groups; programs for children and youth; and various strategies to increase the capacity of support networks and refugee communities to sustain their members.

The focus of the STARTTS's approach is on building capacity and empowering people and communities to take control over their own lives, using a strengths-based approach and building on individual, family, community and cultural strengths. Funding is primarily provided by the NSW Department of Health, the Federal Department of Health and Ageing and the Department of Immigration and Citizenship, the latter for assessment and short to medium term counselling intervention under the Integrated Humanitarian Settlement Strategy (IHSS).[7]

1.4 The Mental Health Legal Services Project

For many years, PIAC has worked towards making the justice system more accessible for marginalised and disadvantaged clients by developing and piloting models for responding to unmet legal need, exploring and promoting innovative ways of funding and progressing public interest law, and identifying, challenging and preventing systemic barriers to access to justice.

In 2008, PIAC launched the Mental Health Legal Services Project (MHLSP), a two-year initiative funded by Legal Aid NSW and PIAC. Through the MHLSP, PIAC aims to develop appropriate and sustainable responses to the unmet legal needs of people in NSW who are mentally ill, and to systematically identify and respond to barriers to justice faced by these people. In 2009, PIAC received additional funding from the NSW Public Purpose Fund to enable the establishment of four pilots to test different models of service delivery aimed at improving access to justice for people with mental illness. Each of the pilot programs seeks to facilitate a more holistic service through creating a direct interface between legal services and other supports, such as non-legal advocacy, social work, clinical treatment, rehabilitation and community development.[8] This funding has been supplemented with a one-off grant in 2009 from the Federal Attorney-General through the Community Legal Services Program.

Through its contact and consultations with STARTTS over the years, PIAC became aware of particular difficulties experienced by the clients of STARTTS in accessing the justice system. Social disadvantage and economic marginalisation experienced by people with mental illness are greatly exacerbated for refugees who are torture and trauma survivors due to a range of factors including physical and mental health problems, lack of English skills and lack of formal education. The consequence of torture and other traumas experienced in the context of organised violence is that not only are individuals, families and communities placed in a vulnerable position in the host country, at risk of secondary victimisation, but their ability to access and utilise their internal resources to their full potential is also undermined. This places refugees at a profound disadvantage when attempting to negotiate the complex demands of exile, migration and resettlement processes[9], let alone in dealing with other legal issues that arise.

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7 More information on STARTTS's services and programs can be found at <http://www.startts.org.au>.

8 For further information about PIAC's Mental Health Legal Services Project, see Stephen Kilkeary, 'Making Human Rights 'Real' in Mental Health' (2009) 29 *PIAC Bulletin* 6 <http://www.piac.asn.au/publications/pubs/Bulletin29_20090531.html> at 30 October 2009.

9 J Aroche and M Coello, 'Towards a systematic approach for the treatment and rehabilitation of torture and trauma survivors: the experience of STARTTS in Australia' (Paper presented at the 4th International Conference of Centres, Institutions and Individuals Concerned with Victims of Organised Violence: DAP, Tagaytay City, Philippines, 5-9 December 1994).

In recognition of these difficulties, one of the two-year pilot projects within the MHLSP focuses on assisting STARTTS's clients and potential clients to access mainstream legal services. This pilot project involves a PIAC solicitor working at STARTTS four days a week to provide legal information, advice and referrals to STARTTS's clients who have pressing legal needs.

A significant number of the matters that the PIAC solicitor has dealt with since commencing working at STARTTS in June 2009 have involved clients who are seeking to be reunited with family members through the Australian Government's Refugee and Humanitarian Entrant Program.

2. The current inquiry

PIAC and STARTTS welcome the opportunity to provide this joint submission to the Federal Parliamentary Joint Standing Committee on Migration's Inquiry into the Migration Treatment of People with a Disability (the Inquiry).

The Inquiry is particularly timely in the light of Australia's recent ratification of the United Nations *Convention on the Rights of Persons with Disability* (CRPD).[10] We also note that the Inquiry follows the recommendation of the Joint Standing Committee on Treaties (JSCOT) in October 2008:

> … that a review be carried out of the relevant provisions of the *Migration Act* and the administrative implementation of migration policy, and that any necessary action be taken to ensure that there is no direct or indirect discrimination against persons with disabilities in contravention of the (Disability) Convention.[11]

It is to be hoped that the Inquiry will provide an opportunity to remove discrimination against people with disability from migration laws and processes in Australia.

The Terms of Reference of the Inquiry are:

1. Report on the options to properly assess the economic and social contribution of people with a disability and their families seeking to migrate to Australia.
2. Report on the impact of funding for, and availability of, community services for people with a disability moving to Australia either temporarily or permanently.
3. Report on whether 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 should be a factor in a visa decision.
4. Report on how the balance between costs and benefits might be determined and the appropriate criteria for making a decision based on that assessment.
5. Report on a comparative analysis of similar migrant receiving countries.

This joint submission of PIAC and STARTTS addresses Terms of Reference 1, 3 and 4.

While acknowledging that Australia's migration laws and processes affect all people with disability who are seeking to migrate to Australia, we have focused in this submission on the particular position of those

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[10] *Convention on the Rights of Persons with Disabilities*, opened for signature 31 March 2007, Doc.A/61/611 (entered into force 3 May 2008), ratified by Australia on 17 July 2008 (entered into force for Australia on 16 August 2008).

[11] Joint Standing Committee of Treaties, Parliament of Australia, *Report 95: Review into Treaties Tabled on 4 June, 17 June, 25 June and 26 August 2008* (2008) 23.

seeking to enter Australia under the Refugee and Humanitarian Program (refugees and prospective humanitarian entrants). STARTTS's contribution is focused on experiences of refugees applying within Australia and refugees applying overseas under the humanitarian entrant program (referred to in this submission as refugees applying overseas), while PIAC's contribution focuses on migration laws and their impact on people with disabilities more generally.

3. The Health Requirement under Australian migration law

Migration law in Australia has prescribed health requirements designed to ensure that Australia takes appropriate precautions to minimise public health risks and contain public expenditure on health and community services, so that Australian residents have access to health care and other community services.[12]

PIAC and STARTTS submit that the prescribed heath requirements are discriminatory towards people with disability and their families. Disability is treated as a cost to society and no consideration is given to the positive contribution that a person with disability may make to the economic and social well being of the Australian community. Refugees and prospective humanitarian entrants with disability and their families are at particular disadvantage under this system.

3.1 The legislative framework

The legislative framework underpinning the health requirement is principally governed by the *Migration Act 1958* (Cth) (the Act), the *Migration Regulations 1994* (Cth) (the Regulations) and the Department of Immigration and Citizenship (DIAC) *Procedures Advice Manual 3* (PAM 3).[13]

Section 45 of the Act provides that an applicant wishing to migrate to Australia must apply for a visa of a particular class. The criteria for a valid visa are set out in section 46 of the Act. A visa is invalid if the applicant has not complied with one or more of the prescribed criteria for the class of visa. According to section 47, the Minister is not to consider an application that is not a valid application.

Section 60 of the Act enables the Minister to require a visa applicant to visit, and be examined by, a 'person qualified to determine the applicant's health, physical condition or mental condition…'

Section 65 of the Act enables the Minister to grant or refuse a visa depending on whether he or she is satisfied that the applicant meets the health criteria.

Sections 351 and 417 of the Act provide the Minister with a discretionary power to substitute a more favourable decision if the applicant has been to a review tribunal.

Section 496 of the Act enables the Minister to delegate the power to consider and decide whether an applicant meets the health criteria as well as other aspects of the application. Consequently, in many cases, a medical officer of the Commonwealth (MOC) will provide an opinion that an applicant meets the health criteria. The section 65 delegate is then required to consider this opinion in determining the visa application.

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12 Department of Immigration and Citizenship, *Procedures Advice Manual 3* (2009) Schedule 4/4005-4007 – The Health Requirement – An Overview.

13 Ibid The Health Requirement

Schedule 2 of the Regulations sets out the criteria for visa classes and subclasses. For most visa subclasses, the criteria prescribed in Schedule 2 to the Regulations require applicants, and all their family members, including non-migrating family members, to satisfy the Public Interest Criteria (PIC) in Schedule 4 to the Regulations.

Schedule 4 contains three health-related PIC's including PIC 4005, PIC 4006A and PIC 4007. PIC 4005 is the 'standard' Health Requirement. PIC 4006A prescribes the standard Health Requirement, but also provides for a waiver where the applicant is applying under subclass 418 Educational visa and 457 Business visa; that is, if the applicant's sponsor (for a 418 visa) or employer (for a 457 visa) is prepared to sign an undertaking to meet costs relating to the applicant's health condition. PIC 4007 prescribes the standard Health Requirement and also provides for a 'health waiver' for permanent visa applicants.

The standard Health Requirement prescribed in Schedule 4 PIC 4005 requires that the applicant be free from tuberculosis; free from a disease or condition that is a threat to public health; and if the applicant has a disease or condition, the particular disease or condition must not require health care or community services that would likely result in a significant cost to the Australian community or prejudice the access of an Australian citizen or permanent resident to health care or community services.

There is no definition of the concept of 'significant cost' in either the Act or Regulations. PAM 3 provides some policy guidance. Currently PAM 3 sets the policy threshold for the level of costs regarded as significant at $21,000. The amount of $21,000 applies to permanent visa applications up to a five-year period, and a three-year period for visa applicants over the age of 70 years old. The PAM 3 guidelines allow the delegate to extend the five-year time period in cases where it is reasonably identifiable that costs for health care services would extend beyond the five-year period.[14] In many cases involving children with disability, the costs are calculated over the period of the child's life (see the case studies in 3.5 below).

All applicants for visas to which Schedule 4 PIC 4005, 4006A or 4007 health criteria apply must satisfy the MOC or the section 65 delegate that they meet the Health Requirement. If the applicant does not meet the Health Requirement, they cannot be granted a visa unless the prescribed Schedule 4 health criterion for that visa specifically provides for a 'health waiver' and a delegate assesses them as meeting requirements for exercise of that health waiver.

PAM 3 gives guidance as to how the MOC or section 65 delegate should assess the Health Requirement. For most visitors, a personal health declaration on the application form is accepted as evidence that a person has met the health criteria. However, permanent visa applicants need to complete the health declaration form and additionally undertake a chest x-ray, a full medical examination and an HIV test.

The health declaration seeks information relating to the applicant's current health status. PAM 3 contains a table of diseases and conditions that notify the delegate to require an applicant to undergo further health assessments before the grant of a visa is made. The table includes the following diseases and conditions:

- tuberculosis (current or past);
- mental illness, including bipolar disorder and depression;
- blindness;
- cerebral palsy;
- Crohn disease;
- diabetes (if the applicant is aged 40 years or over);
- epilepsy;

[14] Ibid [56.2].

- haemophilia;
- heart disease;
- hepatitis B and C;
- intellectual impairment;
- multiple sclerosis;
- renal failure;
- rheumatism;
- ulcerative colitis;
- cancer in the last five years;
- cystic fibrosis;
- HIV; and
- organ transplant recipient.[15]

The health declaration is mandatory. Failure to honestly report a known disease or a condition is sufficient to invalidate the visa application.[16]

Unlike for temporary visas, most permanent visas, as well as provisional and/or temporary visas that lead to a permanent visa, require all members of the family unit (even those not migrating with the applicant) to make a health declaration and to undertake medical tests. 'Family unit' is defined in Regulation 1.12. It includes any dependent children under the age of 18, regardless of the custody or access arrangements in place. For these visas, the Health Requirement is a 'one fails, all fail' criterion. That is, if any members of the family unit fail to meet the Health Requirement and no health waiver is available, no family member will be granted a visa (including the applicant seeking to satisfy the primary criteria).

If the applicant (or member of the family unit) has an identifiable disease or condition, Regulation 2.25A requires the Minister (or delegate) to seek an MOC's cost-assessment opinion as to whether the applicant meets the Health Requirement. An applicant will fail the Health Requirement if it is the opinion of the MOC that the applicant (or member of the family unit) has a disease or condition that is likely to be a significant cost in the areas of health care and community services and/or prejudice the access of Australians to those services.

The MOC cost assessment is based on a hypothetical person with the same severity of disease or condition. It is not relevant whether or not these services will actually be used. Under Regulation 2.25A(3) the opinion and cost assessment of the MOC is final and cannot be reviewed.

3.2 Waiver of the Health Requirement

A person applying for a permanent visa may apply for a waiver to the Health Requirement if they satisfy all other public interest criteria for the grant of the visa applied for and the Minister is satisfied that the granting of the visa would be unlikely to result in undue cost to the Australian community or undue prejudice to the access to health care or community services of an Australian citizen or permanent resident.[17] A waiver is discretionary and dependent on the MOC cost-assessment opinion and any submissions provided by the applicant. If a health waiver is not available then the applicant may make a request to the Minister for a more favourable decision pursuant to the discretionary power available to the Minister under section 417 of the Act.

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15 Ibid [17].

16 *Migration Act 1958* (Cth) ss 45 – 47.

17 *Migration Regulations 1994* (Cth) sch 4 Public Interest Criteria 4007 (2)(a); and (2)(b).

PAM 3 provides guidance as to the evidence that would be considered in a health waiver submission, including:

- evidence to show the type of support that the family may offer;
- qualifications and employment prospects;
- whether there are minor Australian children;
- whether the parties involved have established links to Australia;
- if the applicant is a non-migrating dependant, any arrangements in place for the applicant's care and welfare and the likelihood of their future migration; and
- any substantial compelling and compassionate circumstances (other than those that make them eligible for a refugee or humanitarian visa).[18]

In reaching a decision as to whether to exercise the health waiver provisions the delegate will consider the MOC's opinion regarding whether the cost on health and community services is 'undue' when weighed against the submission provided by the applicant.[19]

PAM 3 provides a list of the visas for which the waiver provision applies, including: Spouse/de facto spouse, Interdependent partner, Fiancé, Dependent child, Adopted child, Refugee and humanitarian visas granted overseas, Temporary humanitarian stay, Business skills (permanent), New Zealand Citizen Family Relationship, Business (long stay), and Educational.

3.3 Cost assessment

MOCs assessing the cost of the disability rely on figures provided to them by the Department of Health and Ageing. The costs are assessed to apply to the hypothetical person with the same disease or condition as the applicant. According to PAM 3, the MOC is not to take into account the circumstances of the individual applicant. This cost-assessment process however appears inconsistent with the findings in the cases of *Robinson v Minister for Immigration and Multicultural and Indigenous Affairs* [2005] FCA 1626 (the *Robinson case*) and *Ramlu v Minister for Immigration & Anor* [2005] FMCA 1735 (the *Ramlu case*).

In many cases, the MOC cost assessment is based on the assumption that an applicant with a disease or condition would access all available health and community services. This assumption however ignores the fact that in many cases strong family and cultural ties mean that applicant's with a disease or condition would be more likely to be cared for by a family member and less likely to be put into care.

If the Health Requirement is retained, it should be reformulated to include a statutory requirement that decision-makers take into consideration the particular circumstances of each applicant. This would replace the hypothetical person test with an individualised objective test.

PIAC and STARTTS note that in Canada the equivalent statutory test allows the MOC to determine whether the applicant will actually use the health care facilities and whether such use may place an 'excessive demand' on the services.[20] In our view, this is a fairer test, because it takes into consideration the actual individual rather than the hypothetical person with a similar disease or condition.

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18 Department of Immigration and Citizenship, above n 12, 97.

19 Ibid.

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

3.4 Review of visas refused on health grounds

There are two grounds of review where a visa has been refused on health grounds: the opinion of the MOC that there is significant cost or prejudice to access to health care, and a decision by the delegate not to exercise the health waiver. In some cases there may be a combination of the two grounds where, for example, the delegate has decided not to exercise the waiver on the basis of an incorrect assessment of the costs involved in treating the applicant.

The cost-assessment component of the Health Requirement has been interpreted by Justice Siopis in the *Robinson case* as requiring the MOC to ascertain the level of the condition of the applicant and then to apply the statutory criteria by reference to a hypothetical person who has the same level of the condition.[21]

The *Robinson* case involved an eight-year-old boy with Down Syndrome. The boy's treating doctor had provided a report to the MOC describing the level of the boy's condition as 'mild'. The Department of Immigration and Multicultural Affairs (as it then was) (DIMA) refused the boy's permanent residence visa application because an MOC concluded that a person with his condition would be likely to require special education and allied therapies during his lifetime and that this would result in a significant cost to the Australian community. The boy's family sought judicial review. Justice Siopis decided in favour of the boy. His Honour held that the Migration Review Tribunal (MRT) had made a jurisdictional error by failing to apply a correct statutory test. His Honour explained that the MOC is required by law to ascertain the particular form or level of disease or condition of the visa applicant and then assess whether the provision of health care or community services to a hypothetical person with that particular form or level of disease or condition would result in a significant cost to the Australian community.

Justice Siopis' reasoning in the *Robinson case* was accepted and followed by the Federal Magistrates Court in its decision in the *Ramlu case* and in subsequent court decisions.[22]

In the *Ramlu case*, the applicant was refused a permanent visa on the basis of not meeting the Health Requirement. His eight-year-old son had Down Syndrome. The cost assessment of the MOC found that the child would need special education and supported income as an adult. The costs of these services were assessed as involving a significant cost to the Australian community. The MOC had not taken into account information from a doctor and registered psychologist that showed that the child had potential to learn rapidly, and gain normal levels of independence and competence eventually leading to full-time work. On appeal to the Federal Magistrates Court, the Court found the appropriate test to apply was the hypothetical person with the actual form of the disease or condition and not the hypothetical person with the disease that is described generally.

3.5 Case studies

In recent years, there has been growing concern about the Health Requirement and its operation. A number of prominent cases have highlighted the problems that the application of the health requirement has on migrating families. These include:

1. Mr Shazad Kayani arrived in Australia in 1995 from Pakistan. He applied for, and was granted refugee status. In 1997, he applied to bring his wife and three children to Australia. However, his application

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21 *Robinson v Minister for Immigration and Multicultural Affairs* [2005] FCA 1626 per Robinson J at [43] <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/cth/FCA/2005/1626.html?query=title%28robinson%29> at 21 October 2009.

22 *Ramlu v Minister for Immigration & Anor* [2005] FMCA 1735 <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/cth/FMCA/2005/1735.html?query=ramlu> at 21 October 2009.

was rejected on the ground that one of his daughters has cerebral palsy and did not meet the Health Requirement. The MOC opinion on the cost for health care was $750,000. Mr Kayani was asked to pay an Assurance of Support, but was unable to cover the costs. After repeated applications to DIAC were rejected, and a request for Ministerial Discretion to the then Immigration Minister, The Hon Phillip Ruddock, pursuant to section 417 of the Act was refused, Mr Kayani sunk into a deep depression. In 2001 Mr Kayani set himself alight outside Parliament House. He died 55 days later.[23]

2. Dr Bernhard Moeller, a specialist physician in the small Victorian town of Horsham was in Australia with his family on a 457 Temporary Working Visa. He applied for permanent residency for himself and his family. However, his application was refused on the basis that his 13-year-old son Lukas has Down Syndrome. DIAC cited the potential cost to the community of Lukas's disability, including medical, welfare and education costs. Fortunately, in this case, the public outcry prompted the new Immigration Minister, Senator The Hon Chris Evans, to intervene and establish the current inquiry.[24]

PIAC and STARTTS are also aware of a number of not-so-prominent case studies (provided by the Multicultural Disability Advocacy Association and STARTTS) that highlight the problems with the practical application of the Health Requirements. To protect the privacy and confidentiality of the people involved, names and dates of events have been removed.

3. A family from an Asian country had to leave a child with a physical disability in the care of relatives in the country of origin because the child did not meet the health criteria. After a long separation from her family resulting from the lengthy immigration process, the young girl developed low self-esteem. Feeling abandoned by her parents led her to attempt suicide. When an application was made for the exercise by the Minister of discretion under section 417 of the Act, the child was eventually permitted to come to Australia. She had developed psychosocial problems and was very temperamental and aggressive towards her siblings.

4. A young man with a mild intellectual disability had migrated to Australia with his uncle. Both had come to Australia as refugees. The young man married a woman from his country of origin and applied for her to join him in Australia on a Spouse visa. DIAC asked for an Assurance of Support. The man was in receipt of a Disability Support Pension. The uncle who brought the applicant to Australia was ageing and also in receipt of a pension. The man and his uncle were very isolated and had no social support networks, and were unable to secure an Assurance of Support. The man is very despondent and feels as if he can never have his wife join him here in Australia.

5. A family applied for Global Special Humanitarian Program visas (Subclass 202) to come to Australia. However, their applications were rejected because two of the children in the family did not meet the Health Requirement for entry to Australia. The children both have a condition that results in uncontrolled movement of the eyes and reduced vision. The decision to refuse the family the visas was based on the opinion of one MOC, who had provided a health waiver cost-assessment opinion that stated that the likely cost to the Australian community if the visa was granted would be $630,000 in the case of one of the children, and $616,000 in the case of other. This assessment appeared to be based on an assumption by the MOC that the two children would require eye surgery. In a letter from the delegate notifying her of the decision, the mother was advised of the possibility of the Health Requirement being waived. She was given 49 days to provide any comments she would like to be considered in the final assessment of the application. Because of the difficulty of getting supporting medical evidence in the country of refuge, the mother secured letters from medical practitioners in Australia to show that the children would not require surgery as this would lead to only marginal

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23 *Sydney Morning Herald Newspaper*, (Sydney), 4 April 2001.

24 *The Australian* (Sydney) 1 November 2008.

improvement in their condition. These doctors had not been able to physically examine the children, and had to base their opinions on documentary evidence. The visa application of the family was ultimately refused.

6. B (aged 21) has a developmental disability. He and his family fled Iraq after a bomb killed B's father during the war. B's sister and brother came to Australia as refugees, leaving B in the care of his mother in Jordan. B's mother applied for Refugee and Humanitarian (Class XB) visas to migrate to Australia to join the other family members. DIAC rejected the application on the basis that B did not meet the Health Requirement for entry to Australia. This decision was based on the opinion of an MOC that B would likely require life-long access to income and community support services at a likely cost to the Australian community at $600,000. B's mother was advised of the waiver provision and given 49 days to provide further comments in support of the application. Despite the provision of statements of support from individuals in Australia and an occupational therapist's report confirming that B is in good health and independent in many aspects of his daily life, DIAC refused to waive the Health Requirement.

7. T is a 30-year-old man who lives in Sri Lanka. He has both an intellectual and physical disability and cannot walk without assistance. T's parents and two of his siblings now live in Australia, after being granted Global Special Humanitarian Program visas (Subclass 202). Concerned that T's disabilities would impact on their prospects of getting visas, the family made the agonising decision to leave T behind in Sri Lanka. T has no access to disability support services in the village where he lives and he spends his days at home alone watching television. His only remaining relative in Sri Lanka is his brother who works full time and is only able to provide him with limited assistance. T is very angry with his family for leaving him behind, and his family in Australia are suffering feelings of grief and guilt.

These cases show that the current system can result in people with disabilities being separated from their families, sometimes indefinitely. This has a detrimental impact on the person with disability, as they may be left without any support and in political and social circumstances that are often unstable. There is also a detrimental impact on the other family members in Australia as the emotional, financial and psychological effects of separation from loved ones hinder the resettlement process.

3.6 The Health Requirement and its application

In this section, we discuss the problems with the Health Requirement and the way it is currently applied. In our view, the Health Requirement promotes negative characterisations and perceptions of people with disability and is at odds with Australia's social inclusion policies and international human rights obligations, including the CRPD. In addition, the processes by which the Health Requirement is applied are flawed and can lead to unjust outcomes.

3.6.1 Focus on cost

The Health Requirement characterises people with disability in terms of cost. It is based on the assumption that if a person has a disability, that person will be a financial burden to the community. This was specifically recognised in the case of *MIMA v Seligman* [1999] FCA 117 (1 March 1999), where the Full Court of the Federal Court stated:

> The governing element of the criterion in Item 4005(c)(i) is significant cost to the Australian people. The policy behind the test is clear. It is to limit the entry into Australia for long term residence of people who are likely to be a financial burden on the Australian community.[25]

This has the effect of reinforcing negative stereotypes of people with disability as being a drain on resources, rather than an investment. Essentially it means that people with disability are seen as passive recipients of services, rather than as being capable of contributing to the economic, cultural and social well being of Australia in an active and positive way. This characterisation explicitly devalues all people in Australia living with disability.

The Health Requirement is based on a medical model that is inconsistent with the social model of disability that has been adopted in the CRPD. The social model recognises the inherent equality of a person with a disability and their human worth beyond an economic assessment of the costs of that disability. It considers people with disability as equals, not as objects of paternalism or charity. It also sees disability as an evolving concept resulting from the interaction between persons with impairments and attitudinal and environmental barriers that hinder full and effective participation in society on an equal basis with others.

There is currently no provision in the Health Requirement to offset the positive contributions that a person with a disability may make to Australia against the costs they may impose. If the Health Requirement is to be retained, it should be reformulated so as to also take account of the value and contributions that a person with disability can bring to the community.

Recommendation:

1. ***That the Health Requirement be reformulated in a way that takes into account the positive contributions that a person with disability can make to the community.***

The Health Requirement by its nature discriminates against people with disability. Such discrimination is both direct (by requiring additional tests of medical evidence that are not required of people without disability) and indirect discrimination (setting rules that they do not, or cannot meet) as defined in sections 5 and 6 of the *Disability Discrimination Act 1992* (Cth).

The current test of 'significant cost' to Australia or 'prejudice to the access of an Australian to health services' sets the bar very low and would exclude the majority of potential migrants and refugees with disability.

PIAC and STARTTS note that in Canada there is a higher threshold test that allows the delegate to determine whether the applicant will actually use the health care facilities and whether such use may place an 'excessive demand' on such services.[26] This is a preferable test, as it more likely to satisfy the CRPD requirement of an objective and reasonable justification for interference with equal protection.[27]

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25 *MIMA v Seligman* [1999] FCA 117 at [74] <http://www.austlii.edu.au/au/cases/cth/FCA/1999/117.html> at 21 October 2009.

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

27 See, eg, *Thlimminenos v Greece* [2000] 31 EHRR 411, *Hoogendijk v The Netherlands*, European Court of Human Rights, 6 January 2005.

Recommendation:

2. *That the Health Requirement be reformulated so as to only exclude potential migrants (exception given to refugees and humanitarian entrants) with disability if they have a disease or condition that would impose 'excessive demands' on health and social services.*

3.7 Discriminatory impact

Currently section 52 of the *Disability Discrimination Act 1992* (Cth) (the DDA) exempts from its operation the Act, a legislative instrument made under the Act, or anything that is permitted or required to be done by the Act.[28] In the absence of this exemption, the Act and Regulations would be subject to the DDA in the context of the 'administration of Commonwealth laws and programs'.[29]

This exemption was implemented as a safeguard against 'excessive social and economic costs' that could result from a non-discriminatory immigration policy. However, its effect is that while disability discrimination is usually illegal when perpetrated in Australia, it is a condoned and standard practice for government officials when dealing with potential migrants and refugees with disability.

PIAC and STARTTS acknowledge that the scope of section 52 has been narrowed slightly following the implementation of the recommendations of the Productivity Commission review of the DDA.[30] However, we submit that, in the light of Australia's ratification of the CRPD and the numerous problems with the Health Requirement and processes outlined in this submission, it is inappropriate that there continue to be a blanket exclusion from the DDA of actions done under the Act and any legislative instrument made under the Act. We submit that section 52 of the DDA should be repealed in its entirety.

Recommendation:

3. *That section 52 of the* Disability Discrimination Act 1992 (Cth) *be repealed so that disability is not a consideration under the* Migration Act 1958 (Cth) *when processing visa applications to enter and remain in Australia.*

3.8 Procedural problems

The manner in which the Health Requirement is applied to particular cases lacks transparency, with little useful information being provided by decision makers about the reasons for a decision.

Following an inquiry into the Shahraz Kayani case (cited above), the Commonwealth Ombudsman found that DIMA had inadequately documented its reasons for rejecting the Kayani claims. The Commonwealth Ombudsman stated, 'The history of this case is one of administrative ineptitude and of broken promises'.[31]

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

29 *Disability Discrimination Act, 1992* (Cth) s 29.

30 See the *Disability Discrimination and Other Human Rights Legislation Amendment Act 2009* (Cth). Previously section 52 of the *Disability Discrimination Act 1992* (Cth) exempted the *Migration Act 1958* (Cth), all regulations made under the Act and 'anything done by a person in relation to the administration of the Act'.

31 Commonwealth Ombudsman, *Report on the Investigation into a Complaint about the Processing and Refusal of a Subclass 202 (Split Family) Humanitarian Visa Application* (2001) <http://ombudsman.gov.au/reports/investigation/2001> at 21 October 2009. See also, A Clennell, 'Ombudsman blasts "inept" department over migrant's suicide', *The Sydney Morning Herald*, (Sydney) 23 August 2001; The Hon Phillip Ruddock, Minister for Immigration and Multicultural Affairs, and the Department of Immigration and Multicultural Affairs and others, various titles (Media releases from 2000-01) <http://www.aph.gov.au/library/pubs/online/refugees_s7.htm> at 21 October 2009.

Lack of information about how and why a decision was reached makes applications for review extremely difficult.

Another major deficiency in the process is that the opinion of one MOC is determinative. The fact is that the MOC's opinion may be infected by assumptions and stereotyped prejudices; there is no check or balance to guard against the possibility of bias.

There is also a need for a higher evidentiary threshold so that a person with a disease or condition can only be treated adversely in the migration process after a careful and thorough assessment of the best possible medical evidence available. This could be achieved by a reformulating the statutory test to allow applicants to submit their own expert medical opinion.

In comparison, Canada requires two or more concurring medical opinions before deciding to refuse the visa application on health grounds.[32]

PIAC and STARTTS submit that the requirement for two or more concurring medical opinions would provide an important safeguard against possible an arbitrary, biased or unjustifiable opinion of a single MOC.

PIAC and STARTTS also submit that the reformulated statutory test must include consideration being given to the individual circumstances of the applicant including whether or not the applicant has strong family and/or community supports who would be available to provide care. Thus the test would include whether the applicant would place an 'excessive demand' on the health and services.[33] In our view, this is a fairer test, because it takes into consideration the actual individual rather than the hypothetical person with a similar disease or condition.

To ensure fairness to the impecunious applicant, it is suggested that a fund be established to finance the costs of independent medical opinions for applicants with limited resources.

A further problem is with the health waiver process. A health waiver does not remedy the systematic issue of discrimination against people with disability. It is problematic because it is based on policy guidelines and is discretionary. The delegate making the decision may (not 'must') take into consideration the submissions of the applicant. There is also no requirement that the delegate provide reasons for a health waiver refusal.

Limited grounds for review in Health Requirement appeals is yet another problem for applicants disappointed with a visa application refusal on health grounds. It is often the case that successful outcomes depend very much on the financial resources of the applicant and the extent to which they are able to seek legal assistance or to harness media and public opinion.

Ministerial discretion is another cause for concern. As a last resort an applicant may ask the Minister to intervene and substitute a more favourable decision pursuant to sections 351 and 417 of the Act. Reliance on the opportunity to seek the exercise of Ministerial discretion does not ensure the rights of people, but rather is a 'band-aid' measure that may or may not remedy poor administrative decisions.

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32 *Immigration and Refugee Protection Regulation*, SORC/2002-227 reg 34(a).

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

As a signatory to CRPD, Australia has committed to take 'all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities…'[34] It is the view of PIAC and STARTTS that the Minister's discretionary decision about whether or not to substitute a more favourable decision is arbitrary and contrary to the rule of law. Confidence in the legitimacy of decision-making can only be established when decision makers act in accordance with written and publicly disclosed laws.

A further procedural problem is created by the lengthy processing times. A case brought to the attention of STARTTS involved an urgent Carer visa and Child visa application. The prolonged processing period of ten years saw the death of Australian family members experiencing ill health and stress before a Carer visa was approved.

Processing times should be made public and the Government made accountable so as to ensure delays are kept to a minimum and applicants are treated equally and fairly. The Canadian migration authorities provide a timetable of this type with each visa category given a processing time.[35]

Recommendations:

4. *That a delegate under the* Migration Act 1958 *(Cth) be required to provide reasons for his or her decision when refusing a visa application on health grounds. Reasons for decision should be provided to the applicant allowing for a merits review.*
5. *That the statutory tests under the* Migration Act 1958 *(Cth) be reformulated to allow applicants to submit their own expert medical report on questions such as the severity of the disability, the nature of the care that the disability will require. This would replace the current single opinion of the medical officer of the Commonwealth who provides an assessment on the hypothetical person with the same disease or condition as the applicant.*
6. *That any merits review of migration decisions relating to health or medical conditions include a ground on whether or not the medical officer of the Commonwealth acted lawfully and gave proper weight when reviewing the varying medical opinions in determining the visa application.*
7. *That the Ministerial discretion pursuant to sections 351 and 417 of the* Migration Act 1958 *(Cth) be repealed so that the Australian Government complies with the rule of law.*
8. *That visa processing times are made publicly available to improve openness, set clear criteria against which government performance can be measured and help guard against favouritism and/or bias.*

4. Inconsistency with international obligations

4.1 The *Convention on the Rights of Persons with Disabilities*

The Health Requirement is inconsistent with the CRPD. The CRPD identifies the rights of persons with disabilities as well as the obligations of State Parties to the CRPD to promote, protect and fulfil those rights. The CRPD aims to ensure that people with disability enjoy human rights on an equal basis with others. As a

[34] *Convention on the Rights of Persons with Disabilities* opened for signature 31 March 2007, Doc.A/61/611, art 16(1) (entered into force 3 May 2008), ratified by Australia on 17 July 2008 (entered into force for Australia on 16 August 2008).

[35] Citizenship and Immigration Canada, *Applications processed in Canada* (2009) <www.cic.gc.ca/english/information/times/canada/process-in.asp> at 21 October 2009.

signatory state, Australia has a duty to refrain from acts that would defeat the object and purpose of the convention.[36]

Article 1 of CRPD provides that the purpose of the 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'.

Article 5 of CRPD recognises that all persons are equal before the law, prohibits State parties from discriminating on the basis of disability, and obliges them to guarantee people with disability equal and effective legal protection against all forms of discrimination.

Discrimination on the basis of disability is defined in article 2 as:

> … any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of 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.

Arguably, the effect of the CRPD is that where a State Party chooses to legislate to provide for the entry and stay of non-citizens, such laws must comply with the non-discrimination requirements of article 5. Australia's migration laws, including the Health Requirement, clearly do not comply. People with disability are targeted under the migration laws. Any person with a disability is subjected to health tests and is refused entry if their disability requires health care services that would likely result in a 'significant cost'. As explained above, there is no legislative definition given for 'significant cost'. Decisions are based on a policy threshold figure of $21,000 over the period of the visa.

Other relevant provisions in the CRPD are:

- article 11, which requires State Parties to 'ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters'; and
- article 18, which requires State Parties to 'recognise 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.'

Rejecting immigration applications from people solely on the basis of their disability appears to be contrary to Australia's obligations under these articles also.

PIAC and STARTTS note that Australia has ratified CRPD with a declaration that states its 'understanding that the Convention does not impact on Australia's health requirements for non-nationals seeking to enter or remain in Australia, where those requirements are based on legitimate, objective and reasonable criteria.'[37] It is the view of PIAC and STARTTS that this interpretive declaration is contrary to the object and purpose of the CRPD, and should be withdrawn.

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36 *Vienna Convention on the Law of Treaties*, opened for signature 23 May 1969, 1155 UNTS 331 (entered into force 27 January 1980, entered into force for Australia on 27 January 1980) art 18.

37 United Nations, *Declarations and Reservations to the United Nations Convention on the Rights of Persons with Disabilities* (2008) <http://www.un.org/disabilities/default.asp?id=475> at 21 October 2009.

4.2 The UN *Convention on the Rights of the Child*

Australia is also a signatory to the United Nations *Convention on the Rights of the Child* (CROC).[38] Article 9 of the CROC states that 'Parties shall ensure that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child.'

Many children with disabilities fail the health requirement as the cost assessment is calculated over their lifetime. This can result in children with disability being left behind to an uncertain future. This is clearly not in the child's best interest. PIAC and STARTTS also note article 23(4) of the CRPD, which states that 'in no case shall a child be separated from parents on the basis of a disability of either the child or one or both of the parents.'

Recommendation:

9. *That the Health Requirement be reformulated to be consistent with Australia's obligations under international human rights law, including the UN* Convention on the Rights of Persons with Disability *and the UN* Convention on the Rights of the Child.
10. *That the interpretive declaration in respect of health requirements in migration that was made by Australia upon ratification of the* Convention on the Rights of Persons with Disability *be withdrawn.*

4.3 Inconsistency with Australia's Social Inclusion Policy

The Health Requirement sits uncomfortably with Federal Government policy and statements that people with disability are valued members of the community and make worthwhile contributions.[39] While proclaiming the protection and promotion of disability rights to its citizens, Australia has continued to implement policies that are, in fact, discriminatory towards refugees and potential migrants with disability.

4.4 Antiquated notion of 'public interest'

Although the Health Requirement purports to be based on the public interest, historical analysis of its origins reveals that it is based on a very narrow and outdated notion of what constitutes the public interest. The Health Requirement has its genesis in the *Immigration Restriction Act 1901* (Cth).[40] This legislation excluded from Australia criminals, prostitutes, 'any idiot or insane person' or 'any person in the opinion of the Minister or of an officer, likely to become a charge on the public or upon any charitable or public institution'. It was influenced by eugenics philosophy that was popular in the late nineteenth century, which encouraged the application of the natural selection principal to select people who would be most fit for reproducing and adapting to cultural norms.[41] This same type of reasoning is responsible for ethnic cleansing and for some of the injuries and dislocation of those who are forced to seek asylum. Although the wording of the Health Requirement has changed over the years, its meaning has remained consistent. It is still the case that anyone likely to be deemed a 'significant cost' to the Australian community will fail the public interest criteria of the Act. This is clearly at odds with more contemporary understandings of the term

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38 *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990) ratified by Australia 17 December 1990 (entered into force for Australia on 16 January 1991).

39 See, for example, The Hon Brendan O'Connor MP, Minister for Employment Participation, 'Minister Welcomes OECD Focus on Social Inclusion for People with Disabilities' (Media Release, 18 December 2007).

40 *Immigration Restriction Act 1901* (Cth) s 3.

41 Kylie Young and Eloise Finlay, *Disabled? Sorry, We Can't Afford It: Australia's position on refugees and migrants with disabilities* (2007) Isis International <http://www.isiswomen.org/index.php?option=com_content&task=view&id=660&Itemid=200> at 21 October 2009.

'public interest', which take into account social inclusion and diversity, the benefits of achieving equality and preventing discrimination and prejudice, and which recognise the social and economic contributions that can be and are made by people with disability.[42]

Recommendation:

11. That the Health Requirement be reformulated so as to be consistent with contemporary notions of the public interest that recognise the public good in social inclusion and diversity.

5. The impact of the Health Requirement on refugees applying overseas

5.1 Relevant provisions

Australia's Refugee and Humanitarian Entrant Program is for refugees and others in humanitarian need because they are fleeing persecution.

There is an exception to the Health Requirement given to refugee applicants including their migrating and non-migrating family member applying within Australia pursuant to Schedule 2, subclass 866. All refugee applicants (and their migrating and non-migrating family) must undergo medical testing, but unlike applicants in other visa categories, they do not risk being refused a visa if they do not pass the Schedule 4 PIC 4005 and PIC 4007 health testing requirements. Rather a refugee applicant applying within Australia who fails the health test may be required to undertake a course of medical treatment or supervision by a health authority. The Health Requirement does not apply and a refugee applicant cannot be refused on health grounds.

This Health Requirement exception is not available to the refugee applying overseas under the Humanitarian Entrant Program pursuant to Schedule 2, subclass 200 to 204. The refugee applying overseas and all members of their family including migrating and non-migrating dependants must satisfy the health-testing requirements found in Schedule 4, PIC 4007 unless the Minister is satisfied that it would be unreasonable to require the person to undergo assessment in relation to the health criteria, for example, a situation where submitting to a health test may put the applicant's life at risk. If the refugee applying overseas or a family member fails to satisfy the health test, no medical treatment is provided. The application is simply refused, unless the Minister (or delegate) waives the Health Requirements.

5.2 How the Health Requirement disadvantages refugees applying overseas

The Health Requirement is particularly inequitable when applied in relation to the visa categories under Australia's international humanitarian program.

The United Nations High Commissioner for Refugees (UNHCR) admits that 'the resettlement of persons with medical needs is challenging, and resettlement opportunities are limited'.[43]

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42 Jan Gothard and Charlie Fox, 'Consign Disability Discrimination to the Dustbin of History', *The Australian* (Sydney) 17 November 2008.

43 United Nations High Commissioner for Refugees, 'UNHCR Criteria for Determining Resettlement as the Appropriate Solution' in *Resettlement Handbook*: *Department of International Protection* (2004) at IV/9.

Refugees are more likely to have disabilities than other classes of visa entrants. The World Health Organisation (WHO) estimates that between 2.3 and 3.3 million of the world's forcibly displaced people live with disabilities, one third of them children.[44] Many people who are seeking asylum are fleeing their homelands because they are the victims of war and violence. The nature of war leaves many people physically injured and/or with disability, for example, through the affect of landmines. Many other refugees and asylum seekers have acquired physical impairments or mental illnesses as a result of torture or fleeing natural disasters or threatened violence.

Refugees are high-needs health populations. Compared to other new migrants, refugee groups demonstrate a unique set of health and psychosocial needs as a result of both pre- and post-migration experiences. Refugees are more likely to suffer from particular health problems, often related to physical and psychological trauma, poor nutrition and developmental delay in children. Their poor physical and mental health may also be the result of population health patterns of countries of origin, the conditions in refugee camps and little or no previous access to health care.

As a result of these factors, refugees and prospective humanitarian entrants with disability are more likely to fail the Health Requirement in the first instance and to be denied the opportunity of resettlement in Australia.

Successfully challenging a refusal decision will usually require the applicant to have comprehensive and up-to-date medical evidence. For example, one family who had been denied visas because their daughter has Down Syndrome was ultimately successful after providing 14 extra medical reports, statements from research professionals into Down Syndrome and statements of support from professional colleagues.[45] For many refugees and prospective humanitarian entrants, this would be impossible. Previous medical records may have been lost or left behind during the flight from their homeland. They may not be linked into the health system in their country of refuge and may be forced to rely on sponsors or family members in Australia to try to get supporting evidence from doctors in Australia. These will be unlikely to carry much weight, as the doctors will not have had the opportunity to examine the family member with disability.

In addition, there may be immense financial and practical barriers to obtaining further medical opinions. In the Shahraz Kayani case, for example, the ten-year-old daughter with cerebral palsy had to be examined three times by doctors accredited to the Australian High Commission in Pakistan. This involved three trips from Jhelum to Islamabad, which were costly and exhausting for the child and her mother and ultimately futile.

Language and communication barriers may limit access to information about review processes and assistance with review applications. Refugees and prospective humanitarian entrants are also less likely to be able to afford the cost of expert advice from migration agents and lawyers in navigating their way through the complex review process.

Unlike the Moeller family (involving permanent visa applications by a specialist physician that were refused on the basis that their 13-year-old son has Down Syndrome) refugees and humanitarian entrants do not generally have the resources or opportunities to bring the unfair application of Health Requirement to the attention of the Australian media. In many cases, the unfair application of the Health Requirement would simply go unnoticed.

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44 *People with Disabilities* (2009) UNHCR: <http://www.unhcr.org/pages/4a0c310c6.html> at 21 October 2009.

45 Sharon Ford and Jan Gothard, 'Discrimination and Immigration: An Australian (Bad) Example' (Paper presented at the 8th World Down Syndrome Congress, Singapore, 14-18 April 2004).

5.3 The plight of those left behind

Refugees with disability applying overseas and their families applying overseas who are refused visas because of the Health Requirement will often be left in dangerous situations of conflict.

People with disability living in conflict situations are often the most marginalised groups of people. Social, physical and attitudinal barriers limit their opportunities for full participation in society.[46]

During conflict, refugees with disability often lose their support networks, leaving them in a very vulnerable situation. They are increased risk of discrimination, harassment, exploitation, physical and sexual abuse and neglect. In many countries refugees with disability face double discrimination because of their disability and their status as foreigners and refugees.

If left behind in refugee camp, a person with disability may be deprived of access to essential goods and services. Camps are typically not designed in accordance with standards of universal design and accessibility. As a result it can be difficult for people with disability to move around independently and access essential facilities such as toilets, showers, food distribution centres, education and healthcare facilities and the shelter itself may not be accessible.[47]

Stigma and discrimination against people with disability can lead to refugees and internally displaced persons with disability being denied access to essential services and supplies. This can be especially the case if resources are scarce, and other camp inhabitants or staff members decide that the available resources would be better expended upon people other than those with disability. This may also apply where refugees and internally displaced persons with disability are housed in more mainstream community settings, especially where such communities are struggling to cope with natural disaster and conflict.

Refugee women with disability have dual vulnerabilities of gender and disability and can face a nightmare of exploitation and neglect. In societies in which a woman's power is derived from her status as a mother and wife, the social position of women with disability becomes more precarious due to the perception that they are unsuitable for marriage.[48] The majority of the world's people living with disability live in rural areas where physical labour is often performed by women in the home and in the field. Women with disability are often seen as inefficient and therefore of 'inferior value'. Consequently, women's status is diminished by disability, leaving them even more vulnerable.[49]

People with disability have less ability to flee armed conflict or persecution. As a result they are often left behind when those around them flee, and may face difficulties accessing family tracing programs.

5.4 Refugees applying overseas

The Migration Act as it currently stands provides an exemption to the application of the Health Requirements to refugees and their migrating and non-migrating family members applying within Australia. PIAC and STARTTS submit this exemption should also be extended to refugees (humanitarian entrants) and

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46 Women's Commission for Refugee Women and Children, *Disabilities among refugees and conflict-affected situations* (2008) <http://www.womensrefugeecommission.org/programs/disabilities> at 21 October 2009.

47 Disabled People's International, *CRPD Guide # 40 'Refugees and Internally Displaced Persons with Disabilities'* (2009) <http://v1.dpi.org/lang-en/resources/details.php?page=950> at 21 October 2009.

48 Lina Anani, 'Refugees with Disabilities: A Human Rights Perspective' (2001) 19(2) *Refugee* 23.

49 Council of Canadians with Disabilities, Disabled Peoples' International and Manitoba League of Persons with Disabilities, *Disabled People and Foreign Policy: a call for Inclusion Brief to the Special Joint Committee reviewing Canadian Foreign Policy* (1994).

their migrating and non-migrating family members applying overseas under the humanitarian entrant program.

The application of the Health Requirement indirectly discriminates against refugees (humanitarian entrants) applying overseas in a number of ways:

- Unlike business migrants, refugees are unlikely to be able to demonstrate that they have the ability to mitigate potential costs associated with their disability (or the disability of a family member). Lack of formal education and work opportunities may make it difficult for them to demonstrate that they have the potential to provide economic and social benefits to the Australian community.

- It is inequitable to subject refugees applying overseas under the humanitarian entrant program to the same health criteria as voluntary migrants, particularly where this involves an economic 'cost-benefit' analysis. This is not to say that we do not believe that refugees and humanitarian entrants are not capable of integrating and making positive contributions to the Australian community. Many of STARTTS's clients and former clients have gone on to make significant contributions to the community. However, it is unfair and inequitable to expect them to demonstrate their potential to do this when they are applying for a visa.

- The reason for the refugee migrating to Australia is to flee persecution and has nothing to do with creating economic and social benefits for Australia. Those benefits while possibly substantial are secondary to the primary intent of the Refugee and Humanitarian Program. It is acknowledged that health tests are an important means of protecting public safety, but in the case of the refugee and humanitarian entrant any finding of a disease or condition should be immediately followed by relevant treatment and should not impact on the migration outcome. It is unfortunate the treatment of many illnesses are not provided overseas but this is mostly due to the nature of the refugee experience.

PIAC and STARTTS are strongly of the view that Australia's refugee applying under the Humanitarian Entrant Program should be based on protection requirements and not on perceptions of integration capacity. We note with deep concern the comments by the previous Immigration Minister, The Hon Kevin Andrews, about the alleged failure of African refugees to integrate. These comments were used to justify significant cuts in the intake numbers of refugees from Africa. We strongly oppose basing any refugee and humanitarian intake decision on unreliable information of this nature.

It is the view of PIAC and STARTTS that refugees and prospective humanitarian entrants should be accepted on the basis of need and compliance with Australia's international human rights obligations. The Health Requirement should not apply to refugees applying overseas. They should be required to submit to a health test, but should not be at risk of being refused a visa if they do not pass the Schedule 4, PIC 4005 and PIC 4007 health-testing requirements. Rather, if they fail the health test they should be required to undertake a course of medical treatment or supervision by a health authority.

PIAC and STARTTS note that some countries, for example, New Zealand, have a specific category within their quota system for refugees with disability or medical conditions. Australia should consider implementing a similar category so as to give priority to refugees with high health and social needs. This could be justified on the basis that disability substantially increases vulnerability in conflict-affected situations.

Recommendation:

12. *That refugees and humanitarian entrants applying overseas should not be subject to the Health Requirement in so far as if they do not pass the health testing they should be required to undertake medical treatment. There should be no risk of refusal if they do not pass the health tests.*
13. *That a special visa category be created for refugees with disability or medical conditions within the migration quota system.*

6. Conclusion

Australian migration law and policies as they currently stand discriminate against people with disability. There is little or no protection against arbitrary and unjustifiable decisions. People with disability are treated as a cost burden. In its worst application, children with disability are targeted because the cost-assessment process quantifies access to health and community services over a lifetime.

PIAC and STARTTS support a reformulation of the Health Requirement that allows the economic and social benefits of a person with disability becoming a member of the Australian community to be taken into account in the visa decision-making process. The current system, which focuses only on cost, is unjust and at odds with Australia's social inclusion policies and its obligation under the CRPD.

The reformulated Health Requirement must balance any consideration of safeguarding community resources and promoting social and economic sustainability with consideration of family and community ties, and productivity and employment prospects.

While an exemption to the Health Requirement currently exists for refugee applicants applying within Australian, PIAC and STARTTS propose that this exemption be extended to refugee applicants applying from overseas under the humanitarian entrant program.

This submission provides the Joint Standing Committee on Migration with ample evidence that the Health Requirement needs to be reformulated to comply with non-discrimination and the social model of disability that underpins the United Nations *Convention on the Rights of Persons with Disabilities*.

It is now time for the Australian Government to honour its commitments under that Convention and under the *Convention on the Rights of the Child* and remove the inconsistencies of migration law and policy in Australia with fundamental rights for people with disability.