Australian Federation of AIDS Organisations (AFAO)

Submission to the Joint Standing Committee on Migration

Inquiry into the Migration Treatment of Disability

4 November 2009

"*We are all sick because of AIDS - and we are all tested by this crisis. It is a test not only of our willingness to respond, but of our ability to look past the artificial divisions and debates that have often shaped that response. When you go to places like Africa and you see this problem up close, you realize that it's not a question of either treatment or prevention – or even what kind of prevention – it is all of the above. It is not an issue of either science or values – it is both. Yes, there must be more money spent on this disease. But there must also be a change in hearts and minds, in cultures and attitudes. Neither philanthropist nor scientist, neither government nor church, can solve this problem on their own - AIDS must be an all-hands-on-deck effort.*"

Barack Obama [World AIDS Day Speech, Lake Forest, CA, 12/1/06]

About AFAO

The Australian Federation of AIDS Organisations (AFAO) represents Australian HIV/AIDS community based organisations at a national level. Our membership includes State and Territory AIDS Councils, the Australian Injecting and Illicit Drug Users League, Scarlet Alliance (the national organisation representing sex workers) and the National Association of People Living with HIV/AIDS (NAPWA). AFAO's activities include the provision of HIV policy advice to the Commonwealth Government, advocating for our member organisations, developing and formulating policy on HIV/AIDS issues, and promotion of medical and social research into HIV/AIDS and its effects.

AFAO's perspective on this Inquiry

A review of the migration Health Requirements is long overdue, and AFAO applauds the Government for initiating this Inquiry.

Recent media interest in a case of a doctor being refused permanent residence because of his child's congenital disability has been predominantly sympathetic to the plight of the family involved[1]. However, reporting of cases involving migrants and refugees with HIV has generally been sensational and inaccurate – binding together negative stereotypes of refugees and people with HIV that can reappear from time to time.

For new residents who discover their HIV positive status as a result of applying for Australian residence, dealing with such stigmatisation is just one of many challenges associated with the diagnosis, especially for refugees. There is a real risk that recent media interest in the criminal convictions of African men for offences involving transmission of HIV may also feed into the demonisation of migrants and refugees with HIV[2]. The incidence of post-arrival HIV diagnoses among people from high prevalence countries illustrates the need for Government initiatives that respond to such media stereotyping, otherwise the effectiveness of strategies for such communities will be seriously undermined.

[1] See Catholic Bishop calls for review of immigration procedures in relation to people with disability (Australian Catholic Bishops Conference, Media Release, 31/10/08) and Beheaded after trying for asylum in Australia (Sydney Morning Herald, 31/10/08)

[2] A. Pearson and C. Newman, ' Making Monsters: heterosexuality, crime and race in recent Western media coverage of HIV" (2008) National centre in HIV Research

This review is an opportunity to reform over-arching policies fundamental to the treatment of people with disability under Australia's Migration, Refugee and Special Humanitarian Programs. AFAO believes that whether or not Australia's discrimination against people on the grounds of disability under migration law was ever justifiable, the time has come to remove discrimination on the grounds of disability from our migration program.

This submission relates primarily to policies affecting people with disability in respect of permanent visa applications – for both migrant and humanitarian applicants. Although the Terms of Reference do not specifically refer to Australia's refugee and special humanitarian programs, given that the Health Requirement is currently applied to applicants for permanent protection as well as to prospective migrants, our submission covers the application of the Health Requirement to refugee and humanitarian applicants as well. AFAO's submissions regarding humanitarian applicants and refugees are made in the strongest possible terms.

For AFAO, the central issues for the Inquiry in respect of people with HIV are:

- whether Australia's ratification of the **United Nations Convention on the Rights of Persons with Disability (UN CRPD)** must drive reform of Australia's migration legislation, policies and guidelines in respect of the Health Requirement generally, and particularly in respect of its application to people found to be HIV positive;

- whether **future costs** likely to be associated with a person's HIV positive status may be realistically estimated, and whether the Health Requirement can be applied fairly and equitably in respect of HIV;

- whether a **cost/contribution test** would be a viable alternative to the current Health Requirement for migrants and refugees with HIV;

- whether the exemption of the Migration Act from the **Disability Discrimination Act** is no longer supportable;

- **settlement issues** faced by migrants and refugees with HIV, especially for people from countries with high prevalence of HIV/AIDS;

- **cross-portfolio and Social Inclusion issues** affecting the capacity of migrants and refugees with HIV to settle in the Australian community and access appropriate **health care and community services**;

- whether there should be **no Health Requirement for refugees, and whether,** given the nature of Australia's migration program, the Health Requirement should only apply to certain visa sub-classes.

Regarding the status of HIV as a disability, we note that Article 1 of the UN CRPD utilises a social model of disability, defining persons with disability to 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. A person living with HIV clearly has a disability as defined under the CRPD, as well as under the Disability Discrimination Act 1992.

United Nations Convention on the Rights of Persons with Disabilities (UN CRPD)

Siracusa Principles

The UN Commission on Human Rights' *Siracusa Principles* stipulate that any restriction on human rights must be prescribed by law and deemed necessary to achieve a legitimate goal. The means used to achieve the goal must be as least restrictive as possible.[3] Australia, as a sovereign nation, may impose visa and immigration restrictions provided these do not infringe on our international human rights obligations, and restrictions constituting discrimination (direct or indirect) may be justified if failure to apply discriminatory policies would result in excessive economic or social costs. This was the Australian Government's justification for exempting the Migration Act from the Disability Discrimination Act 1992 when it was introduced, and constitutes the stated rationale for retaining that exemption (discussed below).

Given the Government's commitment to meeting Australia's United Nations Charter and Convention responsibilities, and the global effort in recent years to recognise and further the human rights of people with disability, the ongoing validity of this rationale must be re-examined.

The Government's commitment to the rights of people with disability was given effect with its ratification of the UN CRPD on 17 July 2008, and Australia became a Party the Optional Protocol on 21 August 2009. The Government acknowledges that ratification of the CRPD represents a substantial commitment, as espoused on the Attorney-General Department's web-site:

> " ... Australia has joined other countries around the world in a global effort to promote the equal and active participation of all people with disability". [4]

The strength of this commitment was diluted somewhat by the Government's submission of an Interpretive Declaration on its ratification of the CRPD. This included the statement that*:*

> "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."[5]

The Government is thus not merely committed to meeting its responsibilities to people with disability in terms of its domestic laws, it is committed to "a global effort to promote" the equality of people with disability internationally. This commitment will

[3] "Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights" (1984), UN Document E/ CN.4/1984/4

[4] Australian Government Attorney-General's Department, 'United Nations Convention on the Rights of Persons with Disabilities' accessed 22 October 2009 <http://www.ag.gov.au/www/agd/agd.nsf/Page/Humanrightsandanti-discrimination_UnitedNationsConventionontheRightsofPersonswithDisabilities

[5] Australia's Declaration upon ratification of the United Nations Convention on the Rights of Persons with Disabilities (adopted 13 December 2006, entered into force 3 May 2008) A/RES/61/106 (CRPD Declaration)

prove to be without foundation unless Australia's own migration and refugee programs are reformed such that they are consistent with the global rights of people with disability which Australia has affirmed. To put it bluntly, the pot can't call the kettle black.

In AFAO's view, Australia's legislation and procedural policies that seek to limit the intake of people with disability do not satisfy the *Siracusa Principles*; they are too restrictive, are not applied equitably and do not meet the stated goals. We also propose that in terms of the Interpretive Declaration, Australia's Health Requirement can no longer be said to be based on "legitimate, objective and reasonable" criteria.

Australian Legislation and policy affecting migrant and refugee intake

Australia's Disability Discrimination Act exemption

We understand that the rationale for exempting Australia's migration legislation from the Disability Discrimination Act 1992, was that it was deemed necessary in order to retain the Health Requirement, and so allow certain sub-classes of permanent and temporary visa applications to be refused if the main applicant, or a member of their family included in the application, has a "disease or condition" which constitutes a "disability" under the Disability Discrimination Act. The final report of the 2004 Productivity Commission Review of the Disability Discrimination Act 1992 endorsed this view, noting that:

> "The criteria for Australia's various visa entry categories are designed to address a wide range of health, labour market, social welfare, financial and other government policy considerations. They are, by nature and design, discriminatory. Some of these criteria may indirectly discriminate against some people with disabilities, in that they will be less likely to meet the criteria than people with no disability. However, the Australian Government considers these entry criteria necessary for the health and welfare of the Australian community. Their exemption from the DDA [s.52(a)] is therefore appropriate."[6]

An issue of fundamental importance for this Review is whether the *Migration Act 1958* should continue to be exempt from the *Disability Discrimination Act 1992*. AFAO's view is that Australia cannot meet its stated domestic responsibilities and international commitments to prevent discrimination on the grounds of disability while the exemption remains in place.

Mandatory HIV testing

Although the fact that being HIV positive cannot in itself disqualify a person from any visa sub-class, a test for HIV is a mandatory part of the final health check for all prospective migrants, and to off-shore applicants for refugee and humanitarian visas.

On-shore applicants for protection visas must undergo a health check but the Health Requirement does not apply. Further, if an on-shore applicant for a protection visa is found to have a disease or condition that poses a threat to public health, they will be

[6] Productivity Commission, *Review of the Disability Discrimination Act 1992*, April 2004, p348

granted a visa but will be required to undergo any necessary treatment to control the risk.

Except for on-shore refugees, children under 15 years are compulsorily tested for HIV as part of the health check, where they are to be adopted by an Australian resident, where they have a history of blood transfusions, or where it is clinically indicated.

We understand that where an HIV test is required, the blood test is taken as part of the Health Requirement examination conducted by Health Services Australia for on-shore non-refugee applicants, and by an approved "panel doctor", as part of the final health check, for off-shore applicants. The next step is for the Medical Officer of the Commonwealth (MOC) to prepare a report estimating future costs associated with the person's condition. DIAC then determines whether the person meets the Health Requirement.

The Health Requirement as it applies to people with HIV

The only disease or condition which currently automatically results in the refusal of a visa for migrant and off-shore refugee applicants is active TB, by virtue of the Public interest Criteria of the Migration Regulations. Rejection of applications for people with active TB is made under the Public Health Criteria of the Migration Regulations. Applicants with other diseases or conditions (including diseases and conditions which are disabilities, such as HIV), are potentially eligible for most visa sub-classes, subject to either meeting the Health Requirement or having the Health Requirement waived.

We understand that perceived risk to public health is not generally an issue regarding HIV (discussed further below), although health care workers applying for temporary visas can, in limited situations, be deemed by DIAC to be a public health risk. For migrant and off-shore humanitarian and refugee applicants with HIV (and for the other family members on a visa application), the primary issue is the estimated future cost of antiretroviral medication and health care.

A person with HIV can theoretically meet the Health Requirement as is the case for any disability, unless the Health Requirement is waived (discussed below) they will be refused a visa if:

> "… provision of the health care or services relating to the disease or condition would be likely to:
>
> (a) result in a significant cost to the Australian community in the arrears of health care or community services; or
>
> (b) prejudice either 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." [7]

The cost/prejudice assessment

Until recently, the estimate of likely future costs associated with HIV was such that very few people with HIV passed the Health Requirement. The future costs associated with HIV were regarded as necessarily "significant" and/or it was

[7] Migration regulations, Schedule 4 – Public Interest Criteria and Related Provisions (4005-07 of Schedule 4)

considered that the need for health care and community services would necessarily "prejudice" Australians' access to these services. Although the Health Requirement was at times waived (discussed below), the MOC applied the Health Requirement such that permanent visa applications were generally refused to applicants found to be HIV positive, due to the weight given in the standard costing to the future cost of medications potentially to be borne by the Pharmaceutical Benefits Scheme.

In the light of several appeals[8] highlighting inadequacies in these assessments, the MOC is now required to make an assessment in respect of the individual applicant's likely future costs. Current policy regarding the assessment of future cost in relation to HIV/AIDS is set out in the Notes for Guidance for Medical Officers[9] (the Notes), which stipulate that the assessment must include a lifetime estimate of the cost of medication and health-care, including hospitalisations. We understand that such costing was routinely costed at $250,000, but the Notes now provide detailed guidelines for costings, including for pregnant women and children.

We are unaware whether this revised policy has resulted in a significant increase in the number of visas granted to people with HIV. However, even if there has been a recent increase in decisions that people with HIV meet the Health Requirement, we understand that the various formulae for estimating costs still precludes most people with HIV from obtaining permanent visas unless they are able to secure a waiver.

Waiver

For some visa sub-classes, and the Health Requirement may be waived by the Department of Immigration and Citizenship (DIAC) on "compassionate grounds". The Health requirement is waived where granting of the visa would be unlikely to result in:

- undue prejudice to the access to health care or community services of any Australian citizen or permanent resident; or
- undue cost to the Australian community.

Waiver cannot be exercised where the visa applicant is assessed as representing a risk to public health or safety in Australia.

We understand that factors taken into account when determining whether prejudice/cost would be "undue" may include potential hardship if the applicant is returned to their country of origin, the impact on their relationships in Australia, and their state of health.

Does application of the Health Requirement discriminate against people with HIV?

In 2007 the Australian National Audit Office (ANAO) reported on its assessment of the effectiveness of DIAC's implementation of the Health Requirement in terms of the requirements of section 60 of the Migration Act 1958, the health criteria set out in the Migration Regulations 1994, and under DIAC's own guidelines. The ANAO found that

[8] These appeals notably include the cases of Seligman, Robinson and Applicant Y which were directed to the validity of the MOC report. These decisions clarified that the MOC report must give an estimate of costs based on a hypothetical person with the same state or form of the condition as the applicant. Furthermore, the Bui case clarified that considerations in the Department's decision regarding the waiver should take into account compelling and compassionate factors including social and cultural contributions of the applicant and must not be limited to an economic calculus of the costs/benefits.

[9] Notes for Guidance for Medical Officers. of the Commonwealth of Australia: Financial implications and consideration of prejudice to access for services associated with infection with human immunodeficiency virus and acquired immune deficiency syndrome (HIV/AIDS), 9 July 2008

DIAC complied with the intent of the Migration Act and health criteria but found that DIAC's administration was deficient. One effect of these deficiencies was that,

> "DIAC could not determine the effectiveness of its implementation of the health requirement in protecting Australia from public health threats, containing health costs and safeguarding access of Australians to health services in short supply – important DIAC objectives under the health requirement."[10]

AFAO contends that these general deficiencies identified by the ANAO undermine the whole basis of the Health Requirement and its rationale. We propose that the fundamental nature of these deficiencies is such that it cannot be said that the Health Requirement is based on "legitimate, objective and reasonable criteria", according to Australia's Interpretive Declaration.[11]

DIAC faces an impossible task attributing potential future costs for an individual in respect of a condition such as HIV, especially now that the effectiveness of antiretrovirals means enhanced quality of life, general health and life expectancy for people with HIV. It seems that this difficulty has resulted in what is still effectively a blanket policy that migrants and refugees with HIV fail the Health Requirement in the first instance (i.e., before any waiver consideration), on the grounds that the cost borne by the Pharmaceutical Benefits Scheme in meeting the cost of antiretrovirals would, pursuant to the Health Requirement, "result in a "significant" cost to the community" or for waiver, whether that cost would be "undue" (underlining ours).

We propose that as application of Health Requirement generally results in the refusal of a permanent visa to a person with HIV in the first instance, this contravenes Article 5(1) of the CRPD[12], whereby all persons are equal before and under the law, and entitled, without any discrimination, to the equal protection and equal benefit of the law. AFAO's view is that applying the Health Requirement to people with disability contravenes our obligations under the Convention. The policy to test all permanent visa applicants for HIV and to generally refuse visas to people with HIV, adds a second layer of discrimination. We propose that if not for the exemption of migration law from the *Disability Discrimination Act 1992*, this targeted discrimination would be unlawful under domestic law. As the situation now stands, application of this policy is an abrogation of our human rights commitments under international law.

The 2007 ANAO report also examined DIAC's ability to ensure consistency in its waiver decisions. Its key findings were that:

> "Due to limitations in DIAC's health waiver process and tracking of decisions, DIAC was not able to show whether it had considered the health waiver for all eligible visa applicants, or accurately report the number of health waivers granted. Due to incomplete records, data on health conditions for waivers was also unreliable. Furthermore, DIAC could be underestimating the annual cost in exercising health waivers because of its low compliance in reporting of health waiver decisions."[13]

[10] Administration of the Health Requirement of the Migration Act 1958, Australian National Audit Office, Commonwealth of Australia 2007, p. 18
[11] CRPD Declaration (n. 5)
[12] United Nations Convention on the Rights of Persons with Disabilities (adopted 13 December 2006, entered into force 3 May 2008) A/RES/61/106 art. 5(1)
[13] ANAO report – op cit

Although DIAC may have improved the consistency of its waiver decisions since the ANAO investigation, we propose that given the imprecise nature of the Health Requirement itself, with the requirement to estimate future costs to the health care system associated with a person's disability, it is unlikely that either Health Requirement or waiver decisions could ever be consistently applied. In this respect the Interpretive Declaration is relevant, the Government having indicated that any requirements restricting the migration of people with disability would be "based on legitimate, objective and reasonable criteria."

We propose that while the Health Requirement and waiver provisions may have been formulated with the intention of creating "legitimate, objective and reasonable criteria", applying them consistently or fairly has proven to be impossible. As such, Australia is failing to meet the terms of its Interpretive Declaration.

Public health risk assessment

The 2007 ANAO report on the Administration of the Health Requirement [14] referred to potential issues with regard to HIV and hepatitis C in terms of DIAC's capacity to identify potential public health risks posed by migrants from high-prevalence countries.

It is important to note that current scientific knowledge and public health best practice mean that HIV does not represent a direct threat to public health given the manner in which it is transmitted. This is reflected in the United Nations International Guidelines on HIV/AIDS and Human Rights, which state that:

> "There is no public health rationale for restricting liberty of movement or choice of residence on the grounds of HIV status. […] Therefore, any restrictions on these rights based on suspected or real HIV status alone, including HIV screening of international travellers, are discriminatory and cannot be justified by public health concerns."[15]

Apart from the fact that restricting the migration of people with HIV on public health grounds would contravene the UN guidelines, such a policy would be counterproductive to efforts to de-stigmatise HIV. A 2008 International Migration Organisation study found that exclusion of migrants and refugees from countries with high HIV prevalence served to compound the stigmatisation and discrimination against people living with HIV.[16]

AFAO doubts that introducing such restrictions is under consideration by the Government. However, the fact that the ANAO saw fit to refer to potential public health risks posed by migrants from high prevalence countries in the context of its review of the administration of the Health Requirement, points to issues regarding perceptions of the nature of HIV and its transmission. There needs to be clear delineation of what can and cannot constitute a public health risk, particularly given widespread misconceptions in the community, fed by the media at times, regarding migration and refugee policies.

[14] Ibid
[15] UNHCR and UNAIDS, 'International Guidelines on HIV/AIDS and Human Rights', (2006) HR/PUB/06/9, available at: <http://www.unhcr.org/refworld/docid/4694a4a92.html> para 127.
[16] International Migration Organisation, 'Comparative Study of the Laws for Legal Immigration in the 27 EU Member States' (2008) <http://www.iom.int/jahia/webdav/shared/shared/mainsite/law/legal_immigration_en.pdf>, p. 44.

Comparable countries' health requirement policies re migrants and refugees

Other countries' health requirement policies regarding migrants and refugees vary from strict restrictions to no restrictions whatsoever. For example, China and the United Sates (at least until January 2010 – see below) are among 13 countries that ban people who are HIV positive from entering their borders,[17] while most European countries provide no restrictions on people living with HIV.[18] Canada and New Zealand, on the other hand, have similar restrictions to Australia's Health Requirement policy.

In Canada, applicants intending to stay in Canada for more than six months are required to undergo a medical examination, including HIV testing. A positive test result is grounds for refusal of permission to immigrate. If all other criteria are satisfied, waivers are given to HIV positive refugees, to sponsored spouses or common law partners of Canadian citizens and permanent residents, and to children of Canadian citizens or permanent residents.

In New Zealand, permanent residency applicants must undergo HIV testing. Waivers of New Zealand's health requirement may be available to HIV positive refugees and family members of New Zealand citizens and residents. However, unlike Canada or Australia, a maximum quota of 20 HIV positive people will be accepted as refugees in any one year.

US HIV ban to be lifted

Section 212(a)(1)(A)(i) of the United States' Immigration and Nationality Act states that any foreign national with a "communicable disease of public health significance" is "inadmissible." The U.S. has to date designated HIV as a communicable disease of public health significance. Therefore, infection with HIV renders inadmissible (unless eligible for a waiver) any alien who is likely at any time to become a public charge. Inadmissibility denies the applicant entry into the country.[19]

On 29 June 2009, the U.S. Department of Health and Human Services published a proposed regulation which will remove HIV from its list of "communicable diseases of public health significance", thereby lifting the HIV ban. [20] President Obama announced the finalisation of the process on 1 November 2009, and declared that the ban would be fully lifted by early 2010. We understand this to mean that that mandatory testing for HIV will no longer be required, and people with HIV will be allowed to migrate to the U.S. if they meet all other conditions of admissibility.

The rationale behind the proposed U.S. reforms is that while HIV remains a serious health condition, maintaining HIV infection on the list of communicable diseases is no longer valid based on current scientific knowledge and public health best practices. It is interesting to note that the reforms are being presented as a means of reducing the stigma and discrimination associated with HIV. Most importantly, the reforms will

[17] International AIDS Society, 'Banning Entry of People Living with HIV/AIDS' (2007) accessed on 22 October 2009 <http://www.iasociety.org/Web/WebContent/File/ias_policy%20paper_07%2012%2007.pdf>.
[18] Deutsche AIDS-Hilfe e.V., 'Quick Reference Guide 2008/2009: Entry and residence regulations for people living with HIV and AIDS (2008) 8th edition (Berlin) pp. 12-44.
[19] Immigration Equality, 'HIV Ban: the End Is in Sight' accessed 21 October 2009 <http://immigrationequality.org/template.php?pageid=5>.
[20] Associated Press – Fri Oct 30

remove a government-imposed barrier that does not appear to provide a significant public health benefit and is at odds with human rights considerations. [21]

Proposals for reform of the Health Requirement

Refugees

AFAO questions why the legislation and policies making up Australia's Migration, Humanitarian and Refugee Programs recognise the absolute unacceptability of discriminating against people on the grounds of ethnicity or race but discrimination of the grounds of disability remains firmly in place.

We propose that the fact that the Health Requirement is applied in respect of off-shore refugee applicants is absolutely unsupportable, and contrary to the Government's stated policy that consideration of a claim for Permanent Protection should involve no issues other than the person's need for protection. AFAO is strongly of the view that a person's disability is irrelevant to their claim for protection. The fact that a person with HIV may require antiretroviral medications, hospitalisation and access to community programs is irrelevant to the context of their need for asylum and resettlement, whether their application is lodged off-shore or on-shore.

Apart from the fact that maintaining refugee intake policies that discriminate against refugees with disability is contrary to the Government's stated commitment to our international human rights commitments, it is important to note the effect of current policies on those who are refused permanent protection due to diagnosis with HIV.

We understand that there are generally minimal health-care and support services available in refugee camps for people who discover that they have HIV as a result of testing associated with the Australian Health Requirement, and that the UNHCR has raised its concerns regarding these issues with the Government. Off-shore refugee applicants who are refused Australian residence on the grounds of their HIV status are effectively left in the lurch – remaining in camps with the knowledge that they are HIV positive but with no or limited access to appropriate counselling, including pre-test, post-test and diagnosis counselling. Given this context, the limited availability of waiver for off-shore humanitarian applicants is unconscionable, and the policy rationale for treating on-shore applicants for Permanent Protection more favourably is unfathomable.

The issues faced by off-shore applicants are compounded for a person affected by the "one fails, all fail" policy for families. Knowledge that their own HIV positive status means that all of their family will be refused protection by Australia can place an enormous burden on the person diagnosed with HIV, in terms of guilt and shame, and in terms of the reaction of the rest of their family – if they disclose the diagnosis. These issues are of particular concern for refugees, where family members deliberately excluded from a permanent protection application can be left behind in situations made more vulnerable by the loss of family support. Tragically, the UNHCR advises that some people diagnosed with HIV have committed suicide so as to enhance their family's prospects of permanent protection.

We propose that any HIV testing of an off-shore applicant as part of the Australian Health Requirement test prior to approving their permanent visa should be purely

[21] United State's of America's Department of Health and Human Services' Federal Register /Vol. 74, No. 126 /Thursday, July 2, 2009 / Proposed Rules, <http://edocket.access.gpo.gov/2009/pdf/E9-15814.pdf>

voluntary. If there is to be mandatory testing of refugees, the test should be after permanent protection is granted, and only once the person has arrived in Australia – thereby effectively treating off-shore humanitarian and refugee applicants the same as on-shore applicants.

Viability of a cost/contribution test for individual applicants with disability

Given the Terms of Reference of the Inquiry, it is clear that the Government is considering replacing the cost/prejudice test with a test which includes an assessment of the economic and social contribution that a potential resident, and their family, would make if granted residence. A new Health Requirement is apparently envisaged which would attempt to balance these economic and social benefits against any cost associated with the applicant's (or a member of their family's) disability. The Inquiry seeks submissions on options for "properly" assessing the likely economic and social contributions a potential migrant with a disability and their family, would make.

For people with HIV, this would mean that the issues outlined above regarding ascribing costs of treatment and care in respect of an individual with HIV, would be carried over.

Formulating a cost/benefit test regarding HIV which genuinely assessed an individual's circumstances would need to involve complex actuarial projections taking into account the person's age, co-morbidities, past HIV treatment and adherence, potential changes in treatment costs (especially regarding the cost of antiretrovirals), cultural issues (including health literacy), family situation, and their employment prospects.

Unfortunately, greater the focus on individual factors such as these would mean that an asylum seeker with HIV who has been displaced for some time would generally be disadvantaged – being less likely to have had an early diagnosis and less likely to be asymptomatic than migration applicants. A skilled migration applicant with HIV from a developed country, who was diagnosed early and has had access to optimal antiretroviral treatment, is more likely to have lower future costs – and is also more likely to be assessed as potentially making significant economic contributions. They are also likely to be able to provide evidence that will assist in securing a waiver.

Where a person with HIV is either a member of a family seeking residence, or seeking to join family in Australia, a benefit test would also need to take into account the attributes of each member of the family and their role within the family, so as to incorporate a proper assessment of the potential benefits to society of keeping the family together. (AFAO has had the opportunity to read the submission to the Inquiry made by Professor Ron McCallum AO and Professor Mary Crock. The submission provides an analysis of the minimum components of a test which seeks to balance costs and benefits.)

Due to the effectiveness of antiretroviral medications, many migrants and refugees with HIV now have long and productive working lives, making significant tax and other economic contributions, and potentially self-funding retirement and medical insurance. These contributions, tangible or otherwise, would need to be balanced against potential medical and health care costs, and also against less tangible benefits migrants make to community and cultural life. For people applying as carers, costings would need to take into account the significant economic contribution made by carers, and health care costs potentially saved by Commonwealth and

State/Territory service providers. Similarly, potential care roles met by people applying for residence as partners, or under the Family Reunion Program would need to be factored into the analysis, as would the effect of family reunions in the context of the Government's Social Inclusion Agenda.

Selectivity of migration program

Current policies regarding people with HIV appear to give no consideration to the nature of the visa subclass the person is applying for until the issue of whether the Health Requirement should be waived comes into play, and then waiver is all but inevitable for certain categories of people. This not only makes the system costly, but also gives grounds for criticisms such as those made by the ANAO.

AFAO proposes that given the nature of Australia's Migration Program with its highly defined sub-classes for which eligibility criteria include cost/benefit considerations, there is no need for a prescriptive over-arching Health Requirement, and that the Public Health Criteria restricting the entry of people with contagious diseases (or conditions that otherwise pose a threat to public health) is sufficient. Selectivity has been built into Australia's migration and refugee programs - with a plethora of visa sub-classes with complex eligibility criteria focussing on the applicant's business acumen and wealth, or their professional skills, or the needs of Australian family for family reunion, or whether they are joining a partner or adoptive parent, or whether they will meet the personal care needs of an Australian.

We propose that the applying the Health Requirement to a person who is otherwise eligible for a particular sub-class of visa runs counter to the policy rationale for creating the complex system of visa sub-classes. Applying the Health Requirement in respect of a person with HIV after the long process of establishing their eligibility for a particular visa is poor public policy. It is also contrary to the principles if legitimacy, objectivity and reasonableness set out in Australia's Interpretive Declaration.

Obligations to source countries

If Australia is to continue compulsorily testing prospective migrants for HIV as part of the application process, we propose that Australia has a moral responsibility to people found to be HIV positive who are refused a visa. We must acknowledge the flow-on effects of our policy to test for HIV. Where there are no counselling and treatment programs in place, our international aid programs need to address such unmet need in advising those countries regarding the development of best practice HIV community and health programs. Australia is in no position to chest-beat regarding the need to recognise and respect the human rights of people with HIV in those countries, when our migration policies effectively discriminate against people from those countries who are diagnosed with HIV in processing their application to migrate here.

Temporary visas

While the primary focus of this submission is the impact of Health Requirement policies on potential migrants and refugees, we propose that the application of the Health Requirement in respect of temporary visas can ultimately be counter-productive to the effectiveness of Australia's domestic and international HIV/AIDS response.

The most basic of these issues is the fact that people on Bridging Visas are ineligible for Medicare, the PBS and Social Security income support while they await the determination of their substantive claim. Without Medicare, PBS subsidised antiretrovirals and Pension Concessions, access to proper medical treatment and support services can be severely affected. Whether or not a person with a Bridging Visa proceeds to permanent residence, such policies compromise the effectiveness of cross-portfolio policies targeting HIV/AIDS in culturally and linguistically diverse (CALD) communities.

With regard to our international commitments, we understand that health check requirements for applicants for temporary visas generally depend on the applicant's proposed length of stay in Australia, the purpose of the proposed stay, the prevalence of TB in their country of origin, and on any other factors (discretionary). HIV tests may be required if the applicant intends to work as, or study to become, a doctor, nurse, dentist or paramedic in Australia.[22]

We propose that applying the Health Requirement in respect of students seeking temporary visas can be counter-productive to Australia's international development commitments. Under the Australian Agency for International Development's Development Scholarship Program ", overseas students can obtain Australian tertiary qualifications at participating Australian higher education institutions and technical colleges."[1] This equips scholars from developing countries with the skills and knowledge to drive change and achieve sustainable development outcomes in their own country. If a Student Visa applicant from a developing country is required to be tested for HIV as part of their health check, and they are found to be positive, they will generally fail the Health Requirement - with no waiver available for Student Visas.

Settlement issues

Need for targeted settlement programs

Researchers have identified a number of common stressors for people with HIV from CALD communities. [23] [24] These may include:

- the need to simultaneously deal with an HIV positive diagnosis and the rejection of the claim for permanent residence, and then await a waiver decision;
- limited access to treatment, Medicare, Social Security income support, and care services, depending on the visa-subclass;
- delayed diagnosis of HIV. Between 1998 and 2007, between 60% and 80% of people from Africa, the Middle East, Asia, South America and Europe (excluding UK) who were diagnosed with AIDS had a late HIV diagnosis, compared to around 40% of Australian born diagnoses;[25]

[22] Department of Immigration and Multicultural Affairs, Media factsheet 22- The Health Requirement, www.immi.gov.au

[23] H. Korner, M. Petrohilos, D. Madeddu, 'Monograph 4: Living with HIV and Cultural Diversity in Sydney' (2005) National Centre in HIV Social Research (NCHSR).

[24] Annual Surveillance Report 2008 National Centre for HIV Epidemiology and Clinical Research (NHECR) figure 45, p.30.

[25] Annual Surveillance Report 2008 National Centre for HIV Epidemiology and Clinical Research (NHECR) figure 45, p.30.

- additional barriers to accessing health care services for HIV positive women from some CALD communities, due to power relationships within the family, e.g., a controlling husband refusing to allow engagement with services;
- HIV-positive people with limited English experiencing difficulty negotiating various health and support services; and
- due to the stigma associated with HIV in their country of origin, people with HIV from some CALD communities can fear that their community will discriminate against them. This means that a person with HIV may not trust service providers or interpreters from their community.

All of these issues are relevant to people with HIV who were born in high prevalence countries. Since systematic collection of data about country of birth began in 2002, the highest estimated incidence of HIV (i.e., the number of diagnoses per 100,000 of the population group in terms of region of birth), has consistently been among people from sub-Saharan Africa.[26] These issues are also typical of the kinds of difficulties people from high prevalence countries in CALD communities face in other western countries. [27] [28] [29]

The importance of developing appropriate, well-targeted settlement and ongoing community services for new migrants and refugees with HIV is recognised under the National HIV/AIDS Strategy (current and pending), especially given that late presentations for testing mean that the decline in HIV and AIDS diagnoses in people born overseas has not matched the decline in the Australia-born population. [30] Community health services need to be better resourced so as to provide effective ethno-specific HIV counselling, treatment and education targeted to CALD community needs, having regard to the mine-field of treatment, interpersonal and disclosure issues for a person recently diagnosed with HIV settling in a new country.

There are particular disclosure issues for women from high prevalence countries. Cultural norms of high-prevalence countries often require careful, ethno-specific case management due to the risk for many of domestic violence following disclosure to their partner and/or other family members. HIV education programs for migrant and refugee women from high prevalence communities who are planning children need to be better resourced.

Settlement programs also need to provide sexual health, education and support programs for HIV negative migrants and refugees from high prevalence countries, e.g., for people from Thailand, Cambodia and sub-Saharan Africa. Given the absence or inadequacy of effective community health education programs in such high prevalence countries, specific programs for women and men (whether they are single or partnered, and whatever the person's stated sexual orientation), need to be in place as part of the early stage of settlement programs. These programs also need to focus on de-stigmatisation of HIV. This is especially so for DIAC funded Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) programs for refugees who have survived torture or other traumatising events, only to be then diagnosed with HIV.

[26] Annual Surveillance Report 2009, NCHECR, Table 1.1.5, p.37
[27] M. Duckett, 'Migrants right to Health' (2001) UNAIDS
[28] Avert, 'HIV and AIDS amongst Africans in the UK' accessed 21 October 2009 <http://www.avert.org/aids-africans-uk.htm>
[29] A. Prost, J. Elford, J. Imrie, et. al. 'Social, Behavioural, and Intervention Research among People of sub-Saharan African Origin Living with HIV in the UK and Europe: Literature Review and Recommendations for Intervention' (2008) 12 (2) AIDS Behaviour pp. 170 – 194
[30] 2009 NCHCR

We also note research that provides evidence of the potentially negative effects of requiring HIV testing as part of the Health Requirement. In a recent survey among four Australian CALD communities (Thai, Cambodian, Sudanese and Ethiopian), participants reported very low levels of prior testing for HIV, even for those with permanent residence. This means that the testing for HIV in the context of the Health Requirement has in no way contributed to their health literacy, and an opportunity to educate the person regarding HIV has been lost.[31]

The Immigration Rights and Advice Centre's (IARC's) experience is similar. In its submission to this Inquiry, which we have had the opportunity to read, IARC notes that in its experience many of their clients are bewildered by the immigration process. When attending for health checks, many have no knowledge that they are going to be tested for HIV and they complete the process having no idea that their blood is be tested for HIV. The psychological effect of a positive result in this situation is inevitably devastating and as acknowledged by the UNHCR, the flow-on effects can be tragic.

Need for reform of social security waiting periods

If settlement programs are to be at all meaningful for migrants with disability, there is a pressing need to reform social security legislation and policies regarding residential waiting periods for income support payments.

Refugees are exempt from social security residential qualification criteria and waiting periods. If a refugee is granted Disability Support Pension (DSP), they receive a Pension Concession Card immediately, and are thereby able to access a range of disability services. If granted another income support payment they will receive a Health Care Card, and if they are not entitled to a Social Security payment due to income, they will be entitled to a HCC if their income is low. These policies are in acknowledgement of the more complex settlement issues faced by refugees.

We propose that there is a need to recognise and similarly respond to the settlement issues faced by migrants with disability.

For migrants, a ten year residential qualifying period generally applies for DSP and therefore for the Pension Concession Card. There is no waiting period if the person's incapacity to work due to their disability arose since arrival in Australia, but this is notoriously difficult to establish. Establishing pension entitlement may take lengthy appeals involving active case management on the part of community agencies and advocacy organisations.

AFAO notes the National Ethnic Disability Alliance's May 2009 submission to the Review of the Tax and Transfer System, in which it argues that the DSP qualifying period is discriminatory, and can result in inhuman and degrading treatment under article 25 of the UN CRPD.[32] AFAO supports NEDA's call for the abolition of the ten year qualifying residence period for DSP.

Rather than seeking pension, the more common situation for new migrants is the need for short-term social security assistance in order that they and their family can

[31] This discrepancy is alluded to in the discussion of the study (p. 16).carried out by NCHSR/MHAHS - "CALD Periodic Survey" available at http://nchsr.arts.unsw.edu.au/publications/ (P. 10)
[32] Migrants with Disability and the 10 Year Qualifying Residence Period for the Disability Support Pension, May 2009, National Ethnic Disability Alliance.

establish a home, engage with settlement services (if required) and commence job-seeking. Although a new migrant may potentially qualify for Newstart Allowance, Youth Allowance or Parenting Payment, for example, these payments are subject a two year newly arrived resident's waiting period (NARWP), as is the Health Care Card. This means that although the person may qualify for one of these payments and although they may be without means of support and in hardship, payment cannot be made until they have resided in and been physically resident in Australia for at least two years.

The only income support payment that may be payable within the two year NARWP is Special Benefit. However, the legislation prescribes that payment may only be made if the person is in "severe financial hardship … for reasons beyond (their) control". Policy and case law interpretation of this proviso means that a person whose inability to self-support is considered to be related to disability which existed prior to the person taking up residence, is refused Special Benefit – however dire their personal and health situation. They will also be refused a Health Care Card, and thereby ineligible for concessional rate anti-retroviral medications under the PBS. Although these costs can be met by state/territory departments and agencies, there is a risk that the person will instead not adhere to treatment. This is neither in the person's interest, or the community's. It also makes a nonsense of the rationale for the Health Requirement and waiver policies - the Health requirement may have been waived for the migrant on compassionate grounds; but they are denied means of support, ready access to treatment and in most states and territories, public housing. These flow-on effects are glaringly counter-productive to effective settlement of a person with disability.

In AFAO's view the fact that a destitute migrant with physical or psychiatric disability can be denied income support for up to two years is unconscionable and completely contrary to the principles underlying the Government's Social Inclusion Agenda. There is a need for cross-portfolio reform of policies that are counter-productive to migrants and refugee settlement policies.

Reform

For the reasons outlined, we propose that the Health Requirement be withdrawn. AFAO acknowledges that costs would flow from this reform, but this would be partly balanced by administrative savings.

Most importantly, we must also emphasise that although abolishing the Health Requirement would result in a larger number of people with HIV being accepted for permanent residence, the number would be very small.

In 2007-2008 the number of permanent visa holders taking up residence in Australia was 205,940 and a total of 1,532 temporary and permanent visa applicants were refused a visa on health grounds. Of these 1532 refusals, only 244 were on the grounds of applicants failing the Health Requirement on cost/prejudice grounds, and of these 244 refusals, only 71 were on the grounds of some form of disability.[33]

AFAO agrees with the National Ethnic Disability Alliance that the reform of Australian migration and social security laws must form part of the Government's

[33] Department of Immigration and Citizenship, 'Immigration Update: 2007-2008', p.8.

implementation plan for the UN CRPD[34]. There would be financial outlays flowing from such reform, but these must be balanced against the potential financial and social contribution which would be made by the relatively small number of people each year who would otherwise be refused residence or entry.

AFAO is firmly of the view that whatever reforms result from this Inquiry, off-shore applicants for protection and humanitarian visas should no longer be denied visas on the grounds of ill-health or disability.

For migrants, we propose that Australia's complex and targeted migration program, with its wide range of visa sub-classes, constitutes a fair and reasonable means of selecting migrants on the basis of potential economic and social contribution. The Health Requirement represents an administratively clumsy second tier that results in Australia contravening its stated commitments to the rights of people with disability, and undermines our credibility as a proponent of the human rights of people with disability.

We contend that amending the Health Requirement so as to incorporate a benefit analysis would not adequately address the issues raised in this submission. For AFAO, the preferable reform would be to amend the Health Requirement such that it solely consists of the Public Health Criteria whereby people with conditions posing a risk to public health (such as active TB), are precluded from entering Australia.

Recommendations

In summary, AFAO recommends:

- that the exemption of the Migration Act from the Disability Discrimination Act 1992 be revoked;
- that Australia's Interpretive Declaration in respect of the UN Convention on the Rights of persons with Disabilities be withdrawn;
- that whether or not the Interpretive Declaration is withdrawn, the Health Requirement should only apply in respect of conditions that impose a potential public health risk and should not apply in respect of a disease or condition that constitutes a disability (including HIV);
- that if the Health Requirement (in its current form or as amended) continues to apply in respect of disability, compulsory testing for HIV in the absence of adequate follow-up services undermines the international HIV response and should cease;
- that if the Health Requirement (in its current form or as amended) continues to apply in respect of disability, it should not apply to humanitarian and refugee applicants, whether their claim is made off-shore or on-shore, and no regard should be had to disability or chronic illness in the determination of claims for protection;
- that if the Health Requirement (in its current form or as amended) continues to apply in respect of disability, specified classes of person should be made exempt from the Health Requirement (e.g., partners, carers, natural or adoptive children of Australian citizens or residents);

[34] Refugees and Migrants with Disability and the United Nations Convention on the Rights of Person with Disabilities, National Ethnic Disability Alliance, Harris Park NSW, July 2008, p7-8

- that if the Health Requirement (in its current form or as amended) continues to apply in respect of disability, the fact that one member of a family fails the Health Requirement should not result in other members of the family also failing;
- that for applicants granted permanent protection off-shore, any compulsory testing of refugees for HIV should be after their arrival in Australia, and any person granted permanent protection who is HIV positive should be referred to culturally appropriate support and health services; and
- that the residential waiting periods applying to social security income support payments undermine settlement policies and Social Inclusion and should be revoked.

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