Submission No 66

JOINT STANDING COMMITTEE ON MIGRATION

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Inquiry into immigration treatment of disability

Submission from the Department of Immigration & Citizenship

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Contents

SUMMARY

It has long been considered important for Australia and for the continuation of its many successful visa programs that public health risks and health costs are not unduly increased by visa holders, whether temporary or permanent. Consequently, almost all visa applicants are required to meet Australia's health requirement in order to be granted a visa.

To deliver a successful immigration program, a balance must be achieved between the need to manage potential threats to public health and protect Australia's health care system and the legitimate expectations of migrants – including their desire for family members to accompany them and remain permanently in Australia.

The Australian immigration health requirement is not about prohibiting people with a disease or condition from coming to Australia; people with health conditions can and do migrate to Australia and Australia benefits from their valuable contribution. Where a health condition gives rise to substantial costs that will potentially be borne by the Australian community these costs must, as required by legislation, be considered in assessing a visa application.

Disability for the purposes of the health requirement is not defined in the Migration Act, Migration Regulations or the Procedure Advice Manual. Rather, the health requirement relates to health and community costs or prejudice to access to services that may arise from a particular disease or condition. This could include people with cancer, an acquired brain injury, HIV, intellectual impairment or many other conditions.

What the health requirement has delivered is:

- A stable and low Tuberculosis incidence rate over the past 30 years.
- Reduced costs to health budgets and preserved access to those health services which are in short supply. For example, it is estimated that in 2008-2009 alone at least $70 million in health care and community costs were avoided.

There has been some public criticism of Australian Governments and the Department of Immigration and Citizenship (DIAC) following the refusal on health grounds of visa applications. These applications were refused because the visa applicant, or a dependent visa applicant, had a disease or condition that was assessed by a Medical Officer of the Commonwealth (MOC) as likely to result in significant costs. The Minister has intervened in some of these cases to achieve a positive outcome for the affected families in light of the compelling circumstances involved. Conversely there has been criticism at times that DIAC is too lenient in applying the health requirement.

DIAC has recently worked with State and Territory governments to implement health waiver provisions for certain permanent onshore skilled visa subclasses. These provisions allow DIAC to consider exercising a waiver of the need to meet the health requirement, where it may be in the best interests of the Australian community to do so (after seeking the views of the relevant State or Territory governments).

DIAC is also currently reviewing the significant cost threshold with a view to updating the threshold and ensuring that its methodology is fair, accurate and based on up to date information.

DIAC administers, and is the public face of the health requirement. As primarily an immigration department, DIAC takes advice from health and community service agencies in determining the composition of the health requirement. Similarly, while the health requirement is founded on Commonwealth legislation, States and Territories share the impact of decisions to issue, or not issue, visas to applicants with disease or other health conditions.

One of the widely shared concerns in relation to the Moeller case, which lead to this inquiry, was the lack of flexibility for mitigating factors to be considered in the initial decision to refuse the visa on health grounds, a factor that has since been addressed. Section 3 of this submission discusses how additional flexibility to consider non-health related economic and social factors might be introduced.

Another often-raised concern is the failure to have regard to the capacity of the applicant to defray their potential impost on health budgets and services through self-funding or self-insuring. Governments have chosen not to pursue this path because of the difficulty of making such assurances binding and enforceable.

In considering changes discussed in this submission and raised in other submissions to the Committee, it may be useful to reflect on the fact that the current arrangements have, prima facie, been effective, and with the exception of recent issues raised in relation to people with a disability, been largely non-controversial for at least the past 20 years.

Structure of the submission

- **Part One** provides an overview of the current legislative and health policy frameworks, their history and the reasoning behind them. It also explains the role of DIAC and other agencies in implementing the health requirement.
- **Part Two** contains information regarding the current arrangements – first from a domestic and then from an international perspective. It includes a preliminary analysis of the economic impact on migrants from a health perspective. It also examines previous recommendations for review of the health requirement and provides an analysis of the approach by like-minded countries to the migration-health nexus.
- **Part Three** explores an option for improving the current arrangements that would allow a more flexible approach towards immigration health policy.
- **Part Four** contains concluding comments.

PART ONE: BACKGROUND

This first part of the submission provides an overview of current and previous health screening arrangements for visitors and migrants to Australia.

It also explains the legislative and policy frameworks within which Departmental decision-makers must currently operate when assessing an applicant against Australia's health requirement, as well as the role of other Government agencies in the immigration health process.

OVERVIEW

1) WHAT IS THE HEALTH REQUIREMENT?

Almost all applicants for visas to visit, or migrate to, Australia are required to meet "the health requirement" outlined in Australian migration law in order to be granted a visa. That is, they must undergo health assessments where requested and be assessed as having a standard of health appropriate given their proposed length of stay and activities in Australia.

This requirement aims to:

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

A visa applicant will be found not to meet the health requirement if they are:

- considered to be a threat to public health (e.g. if they have active TB) or a danger to the community, or
- are assessed as having a disease or condition that would be likely to :
    - result in significant costs to the Australian community; or
    - prejudice the access of Australian citizens or permanent residents to health care and community services.

Where this occurs a visa cannot be granted unless a "health waiver" is available. Currently, such waivers are only available for certain visa subclasses (mainly in the family and humanitarian visa streams)[1]. Waivers are only exercised in limited circumstances (e.g. where the decision-maker believes that there are significant compelling and compassionate reasons to do so).

The legislative framework within which such decisions are made is discussed below at Section 5 The legislative framework. Further information about health waivers is also available below at Section 8 Health waivers.

2) WHY DO WE NEED A HEALTH REQUIREMENT?

Many countries had health and medical requirements in place at their borders long before specific immigration regulations were introduced[2].

Traditionally, such "regulations" were introduced on the grounds that Governments needed to protect their communities against threats to public health – that is, to prevent the spread of

[1] It should be noted that special health requirements are also in place for certain cohort of clients such as individuals who lodge Protection visa applications in Australia. These applicants are not required to meet the "health requirement". They must still, however, undertake the same health examinations as other permanent visa applicants, and a visa cannot be granted until the results of these assessments are finalised. This is because Australia owes protection obligations to people assessed as refugees, regardless of whether they would normally meet the health requirement.

[2] See discussion by P. van Krieken "Health and Migration: the Human Rights and Legal Context", in T. Aleinkoff and V. Chetail, Migration and International Legal Norms, 2003, Cambridge.

communicable diseases across their own borders. Many traditional immigration countries (e.g. Australia, Canada and the USA) have pre-departure health screening processes in place for visitors and migrants based on a risk management framework[3]. Other countries, such as member states of the European Union, have post-arrival screening processes in place for similar reasons[4].

Such screening processes are consistent with the World Health Organisation's (WHO) Global Plan to Stop TB, 2006-2015[5]. With 9 million new TB cases each year and nearly 2 million TB deaths, the plan's goal is to eliminate TB as a public health problem and ultimately to secure a world free from TB.

There are other reasons why countries impose health requirements on visitors and migrants. These generally relate to issues of cost and protection of their health care systems. As Peter van Krieken reports:

> "The intent of regulations in this area is to reduce the costs or demands for health care or social services that migrants may require after their arrival. Attention is therefore focused on chronic, high treatment cost diseases and is most often observed in nations that have state-supported national insurance health plans. These practices are applied to immigrants but often waived for refugees"[6].

Successive Australian Governments have deemed it appropriate to set health requirements to meet both the objectives addressed above – i.e. both potential public health threats, and potential costs or demands on health care or social services which arise from the entry of non-citizens.

DIAC (in conjunction with the Department of Health, Housing and Community Services until the mid 1990s) has traditionally been seen as responsible for both:

- managing the risks to public health that would arise from the entry of people to Australia carrying serious diseases such as active TB; and
- preventing the entry of non-citizens who, due to a disease or condition, are likely to become a impost on the Australian taxpayer, or on Australian health care facilities and institutions.

3) A HISTORY OF THE HEALTH REQUIREMENT

Applicants for temporary and permanent visas to Australia have been subject to an immigration "health requirement" in one form or another since 1901. A detailed history of Australia's health requirement and how it has changed over time is provided at **Attachment A**.

[3] In most cases, these frameworks are based on tuberculosis prevalence rates (TBIR) for different countries. See *Form 1163i Health requirement for temporary entry to Australia* (http://www.immi.gov.au/allforms/pdf/1163i.pdf) which includes a "risk matrix" that assesses which medicals temporary applicants are required to undertake depending on their country of origin and other factors. Countries are assigned "risk levels" according to their TBPR. .

[4] See further discussion of health screening arrangements in other like minded countries below at Section 14 Australia's health requirement: an international comparison.

[5] See WHO *The Global Plan to Stop TB 2006-2015* (http://www.stoptb.org/globalplan/plan_main.asp)

[6] See van Krieken, op. cit., p. 296.

THE CURRENT ARRANGEMENTS

The following section of the submission outlines the current legal and policy arrangements that are in place.

4) AGENCY ROLES

DIAC's role

DIAC advises Government on and administers Australia's health requirement for migrants and visitors to Australia, including assessing the health of visa applicants in accordance with the current legislative requirements set out in the *Migration Act 1958* and the *Migration Regulations 1994.*

DIAC's health assessment processes and the current policy settings which determine what health assessments visa applicants must undergo to meet these requirements are also discussed below at Section 6 The policy framework.

The role of the other Government agencies

In determining the health requirement, DIAC takes advice from the Department of Health and Ageing (DoHA). In addition, DoHA:

- provides advice on the cost and availability of healthcare, which assists DIAC to formulate and update the list of health and community services in limited supply;
- for programs funded by DoHA, informs DIAC of any specific issues that have major implications for the administration of the health requirement. This particularly includes any medical treatments or health conditions that are likely to result in significant cost to the Australian health care system; and
- provides DIAC with public health advice and broader health policy advice.

Other Government agencies have input into the current arrangements. For example, the threshold at which visa applicants are assessed as having a disease or condition likely to result in "significant costs" was determined by an interdepartmental committee comprising DIAC, DoHA and the then Department of Family and Community Services.

Until the mid 1990s the then Department of Health, Housing and Community Services (DHHCS) played a more active role in terms of immigration assessments, as well as providing advice in terms of the health requirement. For example," designated examiners", the predecessors to panel doctors, were selected with the help of a Regional Medical Director (RMD) from DHHCS or upon the advice of the National Office of DHHCS. In 1992, there were, for example, two RMDs (one in Paris and one in Bangkok) who provided advice to DHHSC and the Department of Immigration, Local Government and Ethnic Affairs (DILGEA) on policy and procedural issues. The main focus of RMDs was the selection and supervision of "designated examiners".

DIAC is not a health or community services agency, and relies heavily on other relevant agencies for advice on the formulation of legislation and policy that adequately reflects Government and community expectations and current trends in health and community services.

5) THE LEGISLATIVE FRAMEWORK

The Migration Act 1958 (the Act)

The Act:

- provides that if a visa decision-maker is satisfied that the applicant has met the "health criteria" and the other criteria prescribed by the Act or Regulations for that visa, he or she is to grant the visa. If not satisfied, they are to refuse to grant the visa (see Section 65 of the Act);
- defines "Health criterion" (see sub-section 5(1)) as a prescribed criterion for the visa that:

  (a) relates to the applicant for the visa, or the members of the family unit of that applicant (within the meaning of the regulations); and

  (b) deals with:

  (i) a prescribed disease; or

  (ii) a prescribed kind of disease; or

  (iii) a prescribed physical or mental condition; or

  (iv) a prescribed kind of physical or mental condition; or

  (v) a prescribed kind of examination; or

  (vi) a prescribed kind of treatment;

- enables the Minister to delegate the power to consider and decide whether an applicant meets the health criterion – and to delegate to another person the power to consider and decide all other aspects of the application (see Section 496 of the Act); and
  - In practice, this section (together with Regulation 2.25A) allows for most decisions regarding whether someone meets the health requirement to be made by a Section 65 delegate (i.e. by a visa decision-maker without input from a medical officer).
  - Where a significant medical condition is identified or the applicant has undertaken their medical examinations in a specified country[7], the results of their examinations must be referred to a Medical Officer of the Commonwealth (MOC) for an opinion as to whether or not they meet the health requirement. Consequently, a finding that the applicant meets or does not meet the health requirement (as long as they have completed the required examinations) will always be made by a MOC.
  - These regulatory requirements are discussed further below.
- provides DIAC with the power to require an applicant to undergo medical examinations to determine whether or not they meet the health requirement (see Section 60 of the Act).
  - Which medical examinations visa applicants will be requested to undertake is determined on a risk management basis and outlined in policy (see Section 6 The policy framework below).

The Migration Regulations 1994 (the Regulations)

The "health requirement" itself is provided for as part of the Public Interest Criteria ( ) prescribed in Schedule 4 to the Regulations.

- The "standard" health requirement is provided for at PIC 4005. This applies to most temporary and some permanent visa subclasses.
- PIC 4006A and PIC 4007 contain similar provisions yet also provide for a waiver of the need to meet the health requirement. PIC4006A only applies to Business (Long Stay) visas (Subclass 457). PIC 4007 applies to a limited range of visas mainly in the humanitarian and family visa streams.

The text of the three "PICs" (i.e. PIC 4005-4007) is provided at **Attachment B**.

Attachment C outlines which PIC applies to each visa subclass. All applicants for a visa to which these Schedule 4 health related criteria apply must satisfy a Section 65 delegate (or a MOC where appropriate) that they meet the health requirement in order to be granted a visa. Otherwise, the

[7] A gazette notice lists countries where a permanent visa applicant can undertake medicals that will be able to be cleared by a Section 65 delegate rather than a MOC. Countries that are eligible for "local clearance" in relation to temporary visas is decided under policy and outlined in the Health PAM (*PAM3: Sch4/4005-4007: The health requirement*)

visa will be refused unless a health waiver is available. A waiver is available where PIC 4006A or PIC 4007 applies (see also Section 8) Health waivers below for more information).

The Regulations also enable the Minister to appoint a MOC (Regulation 1.16AA) and outline situations in which a MOC opinion must be sought in deciding whether an applicant meets the health requirement for grant of a visa (Regulation 2.25A).

As noted above, in many cases, a decision is able to be made by a s65 delegate as to whether an applicant meets the health requirement ("local clearance") based on an assessment by a panel doctor overseas or a doctor at Health Services Australia (HSA) if applying onshore in Australia. But where local clearance is unavailable (e.g. because a significant medical condition has been identified, or the country in which the applicant undertook their medicals is not eligible for local clearance), cases must be referred to a MOC for an opinion as to whether the applicant meets the health requirement.

In such cases, visa decision-makers are required to take the opinion of the MOC as correct and cannot dispute their findings. See the relevant extract of the Regulations at **Attachment D**.

Assessing applicants against the health requirement

Applicants will be found not to meet the health requirement if they are assessed by a MOC as:

- having active TB;
- being a threat to public health;
- being a danger to the community; or
- having a disease or condition that would be likely to:
  - result in significant costs to the Australian community; or
  - prejudice the access of Australian citizens or permanent residents to health care and / or community services.

Active TB is the only condition that in itself will prevent the grant of a visa to Australia as it is specifically mentioned in the regulations and is also considered to be a "threat to public health". More recently, following advice from DoHA, the threat to public health has also been expanded to include health care workers with blood borne viruses who intend to engage in exposure prone procedures (EPPs).

All other conditions and diseases are assessed on the basis of potential costs to the Australian community and prejudice to access that are likely to result if the applicant with that condition were to be granted a visa. In making such an assessment:

- "disease or condition" is intentionally defined broadly and is interpreted to cover mental illness, physical and intellectual disabilities[8], infectious diseases such as Human Immunodeficiency Virus (HIV) infection/hepatitis and other conditions such as obesity and heart ailments;
- costs are considered to be significant where a MOC assesses that the potential costs of the applicant's disease or condition to the Australian community in terms of health care and community services are likely to be more than $21000[9];
  - this threshold has been calculated on the average per capita health care and community service costs for Australians over a minimum period of 5 years, plus a loading of 20% to take into account rapid increases in average expenditure on health and community services.

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[8] The *Disability Discrimination Act 1992* defines ***"disability"***, in relation to a person as: total or partial loss of the person's bodily or mental functions; total or partial loss of a part of the body; the presence in the body of organisms causing disease or illness; the presence in the body of organisms capable of causing disease or illness; the malfunction, malformation or disfigurement of a part of the person's body; a disorder or malfunction that results in the person learning differently from a person without the disorder or malfunction; or a disorder, illness or disease that affects a person's thought processes, perception of reality, emotions or judgment or that results in disturbed behaviour.

[9] DIAC is currently reviewing the significant cost threshold and it is expected to be raised using the current methodology.

- the methodology was initially approved by an interdepartmental committee comprising of representatives from DIAC, DoHA and Family and Community Services in 1995.

- The periods of costing that MOCs assess applicants against the health requirement are outlined below:
  - permanent visa applicants under age 75 – a 5 year period
  - permanent visa applicants aged 75 or older - a 3 year period is utilised, because such elderly applicants have less predictability about outcomes and prognosis over the longer term.
    - For permanent visa applicants, the estimated costs of health and community services over the remaining life-expectancy or to age 65 (whichever is the lower) are also included if reasonably predictable or inevitable.
  - temporary visa applicants - the cost assessment process is adjusted to take into account the applicant's period of stay.

- under policy "health care and community services" are taken to include:
  - hospital services (i.e. both inpatient and outpatient care);
  - residential, nursing home and palliative care;
  - community health care and consultations (e.g. general practitioners, specialists, allied health and other health-care providers, if subject to a public subsidy);
  - rehabilitation services;
  - disability services;
  - supported education and accommodation;
  - home and community care;
  - special education; and
  - social security benefits (e.g. disability income support, employment assistance).

  Note: "Health care" is not defined by the Regulations, but the Regulations do specify that "community services" includes "the provision of an Australian social security benefit, allowance or pension (see Regulation 1.03). The definition of "community services" is, thus, expansive. DIAC has interpreted it to include other community services that could potentially have a costs/prejudice to access impact on the Australian community.

- a MOC must assess whether the applicant would meet any statutory or regulatory test imposed by Australian law that determines whether the applicant would have access to any such community services (e.g. whether the applicant's condition and/or immigration status would entitle them to a Government funded pension or allowance); and

- conditions or diseases likely to "prejudice the access" of Australian citizens or permanent residents to health care and community services are interpreted as those diseases or conditions which DoHA has advised are in short supply:
  - the current list, last updated in December 2008, includes services that are required by people who need:
    - dialysis;
    - organ transplants;
    - blood/plasma products, including coagulation factors and immunoglobulin;
    - fresh blood, or blood components, for people with rare blood groups; or
    - knee and hip joint replacements.

6) THE POLICY FRAMEWORK

Under current health policy arrangements, how an applicant demonstrates that they meet the health requirement varies depending on the applicant's individual circumstances, what visa they are applying for, how long they intend to stay in Australia and what they intend to do while they are here:

- Some applicants are only required to make a health declaration on their visa application or declare their TB status on their incoming passenger card. Others, such as permanent visa applicants, must complete a full medical examination, a chest x-ray (if aged 11 years or over) and an HIV test (if aged 15 years or over)[10].
- Any non-migrating dependants of permanent visa applicants must also complete full medicals and meet the health requirement in order for any of the permanent visa applicants to be granted a visa.

PAM3:Sch4/4005-4007 The Health Requirement (the Health PAM), provides advice and guidance to visa decision-makers about:

- which health assessments are required for particular applicants;
- how they should be undertaken; and
- the process for making a decision as to whether the applicant meets the health requirement.

Where health examinations are required, they must be conducted by Health Services Australia (HSA), the Department's contracted medical service provider, if the applicant is in Australia, or in most cases, by an approved "panel doctor" or "panel radiologist" outside Australia.

Other relevant policy documents include:

- the panel doctor instructions which set out procedural standards that panel doctors are expected to abide by; and
- the Notes for Guidance papers developed for MOCs which include.
    - a general "Principles Paper" which is currently being updated to:
        - outline the legislative and policy framework within which MOCs must operate;
        - provide MOCs with broad guidance when assessing visa applicants within this framework;
        - provide guidance regarding what constitutes a lawful MOC opinion;
        - explain DIAC's approach in determining what constitutes a "significant cost"; and
        - explain in brief the approach to unit costings adopted in the Notes for Guidance papers.
    - 18 separate papers which provide disease/condition specific costing information to help ensure the consistency of MOC opinions and costings are due to be completed by mid 2010. The HIV paper has already been completed, together with the ophthalmology and hepatitis papers.

7) HEALTH UNDERTAKINGS

A MOC may request a "health undertaking" (form 815) as a prerequisite for an applicant being considered to have met the health requirement (see PIC 4005(d), PIC 4006(1)(d) and PIC 4007(1)(d) at **Attachment B**).

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[10] *Form 1163i Health requirement for temporary entry to Australia* (http://www.immi.gov.au/allforms/pdf/1163i.pdf) discussed above outlines which health assessments temporary visa applicants are required to undertake

Undertakings are usually requested if the applicant has a history of treatment for diagnosed or suspected TB but is currently disease-free and is not a "threat to public health". They can also be issued for conditions not defined to be a public health threat such as HIV, Hepatitis B and C, and Leprosy, with the aim of ensuring that the applicant is placed in contact with State and Territory health authorities. Undertakings may also be issued for pregnant visa applicants from low or medium risk countries in terms of TB who have not undertaken an x-ray due to the possible radiological risks to their babies.

Applicants to whom a health undertaking applies agree to contact the Health Undertakings Service (HUS) upon their arrival in Australia (unless already in Australia) and present themselves to a health authority in their State/Territory of residence for a follow-up medical assessment and undergo any treatment as directed.

8) HEALTH WAIVERS

A waiver of the health requirement is available where PIC 4006A or PIC 4007 is attached to the relevant visa subclass. Currently, these PICs apply to limited visas in the humanitarian and family streams. This has generally been the case in the past as well – with it traditionally only considered appropriate to allow for a health waiver in humanitarian cases or where the family members of Australian citizens or permanent residents are involved.

A health waiver provision (i.e. PIC 4007) applies to a number of permanent '2nd stage' visas in the skilled and business skills categories as follows:

- Skilled - State/Territory nominated Independent (Subclass 137)
- Skilled - Designated Area Sponsored (Resident) (Subclass 883)
- Skilled-Regional visa (Subclass 887)
- Investor (Subclass 891)
- State/Territory sponsored Business Owner (Residence) (Subclass 892)
- State/Territory Sponsored Investor (Residence) (Subclass 893)
- Business Owner (Residence) (Subclass 890)

To be granted such visas, applicants need to have held a provisional visa to which PIC 4005 applies (i.e. the applicant and their family would need to have met health to the permanent standard previously and been granted a visa without a health waiver being available).

A flow chart of the health waiver decision-making process is provided at **Attachment E**.

9) HEALTH WAIVERS FOR CERTAIN ONSHORE SKILLED MIGRATION VISAS

For a small number of visas, mainly in the humanitarian and family visa streams there is discretion to waive the health requirement where costs and prejudice to access are not considered "undue". The waiver program has, however, recently been expanded, in recognition that there is a need to have flexibility for some skilled visas where a health waiver would be in the best interests of the community.

Skilled health waiver provisions (i.e. PIC 4007) had been introduced for Subclasses 846, 855, 856 and 857 in October 2006. However, these provisions required State and Territory agreement in order to operate – and until 2009, such agreement had not been acquired, consequently no waivers were available. A flow chart of the skilled waiver decision making process is provided at **Attachment F.**

In late 2008, a high profile case involving a doctor in a regional area, brought to light the need to pursue a skilled health waiver option with State and Territory participation. Following this case the Minister wrote to State and Territory leaders seeking their agreement to participate.

To date all States and Territories, except New South Wales have now been designated as participating jurisdictions under the new arrangements. Visa applicants from States and Territories that have not yet signed up have been offered the opportunity to have their visa decision delayed until such time as the State or Territory has made a decision regarding their participation.

Some participating states have now signed a Memorandum of Understanding (MOU) outlining the agreed implementation and operational arrangements with the Department.

Under the MOU arrangements, in cases where the potential health care and community service costs are estimated to be $100 000 or more, or prejudice to access is 'substantial' or 'extensive', the relevant jurisdiction will be consulted for their view on whether they support a waiver being exercised. The States and Territories will have an advisory role not a determinative role.

10) REVIEW RIGHTS

The Migration Act provides a merits review process for onshore visa applicants and offshore applicants who have a sponsor or nominator in Australia. This consists of a review of the original decision by either the Migration Review Tribunal (MRT) or the Refugee Review Tribunal (RRT).

The primary objective of merits review is to ensure that the correct or preferable decision is reached on the facts before the review body. The Tribunals, in addition to the Tribunal's specific powers, operate within the same legislative framework as the visa decision makers. Therefore, the Tribunal, like the visas decision maker, is bound by the findings of the MOC (reg. 2.25A(3)). The Tribunal however, can consider new information.

Where a MOC finds that an applicant does not meet the health requirement, the applicant is given the opportunity to comment, where natural justice provisions apply, and put forward any additional information which the MOC must consider. A new MOC opinion will be provided if this information is materially different.

If the applicant does not provide any new information or the MOC considers that the new medical information is not materially different, then the visa will be refused on health grounds. The applicant may, as discussed above, be entitled to appeal to the Migration Review Tribunal (MRT).

In terms of the health criteria, an applicant will be given the opportunity to undergo new medical examinations and obtain a new health assessment from a Review Medical Officer of the Commonwealth (RMOC). However, if the RMOC again provides a lawful opinion that the applicant is unable to meet the health requirement, then the MRT is required to accept this opinion as correct (i.e. like DIAC, the MRT thus has no discretion in such matters).

Clients whose visa applications have been rejected by the Tribunals can apply to the Federal Magistrates Court for judicial review. The courts have the power to remit a Tribunal's decision for reconsideration where the decision is affected by jurisdictional error. However, it is possible that an unlawful application of the health criteria could, under certain circumstances, constitute a jurisdictional error.

Where the Tribunal is required to affirm the Department's refusal decision, it is; however, open to the applicant to request that the Minister intervene in his or her case. The Minister is then able to take into account the applicant's individual circumstances, including any compelling or compassionate reasons why a visa should be granted.

PART 2: AN ANALYSIS OF CURRENT ARRANGEMENTS

This part of the submission provides an analysis of current arrangements – first from a domestic and then from an international perspective. It examines previous recommendations for review of the health requirement and provides an analysis of the approach by like-minded countries to the migration-health nexus. It also includes a preliminary analysis of the economic impact of migrants from a health perspective.

A DOMESTIC PERSPECTIVE

11) STATISTICS

Statistics relating to the health requirement including the number of applicants refused visas during the last financial year, the number of health waivers exercised and potential costs involved are included at **Attachment G.**

They indicate that approximately 1 586 individuals were refused a visa on health grounds in 2008-09, saving Australia at least an estimated $70 million in additional health care and community costs.

1992 review by the Joint Standing Committee on Migration[11]

In December 1992, the JSCM published a report entitled *Conditional migrant entry: the Health Rules*[12] following an inquiry into Australia's health requirement. This inquiry focussed on applicants for migration or permanent residence who are refused entry to, or stay in, Australia on the grounds that they suffer from a prescribed disease, a medical condition or disability. The Committee aimed to determine whether any such applicants could be allowed to enter or remain in Australia on a conditional basis.

The Committee made 20 recommendations for improvements to the health requirement and related arrangements. A number of these recommendations may be relevant in the context of a review of current arrangements and addressing some of the recent concerns expressed by the Australian community about these arrangements.

These recommendations included that:

- the Regulations be amended to provide for separate categories of assessment in terms of visa applicants with diseases and medical conditions, and those with disabilities;
- when assessing a person with a disability sufficient emphasis should be given to the likely contribution to the Australian community of the disabled person's family as a unit and to the capabilities of the individual;
- in cases where an applicant does not meet the prescribed health criteria and does not satisfy the health waiver provisions, the applicant or sponsor should pay an up-front fee before a visa can be granted – or potentially enter into a loan arrangement if they are unable to do so; and
- the Minister be provided with discretion to consider the circumstances of the applicant and either waive part or all (in compelling cases), of the up-front fee payable, or that which will be covered by the loan.

[11] Please note that at this time this Committee was called the "Joint Standing Committee on Migration Regulations"
[12] Joint Standing Committee on Migration Regulations, Conditional Migrant Entry: the Health Rules, December 1992.

The Government response provided in 1995 indicated that the Government did not accept that a different category of assessment for disabled applicants was appropriate. Whilst in principle it agreed that an applicant's individual circumstances should be taken into account in making a decision on the health requirement, it argued that the health waiver provisions already provided for this, but advised that this would be considered as part of an ongoing review.

The recommendations in relation to "conditional entry" (e.g. on the basis that an up- front fee would be paid) were also rejected on the basis that such a scheme would be incompatible with, and undermine existing health policy for different visa classes. These recommendations are discussed further in Part 4 of this discussion paper.

1995 Review of Migrant Health Requirements and Associated procedures

Alongside the JSCM review described above, an ongoing-review of the health requirement was undertaken by the Government, which resulted in a number of changes including:

- an amendment to health waiver to allow for greater flexibility;
- changes to the Medical Treatment visa provisions to allow elderly visitors unable to depart Australia on health grounds to remain in Australia for longer periods;
- a waiver for some temporary visa subclasses where an employer signs an undertaking to meet health costs; and
- the removal of Medicare eligibility for business and academic temporary visa subclasses.

As part of this review process, a joint review of some of the fundamental aspects of the health assessment system was also undertaken by then Department of Immigration and Ethnic Affairs (DIEA) and the Department of Human Services and Health (HSH).

This review was completed in 1995. It re-confirmed that the objectives of the health requirement were to both protect Australia from public health risk, and to "minimise the impact on Australia's universal health and welfare systems in terms of both direct budgetary implications as well as in protecting access to the high standards of services available to Australia citizens and residents"[13].

This review also made a number of recommendations, which were adopted, including that:

- the health requirement be amended to provide for assessments to include community service costs as well as health costs (i.e. assisted accommodation, home and community care and income support);
- the degree of certainty required in terms of assessing people against the health requirement be clarified;
- "significant costs" should be interpreted as a cost that is higher than the average annual health and community service costs for Australians;
- for temporary visa applicants, costs be assessed against the length of stay permitted by their visa; for other applicants, a 5 year period be applied (or 3 years if aged 70 years or over) – "with an overriding clause to allow the inclusion of costs that can be identified with reasonable certainty"[14]; and
- when assessing prejudice to access, services which are in short supply should be those that are not generally available or which, on a national basis, are in high demand, waiting lists are common, and the consequence of failure to obtain access is likely to seriously disadvantage an individual.

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[13] Department of Immigration and Ethnic Affairs and the Department of Human Services and Health, Review of the Health Requirement and Associated Procedures, 31 July 1995, p. 4.
[14] Ibid., p. 17.

The review made a number or recommendations that were not implemented, including that:

- costs assessments be modified to take into account the individual circumstances of the applicant (costs assessments currently take into account the form and severity of the applicant's condition but not their broader individual circumstances);
- guidelines for decision makers be amended to more explicitly include assessment of the likely contribution of a disabled applicant and their family to the Australian community;
- an independent review mechanism in respect of health assessments be established; and
- effective procedures be developed for the follow-up of health undertakings that have not been complied with.

Business Temporary Entry: Future directions

In August 1995, the above-named report by the Committee of Inquiry into the Temporary Entry of Business People and Highly Skilled Specialists was published. The focus of this report was on skilled migration issues; however, some comments were made about health assessment procedures for skilled temporary applicants. The report stated that in terms of this particular visa caseload public health costs should not be an issue given the role of the sponsoring organisation in agreeing to take full liability for any such costs. It encouraged the removal of the requirement for skilled temporary visa applicants with an Australian sponsor to undergo medical examinations if staying more than 12 months (as is reflected in the current health matrix for Business (Long Stay) visa - Subclass 457 visa applicants).

Review of health processing of temporary entrants

A review of health requirements for temporary visa applicants was also conducted in 2001, following a recommendation to this effect made by the JSCM in its report on Working Holiday Makers in 1997. This review followed criticism regarding inconsistencies and the "piecemeal" and "outdated" nature of the requirements in place. This review is not discussed in great detail here given that it focussed more on health processing arrangements. However, importantly, it set up a new risk level framework for assessing health of temporary visa applicants based on country TB risk ratings.

ANAO report

The Australian National Audit Office (ANAO) undertook an audit of the Department's administration of the health requirement in May 2007[15]. The ANAO made 8 recommendations for improvement. A list of these recommendations is at **Attachment H.**

The Department accepted all 8 of the ANAO's recommendations and has made significant progress towards implementing them.

Outcomes of fully implemented recommendations

The Department signed an MOU with the Department of Health and Ageing (DoHA) in 2007. This has resulted in greater collaboration with DoHA, ensuring that health risks to Australia are minimised and departmental policies are based on sound and up to date health advice (Recommendation 1).

- The Department and DoHA have reviewed the framework for managing public health risks to ensure that the current arrangements continue to represent the best practice approach to public health risk management for immigration purposes (Recommendation 3).

Outcomes of substantially implemented recommendations

- In March 2009, the Department developed a process for regular review of and released a new health matrix, which is used to assess which health assessments temporary visa applicants are required to undertake in order to demonstrate that they meet the health requirement (Recommendation 4).

[15] See http://www.anao.gov.au/uploads/documents/2006-07_Report_37.pdf

- This matrix is based on up-to-date data from the World Health Organisation regarding TB incidence rates and accurately reflects global TB trends. It will ensure that Australia can continue to minimise risks to public health potentially caused by the entry of temporary and permanent visa holders to Australia.
- The Department is currently scoping the legal and systems issues surrounding front end loaded applications in order to fully implement Recommendation 4.

- A centralised health waiver management system has been implemented to ensure consistency in health waiver decisions (Recommendation 5).
  - It is anticipated that a reporting solution will also be delivered in 2010 that will enable accurate reporting on health waiver decisions, thus fully implementing Recommendation 5.
- The Department has already reviewed the administrative and systems-based procedures for health undertakings, and made significant progress in strengthening the health undertakings framework, particularly for offshore applicants (Recommendation 6).
  - It is anticipated that further improvements to onshore arrangements will be implemented in 2009. Together with the implementation of a robust reporting regime in 2010, this will fully implement Recommendation 6.
- The department has also made significant progress on the Notes for Guidance a series of medical papers that provide guidance on potential costs and conditions to MOCs who use them to assess applicants against the health requirement (Recommendation 2).
  - Three new papers approved (HIV, Ophthalmology and Hepatitis)
  - Three being considered by the relevant medical body (such as the Royal Australasian College of Physicians)
  - Nine papers in the final stages of completion,
  - One undergoing its annual review, and
  - The remaining three still in development

Implementation of the remaining recommendations is a substantial work program which involves coordination of significant policy, process and information technology systems changes. Some significant milestones have, however, already been achieved.

Productivity Commission review

In 2004, the Productivity Commission completed an enquiry into the *Disability Discrimination Act 1992* (the DDA)[16].

Section 52 of the DDA exempts the Migration Act, its regulations and anything done by a person in relation to the administration of the Act from the discrimination provisions of the DDA.

The Productivity Commission considered this exemption as part of the above mentioned review. It noted that Australia's current health assessment arrangements could be seen to discriminate against people with disabilities indirectly "by setting rules that they do not or cannot meet" or directly "by requiring additional tests or medical evidence that are not required of people without disabilities"[17]. Similar objections were also raised by participants in the review.

The Productivity Commission found that the Section 52 exemption should nevertheless remain as the Government considers the health requirement necessary for the health and welfare of the Australian community. However, it noted that "care should be taken in applying and explaining visa

[16] See http://www.pc.gov.au/projects/inquiry/dda/docs/finalreport, pp. 342 to 348.
[17] Ibid., p. 343.

entry criteria to people with disabilities so as to minimise necessary perceptions of disability discrimination".[18]

They also recommended that the exemption for migration legislation in Section 52 of the DDA be amended to ensure that it exempts only those provisions which deal with issuing entry and migration visas to Australia (i.e. not administrative procedures under the Act and the Regulations). DIAC has since indicated its agreement in principle to narrowing this exemption.

Joint Standing Committee on Treaties – report on the Convention on the Rights of Persons with Disabilities

On 19 June 2008, the Joint Standing Committee on Treaties (JSCOT) tabled its interim report on the Convention on the Rights of Persons with Disabilities - recommending Australia's ratification of the Convention.

The Government subsequently lodged its instrument of ratification on behalf of Australia on 17 July 2008 - attaching a declaration about immigration processes. This declaration sets out Australia's understanding of the interaction between the Convention and Australia's immigration processes.

The Government considered a declaration necessary to clarify Australia's understanding that its immigration processes, including the health requirement for visa applicants, comply with the Convention and do not discriminate against persons with disabilities.

JSCOT published its final report on the Convention in October 2008. It recommended 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 Convention".[19]

A separate government response regarding JSCOT recommendations will be provided to the Committee.

12)INTERPRETATION OF THE CURRENT FRAMEWORK BY THE COURTS

A number of significant litigation cases have guided DIAC's current interpretation of the health requirement. These cases are discussed at **Attachment I**.

13)THE ECONOMIC IMPACT OF MIGRANTS IN THE HEALTH SPHERE

DIAC is not aware of any specific studies completed in relation to the impact of visitors and migrants on Australia's health care system and the availability of health services. A number of studies have, however, been completed regarding the economic impact of migrants more generally. ACCESS Economics has, for example, completed studies which profile the impact of migrants on the budgets of both the Commonwealth and the States and Territories respectively – in terms of revenues and outlays[20].

These studies reveal that the overall net economic impact of migrants is positive for both states and territories. A 2006 report by the Productivity Commission similarly found that "the overall economic effect of migration appears to be positive but small"[21]. Indeed, whilst additional migration imposes additional costs (including health and community service costs as outlined below) to the Commonwealth and specifically the State and Territories as outlined below, it shouldn't be forgotten that additional migration also delivers additional revenues both for the

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[18] Ibid., p. 348.

[19] See Recommendation 2, JSCOT, Report 95: Treaties tabled on 4 June, 17 June, 25 June and 26 August 2008, Canberra, 2008, p. 23. See http://www.aph.gov.au/house/committee/jsct/4june2008/report1.htm

[20] For Commonwealth budgetary impacts see Access Economics, "Migrants Fiscal Impact Model: 2008 update" at http://www.immi.gov.au/media/publications/research/_pdf/migrants-fiscal-impact-april-2008.pdf

[21] Productivity Commission, "Economic impacts of migration and population growth", Melbourne 2006.

Commonwealth and the States. Furthermore, as Jason Soon points out, "While it is true that immigrants add to the demands placed on government services, there may well be additional economies of scale both in private and public infrastructure from the increased population created by immigration"[22].

However, additional migration (particularly if current health restrictions were to be removed) could lead to increased pressure on health care systems, particularly where new migrants require health services that are in short supply (e.g. organ transplants or dialysis).

Health expenditure is already very significant and rising - amounting to $103.6 billion in 2007-08 (up from 94.9 billion in 2006-07). In the case of public hospitals, the Australian Government funded 39.2% and the State and Territory Governments contributed 52.8%.[23]

Welfare expenditure (which includes community services such as pensions and high-level residential care) also continues to rise from $57 billion in 1998-1999 to $90 billion in 2005-06 – with cash benefits (e.g. pensions) accounting for 68% and welfare services 32% of this expenditure.[24]

Expenditure on older people is currently the highest ($34 billion). Other significant client groups include families and children ($27 million) and people with disabilities ($17 million).

Federal Government contributions amount to approximately 40% of welfare services expenditure, with State and Territory Governments contributing 29% and local governments 2%.[25] All cash benefits (e.g. pensions) are funded by the Federal Government.

There is pressure on the provision of formal disability services. Funding under the Commonwealth State/Territory Disability Agreement (CSTDA) has increased gradually each year to $3.95 billion in 2005–06, and the number of users of disability services funded under this agreement has increased 16% over the past 2 years, to 217,000 in 2005–06. In spite of these increases, there is still a high level of unmet demand for CSTDA. In 2005 about 29,200 Australians were estimated to have an unmet demand for such services.[26]

Any significant change to the current health requirement would need to be considered in the context of potential impacts on health and welfare expenditure both by the Federal Government and the States and Territories, particularly in terms of prejudice to the access of Australian citizens and permanent residents to health care and community services – including special education costs.

Commonwealth budgetary impacts

The table below developed by ACCESS Economics[27] estimates the impact of 1,000 new migrants on the Commonwealth Budget, using the characteristics of migrants from the 2006-07 migrant intake. This table shows that overall new migrants provide a "substantial contribution to the Commonwealth budget initially, and this contribution grows over time in real terms"[28] – as the incomes of migrants grow and expenses decline.

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[22] Jason Soon, "Stelzer on immigration: lessons for Australia, Policy, vol. 17, no. 4, p. 14.
[23] See Australian Institute of Health and Welfare, "Health expenditure Australia 2007-08", p.1-7, http://www.aihw.gov.au/publications/hwe/hwe-46-10954/hwe-46-10954-c00.pdf
[24] See Australian Institute of Health and Welfare, "Welfare expenditure Australia 2005-06", p. xi, http://www.aihw.gov.au/publications/hwe/wea05-06/wea05-06.pdf
[25] ibid.
[26] See Australian Institute of Health and Welfare, 'Australia's welfare 2007', p. 6, http://www.aihw.gov.au/publications/aus/aw07/aw07-c01.pdf
[27] See Access Economics, "Migrants Fiscal Impact Model: 2008 update", op. cit., p. I.
[28] Ibid.

TABLE 1: NET OPERATING SURPLUS (DEFICIT) PER 1,000 PERMANENT MIGRANTS, CONSTANT 2007-08 PRICES, $M

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 10	Year 15	Year 20
Family - Parents	-4.8	-3.5	-4.0	-3.9	-4.2	-4.7	-9.2	-7.7
Family - Partner and Other	2.1	4.3	3.6	4.3	3.5	6.6	6.6	6.9
Family - Parents Contributory	25.7	-1.2	0.4	-1.2	-1.4	-2.1	-8.4	-8.7
GSM - Sponsored	2.7	5.1	5.1	5.6	5.8	6.7	7.0	7.5
GSM - Independent	4.7	6.7	7.0	8.0	8.3	10.3	10.8	11.7
GSM - Independent - Student	4.6	7.3	6.9	7.3	7.6	9.1	8.9	9.1
GSM - Regional Sponsored	3.8	4.4	4.6	6.0	5.6	6.2	6.4	7.0
Employer Sponsored	13.8	14.3	14.2	14.4	14.4	15.0	15.1	15.2
Business Skills	5.0	5.9	6.0	5.2	5.2	6.0	5.4	4.5
Humanitarian or refugee	-20.1	-7.2	-6.6	-5.8	-5.6	-1.1	1.2	4.3
Total Permanents	3.4	5.4	5.3	5.9	5.8	7.7	7.8	8.4

Such studies also reveal that there are differences in terms of the level of economic contributions by migrants across visa categories - as would be expected given their different skill levels and personal circumstances.

- Skilled migrants contribute strongly to the economy due to, for example, their high incomes, high rates of labour force participation and strong levels of English proficiency. Such migrants are also commonly of a younger age than in other visa categories and unable to access most government services and benefits.
    - It should, however, be noted that currently all skilled migrants are required to meet the health requirement, hence, they are assessed as not having any condition or disease that would potentially result in significant costs to the Australian community,
- Contributions from Family-Partner visa holders are also strong.
- Contributions, in economic terms are, however, negative in terms of Parent and Humanitarian visa holders due to low labour force participation and considerable use of Government services.

Health and community service related costs funded by the Commonwealth which migrants may contribute to include:

- cash benefits such as sickness benefits, age pensions, disability support pensions, mobility allowances;
- provision of Medicare benefits;
- pharmaceutical benefits under the Pharmaceutical Benefits Scheme (PBS);
- funding to the States under Australian Health Care Agreements (public hospitals);
- some welfare services delivered for older people including aged care services (mainly residential aged care and Health and Community Care (HACC); and
- some welfare services that are delivered for people with disabilities.

ACCESS Economics have done some work estimating the migrant usage of such Commonwealth services. The table extracted below[29] which they have prepared summarises the projected health expenses of 1000 new migrants to Australia. It demonstrates the significantly higher health expenses for Parent visa holders – particularly in the non-contributory stream.

[29] Ibid., p. 15.

TABLE 6: HEALTH EXPENSES PER 1,000 MIGRANTS, CONSTANT 2007-08 PRICES ($'000)

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 10	Year 15	Year 20
Family - Parents	3,716.4	3,501.3	3,499.6	3,545.0	3,696.3	4,279.0	4,349.3	4,084.3
Family - Partner and Other	188.4	178.6	947.0	953.5	968.7	1,079.9	1,241.4	1,442.0
Family - Parents Contributory	2,275.8	2,138.9	2,140.9	2,143.2	2,262.5	2,875.8	3,412.6	3,687.6
GSM - Sponsored	811.2	772.1	768.5	764.5	777.8	900.2	1,077.6	1,282.8
GSM - Independent	835.7	784.8	762.6	741.0	746.3	843.0	1,015.7	1,200.8
GSM - Independent - Student	782.9	748.1	756.3	760.3	773.2	850.6	957.9	1,112.7
GSM - Regional Sponsored	-	-	769.6	738.8	749.8	866.3	1,035.5	1,230.5
Employer Sponsored	798.8	770.3	749.7	733.5	755.8	926.7	1,119.6	1,347.9
Business Skills	102.7	92.1	91.6	760.1	795.3	1,009.6	1,243.7	1,551.3
Humanitarian or refugee	918.5	852.7	845.9	841.6	857.7	997.4	1,178.0	1,359.0
Total Permanent	608.1	575.2	843.0	861.1	878.2	1,009.0	1,182.5	1,377.8

Commonwealth revenues would also, however, be acquired from such new migrants – mainly via income tax payments and other indirect taxes. Some migrants also pay a number of user charges – for example, fees for translating and interpretations service, Adult Migrant English Program (AMEP) fees and the significant visa application charges that apply in the case of contributory parent visas.

State and Territory budgetary impacts

The Commonwealth collects the majority of revenues from migrants (e.g. via income tax), whereas states are required to provide migrants with the majority of the services that they need.

This is particularly relevant in the health sphere given the significant contribution of State and Territory funding:

- In 2007-08 governments provided $71.2 billion or 68.7% of the total to fund health expenditure in Australia. This was an increase of $4.9 billion from 2006-07 financial year.[30]
- The Commonwealth contributed $44.8 billion (43.2%) and States, Territories and local government contribute $26.4 billion (25.5%) The remaining $32.4 billion (31.3%) was funded by individuals, private health insurers, and other non-government sources.[31]

The distribution of funding by the Australian Government, state, territory and local governments and the non government sector varies depending on the types of goods and services being provided. The Australian Government provides a substantial amount of funding for medical services, with the balance primarily from individuals. The state, territory and local governments on the other hand provide most of the funding for community and public health services. The governments share most of the funding for public hospital services while individuals account for a large portion of the funding for medications, dental services and aids and appliances[32].

In terms of community service costs, whilst pensions are funded by the Federal Government, the States and Territories are still responsible for approximately 29% of welfare services expenditure (this amounted to $8.4 billion in 2005-06).[33]

Nevertheless, recent studies by ACCESS Economics indicate that States and Territories also benefit from migrants in economic terms[34]. This is indicated in the graph[35] extracted below.

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[30] *Health Expenditure Australia 2007-08*, Australian Institute of Health and Welfare, http://www.aihw.gov.au/publications/hwe/hwe-46-10954/hwe-46-10954-c03.pdf

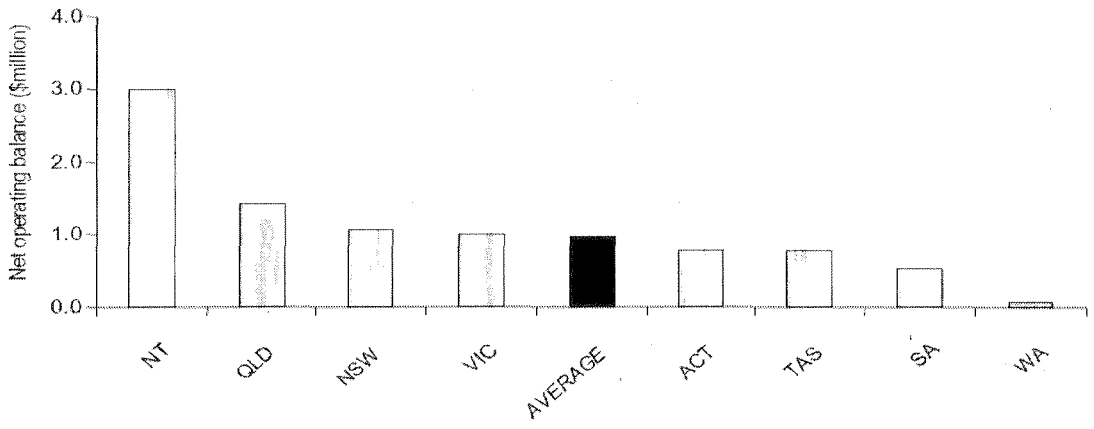
[31] ibid.

[32] ibid.

[33] See Australian Institute of Health and Welfare, *Welfare expenditure 2005-06*, p. 14, http://www.aihw.gov.au/publications/hwe/wea05-06/wea05-06.pdf

[34] See Access Economics, "The impact of permanent migrants on state and territory budgets", Canberra May 2002 and "Migration: Benefiting Australia", 2002 Conference Proceedings available at http://www.immi.gov.au/media/publications/research/conference02/index.htm

Figure 4.12 Net Operating Balance impact, all migrant groups



Health and community service related costs funded by the States and Territories which migrants may contribute to include:

- acute health services;
- aged care and primary health services;
- mental health services;
- public health services;
- disability services;
- community care, community support and access services;
- supported accommodation and respite care;
- special education;
- speech pathology; and
- some dental services.

State revenues which may offset some of the above costs include:

- state taxes (e.g. payroll, gambling, motor vehicles, land tax);
- stamp duty; and
- regulatory fees and fines.

AN INTERNATIONAL PERSPECTIVE

14) AUSTRALIA'S HEALTH REQUIREMENT: AN INTERNATIONAL COMPARISON

Australia's health requirements are generally mirrored in similar migrant receiving countries such as the United States of America (USA), Canada, New Zealand and the United Kingdom (UK).

A summary table of the different arrangements is provided below. A more in depth study of the current arrangements in each country is provided at **Attachment J**.

[35] See http://www.immi.gov.au/media/publications/research/conference02/index.htm at p.125.

Similarities exist between the arrangements in place for these countries – with all countries using health requirements for non-citizens to manage public health risks, and most with measures in place to prevent increase pressure on health care systems arising from the entry of non-citizens.

To enhance the efficacy, management and quality control of immigration medical processing by way of cooperation among the immigration and public health agencies of Australia, Canada, New Zealand, the UK and the USA, the International Immigration Health Working Group (IIHWG) was convened in 2005. Annual meetings are held to discuss the status of different collaborative projects and determine future directions. They also provide representatives of participating countries with the opportunity to exchange ideas and information with a variety of key stakeholders in the host country.

Like Australia, Canada, New Zealand and the UK have universal health-care arrangements in place. In the USA, direct government funding of health care is limited to Medicare, Medicaid and the State Children's Health Insurance Program (SCHIP). These programs cover eligible senior citizens, the very poor, disabled people and children. Everyone else must pay for private health insurance – or obtain coverage via their employer.

Summary

	Public health threat (TB) prevents visa grant	High cost conditions may prevent visa grant	Prejudice to access may prevent visa grant	HIV in itself may prevent visa grant	Waiver available for certain visas
Australia	Y	Y	Y	N	Y
New Zealand	Y	Y	Y	Y	Y
USA	Y	Y	N	Y	Y
Canada	Y	Y	Y	N	Y
UK*	Y	N	N	N	Y

* Note: the UK is currently reviewing the need for more comprehensive health assessment and has put this in place for 16 high priority countries.

Countries which have traditionally not had pre-visa screening processes in place are now beginning to implement similar screening processes to Australia. For example, the UK's pre-entry TB screening program only began in 2005, but is now operating for residents of 15 countries as discussed above. Such initiatives reflect the current health concerns about TB. In the case of the UK, it is also a response to the longer term increase in TB rates over recent years – particularly amongst the foreign born population. Indeed, the UK Border Agency has also advised that whilst the UK TB rate still remains low overall, it is very high in inner cities – with London experiencing more than 44 new cases per 100,000 people[36].

15) AUSTRALIA'S INTERNATIONAL OBLIGATIONS

On 17 July 2008, the Government ratified the UN Convention on the Rights of Persons with Disabilities. This has led to heightened interest in relation to how Australia's health requirements for visa applicants comply with Australia's international obligations.

Ratifying the Convention is part of the Government's broader longer term commitment to improving the lives of both people with a disability and their families and comes as part of a significant set of reforms of Australia's disability laws. In deciding whether to ratify the Convention, the Government assessed existing migration laws, policies and programs including the immigration health requirement and found them to be consistent with the obligations under the Convention.

[36] See P. Elder, "UK: Immigration Health Policies, practical implications and outcomes", presentation given at the International Immigration Health Working Group (IIHWG) conference in Sydney in October 2008.

Australia's declared understanding is 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, and that it does not 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.

Australia remains at the forefront of upholding the rights of people with disabilities, and this Convention is part of the Government's broader longer term commitment to improving the lives of both people with a disability as well as their families.

PART 3: DIAC POSITION

16) APPLYING WAIVERS TO MORE VISA SUBCLASSES

The most commonly voiced complaint about visa refusals which are based on health grounds, is that the individual circumstances of the applicant have not been considered. Those individual circumstances are most often asserted to be offsetting economic or social benefits which the applicant would bring to Australia.

While there are clear public safety and economic benefits to the retention of the health requirement, it is DIAC's view that there would be benefit in widening the circumstances in which economic gains which might be offered by the applicant, could be a consideration in the visa decision.

There are a number of ways in which additional decision-making flexibility could be introduced, including:

- allowing an applicant's individual circumstances (i.e. their personal circumstances as well as the severity and nature of their condition) to be taken into account as part of the assessment as to whether they meet the health requirement, for any visa application.
- allowing individual circumstances to be considered as part of the assessment as to whether the applicant meets the health requirement, for a specified range of visa classes.

The emphasis of the migration program is on economic benefit to Australia and it is DIAC's view that such benefits should be able to be considered in the visa decision, by allowing decision flexibility for permanent skilled and business visa classes (see **Attachment M** for a list of the proposed visa classes).

Existing administrative arrangements for consideration of health waiver applications work reasonably well, and are DIAC's preferred approach to any introduction of decision-flexibility to a wider range of visa classes with a possible review of the impact on services that may 'prejudice access'. This approach separates the independent assessment by a MOC of health requirement provisions, from consideration by the visa decision-maker of other compelling or compassionate factors.

Careful consideration would need to be given to the range of factors a visa-decision maker could have regard to when considering a waiver for a wider range of visa classes. Waivers are currently decided by visa decision makers. Where the cost to the health budget is estimated to be more than $200,000, the visa decision maker takes advice from a central policy adviser. DIAC would propose to retain this approach for a wider range of waivers, to ensure consistent application of policy settings and given the significant economic implications of a decision to grant a waiver in these circumstances. DIAC may also look at whether if a condition may extensively or substantially prejudice access to services for the Australian community that waiver may not apply in the same manner as public health risks cannot currently be waived.

The cost implications of wider availability of waivers are difficult to estimate, because the number of applicants who might seek access to a waiver cannot be determined, and it is also possible that widened application of waiver provisions would have a pull factor and attract applicants who might otherwise have chosen not to apply because they may have failed to meet the health requirement.

It may be no real indication of such costs, but as noted at **Attachment G,** in 2008-09, DIAC waived health in 138 onshore cases where the main applicant or one of their family members failed the health requirement and a health waiver was exercised i.e. the visa was subsequently granted. The estimated health and community service costs provided by the MOCs in these cases amounted to a total of $19 564 500.

State, Territory and local governments are estimated to bear around 25.5 percent of the health expenditure costs and 31 percent of welfare expenditure. Widening the range of permanent visa classes to which a waiver applies will impact States and Territories, and it is DIAC's view that a

decision model involving consultation with States and Territories on the merits of individual waiver applications is appropriate.

The arrangements recently put in place with States and Territories in respect of the onshore skilled visa classes is DIAC's preferred model for involvement of State and Territories, noting that there would be administrative costs and lengthier processing times associated with this model.

PART 4: CONCLUSION

Immigration health policy settings are designed to protect the Australian public against serious public health threats such as active TB and the Australian health care system from excessive additional pressure and expenditure on health care and community services.

Despite attracting criticism over the years, the health requirement has been successful in maintaining low TB rates, containing potential costs to health budgets as well as maintaining access to services in short supply.

That some form of immigration health requirement is necessary has been accepted by Governments for many decades. The policy and administrative settings of such a health requirement involve important public health care and equity considerations. Finding the balance between economic, social and humanitarian concerns, while meeting society's expectation as to access to health care, is not an easy thing to achieve.

It may be time to fine-tune the health requirement to reflect social views on how it impacts those with a disability, but any fine-tuning will need to be carefully done to ensure that it does not introduce other inequities, including a reduction in services to Australians and others with an entitlement to access Australia's health and community services.

It is DIAC's view that while some fine tuning may improve the operation of the health requirement, it is a key element of the migration program and should remain a key factor in a decision on a visa.

ATTACHMENT A: A HISTORY OF THE HEALTH REQUIREMENT

1901-1958[37]

Migrants and other temporary entrants to Australia have been subject to a "health requirement" in one form or another since the *Immigration (Restriction) Act* came into effect in 1901. Whilst the provisions varied over time, in general terms, this Act:

- prohibited migration by individuals with certain infectious or contagious diseases (at one point called diseases of a "loathsome or dangerous character");
    - In 1912, the Act specifically prohibited entry by individuals with pulmonary tuberculosis and trachoma. The diseases specified were to change over time – with additional diseases, such as scabies, prescribed in the Immigration Regulations from 1926 onwards.
- prohibited migration by "any idiot or insane person" or any person "likely...to become a charge upon the public or upon any public or charitable institutions";
    - This wording varied over time to include specific mental illnesses, imbeciles, the feeble-minded, epileptics, chronic alcoholics and those suffering from dementia.
- provided for the health of prospective migrants to be assessed via medical examinations, with certificates of health required to be obtained from approved immigration officials before or when they arrived in Australia; and
- provided for the establishment of "Commonwealth medical bureaux" overseas and a chief medical officer, as well as other qualified medical practitioners to assess applicants for migration.
    - Ships' medical officers were also authorised to conduct medical examinations and issue health certificates.

During this period, the *Quarantine Act 1908* also contained relevant powers in terms of detaining, quarantining and or treating infected prospective migrants, as well as visitors and Australian citizens returning from overseas. It, together with its regulations, contained much of the detail regarding the management and control of infectious and communicable diseases. Again the nature of the listed diseases varied over time to including those such as smallpox, plague, cholera, yellow fever, typhus fever and leprosy. Further details of prescribed diseases are provided at **Attachment K**. Separate regulations were also introduced to deal with particular outreaks of disease.

Immigrants could be deported if found to be suffering from a prohibited disease within three years of entering the country.

From 1920s onwards, there were also provisions that enabled the Government to recover health care costs from a migrant's "guarantor" for a period of up to 5 years. This was known as a "maintenance guarantee" and was required for all migrants[38]. It remained in one form or another until the introduction of the Assurance of Support Scheme in 1982.

1958 to 1993[39]

The Immigration (Restriction) Act was repealed in 1958 with the introduction of the *Migration Act 1958* which remains in place to this day (although significantly amended). Originally, again under this Act, individuals were again considered to be "prohibited immigrants" where they had a "prescribed disease". Much of the detail in terms of the health powers was again found in the related Migration Regulations 1959 as well as in the Quarantine Regulations 1956.

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[37] For a comprehensive summary of immigration health regulations in this period see A. Bashford & S. Howard, "Immigration and Health: Law and Regulation in Australia 1901-1958", in Health & History, 2004, Vol. 6(1), pp. 97-112.
[38] JSCM, op. cit., p. p. 67.
[39] For a comprehensive summary of immigration health regulations in this period see A. Bashford & S. Howard, "Immigration and Health: Law and Regulation in Australia, 1958-2004", in Health & History, 2005, Vol. 7(1), pp. 86-101.

A detailed list of prescribed disease was still provided which included mental illnesses, communicable disease and chronic non-communicable disease - see **Attachment L** for further information.

Significant changes were, however, to occur in 1989 when a new set of Migration Regulations came into effect. These regulations prescribed four new health "criteria", similar to those currently in place, which were assigned to different visa categories as considered appropriate. Any references to specific disease or conditions, except for tuberculosis, were removed from the legislation at this time. From 1992, these health criteria were labelled as Public Interest Criteria ( ) 4005, 4006 and 4007.

1994 onwards

The current "health requirement" (i.e. PIC 4005, PIC 4006A and PIC 4007) has basically remained the same since it was introduced as part of the new Migration Regulations that were enacted in 1994. The only real changes since 1994 were:

- the removal of PIC 4005A (allowed for a health waiver in certain circumstances) and PIC 4006 (required the applicant had to be free of a disease that would affect their offspring if produced) from the Regulations in 1995;
- the introduction of PIC 4006A (a health waiver where an employer undertaking was provided – see further explanation below) in 1995; and
- changes to the health requirement provisions relating to significant costs and prejudice of access in 1999 following related litigation (see Section 12 Interpretation of the current framework by the courts and discussion at **Attachment I**).

ATTACHMENT B: THE HEALTH REQUIREMENT: PIC 4005-4007

4005

The applicant:

(a) is free from tuberculosis; and

(b) is free from a disease or condition that is, or may result in the applicant being, a threat to public health in Australia or a danger to the Australian community; and

(c) is not a person who has a disease or condition to which the following subparagraphs apply:

(i) the disease or condition is such that a person who has it would be likely to:

(A) require health care or community services; or

(B) meet the medical criteria for the provision of a community service;

during the period of the applicant's proposed stay in Australia;

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

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

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

regardless of whether the health care or community services will actually be used in connection with the applicant; and

(d) if the applicant is a person from whom a Medical Officer of the Commonwealth has requested a signed undertaking to present himself or herself to a health authority in the State or Territory of intended residence in Australia for a follow-up medical assessment, the applicant has provided such an undertaking.

[4006 was omitted by SR 1995, 268 - LEGEND note]

4006A

(1) The applicant:

(a) is free from tuberculosis; and

(b) is free from a disease or condition that is, or may result in the applicant being, a threat to public health in Australia or a danger to the Australian community; and

(c) subject to subclause (2), is not a person who has a disease or condition to which the following subparagraphs apply:

(i) the disease or condition is such that a person who has it would be likely to:

(A) require health care or community services; or

(B) meet the medical criteria for the provision of a community service;

during the period of the applicant's proposed stay in Australia;

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

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

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

regardless of whether the health care or community services will actually be used in connection with the applicant; and

(d) if the applicant is a person from whom a Medical Officer of the Commonwealth has requested a signed undertaking to present himself or herself to a health authority in the State or Territory of intended residence in Australia for a follow-up medical assessment, the applicant has provided such an undertaking.

(2) The Minister may waive the requirements of paragraph (1)(c) if the relevant employer has given the Minister a written undertaking that the relevant employer will meet all costs related to the disease or condition that causes the applicant to fail to meet the requirements of that paragraph.

(3) In subclause (2), **"relevant employer"** means the proposed employer (within the meaning of the relevant Part of Schedule 2) in Australia:

(a) of the applicant (if the applicant is an applicant to whom the primary criteria apply); or

(b) if the applicant is an applicant to whom the secondary criteria apply - of the person:

(i) who meets the primary criteria; and

(ii) of whose family unit the applicant is a member.

4007

(1) The applicant:

(a) is free from tuberculosis; and

(b) is free from a disease or condition that is, or may result in the applicant being, a threat to public health in Australia or a danger to the Australian community; and

(c) subject to subclause (2), is not a person who has a disease or condition to which the following subparagraphs apply:

(i) the disease or condition is such that a person who has it would be likely to:

(A) require health care or community services; or

(B) meet the medical criteria for the provision of a community service;

during the period of the applicant's proposed stay in Australia;

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

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

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

regardless of whether the health care or community services will actually be used in connection with the applicant; and

(d) if the applicant is a person from whom a Medical Officer of the Commonwealth has requested a signed undertaking to present himself or herself to a health authority in the State or Territory of intended residence in Australia for a follow-up medical assessment, the applicant has provided such an undertaking.

(2) The Minister may waive the requirements of paragraph (1)(c) if.

(a) the applicant satisfies all other criteria for the grant of the visa applied for; and

(b) the Minister is satisfied that the granting of the visa would be unlikely to result in:

(i) undue cost to the Australian community; or

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

[4008 was omitted by SR 1995, 268 - LEGEND note]

ATTACHMENT C: HEALTH REQUIREMENTS FOR INDIVIDUAL VISA SUBCLASSES

Visa s/c Temporary (T), Permanent (P), Provisional (Prov)	Subclass Description	Health PIC
010	Bridging Visa Class A	None
020	Bridging Visa Class B	None
030	Bridging Visa Class C	None
040	Bridging Visa Class D (Prospective)	None
041	Bridging Visa Class D (Non Applicant)	None
050	Bridging Visa E (General)	None
051	Bridging Visa E (Protection Visa Applicant)	None
060	Bridging Visa F	None
070	Bridging Visa R (Removal Pending)	None
100 (P)	Spouse	4007
101 (P)	Child	4007
102 (P)	Adoption	4007
103 (P)	Parent	4005
106 (P)	Regional Linked	4005
114 (P)	Aged Dependent Relative	4005
115 (P)	Remaining Relative	4005
116 (P)	Carer	4005
117 (P)	Orphan Relative	4005
119 (P)	Regional Sponsored Migration Scheme	4005
120 (P)	Labour Agreement	4005
121 (P)	Employer Nomination	4005
124 (P)	Distinguished Talent	4005
132 (P)	Business Talent	4005
134 (P)	Skill Matching	4005
135 (P)	State/Territory nominated Independent	4005
136 (P)	Skilled - Independent	4005
137 (P)	Skilled - State/Territory nominated Independent	If class UX holder at the time of application – 4007 If not – 4005
138 (P)	Skilled - Australian Sponsored	4005
139 (P)	Skilled - Designated Area sponsored	4005

Visa s/c Temporary (T), Permanent (P), Provisional (Prov)	Subclass Description	Health PIC
143 **(P)**	Contributory Parent	If the holder of a substituted Subclass 676 visa – 4007, or if previously held subclass 173 – "Such health checks as the Minister considers appropriate If not - 4005
151 **(P)**	Former resident	If applicant is a "long residence applicant" who is outside Australia – 4005 If applicant is a "long residence applicant" in Australia or a "defence service applicant" - 4007
155 **(P)**	Five year Resident return	None
157 **(P)**	Three Month Resident return	None
159 **(T)**	Provisional resident return	None
160 **(Prov)**	Business Owner (Provisional)	4005
161 **(Prov)**	Senior Executive (Provisional)	4005
162 **(Prov)**	Investor (Provisional)	4005
163 **(Prov)**	State/Territory Sponsored Business Owner (Provisional)	4005
164 **(Prov)**	State/Territory Sponsored Senior Executive (Provisional)	4005
165 **(Prov)**	State/Territory Sponsored Investor (Provisional)	4005
173 **(Prov)**	Contributory Parent (Temporary)	4005
175 **(P)**	Skilled-Independent	4005
176 **(P)**	Skilled-Sponsored	4005
200 **(P)**	Refugee	4007
201 **(P)**	In country Special Humanitarian	4007
202 **(P)**	Global Special Humanitarian	4007
203 **(P)**	Emergency rescue	4007
204 **(P)**	Woman at Risk	4007
300 **(T)**	Prospective Marriage	4007
302 **(P)**	Emergency (Permanent Visa Applicant)	None
303 **(T)**	Emergency (Temporary Visa Applicant)	None
309 **(Prov)**	Spouse (Provisional)	4007
405 **(T)**	Investor Retirement	4005
406 **(T)**	Government Agreement	4005
410 **(T)**	Retirement	The applicant must be free from TB.
411 **(T)**	Exchange	4005

Visa s/c Temporary (T), Permanent (P), Provisional (Prov)	Subclass Description	Health PIC
415 **(T)**	Foreign Government Agency	4005
416 **(T)**	Special Program	4005
417 **(T)**	Working Holiday (Temporary)	4005
419 **(T)**	Visiting Academic	4005
420 **(T)**	Entertainment	4005
421 **(T)**	Sport	4005
422 **(T)**	Medical Practitioner	4005
423 **(T)**	Media and Film Staff	4005
426 **(T)**	Domestic Worker (Temporary) Diplomatic or Consular	4005
427 **(T)**	Domestic Worker (Temporary) Executive	4005
428 **(T)**	Religious Worker	4005
442 **(T)**	Occupational Trainee	4005
444 **(T)**	Special Category (Between Aust and NZ)	None
445 **(Prov)**	Dependent Child	4007
447 **(T)**	Secondary Movement Offshore Entry (Temporary)	4007
448 **(T)**	Kosovar Safe Haven	If the applicant is outside Australia, the applicant has undergone a medical examination carried out by a medical practitioner approved by the Minister
449 **(T)**	Humanitarian Stay (Temporary)	4007
451 **(T)**	Secondary Movement Relocation (Temporary)	4007
456 **(T)**	Business (Short Stay)	4005 unless the applicant is a person who has prescribed privileges and immunities and the Foreign Minister has recommended that the applicant be granted the visa
457 **(T)**	Business (Long Stay)	4006A IEFAO applicants must satisfy 4005. Health assessments are not required for applicants and their families who are to be accorded privileges/immunity and for whom DFAT has recommended a 457 visa be granted.
459 **(T)**	Sponsored Business Visitor (Short Stay)	4005
461 **(T)**	NZ Citizen Family Relationship	4007
462 **(T)**	Work and Holiday (Temporary)	4005
470 **(T)**	Professional Development	4005
475 **(Prov)**	Skilled - Regional Sponsored	4005
476 **(T)**	Skilled - Recognised Graduate	4005
485	Skilled - graduate	4005

Visa s/c Temporary (T), Permanent (P), Provisional (Prov)	Subclass Description	Health PIC
(T)		
487 (Prov)	Skilled - Regional Sponsored	4005
495 (Prov)	Skilled – Independent Regional Provisional	4005
496 (Prov)	Skilled – Designated Area-sponsored (Provisional)	4005
497 (T)	Graduate - Skilled	4005
570 (T)	Independent ELICOS	4005
571 (T)	Schools Sector	4005
572 (T)	Vocational Education and Training Sector	4005
573 (T)	Higher Education Sector	4005
574 (T)	Post Graduate Research Sector	4005
575 (T)	Non-award Sector	4005
576 (T)	AusAID or Defence Sector	4005
580 (T)	Student Guardian	4005
675 (T)	Medical Treatment (Short Stay)	Applicants undergoing medical treatment do not have to meet 4005, but must not be a threat to public health. Applicants accompanying person seeking treatment must meet 4005.
676 (T)	Tourist	4005
679 (T)	Sponsored Family Visitor	4005
685 (T)	Medical Treatment (Long Stay)	Applicants undergoing medical treatment do not have to meet 4005, but must not be a threat to public health. Applicants accompanying person seeking treatment must meet 4005.
695 (T)	Return Pending	None
771 (T)	Transit	4005
773 (T)	Border	4005
786 (T)	Temporary (Humanitarian Concern)	Must complete a medical examination and a CXR except in certain circumstances.
787 (T)	Witness Protection (Trafficking) (Temporary)	4007
800 (P)	Territorial Asylum (Residence)	4005
801 (P)	Spouse	4007
802 (P)	Child (Residence)	4007
804 (P)	Aged Parent	if holder of substituted subclass 676 at time of application - 4007 if not - 4005
808 (P)	Confirmatory (Residence)	None
820 (Prov)	Spouse (Extended Eligibility)	4007

Visa s/c Temporary (T), Permanent (P), Provisional (Prov)	Subclass Description	Health PIC
834 **(P)**	Permanent Resident Norfolk Island	N/A
835 **(P)**	Remaining Relative	4005
836 **(P)**	Carer	4005
837 **(P)**	Orphan Relative	4005
838 **(P)**	Aged Dependant relative	4005
845 **(P)**	Established Business in Australia	4005
846 **(P)**	State/Territory sponsored Regional established business in Aust	if the applicant resides, or proposes to reside, in a participating State or Territory - 4007 if not - 4005.
850 **(T)**	Resolution of Status	4007
851 **(P)**	Resolution of Status Permanent	Applicant only needs to have completed the examination(s) plus HIV and CXR.
852 **(P)**	Witness Protection (Trafficking)	4007
855 **(P)**	Labour Agreement	If the applicant resides, or proposes to reside, in a participating State or Territory — 4007 If not - 4005
856 **(P)**	Employer Nomination Scheme	If the applicant resides, or proposes to reside, in a participating State or Territory — 4007 If not - 4005
857 **(P)**	Regional Sponsored Migration Scheme	If the applicant was the holder of a class UX, subclass 475 or subclass 487 visa, or if resides or proposes to reside in a participating State or Territory - 4007 if not — 4005
858 **(P)**	Distinguished Talent	4005
859 **(P)**	Designated Parent	4005
864 **(P)**	Contributory Aged Parent	If the applicant was the holder of a substituted subclass 676 visa at the time of application – 4007 If not - 4005.
866 **(P)**	Protection	Applicant only needs to have completed the examination(s) plus HIV and CXR.
881 **(P)**	Skilled – Australian Sponsored Overseas Student	4005
882 **(P)**	Skilled - Designated Area – Sponsored Overseas Student	4005
883 **(P)**	Skilled - Designated Area Sponsored (Resident)	If the applicant or family member was the holder of a Skilled Designated Area sponsored (Provisional) visa – 4007. If not - 4005.

Visa s/c Temporary (T), Permanent (P), Provisional (Prov)	Subclass Description	Health PIC
884 **(Prov)**	Contributory Aged Parent (T)	If holder of a substituted subclass 676 visa – 4007 If not - 4005
885 **(P)**	Skilled-Independent	4005
886 **(P)**	Skilled-Sponsored	4005
887 **(P)**	Skilled-Regional	4007
890 **(P)**	Business Owner (Residence)	Main applicant – 4007 Member of the family unit who holds a Class UR visa – 4007 Other members of family unit - 4005
891 **(P)**	Investor	Main applicant - 4007 Member of the family unit who holds a subclass 162 visa – 4007 Other members of the family unit - 4005
892 **(P)**	State/Territory sponsored Business Owner (Residence)	Main applicant - 4007 Members of the family unit who hold a class UR, subclass 475 or a class UX visa - 4007 Other members of the family unit - 4005
893 **(P)**	State/Territory Sponsored Investor (Residence)	Main applicant - 4007 Members of the family unit who hold a subclass 165 - 4007 Other members of the family unit - 4005
956 **(T)**	ETA Business Entrant Long Validity	4005
976 **(T)**	ETA Visitor	4005
977 **(T)**	ETA Business Entrant Short Validity	4005
988 **(T)**	Maritime Crew	None
995 **(T)**	Diplomatic Temporary	None

ATTACHMENT D: REGULATION 2.25A: THE ROLE OF THE MOC

Reg 2.25A *Referral to Medical Officers of the Commonwealth*

2.25A **(1)** In determining whether an applicant satisfies the criteria for the grant of a visa, the Minister must seek the opinion of a Medical Officer of the Commonwealth on whether a person (whether the applicant or another person) meets the requirements of paragraph 4005(a), 4005(b), 4005(c), 4006A(1)(a), 4006A(1)(b), 4006A(1)(c), 4007(1)(a), 4007(1)(b) or 4007(1)(c) of Schedule 4 unless:

(a) the application is for a temporary visa and there is no information known to Immigration (either through the application or otherwise) to the effect that the person may not meet any of those requirements; or

(b) the application is for a permanent visa that is made from a country (whether Australia or a foreign country) specified by Gazette Notice for the purposes of this paragraph and there is no information known to Immigration (either through the application or otherwise) to the effect that the person may not meet any of those requirements.

Note ***foreign country*** is defined in paragraph 22(1)(f) of the *Acts Interpretation Act 1901* as any country (whether or not an independent sovereign state) outside Australia and the external Territories.

(2) In determining whether an applicant satisfies the criteria for the grant of a Medical Treatment (Visitor) (Class UB) visa, the Minister must seek the opinion of a Medical Officer of the Commonwealth on whether the applicant meets the requirements of:

(a) subparagraphs 675.221(2)(f)(i) and 675.221(2)(g)(i), (ii) and (iii) of Schedule 2; or

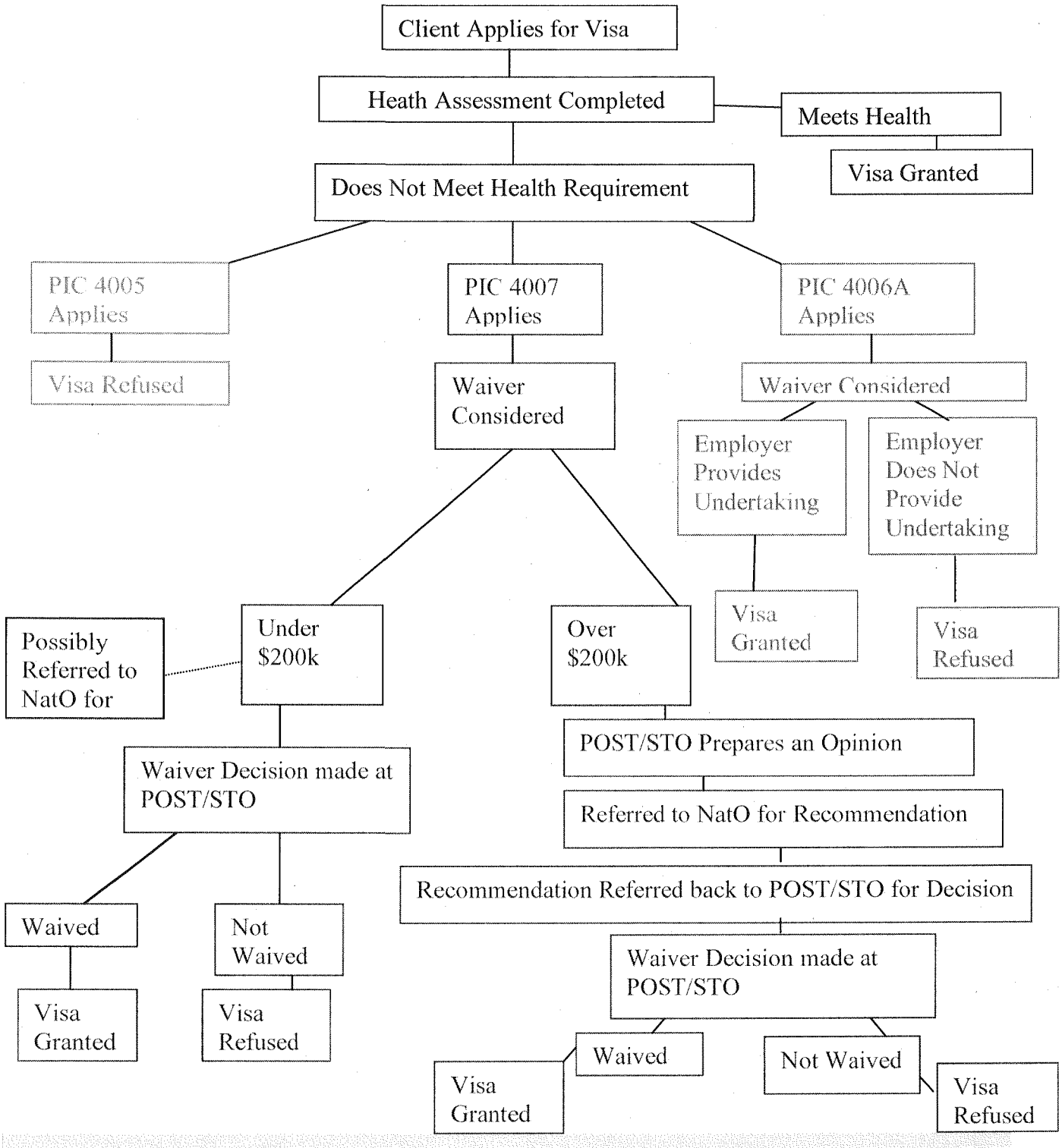
(b) subparagraphs 685.221(2)(f)(i) and 685.221(2)(g)(i), (ii) and (iii) of Schedule 2;

if there is information known to Immigration (either through the application or otherwise) to the effect that the applicant may not meet any of those requirements or be able to satisfy the Minister as to those matters.

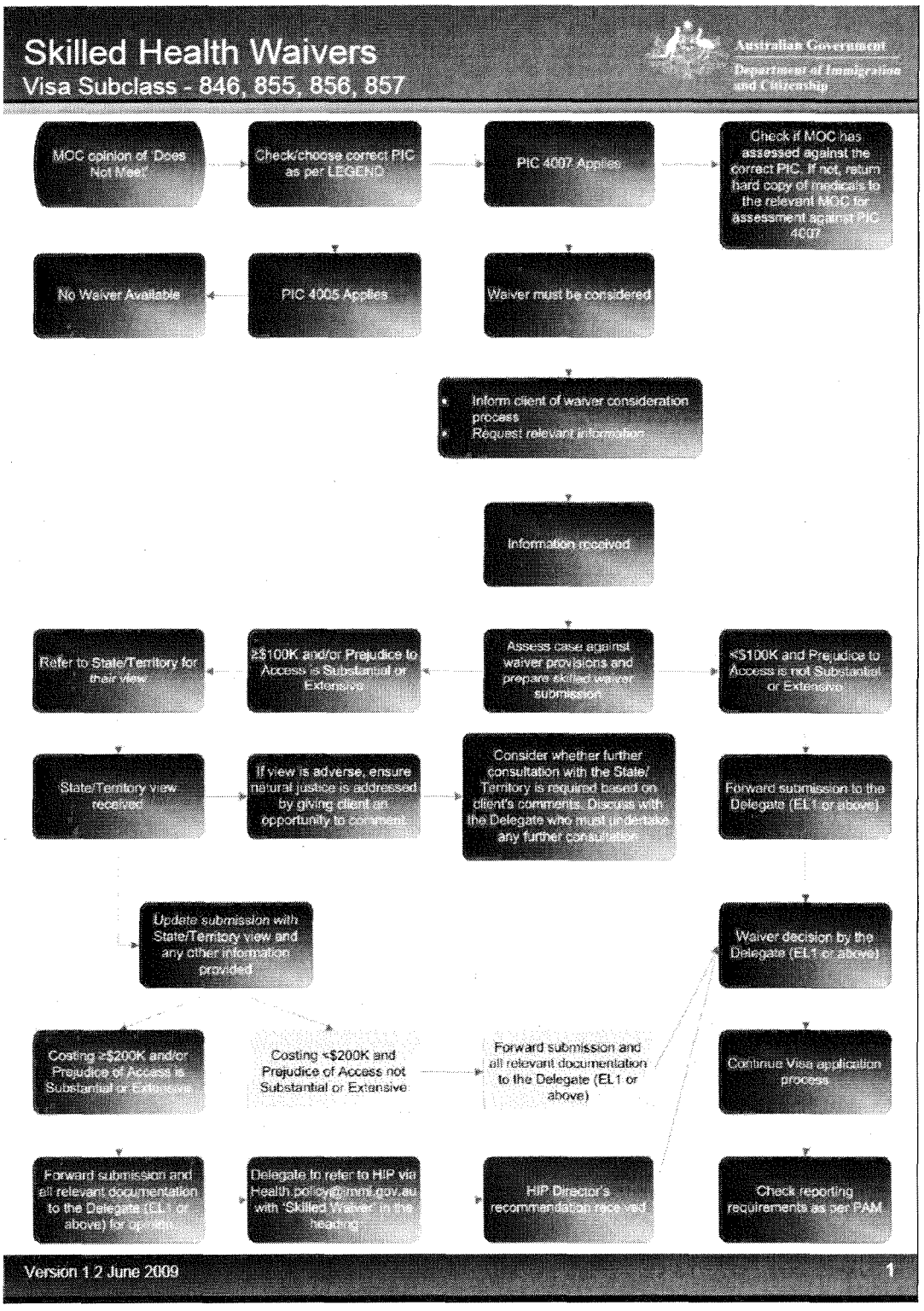
(3) The Minister is to take the opinion of the Medical Officer of the Commonwealth on a matter referred to in subregulation (1) or (2) to be correct for the purposes of deciding whether a person meets a requirement or satisfies a criterion.

[REG 2.25B omitted by SR 1999, 81 with effect from 1/07/1999 - LEGEND note]

ATTACHMENT E: THE WAIVER DECISION-MAKING PROCESS



ATTACHMENT F: SKILLED HEALTH WAIVERS



ATTACHMENT G: STATISTICS

Refusals on health grounds

As indicated in the table below according to subclass, **1,586** clients in the 08-09 financial year were refused visas on "health grounds".

Subclass	Subclass Description	Count
100	Partner	3
103	Parent	124
114	Aged Dependent Relative	1
115	Remaining Relative	14
116	Carer	6
119	Regional Sponsored Migration Scheme	14
120	Labour Agreement	8
121	Employer Nomination	2
134	Skill Matching	4
136	Skilled - Independent	383
137	Skilled - State/Territory Nominated Independent	25
138	Skilled - Australian Sponsored	71
139	Skilled-Designated Area Sponsored	20
143	Contributory Parent (Migrant)	39
163	State/Territory Sponsored Business Owner	32
165	State/Territory Sponsored Investor	8
173	Contributory Parent (Temporary)	10
175	Skilled - Independent	61
176	Skilled - Sponsored	21
200	Refugee	77
202	Global Special Humanitarian	36
204	Woman At Risk	3
300	Prospective Marriage	9
309	Partner Provisional	31
310	Interdependency (Provisional)	3
417	Working Holiday	23
428	Religious Worker	5
442	Occupational Trainee	2
457	Business (Long Stay)	59
461	New Zealand Citizen (Family Relationship) Temporary Visa	1
462	Work And Holiday	1
475	Skilled - Regional Sponsored	17
476	Skilled - Graduate	3
485	Skilled - Graduate	1
487	Skilled - Regional Sponsored	2
495	Skilled Independent Regional (Provisional)	20
496	Skilled Designated Area Sponsored (Provisional)	15
570	Independent Elicos Sector	11
571	Schools Sector	3
572	Vocational Education And Training Sector	35
573	Higher Education Sector	48
574	Masters/Doctorate Sector	6
575	Non-Award Foundation/Other Sector	1
576	Ausaid/Defence Sponsored Sector	12
580	Student Guardian	2
675	Medical Treatment (Short Stay)	1
676	Tourist	71
679	Sponsored Family Visitor	69

685	Medical Treatment (Long Stay)	1
771	Transit	1
801	Partner	3
804	Aged Parent	64
814	Interdependency	3
820	Partner	3
826	Interdependency	3
835	Remaining Relative	1
836	Carer	1
837	Orphan Relative	1
838	Aged Dependent Relative	1
856	Employer Nomination	5
857	Regional Sponsored Migration Scheme	6
864	Contributory Aged Parent (Residence)	17
880	Skilled - Independent Overseas Student	10
884	Contributory Aged Parent (Temporary)	4
886	Skilled - Sponsored	1
892	State/Territory Sponsored Business Owner	4
976	ETA - Visitor Short Stay	43
977	ETA - Business Short Validity (12 Months)	1
		1586

Of these clients:

- 36 failed to meet the health requirement on public health grounds;
- 360 actually failed to meet the health requirement on cost or prejudice of access grounds
- 282 had a family member who failed to meet the health requirement on health costs/prejudice of access grounds (i.e. they were not granted a visa due to the "one fails all fails" rule for permanent visas – i.e. all applicants for the visa as well as any non-migrating dependants must meet the health requirement).
- 864 failed to undergo required health assessments and hence were refused a visa
- 44 clients were refused an ETA and asked to apply for another visa product so that their health could be properly assessed due to a previous adverse health result.

It is estimated that the more than $70 million[40] health and community service costs would have resulted if these visas had been granted.

Of the 360 applicants who failed to meet the health requirement on cost or prejudice of access grounds:

- 74 (approx 21%) related to a client with an HIV infection;
- 53 (approx 15%) related to a client with some level of intellectual impairment
- 41 (approx 11%) related to cancer
- 32 (approx 9) related to renal disease/failure
- 30 (approx 8%) related to heart disease or other cardiac issues
- 27 (approx 7%) related to Alzheimer's/dementia
- 20 (approx 6%)related to blindness or other vision or hearing issues
- 17 (approx 5%) related to neurological issues (including strokes and multiple sclerosis)
- 16 (approx 4%)related to mobility issues or bone issues
- 13 (approx 4%) related to depression/mental health issues
- 6 (approx 2%) related to blood diseases
- 5 (approx 1%) related to diabetes
- 5 (approx 1%) related to lung diseases/related conditions
- 4 (approx 1%) related to liver disease and/or hepatitis
- 18 (approx 5%) related to other conditions

Health Waivers

[40] Please note that DIAC only records costs estimates for "Does not meet" health decisions where a waiver is available and not exercised. Hence, this is a very rough and conservative estimate provided by DIAC's Chief Medical Officer without looking at individual cases details. The total estimated costs could potentially be closer to $90 to 100 million.

Cases processed onshore

Departmental records indicate that in 2008-09, visas were granted **onshore** in **138 cases**[41] where the main applicant or one of their family members failed the health requirement and a health waiver was exercised. The estimated health and community service costs provided by the MOCs in these cases amounted to a total of **$19,564,500.**

The most common health condition for which a waiver was acquired was HIV – with a waiver available in 59 cases (total estimated cost $14,018,000).

Other common conditions included:

- intellectual impairment (26 cases; estimated cost $1,166,000)
- cancer (10 cases; estimated cost $751,500)

42 waiver cases involved applications for a Subclass 457 visa. Almost all other onshore waivers related to Partner visa cases within the family stream.

Cases processed offshore waivers

Departmental records indicate that there were **150** visa applicants with significant health conditions whose applications were processed offshore were granted a health waiver in 2008-09.

The estimated health and community service costs provided by the MOCs in these cases amounted to **$38,163,500**.

[41] Please note that this is based on reports run on available data in ICSE. The accuracy of these reports will remain limited until a reporting solution is in place, which is planned for 2010. It should also be noted that approximately 276 individuals would have been granted visas as a result of the health waivers available in these cases.

ATTACHMENT H: ANAO RECOMMENDATIONS

Recommendations of the ANAO Audit Report No. 37 2006-07: Administration of the Health Requirement of the *Migration Act 1958*

Recommendation 1: "To ensure that health risks to Australia are minimised, the ANAO recommends that DIAC and DoHA develop a protocol, such as a Memorandum of Understanding (MOU), that clearly defines the respective roles and responsibilities of each agency in setting and managing the health requirement of the Migration Act 1958. The protocols or MOU should document mechanisms to achieve a well-coordinated and timely response to support DIAC in setting and reviewing the health requirement".

Recommendation 2: "To provide a sound basis for consistent medical assessments of visa applicants against the health requirement by Medical Officers of the Commonwealth, the ANAO recommends that DIAC: ensure an up to date and complete set of guidelines (Notes for Guidance); and implement a formal process for regular review and appropriate endorsement of these guidelines."

Recommendation 3: "ANAO recommends that DIAC, with assistance from DoHA, formulates comprehensive and current advice on what constitutes a threat to public health for immigration purposes. This advice should be used to inform the development of timely strategies for addressing emerging immigration issues having public health risk".'

Recommendation 4: - "ANAO recommends that DIAC improve its risk management of health assessments by: Documenting the procedure for categorising countries' risks, giving clear indication of the basis on which categories are decided and a process for regularly reviewing them; Regularly updating the gazetted list; Specifications for countries for the purposes of regulations 2.25A; Defining the methodology and reasons for selecting countries for the gazetted list, and the basis for allocating authority for local clearance of health assessments to gazetted and non gazetted countries Evaluating its process for assessing medical reports which are front end loaded, with a view to developing standard procedures and guidelines to manage and monitor this process.

Recommendation 5: - "To encourage consistency in health waiver decisions and enable accurate reporting of health waiver outcomes, the ANAO recommends that DIAC: in line with the department's requirements, ensure that all health waiver decisions are sent to a designated coordination point, such as the Health Policy Section, for review and recording; and ensure that sufficient data is collected to enable accurate monitoring and reporting of the outcome of health waiver decisions, including potential costs to Government".

Recommendation 6: "To improve the effectiveness of health undertakings, ANAO recommends that DIAC: develop guidelines on health undertakings, to provide the basis for more transparent and consistent decisions; and consult with the States and Territories with a view to establishing arrangements to assist DIAC in monitoring and reporting of compliance for health undertakings"'

Recommendation 7: 'The ANAO recommends that DIAC fully scope the IT needs for the health requirement, in consultation with users, and develop a comprehensive strategy and plan for improving management of client records and data collection for purposes of program management, performance and outcome reporting.'

Recommendation 8: 'DIAC's effectiveness measure for its implementation of the health requirement of the Migration Act 1958 is the 'extent to which public health and safety is protected through migration screening'. To enable DIAC to monitor and report its progress against this, the ANAO recommends that DIAC: develop appropriate effectiveness indicators and effectiveness measures to monitor and report its performance in meeting key elements of the Public Interest Criteria, including: diseases of public health threat other than tuberculosis; significant cost to the Australian community; and prejudice to access; and effectively utilise data to set and review the health criteria, procedures and guidelines.'

ATTACHMENT I: IMPORTANT LITIGATION CASES

Robinson v Minister for Immigration and Multicultural and Indigenous Affairs
[2005] FCA 1626

This case involved the decision to refuse a Labour Agreement (Residence) visa on the grounds that the applicant's son could not meet the health requirement as he had Down syndrome which was assessed as likely to result in significant costs to the Australian community. No health waiver was available as PIC 4005 applied to this visa subclass.

In this case, the applicant's lawyers argued that the RMOC opinion was not authorised by the regulations. The Full Federal Court agreed, finding that the Tribunal made a jurisdictional error by relying on an RMOC opinion in which the RMOC had not applied the appropriate "hypothetical person" test. This test:

> *"requires the MOC to ascertain the form OR level of condition suffered by the applicant in question and then to apply the statutory criteria by reference to a hypothetical person who suffers from that form or level of the condition"*[42].

It should be noted that such a hypothetical person could require access to health care or community services in future that they do not currently access.

The refusal decision was thus overturned because of errors in the RMOC opinion which the court felt demonstrated that the appropriate test had not been applied. Such errors included failing to:

- refer to a hypothetical person with the same actual level of the condition – with only general statements made about the condition;
- take in to account that one doctor described the condition as 'mild'; and
- refer to the content of the reports that the RMOC was asked to consider or provide a reason for disagreeing with them.

Ramlu v Minister for Immigration and Anor
[2005] FMCA 1735

This case involved the decision to refuse a Skilled permanent visa on the grounds that the applicant did not meet the health requirement because he had erosive seropositive rheumatoid arthritis which was likely to result in significant costs to the Australian community. No health waiver was available as PIC 4005 applied to this visa subclass.

The applicant in this case was successful with the MOC opinion found to be unlawful for similar reasons to *Robinson*. Indeed, the court re-iterated that MOCs must consider the impact of a disease or ailment upon a hypothetical person to the degree suffered by the applicant. It also clarified that:

> *"4005(c) requires a likelihood (i.e. a probability – not simply just a possibility) of a hypothetical person who has a disease or condition that the applicant has would require health care etc, which is likely to result in significant costs to the Australian community"*[43].

The applicant was successful in this case as the court found that whilst the MOC was not required to provide reasons for their decision, it held that the MOC opinion was not properly formed as:

[42] [2005] FCA 1626 at [43].
[43] [2005] FMCA 1735 at [13]

"the MRT was left in a position where it could not be sure what the relevant disease was, let alone the level of it".[44]

Indeed, the applicant had two diseases/conditions of concern: diabetes and arthritis, but the RMOC did not specify on the basis of which of these two diseases/conditions that the applicant had failed to meet PIC 4005(c)(ii)(A). The judge stated that:

"In my view, in order to be reliable for the purposes of the Regulations, a RMOC opinion must be clear on its fact as to what the disease is to which the public interest criteria relate."[45]

***Blair v Minister for Immigration and Multicultural and Indigenous Affairs* [2001] FCA 1014**

This case involved the decision to refuse a Former resident visa on the grounds that the applicant's son did not meet the health requirement due to the costs associated with his Down syndrome and hypothyroidism conditions. No health waiver was available as PIC 4005 applied to this visa subclass.

DIAC was successful in this case as the court found the MOC had "asked himself the right questions". The court also confirmed that MOCs are entitled and indeed required to form their own opinion as to whether an applicant meets the health requirement even if it conflicts with other medical evidence presented.

The court confirmed the importance of assessing the form or level of the applicant's condition, but clarified that MOCs are not required to quantify cost. Rather they only need to determine whether they were significant. The court stated that a MOC:

"must surely be entitled (and in my view) is required to form his or her own opinion, even if it conflicts with the medical evidence submitted on behalf of an applicant"[46].

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

This case involved the decision to refuse an Aged Parent visa on the grounds that the applicant had a number of medical issues including severe cardiac dysfunction, peripheral vascular disease, hypertension, cataracts and chronic gastritis. No health waiver was available as PIC 4005 applied to this visa subclass.

DIAC was successful in this case. No error of law was found in the case with the court confirming that the MOC:

- was not required to take into account the fact that the applicant's family would pay for the costs involved;
- noted the opinion of the treating doctor but disagreed with it; and
- did consider that the applicant's condition could change but formed the opinion that it may deteriorate.

The court noted that:

"One would expect that a medical officer would be able to assess the nature of a disease or condition and its seriousness in terms of its likely future requirement for health care...one

[44] Ibid at [25].
[45] Ibid at [22].
[46] [2001] FCA 1014 at [33].

would not expect a medical officer to inquire into the financial circumstances of a particular applicant…".[47]

"The criterion...is not a prediction of whether the particular applicant will, in fact, require health care or community services at significant cost to the Australian community".[48]

***Minister for Immigration & Multicultural Affairs v Seligman* [1999] FCA 117**

This case involved the decision to refuse a Senior Executive visa because the applicant's son had borderline intellectual functioning and failed to meet the health requirement on the grounds that his condition would result in a significant cost to the Australian community. No health waiver was available as PIC 4005 applied to this visa subclass.

This appeal looked at the ability of the court to review the opinion of a MOC. DIAC was not successful in this case.

The court found that it would be an error of law for a s65 delegate to rely on an unlawful MOC opinion in making their decision on a visa application, and that the courts could thus overturn a visa refusal decision based on such an opinion. The court stated that:

"… the delegate is only entitled and obliged to take [the medical officer's] opinion as correct if it is an opinion of a kind authorised by the regulations and, it may be added, validly so authorised. If it is not or if it travels beyond the limits of what is authorised, then to act upon it as though it is binding is to act upon a wrong view of the law and to err in the interpretation the law or its application, a ground of review for which s476 provides".[49]

It also indicated that the level of the applicant's son's impairment was a relevant consideration in terms of whether he met the health requirement.

[47] [2001] FCA 1011 at [14].
[48] Ibid at [13].
[49] [1999] FCA 117 at [66].

ATTACHMENT J: HEALTH REQUIREMENTS FOR OTHER COUNTRIES

New Zealand[50]

Health requirements

New Zealand describes the objective of its health requirements as to:

- protect public health in New Zealand;
- ensure that people entering New Zealand do not impose excessive costs and demands on New Zealand's health and special education services; and
- where applicable, ensure that applicants for entry to New Zealand are able to undertake the functions for which they have been granted entry.

All applicants for visas and permits are expected to have an acceptable standard of health unless they are entering New Zealand for specific medical treatment and have been granted a visa or permit for this purpose.

To be granted a visa, applicants must have an "acceptable standard of health" – i.e. they must be:

- unlikely to be a danger to public health;
- unlikely to impose significant costs or demands on New Zealand's health services or special education services; and
- able to perform the functions for which they have been granted entry.

Interpreting the requirements

Active pulmonary TB is considered to be a public health threat as it is a communicable disease from which the New Zealand public cannot be provided protection from exposure and infection.

'Health services' includes all health and disability support services funded through Vote Health (a Government health funding package).

Permanent visa applicants will be found likely to impose significant:

- demands on NZ health services where their condition requires health services for which the current demand in NZ is not being met; and/or
- costs on NZ health services where:
    - in the opinion of an Immigration New Zealand medical assessor, there is a relatively high probability that their condition will require health services costing in excess of $25 000 (utilising current costs);
    - in the case of acute medical conditions, there is a relatively high probability that their condition will require health services costing in excess of $25 000 within a period of 4 years from the date of assessment; or
    - in the case of chronic recurring medical conditions, there is a relatively high probability that over the predicted course of the condition their condition will require health services costing in excess of $25 000.

[50] The following information is drawn from Immigration New Zealand's Operation Manual see Section A4 http://www.immigration.govt.nz/migrant/general/generalinformation/operationsmanual/

In addition, the conditions listed below are deemed to impose significant costs and/or demands on New Zealand's health and/or special education services. Hence, where a visa officer is satisfied (as a result of the advice of an Immigration New Zealand medical assessor) that a permanent visa applicant has one of the listed conditions, that applicant will be assessed as not having an acceptable standard of health. Where this occurs, as in Australia, that applicant as well as any other family members included in the application will not be able to be granted a visa (even if they indicate that they have access to private health care) unless a waiver is available and granted.

Note: Applicants who intend to give birth in New Zealand are also not considered to have an acceptable standard of health as it is likely they will impose significant costs or demands on New Zealand's health services.

Conditions deemed to impose significant costs and/or demands

- HIV infection
- Hepatitis B surface antigen positive, with abnormal liver function
- Hepatitis C, RNA positive, with abnormal liver function
- Malignancies of solid organs and haematopoietic tissue, including past history of, or currently under treatment
    - Exceptions are:
        - treated minor skin malignancies (not melanoma)
        - malignancies where the interval since treatment is such that the probability of cure is > 90% (e.g.: early stage (I & IIA) breast cancer at 5 years; low risk prostate cancer at 5 years; early stage (Dukes A & B1) colorectal cancer at 5 years; childhood leukaemia at 5 years).
- Solid organ transplants, excluding corneal grafts more than 6 months old
- Chronic renal failure or progressive renal disorders
- Diseases or disorders such as osteoarthritis with a high probability of arthroplasty in the next four years
- Central Nervous System disease, including motor neurone disease, complex partial seizures, poorly controlled epilepsy, prion disease, Alzheimer's and other dementia, and including paraplegia and quadriplegia
- Cardiac disease including ischaemic heart disease, cardiomyopathy or valve disease requiring surgical and/or other procedural intervention
- Chronic obstructive respiratory disease with limited exercise tolerance and requiring oxygen
- Genetic or congenital disorders: muscular dystrophies, cystic fibrosis, thalassaemia major, sickle cell anaemia if more than one sickle crisis in 4 years, severe haemophilia, and severe primary immunodeficiencies
- Severe autoimmune disease, currently being treated with immuno-suppressants other than prednisone
- In a person up to the age of 21 years, a severe (71-90 decibels) hearing loss or profound bilateral sensori-neural hearing loss
- In a person up to the age of 21 years, a severe vision impairment with visual acuity of 6/36 or beyond after best possible correction, or a loss restricting the field of vision to 15-20 degrees
- In a person up to the age of 21 years, a severe physical disability, where they are unable to stand and walk without support, and cannot independently dress, eat, hold a cup, or maintain their stability when sitting.

Temporary visa applicants are assessed as to whether they are likely to impose significant costs or demands on New Zealand's health services, taking into account whether there is a relatively high probability that they will need publicly funded health services during their period of stay – e.g. hospitalisation, residential care, high cost pharmaceuticals and/or high cost disability services. Temporary visa applicants with one of the conditions listed above may thus still be able to travel to New Zealand on a temporary basis.

Significant costs on special education services

Significant costs on NZ special education services are only found where the Ministry of Education (MoE) determines that the applicant's condition would entitle them to Ongoing and Reviewable Resourcing Schemes (ORRS) funding. Student visa applicants under age of 21 must be unlikely to qualify for ORRS funding during their period of stay.

Required health assessments

Most applicants intending to stay in New Zealand for six months or more need to provide a completed a medical certificate. This includes undertaking a medical examination and/or a chest x-ray depending on which visa category they are applying under, and how long they intend to stay in New Zealand. As with Australia:

- some visitors from countries with a low incidence of tuberculosis do not need to undergo any health checks if they intend to stay less than 12 months in New Zealand;
- pregnant women and children under 11 years of age are not required to have an X-ray examination;
- visa officers always have discretion to request additional medicals if they consider it appropriate.

Applicants undertake medical examinations with a registered medical practitioner in New Zealand or an approved panel doctor if overseas. Medical reports are valid for 3 months. "Medical certificates" can be re-used for a period of up to 2 years.

Immigration or visa officers use the information provided in application forms as well as "medical certificates" (i.e. the results of medical examinations) where required in order to assess the health status of visa applicants. Similarly to in Australia, in some cases, visa officers may refer medical certificates to an Immigration New Zealand Medical Assessor for advice.

Where a qualified professional disputes the opinion of a medical assessor, a second opinion from a different medical assessor will be sought. Similar arrangements are in place where an MoE panel decision is disputed.

Residence applications can be deferred:

- for 6 months to allow applicant to undergo TB treatment; or
- to allow them to undergo surgery which if successful may result in them achieving an acceptable standard of health.

HIV

In general, HIV is not an issue for temporary visa applicants intending to stay up to 12 months in New Zealand. However, applicants for a Recognised Seasonal Employer visa will not be granted a visa if they are HIV positive.

Furthermore, as noted above, HIV is included on a list of medical conditions deemed to impose significant costs and/or demands on New Zealand's health and/or education services. Hence, an applicant for permanent residence in New Zealand will not be successful unless they are able to acquire a health waiver.

New Zealand also accepts up to 20 known HIV positive refugees every year under a quota system.

Waivers

Applicants who are found not to have an acceptable standard of health will have their visa refused unless they are granted a waiver due to compelling circumstances.

Waivers are available where:

- a residence applicant has met all other requirements for their visa;
- a temporary applicant has met all other requirements for their visas and:
    - has a partner, dependent child who is a NZ citizen or resident,
    - has applied for a visa as a seconded business persons, or
    - is a refugee applicant; or
- a temporary visa applicant intends to give birth in New Zealand and their partner is a NZ citizen or resident, or is applying for a work to residence visa and intends to stay longer than 24 hours.

Factors taken into account include:

- the objectives of health requirements policy;
- the degree to which the applicant would impose significant costs and/or demands on New Zealand's health or education services;
- whether the applicant has immediate family lawfully and permanently resident in New Zealand and the circumstances and duration of that residence;
- whether the applicant's potential contribution to New Zealand will be significant; and
- the applicant's length of intended stay.

A waiver will not be granted if the applicant:

- requires dialysis;
- has pulmonary tuberculosis;
- has severe haemophilia;
- has a physical incapacity that requires full time care; or
- is applying for residence under Family Category policy and was eligible to be included in an earlier application for residence, but was not declared on that earlier application.

United States of America[51]

Health requirements

Under the Immigration and Nationality Act (INA), an applicant can be refused a visa where they have a condition that is considered a public health concern.

The "medical grounds of inadmissibility" are divided into four categories:

- communicable diseases of public health significance;
    - These are defined in the regulations published by the Department of Health and Human Services to include:
        - severe acute respiratory syndrome (SARS);
        - TB;
        - Leprosy;

[51] Further information is available on the website of U.S. Citizenship and Immigration Services (www.uscis.gov)

- HIV/AIDS;
- syphilis (infectious state);
- chancroid (STD, similar to syphilis and herpes);
- gonorrhoea granuloma inguinale (STD, donovaniasis); and
- lymphogranuloma (STD, Chlamydia).

o New regulations were also issued in October 2008 to allow new diseases to be included in the list. At this stage, the Government has indicated that it will take a "risk based approach" to air-borne illnesses such as Yellow Fever and Ebola.

- lack of required vaccinations (for immigrants only);
  - o The vaccinations required are:
    - Mumps;
    - Measles;
    - Rubella;
    - Polio;
    - Tetanus;
    - diphtheria toxoids;
    - pertussis; and
    - *influenza* type B.
- physical or mental disorders with harmful behaviour; and
  - o Physical or mental disorders includes "current physical or mental disorders, with harmful behavior associated with that disorder" and "past such disorder...with associated harmful behavior that is likely to recur".
- drug abuse/drug addiction.

Applicants with a health condition are also potentially inadmissible if a consular officer believes they are likely at any time to become a "public charge"[52].

Required health assessments

All permanent visa applicants, including refugees, must undergo a medical exam which includes:

- a TB skin test if aged two years or older (an x-ray will also be required for applicants who have signs or symptoms of TB or immunosuppression, or a tuberculin skin test (TST) reaction of less than 5 mm);
- an HIV test (if 15 years of age or older); and
- a mental status evaluation.

Temporary visa applicants can be asked to do a physical or mental examination or both at the discretion of a consular officer.

Assessment process

Medical examinations must be undertaken by a designated civil surgeon.

[52] See Section 212(a)(4)(A) of the Immigration and Nationality Act.

If a medical condition is identified as falling within one of the four categories outlined above, the civil surgeon or panel physician must indicate whether the condition is a Class A (i.e. applicant inadmissible) or Class B (i.e. applicant not inadmissible). Active and infectious TB is considered to be a Class A condition.

HIV

In 1993, Congress passed an amendment to the INA which automatically made an HIV-positive foreign national "inadmissible". This was repealed in 2008. Hence, HIV is no longer singled out in immigration law for exclusion. However, as noted above, HIV is still on the list of communicable diseases which means that HIV positive individuals can only apply for a "green card" (i.e. permanent residence) if they qualify for a waiver.

Being "inadmissible" technically also bars short term travel to the USA, although applicants for non-immigrant visas are not generally tested for HIV.

In October 2008, regulations were issued streamlining the process for short-term travellers to obtain a waiver for up to 30 days to the U.S,A, but such travellers must still demonstrate that they are asymptomatic, can cover their medical bills and don't pose a danger to public health.

Waivers are also available for short –term travellers visiting the USA for designated events.

Waivers

Waivers of the medical grounds of inadmissibility are available to a:

- spouse or unmarried son or daughter or the minor, unmarried adopted child of a U.S. citizen or lawful permanent resident (LPR);
- parent of a U.S. citizen or LPR;
- spouse of a US citizen or LPR who has been subjected to domestic violence; or
- refugee or asylum seeker

where the danger to public health and the possibility of the spread of infection created by their admission is minimal, and no U.S. government agency will incur an expense on their behalf without their consent.

No waiver is available where the applicant is likely to become a public charge. However, this section of the Act does not apply to all applicants (e.g. refugees).

Canada[53]

Health requirements

A foreign national can be found to be inadmissible to Canada on health grounds where they have a health condition that:

- is likely to be a danger to public health or safety; or
    - Active tuberculosis and untreated syphilis are considered to be medical conditions that present a risk to public health.

    - Examples given of conditions that may pose a threat to public safety in Canada include:
        - certain impulsive sociopathic behaviour disorders;
        - some aberrant sexual disorders such as paedophilia;
        - certain paranoid states;

[53] For further information please see the website of Citizenship and Immigration Canada (www.cic.gc.ca). Source documents are also available at http://laws.justice.gc.ca .

- some organic brain syndromes associated with violence or risk harm to others; and
- applicants with substance abuse leading to antisocial behaviour such as fighting, impaired driving, or other types of antisocial behaviour.

- would cause excessive demand on health or social services.[54]
  - "Health services" is taken to include any services for which the majority of funds are contributed by governments, including the services of family physicians, medical specialists, nurses, chiropractors, physiotherapists, laboratory services and the supply of pharmaceutical or hospital care.
  - "Social Services" includes any social service (e.g. home care, specialised residence and residential services, special education services, social and vocational rehabilitation services, personal support services and the provision of devices related to those services) that is intended to assist a person in functioning physically, emotionally, socially, psychologically or vocationally and for which the majority of funding is contributed by governments.
  - "Excessive demand" means a demand on health service:
    - where a demand would add to existing waiting lists or increase the rate of mortality and morbidity in Canada as a result of the denial of or delay in the provision of those services to Canadian citizens and permanent residents; or
    - for which the anticipated costs would likely to exceed average Canadian per capita costs over a period of five consecutive years (unless there is evidence that significant costs are likely to be incurred beyond that period in which case an assessment is made in relation to a 10 year period). Like Australia, Canada has a cost threshold in place. This is updated every year. This 2009 threshold is $5143 (which would make the threshold over a 5 year period $ 25 715).

The "excessive demand" determination does not, however, apply to:

- sponsored spouse, common-law partner or child of a Canadian citizen or permanent resident ;
- refugees and their close family members.

Required health assessments

Permanent visa applicants including any dependants (even if not migrating) must undertake a medical examination with a Designated Medical Practitioner.

Temporary visa applicants, which include Tourists, Students and Temporary foreign workers, are generally only required to undertake a medical examination where they intend to stay in Canada for more than six months and have spent six or more consecutive months in a designated country/territory in the previous 12 months (i.e. countries with higher TB incidence rates defined as a three year average estimated sputum smear positive pulmonary tuberculosis rate of 15/100,000 or more).

Temporary foreign workers intending to work in an occupation in which protection of public health is essential must, however, complete a medical examination (e.g. workers in health sciences, teachers, domestics, home carers and day nursery employees, as well as agricultural workers from certain countries) whatever their country of origin and length of stay in Canada.

Medical assessment results are generally valid for a 12 months period.

Assessment process

[54] See Section 38 of the Immigration and Refugee Protection Act (2001, c.27) and Annex 5 to the Immigration and Refugee Protection Regulations.

When determining whether any person is inadmissible on medical grounds, the medical officer is obliged to consider the nature, severity or probable duration of any health impairment from which the person is suffering as well as other factors, such as:

- the communicability of any disease that the foreign national is affected by and the impact that the disease could have on other persons living in Canada (i.e. whether applicant has active TB or untreated syphilis);
- unpredictable or unusual behaviour that may create a danger to public safety; and
- the supply of publicly funded social or health services that the person may require in Canada over a 5 to 10 year period or during the stay in Canada if temporary resident and whether the use of such services will increase the rate of mortality and morbidity by depriving Canadian nationals of these services.

See more information regarding the assessment of the "excessive demand" test below at Waivers.

HIV

Like Australia, Canada does not place any particular restrictions on HIV positive visa applicants. These applicants are assessed against the legislative criteria outlined above. HIV is not considered a threat to public health or safety by the Canadian Government.

Between 2002 and 2007 there were 3,103 foreign nationals who applied to enter Canada and who tested positive for HIV for the first time during their medical examination. Of those who completed an immigration medical examination and were found to be HIV positive, 90 per cent were determined to be medically admissible to the country. Approximately 85% of those applicants were exempt from the excessive demand assessment.

Waivers

There are no "waivers" as such, but these are not required as decision-makers must consider the circumstances of the individual before determining whether "excessive demand" exists (i.e. discretion is available).

Under procedural fairness, any applicant who is likely to be inadmissible under health grounds is offered an opportunity to submit any new medical information deemed useful by the applicant. This information is reviewed by decision-makers. After having reviewed the new material, the decision-maker may:

- maintain his/her initial medical opinion;
- withdraw and provide a new medical opinion of admissibility; or
- withdraw and request for additional medical information.

Applicants who require social services at a level that exceeds the excessive demand threshold are given the chance to provide a credible plan to an immigration officer demonstrating that they will not impose an excessive demand on Canadian social services – the ability and intent of the applicant to offset any excessive demand on social services must be taken into consideration (e.g. will receive non-financial assistance from family member, intends to purchase private sector services).

United Kingdom[55]

Health requirements

Entry Clearance Officers at British visa-issuing posts abroad and Immigration Officers at ports of entry have discretion to refer people subject to immigration control for medical examination.

[55] For further information, please see the websites of the Home Office United Kingdom Border agency (www.ukba.homeoffice.gov.uk, www.ukvosas.gov.au)

The Medical Inspector's advice, including an assessment of whether the person seeking entry has a disease or condition which may interfere with their ability to support themselves or their dependants, is taken into account in deciding whether to admit them to the UK.

The Immigration Officer will also take account of the Medical Inspector's advice in deciding whether a person seeking entry for private medical treatment has sufficient means available to pay for the treatment concerned.

Required health assessments

Anyone subject to immigration control who mentions health or medical treatment as a reason for their visit, appears to be unwell or is seeking entry for more than six months from a country which is high risk for TB should be referred to the Medical Inspector on arrival. The Immigration Officer has discretion to refer for examination in other cases.

Applicants for UK visas valid for longer than six months from certain countries (i.e. Bangladesh, Ghana, Kenya, Pakistan, Sudan, Tanzania and Thailand) also now require a certificate to show that they are free from infectious pulmonary tuberculosis.

HIV

The UK has no HIV related restrictions on entry, stay or residence, provided the person concerned can otherwise meet the requirements of the Immigration Rules. Neither a medical certificate nor an HIV test result is required when entering the country.

Waivers

Immigration Officers have discretion to allow entry even where significant medical conditions have been identified where compassionate grounds exist. In some circumstances, applicants can also appeal against the decision to refuse entry clearance.

ATTACHMENT K: PRESCRIBED DISEASES 1901-1958

Table 1: Restricted Diseases under Commonwealth Quarantine and Immigration Law and Regulation, 1901–58

Date	Disease	Descriptor/symptom	Quar. Act/Reg	Imm. Act/Reg
1901		'infectious or contagious disease of a loathsome or dangerous character'		X
1908	• smallpox • plague • cholera • yellow fever • typhus fever • leprosy	'or any disease declared by the Governor-General to be quarantinable' 'any eruptive disease' 'any disease attended with fever and glandualar swellings'	X	
1912	• pulmonary tuberculosis • trachoma	(amended to) 'serious transmissible diseases or defects' and 'loathsome or cangerous communicable diseases, either general or local'		X
1914	• tuberculosis		X (regs)	
1915	1908 list plus • anterior poliomyelitis • cerebro-spinal meningitis • Malta Fever • scarlet Fever • chicken-pox • measles • whooping cough • gastro-enteritis • typhoid fever •diphtheria • malarial fever • gonorrhoea •syphilis		X	
1917	1912 list plus • soft chancre • venereal bubo • dystentery • tuberculosis		X	
1918	1917 list plus • pneumonia • septicaemia	'any illness attended with glandular swelling'	X	
1919	• Influenza		X (regs)	
1923	Soft chancre replaced by • chancre and chancroid		X	
1926	•scabies			X
1927	• epidemic encephalitis • mumps		X	
1935	• dengue fever		X	
1951	• influenza		X	
1956	• foot and mouth disease • paratyphoid fever • relapsing fever (louse born)		X	

Source: Immigration (Restriction) Act 1901 (Cwlth) and amendments; Immigration Regulations; Quarantine Act 1908 (Cwlth) and amendments; Quarantine Regulations.

Table extracted from A. Bashford & S. Howard, Immigration and Health: Law and Regulation in Australia, 1901-1958, in Health & History, 2004, Vol. 6(1), p. 102.

ATTACHMENT L: PRESCRIBED DISEASES IN 1959

Table 1: Prescribed Diseases 1959 under the Migration Act and Quarantine Act Regulation

	Migration Regulations 1959 (Cwlth)	**Quarantine (General) Regulations 1956 (Cwlth)**
Mental illness	serious mental deficiency, dementia, insanity, epilepsy, dru addiction, alcoholism	no mental illnesses prescribed
Communicable disease	leprosy, syphilis, trachoma, tuberculosis	anterior poliomyelitis, cerebro-spinal meningitis, chancre, chancroid, chicken pox, cholera, dengue fever, diphtheria, dysentery, epidemic encephalitis, foot and mouth disease, gastroenteritis, gonorrhoea, influenza, leprosy, malaria, Malta fever, measles, mumps, paratyphoid fever, plague, pneumonia, relapsing fever (louse borne), scarlet fever, septicaemia, smallpox, syphilis, tuberculosis, typhoid fever, typhus fever, venereal bubo, whooping cough, yellow fever
Chronic non-communicable disease	cancer or other malignant condition, extensive paralysis, blindness, deaf mutism organic disease of the nervous system, leukaemia, primary anaemia	no non-communicable diseases prescribed

Source: Migration Regulations 1959 (Cwlth); Quarantine Regulations 1956 (Cwlth)

Table extracted from A. Bashford & S. Howard, Immigration and Health: Law and Regulation in Australia, 1901-1958, in Health & History, 2005, Vol. 7(1), p. 89.

ATTACHMENT M: LIST OF SKILLED/BUSINESS VISA SUBCLASSES

Visa Subclass	Subclass Description
119	Regional Sponsored Migration Scheme
120	Labour Agreement
124	Distinguished Talent (Australian support)
132	Business talent
175	Skilled - Independent
176	Skilled - Sponsored
845	Established business in Australia
846*	State/Territory sponsored regional established business in Australia
855*	Labour Agreement
856*	Employer Nomination Scheme
857*	Regional Sponsored Migration Scheme
858	Distinguished Talent
885	Skilled - Independent
886	Skilled - Sponsored
887#	Skilled - Regional
890#	Business Owner (Residence)
891#	Investor - Residence
892#	State/Territory Sponsored Business Owner (Residence)
893#	State/Territory Sponsored Investor (Residence)

* PIC 4007 applies to these subclasses 846, 855, 856 and 857 in participating States/Territories
# PIC 4007 applies to a number of permanent '2nd' stage visas in the skilled and business categories as follows:

- Skilled – Regional visa (Subclass 887)
- Investor (Subclass 891)
- State/Territory Sponsored Business Owner (Residence) (Subclass 892)
- State/Territory Sponsored Investor (Residence) (Subclass 893)
- Business Owner (Residence) (Subclass 890)

However, to be granted such visas, applicants need to have held a provisional visa to which PIC 4005 applies (i.e. the applicant and their family would need to have met health to the permanent standard previously and been granted a visa without a health waiver being available).

LIST OF ABBREVIATIONS

ANAO	Australian National Audit Office
CMO	Chief Medical Officer
DDA	The Disability Discrimination Act
DEEWR	Department of Employment, Education and Workplace Relations
DIAC	Department of Immigration and Citizenship
DIEA	Department of Immigration and Ethnic Affairs
DILGEA	Department of Immigration, Local Government and Ethnic Affairs
DHHCS	Department of Health, Housing and Community Services
DoHA	Department of Health and Ageing
FaHCSIA	Department of Family, Housing, Community Services and Indigenous Affairs
ETA	Electronic Travel Authority
HACC	Health and Community Care
HOC	Health Operations Centre
HSA	Health Services Australia
HSH	Department of Human Services and Health
IIHWG	Immigration Health Working Group
JSCM	Joint Standing Committee on Migration
JSCOT	Joint Standing Committee on Treaties
MDR TB	Multi-drug resistant tuberculosis
MCIMA	Ministerial Council for Government Communications
MOC	Medical Officer of the Commonwealth
MRT	Migration Review Tribunal
NMD	Non-migrating dependants
PBS	Pharmaceutical Benefits Scheme
PIC	Public Interest Criteria
RHCA	Reciprocal Health Care Agreement
RMD	Regional Medical Director
RRT	Refugee Review Tribunal
RMOC	Review Medical Officer of the Commonwealth
SCIMA	Standing Committee of Immigration and Multicultural Affairs
TB	Tuberculosis
VAC	Visa application charge
WHO	World Health Organisation
XDR TB	Extensively-drug resistant tuberculosis