Parliament of the Commonwealth of Australia

JOINT STANDING COMMITTEE ON MIGRATION REGULATIONS

CONDITIONAL MIGRANT ENTRY:

THE HEALTH RULES

December 1992

Australian Government Publishing Service
Canberra

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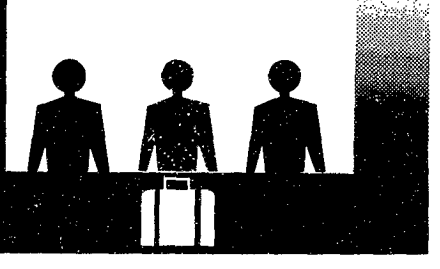

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FOREWORD

There are certain fundamental entry requirements which apply across all immigration categories. These requirements include health and character screening and, for some cases, an assessment of settlement prospects. In all visa classes except the diplomatic or short term medical treatment categories, the criteria for entry or stay include a health requirement.

This inquiry focused on applicants for migration or permanent residence who are refused entry or stay on the grounds that they suffer from a prescribed disease, a medical condition or a disability. The Committee's main brief was to determine whether any such applicants could be allowed to enter or remain in Australia on a conditional basis.

The Committee considered at length the adequacy of the existing health rules as they pertain to migration. The Committee consulted with a wide range of community organisations and individuals, as well as government agencies responsible for administering the migration program and its health components. In particular, the Committee considered the various concerns which were expressed about the lack of flexibility within the existing health rules.

In the report, the Committee has made a series of recommendations aimed at clarifying the existing provisions on the health requirement. In particular, the Committee has sought to remove the perception that the health rules operate against disabled persons in a discriminatory way.

The Committee also has proposed a model for conditional entry to ensure that there is greater flexibility within the system. In particular, the Committee has emphasised the need to take into consideration the likely contribution which individuals and families will make to the Australian community, as well as their ability to meet the costs of treatment and care arising from a medical condition or disability.

During the course of the inquiry, issues related to the health regulations, such as screening for diseases and fraud within the Medicare system, also were brought to the attention of the Committee. These too are addressed in the report.

As Chairman of the Committee, I wish to express my appreciation to all those who contributed to this inquiry. My thanks go to the Subcommittee Chairman, the Hon Clyde Holding, MP, and my fellow Committee members for the time and effort which they devoted to the inquiry. In addition, I would like to acknowledge the work of the Committee's specialist adviser, Dr Kathryn Cronin, whose valuable advice and assistance was appreciated greatly by the Committee. Thanks also are due to the Committee Secretary, Mr Andres Lomp, the inquiry secretary, Mr Clifford Lawson, his predecessor, Mrs Cheryl Samuels, as well as Ms Cassandra Paulus and Ms Dianne Fraser.

Implementation of the Committee's recommendations in this report will contribute towards a fairer migration system, which is flexible enough to allow conditional entry for some who have a disability or a medical condition, without endangering public health or placing an undue burden on Australian facilities and resources.

Dr Andrew Theophanous, MP
Chairman

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TERMS OF REFERENCE OF THE COMMITTEE

The Joint Standing Committee on Migration Regulations was established on 17 May 1990 to inquire into and report upon:

(a) regulations made or proposed to be made under the *Migration Act 1958*;

(b) all proposed changes to the *Migration Act 1958* and any related acts;

(c) such other matters relating to the *Migration Act 1958*, regulations or reports as may be referred to it by the Minister for Immigration, Local Government and Ethnic Affairs.

TERMS OF REFERENCE OF THE INQUIRY

The Joint Standing Committee on Migration Regulations is to inquire into and report to the Parliament on the feasibility of allowing migrant entry to Australia, within existing categories, on a conditional basis.

The circumstances where this conditional entry might be permitted are cases of a health condition or a disability which would disqualify an applicant for a migrant visa principally on the grounds of undue cost or prejudice to the access to health care of an Australian citizen or permanent resident (excluding cases which pose a threat to public health or a danger to members of the Australian community).

In this context, the Committee is to give particular attention to the operation of the Migration Regulations in cases of disability.

In investigating the feasibility of conditional entry the Committee will also examine options for the conditions to apply. For this purpose the Committee will address:

- the nature of conditions which might apply to such cases with reference to the Assurance of Support Scheme, statutory declarations, bonds, deeds, contracts;

- the scope of any such measures in terms of the costs to be covered, duration and the migration categories in which the conditions will be available;

- the implications of such conditions including administrative, cost, legal and enforceability consequences.

MEMBERS OF THE COMMITTEE

Chairman:	Dr Andrew Theophanous, MP
Deputy Chairman:	Mr Philip Ruddock, MP
Members:	Senator Vicki Bourne (to 29.4.92) Dr Robert Catley, MP Senator Barney Cooney Hon Clyde Holding, MP Senator Austin Lewis (from 2.4.92) Senator Jim McKiernan Senator John Olsen (to 2.4.92) Rt Hon Ian Sinclair, MP Mrs Kathy Sullivan, MP
Committee Secretary:	Mr Andres Lomp (from 27.2.92) Ms Robina Mills (to 27.2.92)

MEMBERS OF THE SUBCOMMITTEE ON CONDITIONAL MIGRANT ENTRY

Chairman:	Hon Clyde Holding, MP
Deputy Chairman:	Mr Philip Ruddock, MP
Members:	Senator Barney Cooney Senator Jim McKiernan Senator Austin Lewis (from 2.4.92) Senator John Olsen (to 2.4.92) Rt Hon Ian Sinclair, MP Mrs Kathy Sullivan, MP
Legal Adviser:	Dr Kathryn Cronin
Inquiry Secretary:	Mr Clifford Lawson (from 8.4.92) Mrs Cheryl Samuels (to 19.3.92)
Inquiry Staff:	Ms Dianne Fraser

ABBREVIATIONS

ACROD	ACROD Limited
AGHS	Australian Government Health Service
AICAN	Australian Intercountry Adoption Network
AIDS	Acquired Immune Deficiency Syndrome
AOS	Assurance of Support
AMP	Australian Mutual Provident Society
ASIAC	Australian Society for Inter-Country Aid for Children
BIR	Bureau of Immigration Research
CAAIP	Committee to Advise on Australia's Immigration Policies
CBA	Commonwealth Bank of Australia
Committee	Joint Standing Committee on Migration Regulations
DACA	Disability Advisory Council of Australia
DHHCS	Department of Health, Housing and Community Services
DILGEA	Department of Immigration, Local Government and Ethnic Affairs
DSS	Department of Social Security
HCF	Hospitals Contribution Fund of Australia, Ltd
HIC	Health Insurance Commission
HIV	Human Immunodeficiency Virus
HRC	Human Rights Commission
IRT	Immigration Review Tribunal
Migration Act	*Migration Act 1958*

Minister	Minister for Immigration, Local Government and Ethnic Affairs
MIRO	Migration Internal Review Office
MLC	MLC Life Limited
MMCU	Migrant Medical Clearance Unit, Department of Health, Housing and Community Services
NCID	National Council on Intellectual Disability
NSW	New South Wales
PAM	Procedures Advice Manual
RMD	Regional Medical Director
SHP	Special Humanitarian Program
Social Security Act	*Social Security Act 1991*
TB	Tuberculosis
USA	United States of America

RECOMMENDATIONS

Chapter Three: The Health Requirement

The Committee recommends that:

1. the health regulations set down in the Migration Regulations, Items 9 and 10 of Schedule 1 and regulation 144 be redrafted so that the Commonwealth medical officer is responsible for decisions on medical matters, while the Minister for Immigration, Local Government and Ethnic Affairs is responsible for decisions concerning the costs of treatment and the availability of medical resources; (paragraph 3.27)

2. the demarcation of responsibility in health decision making be set out clearly, and the allocation of responsibility be consistent between the substantive health criteria (Schedule 1, Items 9 and 10) and the waiver provision (regulation 144); (paragraph 3.27) and

3. regulation 144(2)(d) be amended to remove the term 'any' from the text of the provision, so that, as one of the conditions for the grant of a visa or entry permit for classes to which the waiver applies, an applicant must be unlikely, as a result of a disease or condition, to prejudice the access to health care of Australian citizens or Australian permanent residents. Due to concerns, though, that this recommendation may liberalise inappropriately the waiver provision, recommendation 3 should be implemented only if it is possible to make the Minister's decision concerning waiver non-compellable and non-reviewable. (paragraph 3.27)

The Committee, while emphasising that Australia must retain the right to refuse entry and stay on the grounds of disability, recommends that:

4. the existing provisions dealing with the health requirement, namely the Migration Regulations Schedule 1, Items 9 and 10, regulation 144, section 20 of the *Migration Act 1958* and regulation 176, be amended to provide separate categories for assessment of:

   (a) diseases and medical conditions; and

   (b) disabilities. (paragraph 3.58)

The Committee recommends that:

5. the regulations set to accompany the Migration Bill 1992 should provide that non-citizens who are permanent residents should not be vulnerable to cancellation of their visa when they are outside Australia because of a prescribed disease, medical condition or disability, providing that their prescribed disease, medical condition or disability was acquired subsequent to the person's first arrival in Australia. (paragraph 3.68)

Chapter Four: Administration Of The Health Requirement: The Process Of Decision Making

The Committee recommends that:

6. priority be given to the production of the background briefing papers for Commonwealth medical officers on the assessment of medical and disability conditions. These papers should provide up to date and realistic assistance to the Commonwealth medical officers in forming opinions on whether or not applicants meet the health requirement for entry or stay; (paragraph 4.29)

7. the guideline briefing papers issued by the Department of Immigration, Local Government and Ethnic Affairs for use by Commonwealth medical officers in assessing people with disabilities against the health requirement be based on accepted principles for the assessment of disabilities, and be regularly updated in accordance with the latest research data on the various forms of disability; (paragraph 4.41)

8. in assessing a person with a disability, sufficient emphasis 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. To this effect, the Commonwealth medical officer or, where appropriate, the processing immigration officer should gather data relevant to the Minister's decision whether or not to grant a visa or entry permit or, where relevant, to exercise the health waiver, including data on:

   (a) the nature of the disability;

   (b) the age of the person;

   (c) the opportunities for employment and likely benefits to the community of the disabled person and other members of the family unit;

(d) the capacity of the family unit to provide adequate lifetime care and support to the disabled person, without undue cost to the community; and

(e) the extent to which entitlements to government-funded support can be claimed, regardless of a person's means; (paragraph 4.41)

9. unless there are sound reasons to the contrary, the Regional Medical Director Bangkok report to the Department of Health, Housing and Community Services, as is the case for all Commonwealth medical officers and the Regional Medical Director Paris; (paragraph 4.46)

10. consequent upon recommendations 1 and 2, the arrangements for demarcation of responsibility between the Minister for Immigration, Local Government and Ethnic Affairs and the Commonwealth medical officer, as enunciated in the Policy Control Instructions, the Procedures Advice Manual and the background briefing papers be brought into line with the Migration Regulations; (paragraph 4.53)

11. the health screening standards and procedures used in assessing people with disabilities for migration purposes be aligned as closely as possible with the tests applied by the Department of Social Security in determining eligibility for the Disability Support Pension; (paragraph 4.64)

12. in the interests of protecting public health, testing for hepatitis B in particular be wider than is presently undertaken for migration purposes (pregnant women, children for adoption and unaccompanied refugee children) and be introduced for groups which, in relevant medical literature, are recognised as being at high risk. On entry, persons from those groups or countries of origin should be required to produce a certificate of immunisation or accept vaccination by State health authorities as a condition of entry; (paragraph 4.72)

13. an effective and timely reporting system be introduced whereby the results of medical examinations for infectious diseases such as tuberculosis and hepatitis B are passed to State and Territory health authorities by the Department of Immigration, Local Government and Ethnic Affairs, to enable appropriate public health strategies to be implemented by those authorities; (paragraph 4.72) and

14. in the regulations drafted to accompany the Migration Reform Bill 1992, the special category New Zealand visa class be included with those for which the Minister for Immigration, Local Government and Ethnic Affairs can waive the health criteria, provided that the Minister also would exercise such a waiver under similar circumstances for citizens of other countries. (paragraph 4.92)

Chapter Five: Conditional Entry Mechanisms

The Committee recommends that:

15. as a general rule, in cases where an applicant does not meet the prescribed health criteria and does not satisfy the health waiver provisions, before entry or stay may be approved, the applicant or a sponsor pay to the Commonwealth an up-front fee. The amount of the fee should equal the costs, as determined by the Commonwealth Compensation Commissioner, of ongoing treatment, care and assistance, over the lifetime of the applicant, which are likely to arise as a result of the medical condition or disability identified by the Commonwealth medical officer as the reason for the applicant's failure to meet the health requirement; (paragraph 5.64)

16. as a supplement to the up-front fee proposed in recommendation 15, the Government investigate the feasibility of implementing an insurance bond system and/or a loan arrangement for applicants who do not meet the prescribed health criteria or the waiver provisions and who are unable to pay an up-front fee to the Commonwealth. In any such arrangements, the need to protect the revenue over the lifetime of the applicant should be a relevant consideration; (paragraph 5.64)

17. consequent upon recommendations 15 and 16, the Minister for Immigration, Local Government and Ethnic Affairs be provided with a discretion to consider the circumstances of the applicant, particularly the likely contribution which the applicant or the applicant's family may be able to make to Australia, and either:

    a) waive any part of the up-front fee payable by the applicant or a sponsor, or up-front payment to be covered by a bond or a loan; or

    b) in compelling cases, waive in total the up-front fee payable by the applicant or a sponsor, or the up-front payment to be covered by a bond or a loan; (paragraph 5.64) and

18. in determining whether to grant an adoption visa or entry permit to a disabled adoptive child who cannot satisfy the health criteria, the Minister for Immigration, Local Government and Ethnic Affairs consider the financial and other family support able to be provided by the adoptive family and the circumstances of the adoptive child, particularly whether these factors could outweigh any likely costs to the community or access to community resources in short supply. In such cases, the entry or stay should be approved only where appropriate guarantees of support can be provided and where the relevant State welfare authorities have approved the intending adoptive parents as capable of parenting the child. (paragraph 5.74)

Chapter Six: Access To The Health System

The Committee recommends that:

19. in light of the potential for fraud in the existing procedures for enrolment in Medicare and in the use of Medicare cards, the following changes to the Medicare system be implemented:

    (a) the Medicare enrolment procedures for non-citizens be amended to require two original documents as proof of identity, with one of those documents including a photograph; and

    (b) the signature of each nominated Medicare card holder be required to be included on the Medicare card, so that every transaction can be verified as a service to the card holder or another authorised family member; (paragraph 6.35)

20. the definition of 'Australian resident' in subsection 3(1) of the *Health Insurance Act 1973* be amended to prevent persons with temporary entry permits from gaining access to Medicare, but the Government introduce specific legislative provisions to cover specific groups of temporary residents which the Government considers should have access to Medicare, for example those granted Extended Eligibility (Spouse) Temporary Entry Permits and asylum seekers granted Domestic Protection Temporary Entry Permits; (paragraph 6.35) and

21. appropriate legislative amendments be made to ensure that the Health Insurance Commissioner and other appropriate persons be empowered to provide the Department of Immigration, Local Government and Ethnic Affairs with information regarding instances of unlawful access to Medicare by temporary entrants and illegal entrants, and information regarding the extent of indebtedness of temporary residents and/or illegal entrants who have accessed Australia's health system. (paragraph 6.35)

Chapter One

THE INQUIRY

Introduction

1.1 Following the review of Australia's immigration policy by the Committee to Advise on Australia's Immigration Policies (CAAIP), whose report was published in 1988, the then Minister for Immigration, Local Government and Ethnic Affairs, Senator the Hon Robert Ray, announced an inquiry into conditional migrant entry as part of the Government's response to that report. On 8 December 1988, Senator Ray stated:

> The Government has ... decided to examine ways of accepting some family reunion applicants who are currently ineligible because of social or medical factors which could result in their becoming a charge on the Australian community. A parliamentary committee will be invited to consider the existing scheme of assurances of support by sponsors and whether a bonding system for such people can be established under which the Government's social and medical costs will be met.[1]

1.2 The House of Representatives Standing Committee on Community Affairs was originally asked to take up the inquiry, which was commenced in September 1989. The purpose of the inquiry was to examine whether there was any potential for increasing the possibilities for entry for those within existing migration categories who were disabled and therefore unable to meet the health criteria, but who could rely on private or family support after their arrival.

1.3 With the establishment of the Joint Standing Committee on Migration Regulations following the 1990 federal election, the Standing Committee on Community Affairs discontinued the inquiry. Instead, the Minister for Immigration, Local Government and Ethnic Affairs (the Minister), the Hon Gerry Hand MP, wrote to the Chairman of the Joint Standing Committee on Migration Regulations in March 1991, proposing the transfer of the inquiry from the Community Affairs Committee to the Migration Regulations Committee, with revised terms of reference.

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1 Parliamentary Debates (Hansard), Senate p. 3756.

1.4 The Joint Standing Committee on Migration Regulations (the Committee) accepted the inquiry into conditional migrant entry on 9 July 1991. A Subcommittee was formed shortly afterwards to conduct the inquiry. The members of both the Committee and the Subcommittee on Conditional Migrant Entry are shown on page ix of this report.

1.5 The revised terms of reference for the inquiry required the Committee to inquire into and report to the Parliament on the feasibility of allowing entry to Australia, within existing migration categories, on a conditional basis. The circumstances where conditional entry might be permitted are cases of a medical condition or a disability which would at present disqualify an applicant for a migrant entry visa, principally on the grounds of either undue cost to Australian taxpayers or the likelihood of prejudicing access by Australians to health care services and facilities. Cases which pose a threat to public health or a danger to members of the Australian community were not included in the terms of reference. In accordance with the terms of reference, the Committee was to give particular attention to the operation of the Migration Regulations in cases of disability. The Committee also was to examine the options for conditions to apply, and to address:

- the nature of conditions which might apply to such cases with reference to the Assurance of Support Scheme, statutory declarations, bonds, deeds, contracts;
- the scope of any such measures in terms of the costs to be covered, duration and the migration categories in which the conditions would be available; and
- the implications of such conditions including administrative, cost, legal and enforceability consequences.

1.6 During the course of the inquiry, the Committee received submissions and heard evidence not only on matters relevant to conditional migrant entry, but also on various aspects of the health regulations, and on post-arrival medical support arrangements. In this report, therefore, the Committee considers a range of issues relating to migration and health.

Background to the inquiry

1.7 In its report, CAAIP noted the existence of certain basic entry requirements across all immigration categories. These include health and character screening and, for some cases, an assessment of settlement prospects. In relation to health screening, CAAIP acknowledged that the then existing procedures had generated considerable debate, and that strong views had been put to it, particularly from organisations representing the interests of people with disabilities.[2]

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2 CAAIP, *Immigration: A Commitment to Australia*, AGPS Canberra, 1988, p. 94.

1.8 The current legislation continues to prescribe health criteria as one of the basic requirements for entry or stay in all immigration categories. These requirements are embodied in the Migration Regulations, Schedules 1, 2 and 3, and regulations 144 and 176. In addition, section 20 of the present *Migration Act 1958* provides that if a person suffering from a prescribed disease or condition enters Australia and that person's entry permit does not carry an endorsement showing that the immigration officer granting the permit knew of the person's disease or condition, the person can be an illegal entrant, liable to deportation.

1.9 In order to be granted a visa or entry permit, a person must meet specified criteria for the class of visa/entry permit sought. In all except the diplomatic or short term medical treatment visa classes, the criteria include the health requirement.[3]The regulations provide that in certain visa or permit classes, the health requirement relating to medical conditions and disabilities can be waived, providing that there will be no undue harm or costs to the Australian community arising from the person's entry or stay.

1.10 During preparation of this report, the Migration Reform Bill 1992 was introduced into and debated in the Parliament. The Committee gave some consideration to arrangements in the Bill as they affect the operation of the health rules. The Committee noted that health criteria continue to be a ground for exclusion from entry or stay and likewise a ground for cancellation of a person's visa.

Conduct of the inquiry

1.11 The inquiry was advertised in the national press as well as various regional newspapers on 13 July 1991.

1.12 The Committee received 69 submissions and held four public hearings, one in Melbourne and three in Canberra, between August 1991 and March 1992. The submissions received by the Committee are listed at Appendix A. The exhibits tendered during the inquiry are listed at Appendix B. The witnesses who appeared before the Committee at the public hearings are listed at Appendix C.

1.13 References in the footnotes to particular page numbers in the submissions identify the sequential numbers at the foot of each page in the published volumes of submissions. This practice has been adopted in order to avoid confusion with the original page numbers assigned by the authors of the individual submissions.

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3 DILGEA, Procedures Advice Manual, Health Requirement Topic 2: Reasons for the health requirement and how it is assessed, p. 1, March 1991.

Key issues

1.14 During the inquiry, the main issues relevant to the terms of reference were identified as follows:

- the numbers adversely affected by health requirements for entry or stay are small both in comparison with the numbers applying and the numbers accepted for entry or stay in Australia. In this regard, the Department of Immigration, Local Government and Ethnic Affairs (DILGEA) provided the Committee with migration application statistics showing the small volume of rejections on health grounds;

- despite the small numbers adversely affected, there is an important principle at stake in the form and application of the health rules. This principle received close attention from the Committee. The Committee recognised that the primary obligation is to protect the community from risk to public health. At the same time, a balance should be struck between, on the one hand, the need to protect Australian community resources and access by Australian residents to expensive and often scarce medical and welfare facilities, and, on the other hand, the legitimate aspirations of migrant applicants and their sponsors, as well as the compassionate and humanitarian aspects of the migration program;

- there are concerns about the way in which the health requirement for permanent entry is administered, in particular:

  - perceived inconsistencies in decision making;

  - processing delays and duplication of paper work between agencies; and

  - monitoring procedures established by DILGEA and the Australian Government Health Service (AGHS);

  there is an inadequate degree of interaction and exchange of information between the various government agencies responsible for particular aspects of the migration program and post-arrival community services programs; and

- access to Medicare by illegal entrants (and others), and the impact on the State public health systems of Medicare ineligible people, such as illegal entrants and some holders of temporary entry permits, indicates the need for more structured checking mechanisms.

1.15 In the report, the Committee has proposed a model for allowing permanent entry of some applicants currently refused entry on the grounds of failing to meet the health requirement. The Committee's recommendations in this regard, and in relation to the other issues identified above, are detailed in this report.

Structure of the report

1.16 In the report, the Committee has focused on the following areas:

- the number of cases refused entry to or stay in Australia on health grounds, and the profile of such cases (Chapter 2);
- the law pertaining to the health requirement (Chapter 3);
- the process of health decision making, the guidelines and standards used and how these are applied (Chapter 4);
- the means and circumstances under which conditional entry might be permitted (Chapter 5); and
- the issue of access to Australia's health system, including access to Medicare benefits (Chapter 6).

Chapter Two

HEALTH REFUSALS

Introduction

2.1 As a starting point for its examination of the health requirement, the Committee sought to obtain an overview of the number of cases refused entry to or stay in Australia on health grounds, as well as a profile of such cases.

2.2 For the purpose of ascertaining the numbers of applicants adversely affected by the health requirement under current legislation, and therefore the potential size of any conditional entry scheme, the Committee sought relevant statistical information from DILGEA.

2.3 In addition, the Committee received a number of submissions and letters from individuals who had been affected by decisions on their ability to meet the health requirement criteria. In examining these cases, it was not the Committee's intention to resolve individual situations, but rather to gain some understanding of the human dimension underpinning the operation of the health requirement.

The health profile

2.4 At the public hearing on 19 February 1992, DILGEA tabled statistical documents which showed the number of health rejections for the period 1986/87 to 1991/92 (see Tables 2.1 and 2.2), and the number and general description of cases in which the health waiver had been exercised since December 1989, when regulation 144 came into effect (see Table 2.3).

2.5 In evidence, and as shown in Table 2.1, DILGEA indicated that, for the six years covered by the statistics in the table, approximately 40 per cent of cases finalised were refused entry on various grounds and, of these, only a relatively small percentage were related to health grounds.[1] The actual percentage figures for health rejections as a proportion of total rejections in any one year has been within the range of only 1.0 per cent to 1.8 per cent. In each of the years 1987 to 1990, the parent category was the one most consistently refused on health grounds. This is not surprising, given the age of such applicants. Nor is it surprising in the context of Australia's health criteria, which permit refusals on disability grounds.

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1 Transcript of evidence, 19 February 1992, p. 120.

TABLE 2.1 - CASES REJECTED ON HEALTH GROUNDS : 1986-1992

Year	Cases Finalised	Total Rejections as % of Cases Finalised	Health Rejections	% Health Rejections as % of Total Rejections	% Health Rejections as % of Cases Finalised
1986/87	96 570	37 891 (39.2%)	396	1.0%	0.4%
1987/88	110 584	42 595 (38.5%)	763	1.8%	0.7%
1988/89	138 588	58 828 (42.4%)	895	1.5%	0.6%
1989/90	113 425	50 538 (44.6%)	762	1.5%	0.7%
1990/91	93 639	36 224 (38.7%)	*	*	*
1991/92 (July - January)	41 276	15 891 (38.5%)	*	*	*

* Figures unavailable.

Source: Migration Program Management System, DILGEA. Exhibit 1.

TABLE 2.2 - CASES REJECTED ON HEALTH GROUNDS BY MIGRATION CATEGORY 1987-1990

		1987/88	1988/89	1989/90
FAMILY				
100	Spouse	23	26	28
101	Child	2	4	2
103	Parent	306	430	336
104	Preferential family	20	15	14
105	Concessional family	206	130	124
300	Prospective marriage	16	25	22
Sub-total		573	630	526
SKILL				
120	Labour agreement			1
121	Employer nomination	22	32	40
122/123	Business	20	53	44
124	Distinguished talent			2
126	Independent entrant	111	152	121
	Sub-total	153	237	208
OTHER				
150	Former citizen		3	1
152	Family reunion (NZ)	5	1	1
	Sub-total	5	4	2
REFUGEE/HUMANITARIAN				
200-205	Refugee/Humanitarian	32	24	26
	Sub-total	32	24	26
TOTAL		763	895	762

Source: Unpublished DILGEA data, Submissions Vol. 3, p. 57.

TABLE 2.3 - EXERCISE OF THE HEALTH WAIVER DECEMBER 1989 TO FEBRUARY 1992#

1. MEDICAL CONDITIONS - TOTAL 41

SPOUSES (Category 100):Medical Condition - Total 27

Nature of Condition	Reason For New Decision	PA/DEP*
Bronchial Asthma	Compassionate-Aust.Spouse	PA
Prostate Cancer in October 90	Compassionate-Former Res	PA
Lung Tumour	Compassionate	PA
Untreated Diabetes Myelitis	Compassionate, Spouse	PA
Possible Kidney Failure	Compassionate-Aust Spouse	PA
Willibrand Jurgens Disease	Compassionate-Father in Aust/Refugee	DEP
Aortic Valvular Insufficiency	Compassionate-Wife,Children in Aust	PA
Congenital Heart Disease	Compassionate	DEP
Post Viral Syndrome	Compassionate-Spouse	PA
Previous Drug Addiction	Compassionate-Aust Spouse	PA
Valvular Heart Disease	Compassionate-Wife,Children in Aust	PA
Removed Bilateral Carcinoma-Ovary	Compassionate	PA
Hudonephrosis/Calculus Disease	Compassionate	DEP
Genital Warts	Compassionate-Aust Spouse	PA
Malignant Melanoma	Compassionate	PA
Parkinson's Disease	Compassionate-Aust Spouse & Children	PA
Removed Tumour	Compassionate-Spouse	PA
Chronic Persistent Hepatitis	Compassionate-Aust Spouse	PA
Panic Attacks/Liver Enzyme Abnormalities	Compassionate-Aust Spouse	PA
Carcinoma of Breast	Compassionate-Aust Spouse	PA
Right Hemithyroidectomy	Compassionate-Aust Spouse	PA
Biliary Cirrhosis	Compassionate-Aust Spouse	PA
Overweight	Compassionate-Aust Spouse	PA
Overweight	Compassionate-Aust Spouse	PA
Alcoholism	Compassionate-Aust Spouse/Child	PA
Overweight	Compassionate	PA
Melanoma	Compassionate-Wife/Daughter Aust Res	PA

CHILD (Category 101):Medical Condition - Total 1

Sequelae Poliomyelitis	Compassionate	DEP

* PA Principal Applicant
DEP Dependant

\# Source : DILGEA Exhibit 2, 19 February 1992

MEDICAL CONDITIONS (Cont.)

HUMANITARIAN (Category 200, 201, 204, 205):Medical Condition -Total 7

Infiltrating Ductal Carcinoma of Breast	Humanitarian	DEP
Hypertension, Diabetes Myelitis	PA & Family in Danger	PA
Post Encephalitic Encephalopathy	Humanitarian-Family Accepted Under Camp Clearance	PA
Requires Tracheostomy & Gastrostomy	Humanitarian/Family in Danger	PA
Not Specified-Cardiac Vascular?	Humanitarian	PA
Diabetes	Humanitarian	PA
Rheumatic Heart Disease/Corneal Ulcer	Humanitarian	PA

PROSPECTIVE MARRIAGE (Category 300):Medical Condition - Total 6

Nature of Condition	Reason For New Decision	PA/DEP
Hypertension	Compassionate-Fiance	PA
Pulmonary Stenosis	Compassionate	PA
Congenital Heart Disease	Compassionate	DEP
Cardiomyopathy/Cardiomegaly,heart failure	Compassionate-Aust Fiance	PA
Arthritis	Compassionate	PA
Overweight	Compassionate-Aust Fiance	PA

2. INTELLECTUALLY DISABLED - TOTAL 9

SPOUSES (Category 100):Intellectually Disabled - Total 4

Serious Mental Deficiencies	Compassionate-Aust Step Father	DEP
Downs Syndrome	Compassionate-Close Family Reunion	DEP
Mental Retardation	Compassionate-Aust Spouse	PA
Downs Syndrome	Compassionate-Mother's Defacto Aust Citizen	DEP

HUMANITARIAN (Categories 200, 201, 202, 205):Intellectually Disabled - Total 3

Mental Retardation with Grand Mal Convul	Humanitarian-Father in Danger	DEP
Mental Retardation & Kypho-Scoliosis	Humanitarian	DEP
Mental Retardation & Kypho-Scoliosis	Humanitarian	DEP

PROSPECTIVE MARRIAGE (Category 300):Intellectually disabled - Total 1

Mild Retardation	Compassionate	DEP

EXTENDED ELIGIBILITY (SPOUSE)(Category 820):Intellectually Disabled - Total 1

Grand Mal,Slow Mental Dev,R.Hemparesis	Compassionate	DEP

3. PHYSICALLY DISABLED - TOTAL 28

SPOUSES (Category 100):Physically Disabled - Total 8

Congenital Deafness	Compassionate	PA
Congenital Right Hip Dislocation	Compassionate-Aust Spouse,Child	PA
Blindness	Compassionate	PA
Poor Vision-Horizontal Nystagmus/Hypermetropia	Compassionate-Aust Spouse	PA
Back Injury	Aust Spouse,High Disability Investment Income	PA
Deaf and Mute	Compassionate	PA
Sponge Kidneys	Compassionate/Humanitarian	PA
Profoundly Deaf	Compassionate-Aust Spouse	PA

ADOPTIONS (Category 102):Physically Disabled - Total 3

Nature of Condition	Reason For New Decision	PA/DEP
Surgical Ops Face, Skull, External, Internal	Compassionate-Adoption by Aust Cit	DEP
Cleft Palate	Compassionate-Intercountry Adopt	PA
Partially Cleft Lip and Palate	Compassionate-Child for Adoption	PA

HUMANITARIAN (Categories 200, 201, 205):Physically Disabled - Total 10

Both Hands Amputated	Humanitarian	PA
Impaired Hearing in Both Ears	Humanitarian	DEP
Disability From Poliomyelitis	Humanitarian/Family in Danger	DEP
Amputated Leg to Thigh/Diabetes	Humanitarian/Family in Danger	PA
Cleft Palate	Compassionate	PA
Amputated Fingers	Compassionate/Humanitarian	PA
Paralysed Rt Leg,Pelvic Deformity	Family Reunion,Camp Clearance	PA
Hydrocephalus,Cleft Palate,Hare Lip	Humanitarian	DEP
Deaf and Mute	Compassionate-Family Support	DEP
Deaf and Mute	Compassionate-Family Support	DEP

PROSPECTIVE MARRIAGE (Category 300):Physically Disabled - Total 6

Visual/Surgical Correction Needed	Compassionate	PA
Low Vision Standard	Compassionate	PA
High Myopia,Bilateral-May Cause Blindness	Compassionate-Relationship with Aust Resident	PA
Retinal Degeneration	Compassionate	PA
Poor Vision	Not Serious-Glasses Will Help	PA
Atrophy of Right Arm and Leg	Compassionate-Aust Fiance	PA

SPOUSE (AFTER ENTRY)(Category 801):Physically Disabled - Total 1

Profoundly Deaf	Compassionate-Aust Spouse	PA

4. PSYCHIATRIC CONDITION - TOTAL 11

SPOUSE (Category 100):Psychiatric Condition - Total 9

Depression/Personality Disorders	Compassionate-Aust Spouse	PA
Paranoid Psychosis	Compassionate-Aust Spouse	PA
Manic Depression and Psychosis	Compassionate-Aust Spouse	PA
Depressive Psychosis	Compassionate-Aust Spouse	PA
Psychiatric Discharge From Army	Compassionate	PA
Manic Depressive	Compassionate-Aust Spouse	PA
Chronic Anxiety Condition	Compassionate,Skilled	PA
Schizophrenia	Compassionate-Aust Spouse/Former Resident	PA
Agoraphobia	Compassionate-Spouse	PA

CHILD (Category 101):Psychiatric Condition - Total 1

Nature of Condition	Reason For New Decision	PA/DEP
Schizophrenia	Compassionate-Parents in Australia	PA

PROSPECTIVE MARRIAGE (Category 300):Psychiatric Condition - Total 1

Psychiatric,Inability to Work	Compassionate	PA

5. NOT SPECIFIED - TOTAL 9

SPOUSE (Category 100):Not Specified - Total 6

Not Specified	Compassionate-Aust Spouse	PA
Not Specified	Compassionate-Aust Spouse	PA
Not Specified	Compassionate-Dependant of Applicant Class 100	DEP
Not Specified	Compassionate-Family Reunion	PA
Not Specified	Compassionate-Aust Spouse	PA
Not Specified	Compassionate-Aust Spouse	PA

HUMANITARIAN (Category 201, 202):Not Specified - Total 3

Not Specified	Humanitarian/Family in Danger	DEP
Not Specified	Humanitarian-P/A Under Severe Risk	PA
Not Specified	Humanitarian	PA

Source : DILGEA Exhibit 2, 19 February 1992

2.6 Table 2.2 provides more detailed information on health rejections by migration category. However, those statistics cover the years 1987/88 to 1989/90 only.

Use of the health waiver

2.7 Before the introduction of the Migration Regulations in 1989, there was scope for waiving the health requirement in any visa/entry permit category. A study by DILGEA revealed that 85 per cent of cases where decisions varied from medical advice were in the preferential family and refugee/Special Humanitarian Program categories. Of those, 45 per cent were parents (30 per cent retirement age, 15 per cent working age) and a third of all the cases involved people aged over 65 years.[2]

2.8 Under the existing Regulations, the waiver is now available for certain medical conditions suffered by some applicants in the refugee and humanitarian classes and certain, but not all, of the close family visas and entry permits. Parents and other preferential family classes are not eligible for the waiver. Table 2.3 shows the number of applications approved through the exercise of the health waiver. It also illustrates the broad range of medical conditions which have been considered and passed as acceptable for entry under the health waiver provisions of regulation 144.

2.9 A descriptive sample of case studies to which the waiver has been applied was provided by DILGEA as an attachment to its submission.[3] This material is briefly summarised in the following paragraphs as being illustrative of the factors and case types required to be considered by the Minister in assessing the impact on public health access and welfare costs before approving or refusing the grant of a visa or entry permit under regulation 144.

2.10 Case 1 outlined the circumstances surrounding an application for the Class 201 (Humanitarian) migration category by the 16 year old child of the principal applicant. The health condition which failed to meet the health requirement was listed as intellectual disability involving moderate mental retardation and grand mal convulsions. The processing office reported that the child had been assessed as likely to become a significant long term charge on public funds. The decision maker nevertheless exercised the waiver because strong humanitarian/compassionate factors were deemed to outweigh the potential costs.

2.11 Case 2 concerned the application for the Class 100 (Spouse) migration category by an applicant aged 41 years. The applicant suffered from a physical disability involving a back injury, but was assessed as unlikely to become a charge on public funds as he was in receipt of a transferable income of US $75,000 from

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2 Submissions Vol. 2, p. 92.

3 Submissions Vol. 2, pp. 113-117.

disability payments and investments. He thus would have been ineligible under the income test to receive a social security pension. This information had not been available to the assessing Commonwealth medical officer.

2.12 Case 3 described an application for the Class 205 (Humanitarian) migration category by a person aged 34 years with a physical disability, which resulted from amputation of three of his fingers. The Department of Health, Housing and Community Services (DHHCS) assessed the applicant's condition as precluding his intended occupation in Australia and therefore considered that the person had the potential to become a significant charge on public funds. However, the processing office exercised the waiver because of the following factors:

- the applicant's demonstrated consistent employment record as a cleaner and construction worker;
- the high possibility of the applicant obtaining similar work in Australia;
- the applicant had been financially self-sufficient during his stay in Hong Kong, where he managed to save the equivalent of AUS $2,000;
- the applicant's demonstrated self-motivation to learn English;
- Australia's obligation under the Camp Clearance Program to accept him for resettlement, as his only living relative outside Vietnam had settled here.

2.13 Case 4 related to an application for the Class 200 (Humanitarian) migration category by a person aged 48 years with a medical condition, diagnosed as rheumatic heart disease and a corneal ulcer. Although the applicant was assessed as likely to become a moderate charge on public funds, the processing office exercised the waiver because the applicant was one of the few remaining Camp Clearance cases in Malaysia who had not been accepted for resettlement, and the applicant had strong links with Australia, with a sister living here and no relatives in any other resettlement country.

2.14 Case 5 concerned an application for the Class 100 (Spouse) migration category by a person aged 32 years with a medical condition diagnosed as chronic anxiety. He was assessed as likely to require significant care and treatment, but not as a significant charge against public funds. This decision was reached because the applicant had the support of his Australian spouse, and because of his demonstrated steady employment record as a skilled tradesman, his intention to settle in an economically depressed area where his skills offered potential economic benefit, and the compassionate circumstances motivating his return to Australia.

2.15 Case 6 outlined an application for the Class 300 (Fiance) migration category by a person aged 24 years with a medical condition diagnosed as being a psychiatric condition. The applicant was assessed as being potentially unable to undertake responsible employment and, as a consequence, as being likely to become a long term charge on welfare funds. However, the processing office exercised the waiver because the relationship between the applicant and the sponsor was well established, and the sponsor had had stable employment with one company since his arrival in Australia in December 1985.

2.16 Following DILGEA's appearance at the public hearing on 19 February 1992, the Committee sought information from DILGEA on the numbers of appeals lodged against rejections on health grounds. DILGEA advised the Committee that statistical data currently compiled on the volume of appeals to the Migration Internal Review Office (MIRO) and the Immigration Review Tribunal (IRT) only provides information on visa and permit classes and outcomes, not the reasons for the appeals. However, DILGEA did venture to suggest that 'the number of cases where appeals are lodged against rejections on health grounds is in the order of 5 per cent'.[4]

Other case profiles

2.17 While statistics certainly indicate the volume of applicants who are or have been adversely affected by the application of the health requirement, the examples of case histories cited in submissions and evidence clearly showed the range of personal circumstances behind the abstract data. Mindful of the compassionate nature of many of the cases brought to its attention, the Committee examined these in order to gain an insight into what is at stake when decisions are made on the health criteria and on application of the waiver provisions.

2.18 In particular, the Committee gained this insight through an examination of various decisions of the IRT on the operation of the health rules. It is emphasised that the Committee in no way sought to judge the merits of any of the individual decisions which it examined or to question the decisions taken in any of those cases.

2.19 The following case studies provided useful information to the Committee on the administration of the health requirement and the range of health and disability issues that arise.

2.20 In Re Papaionnou, the IRT affirmed the decision under review not to grant Mr Papaionnou a spouse visa and held that it did not have the power to review the opinion of a Commonwealth medical officer. The basis for the decision was that Mr Papaionnou did not meet the health criteria, nor the conditions for waiver of those criteria.

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4 Submissions Vol. 3, p. 31.

2.21 Mr Papaionnou had a history of chronic renal failure and after arrival in Australia on a tourist visa was admitted to hospital for dialysis treatment totalling nearly six months from 1988 to 1990. The Australian-Greek community met some of the costs of this treatment through a charity drive. During his period as a patient, Mr Papaionnou met and married a nurse at the hospital and applied for change of status, which was refused. After the principal's return to Greece, his subsequent application for a spouse visa was refused on medical grounds. His spouse then applied to MIRO and the IRT for review of the decision.

2.22 The IRT, in reviewing the 'undue harm or undue cost' criteria, took into consideration the strong compassionate circumstances applying in this case. The medical evidence before the IRT showed that Mr Papaioannou would require dialysis and that he would be a candidate for a kidney transplant if a donor could be found. Although this would affect the health of an Australian citizen or resident by displacing him or her from a transplant waiting list, the IRT was not prepared to accept that this necessarily constituted 'undue' harm to the community. It observed that a renal transplant waiting list differed from an ordinary surgical waiting list in that tissue matching had to occur between donor and patient, so that the addition of an extra person to a renal transplant waiting list did not have direct consequences for those who might be lower on the list. However, the IRT found that the long-term costs of Mr Papaioannou's health care would be 'undue'. There was a large debt of outstanding hospital costs and, although his wife could make a financial contribution to her husband's health care, and the Greek community had donated a considerable sum for Mr Papaionnou's medical costs, he himself could not make any financial contribution, as his health prevented him from entering the workforce. The IRT recognised that Mr Papaionnou's wife would face extraordinary difficulties in supporting herself and her husband in Greece, and that her husband had a much better chance of a transplant in Australia. Despite the positive factors in this case, the IRT found, with considerable regret, that undue cost would be likely to result to the Australian community if the visa was granted. Accordingly, the health criteria could not be waived and the IRT affirmed the decision not to grant the spouse visa.

2.23 In Re Wong, an Australian couple had been granted approval by the Department of Community Services to adopt two orphans from Hong Kong, Wai Man Wong and Wai Lok Wong, aged three and four respectively. While Wai Lok's application for migration had been approved, Wai Man's had been rejected because, in the Commonwealth medical officer's opinion, he did not meet the health requirement. Wai Man suffered from cerebral palsy with left hemiplegia. The medical officer's opinion was that Wai Man would require specialised schooling and continuing physiotherapy and speech therapy.

2.24 The IRT obtained a video of Wai Man showing him engaged in various activities as part of his daily routine. It then requested the Spastic Welfare Association of Western Australia to assess him. This assessment, together with the video and other assessments, was sent to the medical officer who responded that

Wai Man had shown sufficient improvement in his condition to be considered to meet the health criteria. All other criteria being met, the IRT set aside the decision under review and substituted a decision granting Wai Man Wong an adoption visa.

2.25 In Re Bishay, the applicant was a 36 year old Egyptian who had suffered from poliomyelitis in infancy, leaving him with a marked weakness in his lower limbs. He also was markedly overweight. Mr Bishay applied to enter Australia on a Business (Joint Venture) visa, but a Commonwealth medical officer had concluded that he failed to meet the health requirement for entry. The IRT noted that it was unable to review a decision of a Commonwealth medical officer, but undertook to submit further medical evidence to the Director of the Migrant Medical Clearances Unit (MMCU), with a request that the earlier decision be reviewed. In her response, the Director affirmed the earlier decision that Mr Bishay did not meet the health criteria for entry.

2.26 In affirming the decision under review, the IRT commented on the inability of the medical officer to weigh the economic benefits which might result from the joint venture proposal against the costs which might be incurred by the Australian community in providing medical services to the applicant.

2.27 In Re Dusa, the applicant had been refused a parent visa on the grounds that he failed to meet the health requirement. Mr Dusa had broken his leg some time before and this had left him with a swelling in his ankle area. He had reasonable mobility and did not require regular medical treatment. The IRT referred additional medical evidence to the MMCU, but the medical officer remained of the opinion that Mr Dusa's disability would prevent him from obtaining employment and would require the use of specialist services as he grew older. The IRT therefore was obliged to find that Mr Dusa did not satisfy the health criteria and that his application for a visa accordingly failed. In doing so, the IRT noted that it was unable to agree with the conclusion reached by the medical officer and called for merits review to be extended to this area of decision making. It observed that, in the meanwhile, the only avenue for applicants dissatisfied with the opinion reached by the medical officer was through judicial review by the Federal Court.

2.28 In Re Storti, the IRT reviewed the decision to refuse the grant of a Spouse Permanent Entry After Entry visa, which she had applied for on the basis of her de facto relationship with an Australian permanent resident. Ms Storti, a citizen of the United States of America (USA), had a congenital cardiac condition which resulted in a dramatically reduced life expectancy and which could only be remedied by a heart/lung transplant. Her spouse had been convicted of a minor offence in Western Australia and therefore was ineligible to enter the USA for five years.

2.29 The Commonwealth medical officer's opinion was that Ms Storti failed to meet the health requirement because the transplant procedure was extremely expensive, transplant patients required expensive medical and specialist supervision for the rest of their lives, and she might take precedence over an Australian citizen or resident on the transplant program if that person was not as well matched with

a donor. The IRT found that the compelling issues of cost and access to the transplant program outweighed the potential damage that might be caused to the de facto relationship by refusal of entry, and therefore affirmed the decision under review not to invoke the health waiver.

2.30 In Re Clancy, the original decision was not to grant a parent visa because the applicant failed to meet the prescribed health criteria. Mr Clancy was legally blind and, in the opinion of the Commonwealth medical officer, failed the vision test. The IRT arranged for a social work assessment of Mr Clancy to be undertaken in London to ascertain his capacity for independent living. The resulting report indicated that Mr Clancy lived an independent life notwithstanding his visual impairment and he had no need of state or voluntary welfare support. This evidence was submitted to the Director of the MMCU, who requested a further report from a specialist ophthalmologist. On the basis of this further medical evidence, the Director's opinion was that Mr Clancy met the health criteria and the IRT accordingly set aside the decision under review and granted a parent visa.

Decisions on aged relatives

2.31 During the inquiry, the Committee received many letters from families of aged relatives who had been refused permanent entry or stay because of their inability to meet the health criteria. Some of these cases received wide publicity in the national press and on television when departure notices were served on a number of elderly persons who had been refused permanent stay in Australia. Further examples were cited in a letter and attachments from Senator Margaret Reynolds, which was accepted as Exhibit 12 to the inquiry. This issue is discussed in detail in Chapter 5 of the report.

Factors in administering the health requirement

2.32 The statistical data and case profiles considered by the Committee were very useful in setting out the ambit and complexity of the problem. The issues addressed in the following chapters are informed by central understanding of the operation of the health rules. Firstly, the numbers adversely affected are small. However, the decisions are difficult ones. The evaluation of disease and disability, and the computation of the likely costs of care and treatment are not easy. As certain case examples show, there can be conflicting expert opinion on particular cases and diagnoses can change over time. In order to evaluate disabilities, medical officers can require detailed case information. In certain children with disabilities, it is notoriously difficult to predict accurately their probable development and, therefore, the expected future health costs.

2.33 An additional layer of difficulty in health cases arises because of the real emotional issues at stake in such cases. The refusal can in some cases result in the separation of spouse, of parents and their children. Further, the Government is charged with the responsibility of protecting the community interest in health and welfare services. In Australia's health system, much of the funding comes from the public purse and, in times of escalating health costs, the Government has a particular responsibility to scrutinise additional expenditure. In cases where medical services are in short supply and there is a waiting list of Australian citizens and residents to secure access to such services, the Government's responsibility must be to ensure that their access is not prejudiced or delayed.

2.34 Although the numbers of cases adversely affected by Australia's health rules are small, the principles at stake more than justify the time and attention of the Committee.

Chapter Three

THE HEALTH REQUIREMENT

Introduction

3.1 It has long been part of Australian immigration law that persons may or indeed should be excluded from entry if they fail to meet certain health standards. From 1901, Australia's migration legislation has contained provisions which set prescribed health criteria for those non-citizens seeking to enter or stay. From 1901, it also has been Australian law that whenever persons who suffer from prescribed diseases or disabilities enter Australia without express exemption being given on account of their disease or disability, the person can be found to be a prohibited immigrant or a prohibited non-citizen, now termed illegal entrants. Prohibited immigrants, prohibited non-citizens and illegal entrants have been or are liable to deportation.

3.2 Australia's exclusionary health rules are mirrored in the immigration law of the USA and Canada.

3.3 The objective of Australia's health requirement is to protect the resident Australian community's:

- standards of public health and safety;
- public expenditure on health and welfare; and
- access to health services.

3.4 Evidence to the Committee was that while there is widespread acceptance of the migration health requirements which seek to protect the Australian community from risk to public health, other aspects of the health requirement are more controversial. This includes those provisions which aim to protect community access to health care, and which seek to ensure that the community is not required to pay undue health or welfare costs. In examining the existing health requirements, the Committee considered that it was important to achieve a balance between, on the one hand, the need to protect Australian community resources and access to medical and welfare facilities by Australians, and, on the other hand, the legitimate expectations of migrant applicants, their families and sponsors, as well as the humanitarian and compassionate aspects of the migration program.

Legislative provisions

3.5 Under the Migration Act, a person must satisfy all the criteria for a particular visa or entry permit before the person can be granted that visa or entry permit. In Schedule 1 of the Migration Regulations, certain criteria are listed which are applied generally to all or most visa or entry permit classes. Generally, all non-Australians seeking entry or stay, whether as principal applicants or their dependants, must satisfy general health criteria which are set down in Schedule 1 (Items 9 and 10). There are two visa classes excepted from the health criteria, namely diplomats and those coming to Australia expressly for short term medical treatment.

3.6 In accordance with the regulations, a person meets the health requirement if he/she is free from:

(a) tuberculosis or any other communicable disease of a fatal or serious nature which, in the opinion of a Commonwealth medical officer, is a threat to public health in Australia, and is not suspected of having contracted such a disease; and

(b) any other disease or condition which, in the opinion of a Commonwealth medical officer, would be a danger to members of the Australian community; and

(c) any disease or condition which, during the applicant's proposed period of stay in Australia, would, in the opinion of a Commonwealth medical officer:

(i) require significant care or significant treatment (or both); or

(ii) require care or treatment (or both) involving the use of community resources in short supply; or

(iii) prevent the applicant from pursuing his or her intended occupation (if any) in Australia; or

(iv) would result in the applicant becoming a significant charge on public funds.

3.7 In the case of applicants for a permanent entry permit, the Migration Regulations require not only that such applicants be free from the prescribed diseases or prescribed conditions listed above, but also that they be found to be free from any condition which, in the opinion of a Commonwealth medical officer, would result in offspring who are affected by a prescribed condition or prescribed disease.

3.8 It is clear from the text of the regulation that decision making on health matters essentially is delegated to Commonwealth medical officers. The Minister or the Minister's delegate decide whether or not to grant a visa or entry permit, but the threshold decision as to whether the applicant satisfies the health criteria is reserved essentially to the Commonwealth medical officer.

3.9 This, at least, is the theory concerning the health regulations. In fact, as one begins to grapple with the text and meaning of this regulation, the matter seems far more complicated. This is demonstrated in recent IRT decisions on health refusals. The IRT has studied the health regulation in order to answer the question whether the substance or the fact of a health refusal can be reviewed by the IRT. The IRT has jurisdiction to review decisions of the Minister, not decisions of a Commonwealth medical officer, which are binding on the Minister.

3.10 A close study of the health provisions reveals that the regulation requires two decisions to be taken. The first is whether a person is free from tuberculosis or any other communicable disease of a fatal or serious nature, or any other disease or condition. The second decision, expressed as an opinion of the Commonwealth medical officer, concerns whether the disease or condition is a threat to public health, a danger to the Australian community, or requires costly care or treatment. The decision whether or not the person is free from tuberculosis or communicable disease or other disease or condition is not expressly reserved to the Commonwealth medical officer, and therefore is one for the Minister, no doubt on the advice of the Commonwealth medical officer. In the regulation, the Commonwealth medical officer is given the express task of forming an opinion as to whether the disease or condition is a public health threat, or requires costly care or treatment. The Commonwealth medical officer's decision on these matters would be binding on the Minister.

3.11 At its best, the regulation is unclear and confusing. At its worst, if the meaning given to the regulation above is correct, it appears that the Minister is required to make an essentially medical decision, while the Commonwealth medical officer, in assessing the costs of care and treatment, is allocated a decision which appropriately could be taken by the Minister. This textual confusion and consequent uncertainty concerning the demarcation of responsibility for health decision making is evidenced in other health regulations, notably regulation 144 dealing with the Minister's power to waive aspects of the health rules. This confusion is reflected further in the decision making arrangements on health matters (see Chapter 4).

Health waiver

3.12 Provisions exist in the Migration Regulations for certain aspects of the health requirement to be waived for certain applicants, where the applicant does not meet the health standards but the Minister is satisfied that undue harm or undue cost would be unlikely to result to the Australian community if the visa or entry permit were granted. Regulation 144 prescribes the circumstances in which the waiver may be applied and identifies the limited visa and permit classes for which this concession is available.

3.13 Under the Migration Regulations, the waiver is now available to the humanitarian classes and some but not all of the close family visa and permit classes. Parents and preferential family classes, such as the special need, aged dependant and orphan relative, are excluded from the operation of the waiver.

3.14 Prior to the codification of the migration rules in 1989, there was scope for waiving the health requirement in any category. Statistics on the use of the waiver are provided in Chapter 2.

3.15 Under regulation 144(2), the Minister may grant a visa or entry permit to persons in visa or permit classes to which the waiver applies if a Commonwealth medical officer has formed the opinion that the applicant:

(a) is free of tuberculosis and other communicable diseases of a fatal or serious nature which are a threat to public health in Australia; and

(b) is free of other diseases and conditions which are a danger to members of the Australian community; and

(c) is free of diseases and conditions which are likely to result in offspring being produced with disease or condition referred to in paragraph (a) or (b); and

(d) is unlikely, as a result of a disease or condition, to prejudice the access to health care of any Australian citizen or Australian permanent resident.

3.16 Regulation 144(3) provides that:

> The Minister is not to grant a visa or entry permit referred to in this regulation unless the Minister is satisfied that undue harm or undue cost would be unlikely to result to the Australian community if the visa or entry permit was granted.

3.17 The classes for which the waiver concession is available include:

- adoption
- camp clearance;
- child;
- emergency rescue;
- former citizen;
- global (special humanitarian program);
- in-country special humanitarian program;
- Lebanese concession;
- Lebanese (temporary);
- prospective marriage;
- refugee;
- spouse;
- spouse (after entry);
- Sri Lankan (temporary);
- woman at risk;
- PRC (temporary);
- December 1989 (temporary);
- December 1989 (permanent);
- extended eligibility (spouse);
- interdependency (temporary);
- extended eligibility (interdependency); and
- interdependency (permanent).

3.18 The waiver is available for cases which represent a significant but not undue cost to the Australian community, and where undue harm would be unlikely to result to the Australian community.

3.19 The waiver must be considered in all cases where the health requirement is not met and the application is being considered in a visa or entry permit class where the waiver may be exercised.

3.20 When the text of the waiver provisions is examined, certain problems can be identified. The waiver test is designed to mitigate the rigours of the health criteria in certain circumstances and for certain applicants. In fact, the waiver provision as presently drafted sets a higher and more exacting test for health standards than the substantive health criteria. It is difficult, for example, to see how any person having failed the health test would be able to show that he/she is unlikely to prejudice the access to health care of *any* Australian citizen or resident. Yet, as indicated above, this is the test set down in regulation 144(2)(d).

3.21 While acknowledging the problems of definition arising within the waiver test, the Committee notes that the waiver has been exercised in spite of these difficulties, and entry has been permitted.

3.22 A further matter of concern to the Committee was that the confusing demarcation of responsibilities described for the Schedule 1 criteria is repeated in this regulation. In regulation 144, the Commonwealth medical officer is required expressly to give an opinion on two questions, namely whether the applicant is free from disease or condition, and whether the applicant's disease or condition will prejudice access to health care of any Australian citizen or resident. If the text of this waiver provision is compared with the substantive health criteria in Schedule 1, it can be seen that in the waiver arrangements the Commonwealth medical officer decides on whether the person is free from disease or suffers a medical condition, as well as the likely impact on health care and health access. The formal waiver decision is a matter for the Minister, who, under regulation 144, has responsibility for deciding whether undue harm or undue cost will result if the visa or entry permit is granted. This, of course, conflicts with the substantive regulation, under which the Minister ultimately decides on medical matters and the Commonwealth medical officer's opinion concerning health access and the costs of medical treatment is binding on the Minister.

Conclusions

3.23 In their present form, the regulations produce confusion as to the scope of responsibility and the substance of decision making in health matters. In the Committee's view, the regulations require redrafting to define clearly the demarcation in health decision making. The demarcation should provide that the Commonwealth medical officer is responsible for decisions on purely medical matters, while the Minister is responsible for those decisions which cover wider public interest issues, such as cost to the community and access to community resources.

3.24 A further problem in the existing regulations is that the wording of the waiver provision is inconsistent with the substantive health criteria in Schedule 1, Items 9 and 10, and sets unrealistic standards. As stated, regulation 144(2)(d) provides that the health waiver can be exercised if it is unlikely to prejudice the access to health care of *any* Australian citizen or permanent resident, but regulation 144(3) precludes the Minister from exercising the waiver unless the Minister is satisfied that undue harm or undue cost would be unlikely to result to the Australian community. While the first part of the regulation is drafted in terms of the impact of the waiver on *any* Australian, the second part of the regulation only requires the Minister to consider the waiver in terms of wider public interest issues. In the Committee's view, this inconsistency should be resolved.

3.25 It is evident that the term *any* within regulation 144(2)(d) is too exacting. It is likely that in most, if not all, situations in which the waiver is considered some Australian citizen or permanent resident would be prejudiced in accessing health care, no matter whether that prejudice is real or potential. The principal issue should be not whether in exercising the health waiver there is likely to be an adverse impact on health access by any Australian, but rather whether in the Minister's view the impact is likely to cause undue harm or undue cost to the general Australian community. Removal of the term *any* from regulation 144(2)(d)

not only would ensure that this principal issue is addressed, but also that the waiver provision is internally consistent and practical. This amendment, though, should be adopted only if it is possible to achieve a non-compellable and non-reviewable Ministerial discretion in such matters.

3.26 In this regard, the Committee is not seeking to water down the strict requirements of the waiver criteria. The Committee fully endorses the principle that non-citizens should not be permitted entry to or stay in Australia if it will prejudice the access to health care of Australian citizens and residents. The Committee, though, considers that the existing provision not only establishes a difficult test for the applicant, but also puts the Commonwealth medical officer in an impossible position. The Commonwealth medical officer is required to determine whether the projected health arrangements for the applicant, and the projected costs arising therefrom, would impact adversely not on health access for the Australian community as a whole, but rather on health access for *any* Australian.

Recommendations

3.27 The Committee recommends that:

1. the health regulations set down in the Migration Regulations, Items 9 and 10 of Schedule 1 and regulation 144 be redrafted so that the Commonwealth medical officer is responsible for decisions on medical matters, while the Minister for Immigration, Local Government and Ethnic Affairs is responsible for decisions concerning the costs of treatment and the availability of medical resources;

2. the demarcation of responsibility in health decision making be set out clearly, and the allocation of responsibility be consistent between the substantive health criteria (Schedule 1, Items 9 and 10) and the waiver provision (regulation 144); and

3. regulation 144(2)(d) be amended to remove the term 'any' from the text of the provision, so that, as one of the conditions for the grant of a visa or entry permit for classes to which the waiver applies, an applicant must be unlikely, as a result of a disease or condition, to prejudice the access to health care of Australian citizens or Australian permanent residents. Due to concerns, though, that this recommendation may liberalise inappropriately the waiver provision, recommendation 3 should be implemented only if it is possible to make the Minister's decision concerning waiver non-compellable and non-reviewable.

Health and illegal entry

3.28 Section 20 of the Migration Act currently sets out circumstances in which a non-citizen may become an illegal entrant. The provision states, for example, that a non-citizen who has entered Australia becomes an illegal entrant if on any occasion when the person entered Australia the person was suffering from a prescribed disease or prescribed physical or mental condition. The prescribed diseases and conditions are defined in regulation 176 as follows:

(a) tuberculosis or any other communicable disease of a fatal or serious nature which is a threat to public health in Australia;

(b) any other disease or conditions which would be likely to endanger the Australian community during the person's intended period of stay in Australia;

(c) any disease or condition which during the person's intended period of stay in Australia:

(i) would require significant care or treatment; or

(ii) would require care or treatment (or both) involving the use of community resources in short supply; or

(iii) would prevent a person who has entered Australia from pursuing an intended occupation in Australia; or

(iv) would result in such a person becoming a significant charge on public funds.

3.29 Section 20 is not intended to exclude all persons with prescribed diseases or prescribed conditions. The section is designed to ensure that if a person has such disease or condition, this fact must be disclosed to the immigration officer before the person is permitted to enter, and if entry is granted, it is done with the full knowledge of the person's health condition. As previously stated, there is capacity to waive aspects of the health requirement. If the waiver provisions apply, the person can be permitted to enter. In such cases, the person's entry permit must be endorsed to show that health criteria has been waived. If the permit is so endorsed, the person with the prescribed condition who enters Australia does not become an illegal entrant. If the prescribed disease or condition is not disclosed, or if it is disclosed but the person's permit is not endorsed appropriately, the person becomes an illegal entrant on entering Australia and is liable to deportation.

3.30 In its earlier report on illegal entrants, the Committee expressed its concerns about permanent residents returning to Australia who, in their absence from Australia, may have contracted a prescribed disease or condition, such that they fall within the inadmissible classes set down in section 20.[1] The Committee notes that the Government has introduced changes to the Migration Act to reflect the Committee's recommendations on this matter.

Disability and the health requirement

3.31 In the Migration Regulations, there is no explicit reference to intellectual or physical disabilities. The term 'diseases and conditions' is used. Neither of these terms is defined. The term 'condition' is broad enough to cover persons with medical conditions, such as asthma or arthritis, as well as persons with intellectual and physical disabilities, and also, for example, persons who have a medical condition, in that they may be HIV positive, but who do not have the related disease, that is, Acquired Immune Deficiency Syndrome (AIDS).

3.32 Schedule 1 of the Migration Regulations provides that applicants with conditions, which includes disabilities, fail to meet the health requirement for permanent entry if their condition is likely to:

- require significant care or treatment (or both);
- require care or treatment (or both) involving the use of community resources in short supply;
- prevent the applicant from pursuing his or her intended occupation (if any) in Australia; or
- result in the applicant becoming a significant charge on public funds.

Reviews of the disability criteria

3.33 Two previous inquiries have considered the issue of disability and the health requirement.

3.34 In 1985, the Human Rights Commission (HRC), in its report entitled *Human Rights and the Migration Act 1958*, argued that disability per se should not be, or even appear to be, an automatic bar to immigration. HRC indicated

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1 Joint Standing Committee on Migration Regulations, *Illegal Entrants in Australia - Balancing Control and Compassion*, September 1990, AGPS Canberra, p.58.

that the existing emphasis on the disabilities, rather than the abilities, of disabled persons should be reversed so that the effect is not to discriminate merely because someone is disabled. HRC recommended that:

- a disabled person seeking to immigrate should be assessed on the basis of ordinary selection criteria applicable to every other applicant; and

- an entry permit not be withheld unless the individual concerned has a condition likely to pose a threat to public health.[2]

3.35 In 1988, CAAIP considered that, as a matter of policy, disabilities should not, of themselves, be reason for exclusion. CAAIP indicated that decisions should be based on the applicant's ability to meet selection criteria and on personal circumstances, such as the extent to which support will be provided by relatives to avoid claims on the public purse. CAAIP recommended that:

> infectious diseases continue to be taken as a basis for excluding immigrants but that applicants with disabilities be assessed in the light of economic and family circumstances and taking account of the public health costs involved in their care and treatment.[3]

3.36 Although amendments were made to the Migration Act in 1989, disabilities are still listed alongside diseases and conditions which pose a threat to public health. Diseases and conditions, which include disabilities, fall within the same criteria in the Migration Regulations.

Disability versus disease

3.37 Much of the inquiry evidence relating to the health requirement was focused on the concerns of organisations representing persons with disabilities. A common view in many of the submissions from such organisations was that it is inappropriate and even discriminatory to include persons with disabilities in the same migration category as persons with diseases and conditions which pose a risk to public health.

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2 Human Rights Commission, *Human Rights and the Migration Act 1958*, p. 92.

3 CAAIP, *Immigration: A Commitment to Australia*, recommendation 50, p. 125.

3.38 In a number of submissions, it was argued that disability should not be regarded as a health problem for the purposes of migration. For example, the Intellectual Disability Rights Service, a unit of the Redfern Legal Centre, commented:

> There may well be justification for a health test which works to exclude people migrating because they have a dangerous and contagious disease that poses a real threat to the health of the people of Australia. However, a policy that treats people with a disability in the same way as it treats people with dangerous and transmissible diseases is unjust.[4]

3.39 In a similar vein, the Western Region Ethnic Disability Services stated:

> Just because a person has a disability, it does not imply that he or she has a health condition as well.[5]

3.40 In many submissions, including those from the Authority for Intellectually Handicapped Persons[6] and the Association of Victorian Migrant Resource Centres[7], it was suggested that the inclusion of disability within the same category as diseases appears to be discriminatory. The Authority for Intellectually Handicapped Persons, for example, pointed out that most forms of intellectual disability are not due to either a condition or disease. The Authority noted that one example of this is Downs Syndrome, which it described as a 'genetic anomaly'. The Authority also indicated that 60 to 70 per cent of intellectual disability is due to currently unknown causes.[8]

3.41 In a joint submission, the Broadmeadows and District Migrant Resource Centre, the Disability Resources Centre, Disabled People's International (Australia) and the Broadmeadows Ethnic Disability Service argued that denial of the opportunity to immigrate on the basis of disability alone infringes several rights contained within the Declaration on the Rights of Disabled Persons, including that disabled persons are entitled to have their special needs taken into account at all stages of economic and social planning, and that disabled persons shall be protected from all regulations of a discriminatory nature.[9]

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4 Submissions Vol. 1, p. 171.

5 Submissions Vol. 1, p. 59.

6 Submissions Vol. 1, p. 105.

7 Submissions Vol. 1, p. 73.

8 Submissions Vol. 1, p. 105.

9 Submissions Vol. 1, p. 55.

3.42 The Disability Advisory Council of Australia (DACA) noted that the *Disability Services Act 1986* does not class disability as a health problem. In its submission, it argued for a consistent approach to disability in all Commonwealth legislation and administration.[10]

3.43 Some of the organisations representing people with disabilities suggested that there is a need to develop within the migration legislation a separate mechanism for assessing people with disabilities. DACA, as just one example, indicated that there is a need to reclassify people with disabilities under a different category of the Migration Act and Regulations. It stated:

> Each case should be considered individually not under the health criteria, but separate criteria devised for people with disabilities ... .[11]

3.44 In response to such submissions, DILGEA commented that applicants for visas and entry permits, including the disabled, are considered against the same criteria, and there is no discrimination in the operation of those criteria. It noted that disabled persons can and do meet the health requirement. DILGEA also indicated that the introduction of specific provisions relating to the entry or stay of disabled persons would place them outside the health provisions in respect of their disability. DILGEA stated:

> This would reintroduce a focus on disability - an approach which groups representing the disabled found objectionable.[12]

Definition of disability

3.45 In considering the proposals to establish a separate category for persons with disabilities, distinct from persons with diseases and conditions which pose a risk to public health, the Committee was anxious to ensure that such a category could be defined appropriately, and would be consistent with prevailing attitudes on disability. To this effect, the Committee examined international covenants and Australian legislation dealing with disability.

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10 Submissions Vol. 1, p. 178.

11 ibid.

12 Submissions Vol. 3, p. 29.

3.46 In the United Nations Declaration on the Rights of Disabled Persons, the term 'disabled person' is defined as 'any person unable to ensure by himself or herself, wholly or partly, the necessities of a normal individual and/or social life, as a result of deficiency, either congenital or not, in his or her physical or mental capabilities'. At paragraph 10 of the Declaration, it is stated:

> Disabled persons shall be protected against all exploitation, all regulations and all treatment of a discriminatory, abusive or degrading nature.

3.47 Australia's Disability Services Act does not provide a precise definition of disability, but rather indicates a target group for the purposes of the Act. The target group consists of persons with a disability that:

(a) is attributable to an intellectual, psychiatric, sensory or physical impairment or a combination of such impairments;

(b) is permanent or likely to be permanent; and

(c) results in:

(i) a substantially reduced capacity of the person for communication, learning or mobility; and

(ii) the need for ongoing support services.

3.48 The latest legislation before the Parliament dealing with disability, namely the Disability Discrimination Bill 1992, provides that disability in relation to a person means:

(a) total or partial loss of the person's bodily or mental functions; or

(b) total or partial loss of a part of the body; or

(c) the presence in the body of organisms causing disease or illness; or

(d) the presence in the body of organisms capable of causing disease or illness; or

(e) the malfunction, malformation or disfigurement of part of the person's body; or

(f) a disorder or malfunction that results in the person learning differently from a person without the disorder or malfunction; or

(g) a disorder, illness or disease that affects a person's thought processes, perception of reality, emotions or judgement or that results in disturbed behaviour.

3.49 The broad definition provided in the Disability Discrimination Bill includes the concepts of physical, sensory, intellectual and psychiatric disability.

3.50 The Disability Discrimination Bill makes unlawful any discrimination on the grounds of disability in the areas of employment, education, access to premises, the provision of goods, services and facilities, accommodation, the disposal of land, the activities of clubs, sport, the administration of Commonwealth laws and programs, and in requests for certain information. Under the Disability Discrimination Bill, a person discriminates against a person with a disability if, in circumstances which are the same or not materially different, the 'discriminator' treats or proposes to treat the person with a disability less favourably than a person without disability.

3.51 The objects of the Disability Discrimination Bill, as set out in clause 3, are:

(a) to eliminate, as far as possible, discrimination against persons on the ground of disability in the areas of:

(i) work, accommodation, education, access to premises, clubs and sport; and

(ii) the provision of goods, facilities, services and land; and

(iii) existing laws; and

(iv) the administration of Commonwealth laws and programs; and

(b) to ensure, as far as practicable, that persons with disabilities have the same rights to equality before the law as the rest of the community; and

(c) to promote recognition and acceptance within the community of the principle that persons with disabilities have the same fundamental rights as the rest of the community.

Conclusions

3.52 The consensus of argument in submissions and evidence from community groups and individuals representing people with disabilities was that the existing regulations, which place disability in the same category as diseases and conditions which are a risk to public health, do not accord with prevailing community attitudes towards disability, and are not consistent with other legislation,

such as the Disability Services Act, in which disability is not classified as a health problem. The Committee is sympathetic to the view, put to it in a number of submissions, that it is inappropriate for persons with disabilities to be coupled with persons who are a public health risk.

3.53 While DILGEA warned that separation of disability into a separate category may be counterproductive, by focusing attention on disability in a way which the existing regulation does not require, the Committee was swayed by the consensus view of those representing the disabled that the existing regulation creates an unfair and inaccurate perception that persons with disabilities are a health problem.

3.54 The Committee, of course, stresses that Australia must retain the right to refuse entry and stay on the grounds of disability. The Committee notes that this was not a major point of contention during the inquiry. Rather, the main concerns were in relation to how that disability is assessed, and under which category that assessment is made.

3.55 The Committee is mindful of the difficulties of definition and classification within the health criteria. The advantage of a broad term such as 'condition' is that it covers a multitude of medical problems. There is no obligation within the regulation to enumerate exhaustively the types of health problems which are sought to be addressed within the regulation. One only has to examine the cases listed in Table 2.3 (Chapter 2) to see the variety of medical conditions evaluated by Commonwealth medical officers. The list of conditions in Table 2.3 clearly demonstrates how difficult it is to classify or define such conditions. For example, should valvular heart disease or chronic persistent hepatitis be classified as a disease, medical condition or disability? The broad definitions and descriptions of disability adopted in the Disability Services Act and the Disability Discrimination Bill do not appear to provide guidance on how this classification could be undertaken for migration purposes.

3.56 Notwithstanding the conceptual and drafting difficulties in this regard, the Committee, on balance, favours the separation of the existing health regulation into two separate categories. The first should deal with diseases and medical conditions, while the second should deal with disabilities. The waiver provisions also should be separated into the same two categories, along with the provisions relating to illegal entry currently in section 20 of the Migration Act and regulation 176.

3.57 The issue of how disability should be assessed within a separate category is discussed in Chapter 4.

Recommendation

3.58 The Committee, while emphasising that Australia must retain the right to refuse entry and stay on the grounds of disability, recommends that:

4. the existing provisions dealing with the health requirement, namely the Migration Regulations Schedule 1, Items 9 and 10, regulation 144, section 20 of the *Migration Act 1958* and regulation 176, be amended to provide separate categories for assessment of:

   (a) diseases and medical conditions; and

   (b) disabilities.

Migration Reform Bill

3.59 While the Committee was finalising this report, the Migration Reform Bill 1992 was introduced into the Parliament. The Migration Reform Bill, amongst other matters, makes certain amendments to the existing health provisions. The Committee, therefore, gave some consideration to these proposed new arrangements. The Committee's deliberations on these proposed arrangements were circumscribed because the regulations which are set to complement and elucidate the new provisions were not before the Committee. The Committee, therefore, was unable to gauge the full import of certain provisions in the Bill. Relevant sections of the Bill, if passed, are set to come into force on 1 November 1993.

3.60 In the proposed arrangements, persons who are not Australian citizens and who are travelling to, entering or staying on in Australia require a visa. Such persons still will be required to satisfy certain health criteria in order to be granted a visa. The health criteria, while not elaborated in the Bill, are defined there as the prescribed criterion for a visa, which is satisfied if the applicant for the visa:

(a) does not have a specified disease;

(b) does not have a specified physical or mental condition;

(c) has a specified physical or mental condition;

(d) has had a specified examination; or

(e) has had specified treatment to prevent disease.

3.61 The Bill contains a new category, the 'health concern non-citizen', which is a non-Australian citizen suffering from a prescribed disease or a prescribed physical or mental condition. The significance of the categorisation is spelt out, though perhaps not in full, in the Bill.

3.62 The Bill also amends the existing section 20 provisions concerning illegal entry. In the Bill, illegal entrants are to be known as 'unlawful non-citizens'. The Bill requires that persons applying for a visa must answer accurately all questions in their visa application form. Failure to answer any one question, or failure to answer a question truthfully, is ground for cancellation of the visa. In addition, under clause 50AB(1), visas can be cancelled if the Minister is satisfied that any circumstances which permitted the approval of the application for the visa no longer exist (paragraph (a)), or the presence of its holder in Australia is or would be a risk to the health of the Australian community (paragraph (e)). If the person's visa is cancelled, the person becomes an unlawful non-citizen who must be arrested and detained pending removal from Australia or the grant of a visa, including a processing or 'bridging' visa. The unlawful non-citizen is required to pay their detention costs and any removal costs.

Conclusions

3.63 The provisions of the Migration Reform Bill, on their face, appear in some respects to widen the scope of the existing illegal entry provisions in section 20. In relation to the health rules, under clause 50AB(1)(a) if a non-citizen who meets the health criteria enters Australia and subsequently is taken ill with a prescribed disease or is disabled, say in a car accident, it appears, from the text of the Bill, that their visa may be cancelled and the person detained and removed. A similar result can be visited upon a non-citizen who subsequent to entry becomes a risk to public health (clause 50AB(1)(e)). A notable example would be a non-citizen who contracts AIDS, even if this was contracted in Australia. Under the proposed Bill, the Minister is permitted to cancel the visa if the person becomes a risk to community health.

3.64 The cancellation provisions in clause 50AB recited above do not apply to permanent residents who are in the migration zone, that is who are at or in Australia, providing that they were immigration cleared on last entering Australia. Permanent resident visas, however, can be cancelled in circumstances set out in clause 50AB while the permanent resident is outside Australia, perhaps on a home visit.

3.65 The intended regulations, which the Committee has not seen, may constrain the Minister's power to cancel visas in such circumstances, or may provide that after a certain time has passed permanent residents will not be visited with a visa cancellation as set down in clause 50AB.

3.66 The Committee's consideration of the Bill was necessarily limited, as the regulations which will accompany the Bill have not been drafted. As already noted, it is essential to examine the regulations in order to assess the full meaning and import of the Bill.

3.67 The Committee did not seek any evidence on the Bill or on any of the proposed regulations. The Committee, nevertheless, considers that if the Bill becomes law, regulations to accompany it should provide that non-citizens who are permanent residents should not be vulnerable to cancellation of their permanent visas when they are outside Australia because of a prescribed disease, medical condition or disability, providing that their prescribed disease, medical condition or disability was acquired subsequent to the person's first arrival in Australia.

Recommendation

3.68 **The Committee recommends that:**

5. **the regulations set to accompany the Migration Bill 1992 should provide that non-citizens who are permanent residents should not be vulnerable to cancellation of their visa when they are outside Australia because of a prescribed disease, medical condition or disability, providing that their prescribed disease, medical condition or disability was acquired subsequent to the person's first arrival in Australia.**

Chapter Four

ADMINISTRATION OF THE HEALTH REQUIREMENT:

THE PROCESS OF DECISION MAKING

Introduction

4.1 The current Migration Regulations and administrative framework are intended, in addition to other matters, to provide a mechanism which identifies those applicants for migrant entry who are likely to impose significant health and welfare costs on the Australian community as a result of a disease or condition. In cases where such an eventuality is judged likely, entry or stay is prevented unless waiver of the health requirement is, firstly, available under the law and, secondly, exercised where circumstances support the judgment that undue harm or undue cost are unlikely to result.

4.2 In its submission, DILGEA expressed the view that the waiver provision effectively accepts that certain significant costs will be borne by the Australian community. These costs can be significant, but must not be undue costs. In certain circumstances, sponsors in Australia may accept some of these costs through the Assurance of Support (AOS) system.[1]

How the health criteria are assessed

4.3 An applicant's ability to meet the health requirement is assessed on the basis of his or her:

- proposed length of stay in Australia;
- intended occupation in Australia; and
- medical history.

4.4 Apart from the visa classes excepted from the health requirement, all applicants for permanent entry and some temporary entrants are required to undergo a comprehensive medical examination and, if aged 16 years or over, a radiological (X-ray) examination as well. The temporary entrants who require health

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1 Submissions Vol. 2, p. 86.

checks are those who are considered to have a potential impact on public health, such as students who will be in a classroom situation, those involved in health care or in the hospitality/ food processing industries, and so forth.

4.5 Applicants required to undergo health checking are provided with standard forms by the migration processing office or by an agent. The term 'processing office' normally means the office where the particular application for a visa or entry permit is being considered. Overseas, it is an Australian Government Mission (usually called a 'post'), where DILGEA officers may be attached. Within Australia, the term refers to DILGEA's State, Regional or Area offices.

4.6 The standard forms used in the health examinations, copies of which appear at Appendix D, are:

- Form 26 Medical Examination (one per person); and
- Form 160 Radiological Report on a Chest X-ray (one per person aged 16 years or over).

4.7 The first part of Form 26 requires the applicant to respond to questions and the second part documents the examining doctor's findings during the clinical examination. It can be seen from the range of topics covered in the form that the most important questions are directed towards identifying public health risk conditions and any conditions that are likely to result in costs to the Australian taxpayer.

4.8 In order to prevent substitutes presenting for examinations, the doctor or radiologist who signs the assessment form at the conclusion of the examination personally must have performed the examination and identified that person against the photograph submitted with the relevant migration application form.

Applicants outside Australia

4.9 Overseas applicants are examined in their country of origin by qualified physicians and radiologists who are chosen either by the applicant or designated by the processing office. The only applicants who may choose their own doctor are those who are:

- resident in Canada, New Zealand or the USA; or
- resident in any other country and applying for entry in the following classes:
  - the independent executive, executive or specialist temporary resident classes; or

- a student/trainee class and coming to Australia for less than 12 months.

4.10 All other overseas applicants are directed by the processing office to designated doctors and radiologists. Most designated examiners overseas are selected by the processing office with the help of a Regional Medical Director (RMD) or Central Office of DHHCS. RMDs are medical officers from DHHCS who are located at overseas posts on DILGEA's establishment. Currently there are two RMD positions, one located in Bangkok and one in Paris, each covering several countries in the respective area. The RMDs are mainly concerned with the selection and supervising of examining doctors and advising DHHCS and DILGEA on general policy and procedural issues.

4.11 Processing offices overseas select for each country for which the office is responsible a minimum number of physicians and radiologists needed to service it. These selected examiners, also known as 'panel doctors', are visited personally from time to time by RMDs or DHHCS, to check on their facilities and to brief them in regard to the requirements for examinations and reports.

Applicants within Australia

4.12 All applicants within Australia attend designated examiners, as there is no provision for such applicants to choose their own examining physician or radiologist. Each processing office in Australia is supplied by the local DHHCS Regional Office with a list of medical officers to whom applicants may be referred for the medical examination, and of appropriate hospitals or chest clinics for the radiological examinations.

Reports on the health examination

4.13 All doctors examining applicants report their findings on the standard form, which provides a checklist for normal/abnormal results. Where, in the doctor's opinion, the applicant's results are abnormal under any of the checked items, comments are to be supplied on Form 26.

4.14 The examining doctors do not advise whether applicants meet the health requirement. They report their findings to the processing office. Some of these processing offices have the authority to clear straightforward cases as meeting the health requirement, on the basis of the examining doctor's report. Such cases comprise applicants for permanent entry examined in Australia, Austria, Belgium, Canada, Denmark, Finland, France, the former Federal Republic of Germany, Greece, Iceland, Ireland, Italy, Japan, Luxembourg, Malaysia, Netherlands, New Zealand, Norway, Portugal, Singapore, South Africa, Spain, Sweden, Switzerland, Thailand, the United Kingdom, the USA and (excluding refugee and

humanitarian visa classes) Hong Kong and Macau. In addition, applicants for non-permanent visa categories who are examined in any country can be cleared by the relevant processing office.

4.15 The more complex cases, and all cases handled by processing offices not possessing clearance authority, are sent for assessment to the Migrant Medical Clearances Unit, which is part of the Australian Government Health Service in Sydney.

Clearance by Commonwealth medical officers

4.16 The MMCU receives the medical documents and x-rays of prospective migrants world-wide and in Australia. The MMCU is staffed by five[2] Commonwealth medical officers, who assess the information contained in the standard health reporting forms and, with reference to health guidelines, form an opinion on whether or not applicants meet the health requirement. In some cases, if the medical condition or disability is complex, additional medical or specialists reports are requested.

4.17 Commonwealth medical officers do not normally examine applicants. They provide advice to DILGEA on the ability of applicants in Australia and overseas to meet the health requirement, if applications have not already been cleared by processing offices authorised to do so. The Commonwealth medical officer's opinion is, according to DHHCS, 'based on obtaining the best available medical evidence, on the natural history of the condition, and on its treatment and prognosis'.[3]

4.18 The RMD Bangkok also has the same clearance powers as a Commonwealth medical officer in relation to applicants examined in Thailand, Malaysia and Vietnam.

Assessments by Commonwealth medical officers

4.19 The response which a Commonwealth medical officer provides to the processing office in relation to each applicant indicates that the applicant either:

- meets the health requirement with or without being subject to satisfactory completion of a health undertaking; or

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2 There are three additional Commonwealth medical officers in the MMCU, although in practice their work is restricted to local change-of-status cases only. These are located in Central Sydney, Parramatta and Melbourne.

3 Submissions Vol. 3, p. 20.

- does not at the time meet the health requirement but could be reconsidered at a later date under specified conditions; or

- does not meet the health requirement.

4.20 Alternatively, the Commonwealth medical officer could indicate that further specified information (*eg* a specialist report) is required before final advice can be given. If in any doubt about the Commonwealth medical officer's advice, the processing office is required to seek clarification, which not only provides the opportunity for the medical officer to change his or her advice, possibly to a more favourable assessment, but, as indicated in Procedures Advice Manual (PAM) Health Requirement Topic 6, 'Decision Making and the Health Requirement':

> ... if requested, to provide the processing office with details which would be helpful in assessment of public health, welfare and access costs, which forms part of the waiver consideration for certain specified classes.[4]

Guidelines for medical officers

4.21 DILGEA, in consultation with DHHCS, has produced guidelines for both the examining doctors and for the Commonwealth medical officers.

4.22 A booklet produced by DILGEA in 1989 and entitled 'Health Requirements - Notes for the Guidance of Doctors and Radiologists Examining Applicants for Visas and Entry Permits' was tendered as Exhibit 3 during the inquiry. This booklet guides examining doctors on the purpose and conduct of the medical and radiological examinations required under the migration legislation. Its format closely follows the sequence of tests which are required to be checked and recorded on the standard forms. The booklet is currently out of print but the Committee understands that a revised version will be produced in due course.

4.23 In describing the guidance provided to Commonwealth medical officers, DILGEA indicated in its submission dated 3 October 1991 that the standards used for health assessments were contained in the Department's document entitled 'Health Standards for Permanent or Long-Term Stay in Australia: Guidelines for Australian Government Medical Officers' (February 1986). This detailed publication was produced by DILGEA with technical advice from DHHCS for the purpose of guiding Commonwealth medical officers on the standards of health considered to be the minimum appropriate for migration purposes.

4.24 The Committee heard in evidence from AGHS on 19 February 1992 that these guidelines were now out of date and were being replaced progressively by background briefing papers, which provide up to date information on specific topic

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4 PAM Health Requirement Topic 6, March 1991, p. 6.

areas, together with broad cost indicators in relation to potential levels of care and treatment required. AGHS stated:

> In fact the Policy and Evaluation Section is not so much reviewing the guidelines as that the guidelines became obsolete with the regulations because they were too prescriptive. [That Section's staff] are actually setting up background briefing papers in the various medical areas in order to assist a medical officer in forming an opinion. So we are now going into conditions, looking at what sort of range of services they might require and trying to arrive at some sort of very broad costing.[5]

4.25 The Policy and Evaluation Section of the AGHS Branch of DHHCS prepares the draft guidelines in consultation with the MMCU, before the documents are issued by DILGEA. The Committee understands that only three briefing papers have been finalised so far. These have been prepared on the topics of Intellectual Disability, Psychiatric Disorders and AIDS. A further paper is being prepared on the topic of the Frail Aged.

4.26 The briefing paper relating to intellectual disabilities was accepted during the inquiry as Exhibit 8. In the introductory sections of that paper, it is emphasised that:

> ... the guidelines are not used in a prescriptive way to categorise individuals but to help the [Commonwealth medical officers] make consistent and equitable decisions.[6]

Conclusions

4.27 Only a few topics have been covered so far by the background briefing papers. The Committee heard in evidence that these briefing papers have been designed to replace the outdated Guidelines, 'Health Standards for Permanent or Long-Term Entry or Stay in Australia'. This means that, except for those few topics now covered by briefing papers, there are no official guidelines for assessing health conditions.

4.28 The Guidelines are of critical importance in assisting Commonwealth medical officers to reach an opinion on whether or not an applicant meets the health requirement, and in achieving consistency in such opinions. The Committee,

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5 Transcript of evidence, 19 February 1992, p. 168.

6 AGHS. *Intellectual Disabilities : A paper developed for the review of migration health standards*, February 1992, p. 2.

therefore, considers that the hiatus which exists between the out of date Guidelines and the distribution of only three replacement background briefing papers to date is undesirable.

Recommendation

4.29 The Committee recommends that:

6. priority be given to the production of the background briefing papers for Commonwealth medical officers on the assessment of medical and disability conditions. These papers should provide up to date and realistic assistance to the Commonwealth medical officers in forming opinions on whether or not applicants meet the health requirement for entry or stay.

Assessment of disability

4.30 Of the background briefing papers issued by DILGEA in consultation with AGHS for use by Commonwealth medical officers, only two of the four documents so far issued by DILGEA cover the area of disability. The one accepted as Exhibit 8 provides guidance in the assessment of intellectual disability. This particular paper describes the nature of intellectual disability, assessment techniques (IQ tests), indicative costs for support in areas such as accommodation, employment, education and income, and availability of community resources.

4.31 The National Council on Intellectual Disability (NCID) voiced the opinion of many other organisations in recognising that the standards used by the Commonwealth medical officer in assessing applicants with a disability are the key issue. NCID went on to highlight perceived inadequacies in the guidelines, claiming that they:

> ... treat the person with an intellectual disability as an individual applying for migration. In our comments we urged the AGHS to reword the paper so that the person's role in the whole family unit would always be taken into full consideration. The process of assessment set out in the draft document views the person with an intellectual disability mainly from the negative aspects of that disability. We believe that the document should also clearly give the opportunity for the assessment to reflect more positively the abilities and capacities of the person concerned.[7]

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7 Submissions Vol. 1, p. 119.

4.32 NCID further argued that reliance on IQ measurement gives emphasis to the negative aspects of a person's intellectual disability. NCID provided the following comments on that segment of the briefing paper:

> It is stressed that people with disabilities must be viewed from the positive aspects of their abilities. IQ levels have only been used to measure the negative aspects of an individual. The behaviour and abilities of people with intellectual disabilities vary across a wide spectrum. Very often the general, negative view of a person's disability will not necessarily disclose the positive facts that the individual has capacities and skills usually associated with a less severe disability, such as selective and discriminatory behaviour with food. Guidelines should be established to measure what people can do rather than what they cannot do. ... It is recommended that assessments be made on adaptive behaviour functioning, as the use only of IQ levels is no longer considered to be a true indicator of the overall intelligence and abilities of a person.[8]

4.33 In reply to criticism about lack of broadly-based guidelines for assessing people with intellectual disabilities, DHHCS pointed out in its supplementary submission that the latest version (February 1992) of the guideline briefing paper now makes particular mention of abilities and capabilities and the place of the family.[9]

4.34 In a number of other submissions, it was put to the Committee that greater flexibility was needed in the interpretation of the health requirement when assessing people with disabilities. For example, the Broadmeadows and District Migrant Resource Centre, Disability Resources Centre, Disabled Peoples' International and the Broadmeadows Ethnic Disability Service argued that it was unfair to reject a family's application purely on the basis of one family member's disability. Citing the 1985 HRC report on the Migration Act, it was suggested in the submission that if the criteria for the family as a whole, including the disabled member, are met, then the disabled family member should not have to make out a special case for entry.[10]

4.35 During the public hearings, the Department of Social Security (DSS) indicated that the health assessment for people with disabilities would be more reliable if it were related to the person's capacity to work, rather than simply a measurement of impairment. The DSS examination for the purposes of determining

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8 ibid., p. 126.

9 Submissions Vol. 3, p. 21.

10 Submissions Vol. 1, p. 54.

eligibility for Disability Support Pension (DSP) focuses on the person's capacity to work. The medical impairment rating is only used as a first step, following which other tests are applied on employability. DSS stated:

> The 20 per cent criterion [DSP threshold test] is one of the first of a number of steps. To be considered for the payment, you need to pass that test as an initial one. So if you do not have at least a 20 per cent medical impairment under the guidelines, then you have no claim against the payment whatever. Having passed that test, other tests are applied on your employability and so on in the country. ... Therefore, I would not think there would be any great concern about that if we were to apply the Disability Support Pension test as a health screen for intending migrants.[11]

4.36 The National Federation of Blind Citizens of Australia, while accepting that all potential migrants should be assessed to ensure that they will be contributing members of the Australian community, argued that blindness of itself does not constitute a health condition likely to result in a person becoming a burden on the community. It stated:

> While blindness and vision disability result from either a health condition or injury, they do not in themselves lead to an ongoing reliance on health services. Normally when a person's eye condition is stable they do not need medication or other intervention in relation to their eyes. Most factors that cause vision loss are traumatic in nature and thus after restorative or compensatory action medical intervention is not needed beyond a low level monitoring function.[12]

4.37 In terms of a blind person's employment capabilities, the Federation noted that blind people in Australia and throughout the western world have for many years proven their ability to work in a wide range of occupations. It added that blind people have traditionally taken advantage of developments in information technology, citing the example of computers and their use in employment and education.

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11 Transcript of evidence. 19 February 1992. p. 186.

12 Submissions Vol. 2, p. 23.

4.38 On the aspect of additional cost burdens, the Federation considered these costs to be marginal. The Federation commented:

> While blind people need specific community support in meeting their information and mobility needs, the availability of this support through rehabilitation training and information services such as specialist libraries and radio for the print handicapped makes them largely self sufficient. In calculating the consequent cost of meeting these needs it is necessary to assess the marginal cost involved, as for example specialist library services are used instead of the generic services provided from community resources for other people.[13]

Conclusions

4.39 The Committee acknowledges that the revised background briefing paper on intellectual disabilities goes some way towards meeting criticisms from community groups. However, as the focus of the paper is still on the level of impairment as assessed by a general intelligence test, it does not yet go far enough in providing the flexibility to consider the more positive factors such as an applicant's likely contribution to the community as part of a family unit.

4.40 Although the guideline material that the Committee has seen does represent a worthy attempt to quantify relevant potential costs and to update the reference material for Commonwealth medical officers in light of medical and other research into disability, the basis for assessment should take into account broader social, economic and skill factors as well, including capacity to work.

Recommendations

4.41 The Committee recommends that:

7. the guideline briefing papers issued by the Department of Immigration, Local Government and Ethnic Affairs for use by Commonwealth medical officers in assessing people with disabilities against the health requirement be based on accepted principles for the assessment of disabilities, and be regularly updated in accordance with the latest research data on the various forms of disability; and

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13 Ibid., p. 24.

8. in assessing a person with a disability, sufficient emphasis 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. To this effect, the Commonwealth medical officer or, where appropriate, the processing immigration officer should gather data relevant to the Minister's decision whether or not to grant a visa or entry permit or, where relevant, to exercise the health waiver, including data on:

   (a) the nature of the disability;

   (b) the age of the person;

   (c) the opportunities for employment and likely benefits to the community of the disabled person and other members of the family unit;

   (d) the capacity of the family unit to provide adequate lifetime care and support to the disabled person, without undue cost to the community; and

   (e) the extent to which entitlements to government-funded support can be claimed, regardless of a person's means.

Consistency in decision making

4.42 In the submissions from the NCID and the Australian Intercountry Adoption Network (AICAN),[14] several examples were cited in relation to different applicants with similar health problems or disabilities which had resulted in contradictory opinions being given by the medical officer as to whether or not the applicants met the health requirement.

4.43 In broad terms, DHHCS explained in its submission:

> The MMCU does not aim to achieve complete consistency of outcome, but consistency of approach. Consistency among the [Commonwealth medical officers] is achieved by adherence to the need to form an opinion on an applicant's health, along the lines set out in Schedule 1, Item 9 of the Regulations.

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14 Submissions Vol. 1, pp. 121-123 and Submissions Vol. 3, pp. 5-9.

> Of the eight [Commonwealth medical officers] in Australia, six doctors are at the same location and are in constant contact with each other concerning cases. The other two doctors consult regularly by telephone. We hold meetings every few months to discuss clearance criteria. There is a commonality of understanding about how conditions are handled and, when doubts exist, cases always are discussed. To DHHCS' knowledge, the advice to DILGEA on health conditions is reasonably consistent.[15]

4.44 In the same submission, DHHCS mentioned one particular problem in relation to maintaining consistency in decision making. This concerns the RMD Bangkok, who is in the special situation of also holding the clearance powers of a Commonwealth medical officer. This officer reports to DILGEA, not to DHHCS, unlike the other RMD in Paris and all other Commonwealth medical officers. DHHCS admitted that 'at times, communication has been a problem. DHHCS has suggested to DILGEA that all Regional Medical Directors should be the responsibility of DHHCS.[16]

4.45 The Committee agrees with the above suggestion and urges DILGEA and DHHCS to address the communication and consistency problems resulting from the existing line of control for the RMD Bangkok.

Recommendation

4.46 **The Committee recommends that:**

9. unless there are sound reasons to the contrary, the Regional Medical Director Bangkok report to the Department of Health, Housing and Community Services, as is the case for all Commonwealth medical officers and the Regional Medical Director Paris.

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15 Submissions Vol. 3, p. 21.

16 ibid., p. 22.

Clarification of responsibility

4.47 The role of DHHCS/AGHS in the migration process was described in submissions and evidence by both DILGEA and DHHCS as an advisory one. PAM Health Requirement Topic 1, section 2 describes the role of DHHCS in the following terms:

> DHHCS has an advisory role to DILGEA on the formulation and interpretation of health requirements as expressed in the Regulations and associated procedures and guidelines. The two departments consult on such matters as:
>
> - determining the content of forms relating to health checking examinations
> - reviewing, and updating as necessary, guidelines to examining doctors and guidelines to Commonwealth medical officers on applicants' ability to meet the health requirement.
>
> DHHCS does not make decisions on applications for visas and entry permits.[17]

4.48 In section 4 of the same PAM topic, reference is made to official instructions and forms relating to administration of the health requirement, which are published through the DILGEA instructions and forms registries. Where necessary, DILGEA consults with DHHCS before issuing new or amending material, but no officer of DHHCS has authority to direct any change to policies, procedures, guidelines or forms relating to administration of the health requirement.

4.49 In evidence, DILGEA responded to questioning about whether DHHCS has an advisory role only in the following terms:

> Yes, the Department of Health makes a judgment about whether or not an applicant may be one for whom there would be significant costs involved if he or she were to enter Australia. ...[18]

4.50 After supplementary questioning by the Committee, DILGEA accepted the Committee's proposition that DHHCS is in overall charge of the health assessment aspects of the program.

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17 PAM Health Requirement Topic 2, p. 3, March 1991.

18 Transcript of evidence, 19 February 1992, p. 126.

Conclusions

4.51 The regulatory confusion concerning the ambit of responsibility in decision making on the health criteria and health waiver (see paragraphs 3.9 to 3.23) appears to be compounded by a similar lack of clarity in processing arrangements for the health criteria. After considering the evidence presented during the inquiry, the Committee was not convinced that the responsibility for decision making on the health criteria and on whether entry or stay should be granted is sufficiently clear in the administrative guidelines or material currently available in the Procedures Advice Manual.

4.52 Given the confusion which appears to exist in the official documentation and the regulations concerning the respective roles of DHHCS/AGHS and DILGEA in the health decision making process, the Committee, in addition to recommendations 1 and 2, sees the need to define these roles more clearly in relation to processing of the health requirement for entry. Much of this confusion stems from the lack of clear demarcation of authority in the Regulations and therefore should be remedied when the recommendations contained in Chapter Three are implemented.

Recommendation

4.53 The Committee recommends that:

10. **consequent upon recommendations 1 and 2, the arrangements for demarcation of responsibility between the Minister for Immigration, Local Government and Ethnic Affairs and the Commonwealth medical officer, as enunciated in the Policy Control Instructions, the Procedures Advice Manual and the background briefing papers be brought into line with the Migration Regulations.**

Screening for disability

4.54 In its initial submission dated 30 November 1989, DSS commented:

> A small but significant problem already exists with migrants who have been given a clean bill of health overseas claiming Invalid [now Disability Support] Pension shortly after arrival in Australia. Part of the reason seems to be the uneven quality of medical assessment made in connection with the application for migration.[19]

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19 Submissions Vol. 1, p. 165.

4.55 At the public hearing on 19 February 1992, DSS indicated:

> We certainly see instances of people who exhibit medical conditions, who have applied for, say, the Disability Support Pension, which stretch the bounds of credibility that the conditions were not pre-existing before arrival in Australia. ... The difficulty stems primarily from the fact that the health screening processes DILGEA engages, and those for granting an Invalid Pension, or Disability Support Pension these days, differ fairly substantially from our own. We have a higher threshold test.[20]

4.56 The Committee noted the statistics provided by Senator Richardson on 15 October 1991 in response to a Question on Notice in the Senate from Senator Alston. Those figures identified the recipients of social security pension and allowance payments who had been resident in Australia for less than two years. Tables 4.1 and 4.2 have been compiled from Senator Richardson's response and show, for example that Invalid Pension recipients numbered 710 in 1990 and 580 in 1991. Sickness Benefit recipients were shown as being 2,480 in 1990 and 2,020 in 1991.

4.57 In evidence, DSS commented on these statistics by indicating that these numbers were significant in the sense that they resulted in financial outlays for the Commonwealth, notwithstanding the likelihood that some of these recipients would be subject to Assurances of Support, which would to an extent reduce the ultimate cost to the taxpayer. On this particular aspect, DSS subsequently provided further advice based on information from DILGEA. This advice was that approximately 15 per cent of all settler arrivals in 1990/91 required Assurances of Support. This factor of 15 per cent can be applied to the numbers shown in Table 4.1 to obtain a broad indication of the number of persons with less than two years' residence in Australia in receipt of social security payments and for whom an Assurance had been provided.[21]

4.58 Table 4.2 shows the associated estimates for total full-year costs of the pensions and benefits listed in Table 4.1 for 1990/91, selectively compiled from the estimates supplied in response to Senator Alston's Question.

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20 Transcript of evidence, 19 February 1992, pp. 184 and 185.

21 Submissions Vol. 3, p. 60.

TABLE 4.1 - SELECTED SOCIAL SECURITY RECIPIENTS WITH LESS THAN TWO YEARS' RESIDENCE IN AUSTRALIA

Pension/Allowance	1990	1991
Age Pension	3,220	2,170
Invalid Pension	710	580
Sickness Benefit	2,480	2,020
Special Benefit	3,310	3,710

TABLE 4.2 - ESTIMATED FULL YEAR COSTS FOR PAYMENT OF PENSIONS AND BENEFITS TO RECIPIENTS SHOWN IN TABLE 4.1

Pension/Allowance	1989/90	1990/91
Age Pension	N/A	$M 14.10
Invalid Pension	N/A	$M 4.48
Sickness Benefit	$M 18.00	$M 23.00
Special Benefit	$M 22.00	$M 33.00

Source: DSS Submission dated 11 March 1992 (No.59) (Tables 4.1 and 4.2)

N/A.: Not available

4.59 The Committee next considered the feasibility, in cases where a disability was present, of aligning the screening tests applied by DILGEA for entry or stay with the health examinations employed by DSS to determine eligibility for the Disability Support Pension (formerly the Invalid Pension).

4.60 The view was expressed by AGHS in evidence that the disability pension examination was a more complicated examination than the standard migration medical, and that there was some concern regarding the capacity or willingness of the panel doctors to carry out a more complex migration medical assessment in disability cases. AGHS nevertheless concurred that there is 'certainly a case for us to look at the forms used by panel doctors overseas and the Disability Support Pension procedures'.[22]

4.61 In a supplementary submission, DSS confirmed the higher costs involved in medical examinations by AGHS for the purposes of the Disability Support Pension, compared with the migration medical examination. The medical examination required by DILGEA is a standard 45 minute examination at a cost of $78, whereas the cost to DSS of an examination for the disability pension is $104 (or $108 if a general practitioner overseen by AGHS is used). It is important to note, however, that the DILGEA medical is based on the 'user pays' principle, while the costs of medical assessments in the pension stream are borne by DSS.[23]

4.62 In further evidence, DSS expressed the view that:

> Certainly it would suit us if the [migration] health screening tests were in line with the Disability Support Pension screening process. Obviously, if that were applied, there would be very little slippage and very little difficulty of the isolated cases one sees through the appeals streams where it is not at all evident whether the condition was pre-existing before arrival in Australia.[24]

Conclusions

4.63 After considering the evidence for and against aligning the health checks used by DILGEA and DSS in disability cases, the Committee formed the view that the incidence of claims for Disability Support Pension within two years of arrival in Australia is a matter of concern, as there is a cost in financial terms if the migration screening tests are not identifying pre-existing disabilities before entry. The Committee therefore considers that DILGEA, DSS and AGHS should ensure

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22 Transcript of evidence, 19 February 1992, p. 170.

23 Submissions Vol. 3, p. 61.

24 Transcript of evidence, 19 February 1992, p. 186.

that the migration screening procedures for people with disabilities are aligned as closely as possible with the tests employed by DSS in determining eligibility for the Disability Support Pension.

Recommendation

4.64 The Committee recommends that:

11. **the health screening standards and procedures used in assessing people with disabilities for migration purposes be aligned as closely as possible with the tests applied by the Department of Social Security in determining eligibility for the Disability Support Pension.**

Screening for diseases

4.65 In the course of the inquiry, the Committee examined other issues emerging from the health screening process, with particular reference to the protection of public health and impacts on the State public health systems.

4.66 At the public hearing on 11 March 1992, the New South Wales (NSW) Health Department outlined some of the difficulties arising with both permanent and temporary entrants who pose a health risk because of infectious diseases such as tuberculosis and hepatitis B. In reply to questions about whether the health screening arrangements in place for permanent migration categories are adequate, the NSW Health Department stated:

> There are good grounds to believe that currently some 55 persons - 10 per cent - receiving treatment in TB clinics in New South Wales are Medicare ineligible. ... I would be cautious in saying that the arrangements are inadequate because of the difficulties in determining the adequacy. By that I mean persons who have, at any particular time, inactive, old tuberculosis may at some stage in the future reactivate and, therefore, an assessment made some time before may not carefully enough be able to assess their risk to themselves or others at a later date. In New South Wales in 1989-90, 45.7 per cent of persons with new cases of tuberculosis were born in Asia, 11 per cent in Europe and 4.6 per cent in Oceania. Twenty-six per cent were Australian white persons. There is concern that the current screening processes may not adequately notify authorities in Australia of the likelihood of a person being at risk. ...

> I would have to agree with your contention that the initial screening program and its administrative arrangements are not perfect. There are, for example, lengthy delays incurred in transmitting both X-ray film and reports. I am aware of some occasions when they arrived well after the person to whom they referred, suggesting that this person had a tuberculosis undertaking, or a TBU as they are known, and requiring them to undertake further surveillance. They are then, of course, lost to the system. The New South Wales Health Department has no access to immigration data specifying these individual persons. Many of these disappear, some - a small number - presenting themselves at a later date requiring treatment for a condition classically but not exclusively tuberculosis. So the system is not perfect. ...
>
> I think the conditions of particular concern are tuberculosis and hepatitis B. The screening of hepatitis B is not commonly undertaken, and we rely for our State health awareness of the situation basically on the country of origin of persons. For example, it is published data that in the Philippines, 12 per cent of persons are hepatitis positive, whereas in Australia the rate is 0.3 per cent. ... There are reasons whereby New South Wales Health believes that screening for hepatitis B could usefully be undertaken amongst certain intending immigrants, particularly where these are women of child bearing age.[25]

4.67 The Committee noted from DILGEA Form 26, Medical Examination (see Appendix D) that in the case of hepatitis B, the only migration categories required to be tested are pregnant women, children for adoption by an Australian resident and unaccompanied refugee children.

4.68 In further evidence, the NSW Health Department indicated:

> I think it would be of benefit to the Australian community as a whole and to intending migrants in particular if that list [for hepatitis B] were reviewed, as I am sure it is from time to time, through Federal and State collaborative mechanisms. The prime concern I bring here today is not an extension of the range of tests performed, but an improvement of the mechanisms

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[25] Transcript of evidence, 11 March 1992, pp. 303-307.

whereby the results of those tests are made available in a timely fashion to those who, ultimately, are responsible for the health care of those persons; that is, the State health authorities.[26]

4.69 It appeared from the evidence, therefore, that the State health authorities have no automatic means of access to migrant health screening information relating to infectious diseases, possibly due to privacy constraints.

Conclusions

4.70 The Committee agrees with the NSW Health Department that it would be beneficial from a public health point of view for wider testing for hepatitis B to be undertaken in the migration process, particularly for members of those groups who are recognised in relevant medical literature as being at high risk. The Committee supports the adoption of a procedure to ensure that entry of persons from those high risk groups or countries of origin would be conditional upon production of a certificate of immunisation or acceptance of immunisation at the point of entry. This strategy clearly would be in the interests of protecting public health standards.

4.71 As a necessary accompaniment to this strategy, the timely transfer of test results and locations of persons with a risk of carrying infection into the wider community is essential. Any impediments to this transfer of information should be removed to facilitate the passing of health data from DILGEA to the State health authorities.

Recommendations

4.72 The Committee recommends that:

12. in the interests of protecting public health, testing for hepatitis B in particular be wider than is presently undertaken for migration purposes (pregnant women, children for adoption and unaccompanied refugee children) and be introduced for groups which, in relevant medical literature, are recognised as being at high risk. On entry, persons from those groups or countries of origin should be required to produce a certificate of immunisation or accept vaccination by State health authorities as a condition of entry; and

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26 Transcript of evidence, 11 March 1992, pp. 315.

13. **an effective and timely reporting system be introduced whereby the results of medical examinations for infectious diseases such as tuberculosis and hepatitis B are passed to State and Territory health authorities by the Department of Immigration, Local Government and Ethnic Affairs, to enable appropriate public health strategies to be implemented by those authorities.**

Failure to meet the health requirement

4.73 PAM Health Requirement Topic 6, 'Decision Making and the Health Requirement' describes the procedures to be followed where applications do not meet the health requirement, as indicated in the following paragraphs.

4.74 In cases where the Commonwealth medical officer's advice is that the applicant has failed to meet the health requirement, and the application is for one of the classes eligible to be granted the health waiver under regulation 144, the decision maker must then assess the potential impact on public health, welfare and access costs in Australia, were the application to be approved. The fact that the application is in one of the specified visa/entry classes is not in itself sufficient to indicate that the health requirement should be waived.

4.75 In making the assessment on public health, welfare and access costs, it is suggested in the Procedures Advice Manual that the decision maker should consider such matters as:

- the extent of social welfare, medical, hospital or other institutional or day care likely to be required in Australia;

- the educational and occupational needs of, and prospects for, the applicant in Australia over the whole period of intended stay;

- the availability of, and local demand for, the appropriate health, welfare, educational and employment services in the area of intended residence in Australia;

- the willingness and ability of a sponsor, other family member or other person or body to provide any special services and care at no public cost. In this regard, it needs to be recognised that commitments such as payment of private health insurance do not thereby exclude the possibility of public cost;

- the potential for deterioration in the applicant's state of health, taking into account not only the known medical factors but influences such as the strains of adjustment to a new environment, lifestyle, occupation, and so on, as relevant to the class and the individual; and

- the overall lifetime (or lesser period according to the length of stay) charge to Australian public funds.[27]

4.76 When the decision maker has completed the assessment of the potential impact on public health and welfare costs and access, the next stage involves weighing the total of these negative factors against the positive factors fulfilled by the applicant within the eligibility criteria for the particular visa/entry permit class. The decision maker then must determine whether the positive factors are such as to outweigh any harm and costs to the general Australian community. Where the positive factors are judged to be stronger, the decision maker may waive the health requirement.[28]

4.77 Subregulation 144 (3) requires the Minister to be satisfied that waiver of the health requirement in the prescribed categories would be unlikely to result in 'undue harm or undue cost' to the Australian community. Guidance in the interpretation of those terms has been given by the IRT, notably in *Re Papaioannou* on 19 April 1991 :

> ... 'undue cost' cannot simply be equated with 'significant cost' ... as this would leave no room for the waiver. Subregulation 144 (3) calls for a balancing of the cost that is likely to result to the Australian community against all the other relevant circumstances of the case. Only then can one say that the cost or the harm is 'undue' - in other words, that it is unjustifiable, or that it goes beyond what is warranted or that it is excessive.
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> ... the waiver provision clearly envisages that a certain level of harm and/or cost can be endured by the Australian community by its operation, as long as this is not unjustified.[29]

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27 PAM Health Requirement Topic 6, Sections 3.2.4 and 3.2.5, March 1991.

28 ibid., section 3.2.9.

29 *Re Papaioannou*, 19 April 1991, pp. 12 and 16.

Review of medical opinions

4.78 Submissions from some community groups and individuals were critical of the absence of any articulated review process for assessing decisions by a Commonwealth medical officer on whether or not an applicant meets the health requirement. For example, in their joint submission, the Victorian Immigration Advice and Rights Centre, the Prahran Migrant Resource Centre and the Refugee Advice and Casework Service (Victoria) argued:

> The health requirement must surely present one of the most difficult areas under the current migration system. The assessment is one governed strictly by the criteria set down in Schedule 1 ... A person who is otherwise acceptable according to current Australian requirements may be excluded on the basis of a disability by an assessment of a single Commonwealth medical officer ... A decision of the Commonwealth medical officer is not reviewable under the current regulations. This omission has been noted by the Immigration Review Tribunal.[30]

4.79 In a supplementary submission, DILGEA confirmed that:

> There are no formal avenues of review of the opinion given by a Commonwealth medical officer. As a matter of practice, in many cases where the Commonwealth medical officer's opinion is that an applicant does not meet the health requirements, the applicant may well approach the Migration Office again with additional information which may be passed to the Commonwealth medical officer for further consideration. ... Where a Commonwealth medical officer opinion is a ground for seeking review, the practice of both MIRO [Migration Internal Review Office] and the IRT [Immigration Review Tribunal] is to pass any new information advanced by the applicant about the applicant's medical condition to the MMCU for a reconsideration of its previous opinion. In these cases, our experience is that the MMCU is willing to review all the available material. On a number of occasions, the MMCU has changed its opinion following referral of new information by a review authority.[31]

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30 Submissions Vol. 1, pp. 75-77.

31 Submissions Vol. 3, p. 30.

4.80 The Committee noted the findings of the IRT in *Re Norin* that 'an opinion formed by a Commonwealth medical officer under item 9 (c) ... is not reviewable by the Tribunal. This is because it constitutes a separate decision by a person not acting as a delegate of the Minister for Immigration, Local Government and Ethnic Affairs'. The IRT went on to indicate that this situation is unfortunate, for the following reasons :

> ... the four Commonwealth medical officers in the Migrant Medical Clearances Unit, who make approximately 85,000 assessments per year, are not resourced to provide reviews of their own opinions at the level demanded by the public of bodies such as this Tribunal. It also means that applicants are left without a remedy from the very review body created by the Parliament to hear their cases.
>
> However, the Tribunal has observed that a Commonwealth medical officer would appear to be obliged to review his or her opinion whenever fresh medical evidence comes to light, at least until the date of the Tribunal's decision (see subregulation 34A(1) of the Regulations).[32]

4.81 While the Committee has noted the arguments for establishing a formal review mechanism for consideration of decisions of the Commonwealth medical officer, it did not pursue this aspect in view of the Minister's announcement in February this year of a review committee to examine a broad range of issues relating to the current review system in relation to migration decisions, chaired by the Hon Ian MacPhee, AO. The Committee understands that the review committee's report was with the Minister for consideration at the time this report was being finalised.

New Zealand visitors with disabilities

4.82 New Zealand and Australia, under the Trans Tasman Agreement, have set up particular travel arrangements for their nationals. Under the present arrangements, New Zealanders travelling to Australia are exempt from the requirement that they obtain a visa to travel to or a permit to enter Australia. This does not mean, however, that New Zealanders have unrestricted rights of entry into Australia. Under the present arrangements, New Zealanders cease to be exempt non-citizens and may be illegal entrants if they enter Australia in breach of the provisions of section 20 of the Migration Act. This means, for example, that a New Zealander suffering from a prescribed disease or condition is presently required

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32 *Re Norin*, 22 November 1991, pp. 7 and 8. See also *Re Nelson*, 9 November 1990 and, particularly, *Re Papaioannou*, 19 April 1991.

to obtain entry clearance and a section 20 endorsement to indicate that the immigration officer knew of their disease or disability and nevertheless granted them entry. If a New Zealander with a prescribed disease or condition is in Australia without such endorsement, she/he can be an illegal entrant liable to deportation. As the Minister observed in a letter to the National Federation of Blind Citizens of Australia, which was quoted to the Committee, the effect of New Zealand's inclusion in section 20 is that if:

> a person from New Zealand has a condition which means they are unlikely to meet the health requirement and this brings them within section 20 of the *Migration Act 1958*, they must have a visa to avoid becoming an illegal entrant on entering Australia. Such conditions are not only those that pose a threat to public health or safety, but those that could result in a significant charge on public funds or the use of community resources in short supply.[33]

4.83 The Committee received submissions and heard evidence at a public hearing on 28 August 1992 concerning disabled New Zealand citizens. Witnesses appearing before the Committee were critical of the fact that New Zealanders with disabilities are required to obtain a visa, whereas New Zealanders without disabilities do not. The arrangements were said to be discriminatory.

4.84 In two cases cited by the National Federation of Blind Citizens of Australia, the disabled New Zealanders concerned were travelling to Australia at the invitation of Australian organisation to participate in specific events. The Federation argued that the likelihood of a blind person visiting Australia for a pre-determined short period generating excessive costs or depleting scarce resources was remote, and that the requirement to obtain a visa was discriminatory in its effects.

4.85 In its supplementary submission, ACROD raised the same issue on behalf of all people with a physical disability and referred to official advice from the Australian High Commission in New Zealand, which stated that New Zealand passport holders are not required to obtain visas for temporary entry, provided that they meet Australian health and character requirements. The Australian High Commission advised:

> Whilst this visa-free arrangement has its advantages for New Zealand citizens, it has also created a problem for Australian Immigration officials at points of entry who are required to be satisfied that all persons entering Australia do not contravene Australian health criteria. ... In the Case of New Zealand handicapped passport holders arriving in Australia without a visa, difficulty can

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33 Transcript of evidence, 28 August 1991, p. 108.

> arise in that Australian Immigration officers at ports of arrival are not aware as to whether the applicant's health condition falls within the criteria laid down in regulation 176. Immigration officers are therefore required to interview applicants - sometimes at length - and to issue an endorsed entry permit if required.[34]

4.86 The Migration Reform Bill 1992 makes certain changes in the travel arrangements for New Zealanders. These changes, if they become law, are due to commence on 1 November 1993. New Zealanders are no longer to be exempt non-citizens. They can be the recipients of a special category visa. New Zealanders are not required to obtain the visa in order to travel to Australia but can be granted it on entry. Under the Migration Reform Bill, the criterion for the special category visa includes that the applicant is a non-citizen who is a New Zealand citizen and holds and has shown an officer a New Zealand passport which is in force and he or she is neither a 'behaviour concern person' nor a 'health concern person'. Significantly, for this report, a health concern person is one suffering from a prescribed disease or prescribed physical or mental condition.

4.87 This appears to mean that New Zealanders who suffer from prescribed diseases or conditions, including disabilities, cannot be permitted entry as New Zealanders. It is, of course, open to any New Zealander to obtain any other class of visa, including a permanent entry visa in which the health criteria can be waived.

4.88 In the Migration Reform Bill, New Zealanders, like other non-citizens, can have their permit cancelled and be removed from Australia. Cancellation can operate because the New Zealander or other non-citizen has failed to answer accurately all questions in a passenger card. It may be, although this is not clear from the text of the Bill, that a New Zealander's special category visa may be cancelled within Australia in circumstances set out in clause 50(AB).

Conclusions

4.89 The Committee considers that there are advantages to New Zealanders in the proposed arrangements in the Migration Reform Bill which formalise and draw attention to the requirement that New Zealanders ought to satisfy the health criteria in order to enter Australia with the benefits of permanent residence. There are difficulties in the present arrangements because not all New Zealanders would know of the health and character criteria. They may enter Australia unknowingly in breach of section 20 and become illegal entrants. In the Migration Reform Bill, not only are all New Zealanders informed of those requirements, but they also are given a right of review to the IRT in respect of a Minister's decision to cancel their special category visa.

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34 Submissions Vol. 3, p. 136.

4.90 Under the Migration Reform Bill, all New Zealanders are required to furnish information concerning their health, and New Zealanders can qualify for the special category visa on entry. There will be , therefore, no longer the discriminatory impact as at present, where only those New Zealanders who cannot satisfy the section 20 health and character criteria are required to obtain a visa.

4.91 The Committee, however, is mindful of the particular circumstances of disabled non-citizens, whether New Zealander or some other nationality. It considers that in any regulations drafted to accompany the Migration Reform Bill, the special category visa class be included with those for which the Minister can waive the health criteria.

Recommendation

4.92 The Committee recommends that:

14. **in the regulations drafted to accompany the Migration Reform Bill 1992, the special category New Zealand visa class be included with those for which the Minister for Immigration, Local Government and Ethnic Affairs can waive the health criteria, provided that the Minister also would exercise such a waiver under similar circumstances for citizens of other countries.**

Chapter Five

CONDITIONAL ENTRY MECHANISMS

Introduction

5.1 The terms of reference for this inquiry directed the Committee to examine the feasibility of allowing migrant entry within existing categories on a conditional basis.

5.2 The circumstances in which such conditional entry might be permitted are cases of a medical condition or a disability which, under current arrangements, would disqualify an applicant for a migrant visa, for the reason that it would require significant or costly care or treatment, because undue cost to the Australian taxpayer would result, or because access to health care by any Australian citizen or permanent resident would be prejudiced. Cases which pose a threat to public health or a danger to members of the Australian community cannot be permitted entry under the health waiver provision and are excluded from the ambit of a possible conditional entry scheme.

Historical guarantee mechanisms

5.3 Since Federation, the Government has been concerned to ensure that new arrivals to Australia do not have diseases which are a public health risk and do not impose undue burdens or costs on the health system. There has been a number of mechanisms designed to prevent the Australian community bearing excessive health and welfare costs incurred by arriving migrants. Background information on the historical development of the guarantee mechanisms leading to the present day AOS scheme was provided by DILGEA in its original submission to the House of Representatives Standing Committee on Community Affairs in January 1990, from which the descriptive material embodied in the following paragraphs 5.4 to 5.8 have been drawn.

5.4 By the late 1920s, the concept of a 'maintenance guarantee' had entered the legislation. It was not required for all migrants. At that time, a landing permit could be provided to anyone who had a guarantor prepared to provide for their maintenance, to refund any public money expended for that purpose and to pay return passage. The guarantee lasted for five years after arrival. In 1955, the costs recoverable from the guarantor became more specific and included:

medical, surgical and dental treatment;

- age, invalid or widow's pension;
- unemployment, sickness or rehabilitation benefits or any other allowance paid by Commonwealth, State, public or charitable institutions.

5.5 These conditions were modified slightly after the introduction of the Migration Act, to include accommodation costs and to reduce the pensions and benefits liability to special benefit only. The duration of the guarantee was effective until the migrant was 'absorbed into the community' or upon attaining ten years residence.

5.6 From 1958 onwards, some classes of migrants routinely required maintenance guarantees. These included persons over retirement age unless financially independent, dependent parents of any age, infirm persons accepted on compassionate grounds and, subsequently, defacto wives with children, children under 18 coming to Australia without their father and (from 1964 onwards) close relatives accepted under relaxed health standards. The maintenance guarantee took the form of a legal witnessed document.

Assurances of Support

5.7 In 1982, the maintenance guarantee arrangement was renamed the Assurance of Support Scheme, to better reflect the way it operated in practice. The recoverable costs remained the same and the classes of migrant for which an AOS was then required by the Minister were:

- children for adoption until the age of 18;
- orphaned unmarried relatives until the age of 18;
- special need relatives if within 10 years of retiring age or older;
- fiance(e)s until marriage;
- parents of, or within 10 years of, retiring age;
- aged dependent relatives;
- last remaining sibling or adult child.

5.8 The AOS scheme has undergone changes over time. For example, many years' experience of the lack of precision in the interpretation of when a migrant became 'absorbed' into the community eventually resulted in replacement of that criterion in 1983 by a finite period, stipulated as ten years or until achievement of Australian citizenship by the person for whom the assurance was required. The

Migration Legislation Amendment Act 1989 put beyond doubt the issue that an AOS remained operative no matter what circumstances might change in the interim, including citizenship. In April 1989, the legislation was amended to extend coverage of the AOS to unemployment benefits, and its duration was reduced to five years, regardless of whether or not migrant applicants had become Australian citizens.

5.9 Regulation 164 A(1) now provides that Assurances of Support have a period of validity of two years, the period commencing from the date of entry or the date on which the relevant entry permit is granted, whichever occurs later. As DILGEA indicated in its submission dated October 1991, the Government announced changes to the AOS scheme in the 1991/92 Budget, including the addition of a refundable bond and a non-refundable health levy. The costs which could be recovered under the AOS were at the same time limited to certain specified social security pensions and benefits.

5.10 An AOS recognises that certain applicants for migration are potentially high users of the Australian health and welfare system. The support costs covered by the AOS are confined to Jobsearch Allowance, Newstart Allowance and Special Benefit payments under the *Social Security Act 1991.*

5.11 Under the provisions embodied in the Migration Regulations, assurers are required to repay some of the health and welfare costs which may be incurred in providing support to these categories of migrants during their first two years of permanent residence in Australia. The purpose of the AOS is to enable the burden of some financial costs to which newcomers might give rise during their initial two years in Australia to be borne by private individuals and not by the general community through the taxation system.

5.12 There are three elements to the AOS provisions:

(i) the Assurance of Support itself;

(ii) a refundable bond, introduced on 20 December 1991; and

(iii) a non-refundable Migration (Health Services) Charge, or 'Health Levy', introduced on 21 August 1991.

5.13 These measures were designed to enable the Commonwealth to recover more effectively the benefits paid out to assured persons and at the same time limit the liability of assurers. The AOS is the only formal policy or procedure presently established for cost recovery under the migration program. However, an AOS does not mean that the person/s covered by it cannot receive social security benefits or other assistance. Rather, it means that the assurer is liable to repay the costs of any support under the Jobsearch, Newstart and Special Benefit programs.[1]

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1 Submissions Vol. 2, pp. 95 and 96.

Migration categories subject to an AOS

5.14 There is a number of migrant classes subject to an AOS. Schedules 1 and 2 of the Migration Regulations include those visa classes for which an AOS can be required at the discretion of the migration officer, as well as classes for which an AOS is a mandatory requirement. The complete list of visa classes to which an AOS is applicable is reproduced at Appendix E of this report. The following visa and entry permit classes are those for which an AOS is an essential requirement:

- Class 103, Parent who meets the balance of family test;
- Class 104, Preferential family (aged dependent, special need, orphaned minor and last remaining relatives);
- Class 206, Lebanese concession;
- Class 804, Aged parent (after entry);
- Class 806, Family and other close ties (only aged dependent, special need, orphaned minor and remaining relatives in this class).

5.15 The classes for which an AOS is an essential requirement are ones in which the applicants must satisfy the substantive health criteria. These are not categories, with the exception of the Class 206 Lebanese Concession, which can be permitted entry by operation of the health waiver provisions.

5.16 The Migration Regulations also provide that an AOS may be a requirement for any other visa or entry permit class except for the 24 classes prescribed in Schedules 2 and 3 of the Regulations. These classes include Return Resident, Refugee and Camp Clearance categories, etc. (Migration Regulations Part 6, Division 1 and Division 2). It will be noted that many of the classes for which an AOS cannot be a requirement are the humanitarian categories for which the Minister can exercise a waiver of the health provisions.

The bond

5.17 The AOS bond is a refundable surety of $3,500 on behalf of principal applicants and $1,500 for other adults in the family aged 18 years and over. All dependent children under 18 years are included in the AOS (and bond) of the principal applicant. The bond must be lodged in a form approved by the Minister and applies only to the limited number of classes for which an AOS is mandatory (regulation 164D).

5.18 The bond must be paid prior to final approval of an application for a visa/entry permit in the relevant class. The bond is lodged with one of the participating financial institutions by the assurer, and is used as a first avenue of debt recovery in relation to the specified social security payments.

5.19 The Commonwealth Bank of Australia (CBA) is currently the sole provider of the service required for a bond under the AOS Scheme. CBA provides a bank guarantee to the assurer (based on a term deposit) and a receipt for the appropriate account. The bank guarantee stipulates that the bank guarantees to pay DSS on demand up to the limit of the guarantee.[2]

5.20 If there is no recourse to the specified benefits during the term of the bond, the amount lodged is returned, with interest, to the assurer. Where debts exceed the value of the bond, the excess is subject to normal DSS debt recovery action under the Social Security Act.

5.21 The circumstances under which assurers may be released from bonds are explained in the Procedures Advice Manual. Regulations are being drafted to allow for the release of the bond to an assurer prior to the end of the two year bond period. The policy currently operates to permit release where there is a change of assurer, a change of case details, where the visa application has been rejected or the applicant has been rejected, or the applicant has not travelled to Australia.

The Migration (Health Services) Charge

5.22 The Migration (Health Services) Charge or 'health levy' was introduced with effect from 21 August 1991 and is a non-refundable tax. It is designed to enable the Government to offset approximately 50 per cent[3] of the likely costs to the Commonwealth of providing access to medical, hospital and pharmaceutical benefits to assured persons in the limited classes for which an AOS is mandatory.

5.23 The health levy applies to the visa and entry permit classes for which an AOS is an essential criterion (see Appendix E). It is not payable in those classes where the AOS is discretionary.

5.24 Persons subject to the levy are principal applicants and each accompanying family member, including children. The amount of the levy is currently set at $822 per person and is payable in addition to the Medicare levy, which is an integral part of the Australian taxation system.

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2 Details of arrangements with the Commonwealth Bank for provision of a bond in accordance with AOS requirements are given in Attachment 9 of PAM Update No. 93, dated 1 June 1992.

3 Explanatory Memorandum to the Migration (Health Services) Charge Bill 1991 and the Migration Amendment Bill 1991.

Some typical examples of the amounts payable under an AOS

5.25 Examples of the bond and levy charges to be paid prior to final approval of visa/entry permit applications in typical family circumstances are shown in Table 5.1. Both the bond and the health levy are 'up front' statutory requirements under the Migration Regulations and cannot be waived.

TABLE 5.1 - EXAMPLES OF BOND AND HEALTH LEVY CHARGES

Family Composition	Bond $	Levy $	Total $
1 adult	3,500	822	4,322
1 adult plus 1 adult dependent	5,000	1,644	6,644
1 adult plus 1 adult dependent plus 1 child	5,000	2,466	7,466

Source : DILGEA Submission (No. 52), 1 October 1991.

5.26 An AOS is, or can be, required in cases where the person has satisfied the health criteria or has secured a waiver of the health requirement. If the person satisfies the health criteria, this indicates a finding that the person does not require significant care or treatment and does not appear likely to become a significant charge on public funds. In waiver cases, the Minister has accepted impliedly that the person may prove a significant but not undue health cost. The AOS scheme is not so much a conditional migrant entry mechanism as a type of community insurance or guarantee scheme levied on particular permit classes or in respect of individual applications. The AOS is meant to undercut the risk of anticipated health or welfare costs likely to arise in the period immediately following migration.

5.27 There is, nevertheless, a conditional component to the AOS scheme. The Minister can refuse to grant a visa or entry permit if the AOS required or requested from the sponsor is not given (Schedule 1, Item 2). Even so, the scheme is for people who satisfy the health criteria or benefit from the health waiver. It is not a conditional migrant entry scheme which facilitates the entry of applicants with a medical condition or a disability who cannot satisfy the health rules or who are outside the terms of the present health waiver. It is this last group who are the focus of the Committee's inquiry.

Conditional visas and entry permits

5.28 There are certain visas and entry permits which currently are issued subject to the condition that an outstanding requirement for the particular class will be met within a specified period after arrival in Australia. Conditional visas are granted when either the visa applied for requires, or emergency circumstances warrant, entry of an applicant to Australia before all requirements have been satisfied. These include the Prospective Marriage visa, the Australian Requirement visa and the Emergency Permanent and Temporary Entry categories.

5.29 Clearly, the four special conditional visa/entry permit categories and the circumstances giving rise to their use are distinctly different from the migration categories upon which this inquiry is focused.

Scope for expanding conditional entry

5.31 This inquiry is concerned with applicants for migration or permanent residence who would be refused on the basis of a medical or disability condition. If conditional entry arrangements are to apply to applicants otherwise excluded on health grounds, it is anticipated that they would be permitted to enter or remain provided that certain conditions are met. This might include a condition that a bond is posted to defray the anticipated medical or support costs of the applicant.

5.32 A variety of views on conditional migrant entry were expressed in the many submissions received during the course of the inquiry.

5.33 There was clear support for conditional migrant entry from organisations representing the disabled, adoptees and people with non-infectious diseases. They supported such mechanisms on the grounds of non-discrimination and on compassionate and humanitarian principles. Discrimination and human rights issues affecting people with disabilities are discussed also in Chapters Three and Four of this report.

5.34 Many organisations advocated the need for a more flexible approach which would allow conditional entry for persons who did not meet the existing health requirement. In a joint submission, for example, the Victorian Immigration Advice and Rights Centre Incorporated, the Prahran Migrant Resource Centre and the Refugee Advice and Casework Service (Victoria) argued that the existing regulations, under which an applicant can be rejected on the basis of a medical assessment that he or she may require significant care and/or treatment, ignore 'the willingness and demonstrated ability of the Australian family members to financially support the applicant for the remainder of his or her life'.[4]

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[4] Submissions Vol. 1, p. 76.

5.35 Several cases were brought to the attention of the Committee to demonstrate the need for greater flexibility. In two cases, which received extensive publicity during the inquiry, one applicant for permanent entry was a diabetic recovering from a stroke, while the other applicant was an elderly person suffering from dementia. Both applicants were in Australia on temporary entry permits and had substantial assets, some income in Australia and private medical and hospital insurance cover. In both cases, the families in Australia argued strongly that they could meet all of the costs of future health care for their relatives without imposing any financial burden on the Australian taxpayer. Neither applicant had any other living relatives in their country of origin.

5.36 In these and other cases, raised in a letter to the Committee from Senator Margaret Reynolds, families and other supporters of the applicants indicated a willingness to post necessary bond guarantees and private health insurance cover prior to the approval of permanent residence. The main point in Senator Reynold's letter was that because of the inflexibility in the existing regulations, the financial circumstances of an individual or his or her family cannot be taken into consideration if health criteria are not met.[5]

5.37 This inflexibility also was demonstrated in the case of Mr Bishay, a disabled inventor, manufacturer and entrepreneur, who applied for a Business (Joint Venture) entry visa but who was refused because he failed to meet the health requirement. His business proposal with an Australian partner comprised the establishment of a production plant for solar energy water heaters and various aids for the disabled. This proposal had the official support of the Albury-Wodonga Development Corporation. In its review of the case, the IRT, in affirming the decision not to grant a visa, commented:

> We reach the above conclusion with some regret, as even a cursory examination of the Department's file suggests that the joint venture proposal would have been of considerable benefit to that area in terms of job creation, export enhancement and in furthering decentralisation. The applicant's submission that Mr Bishay does not represent any burden on the Australian taxpayer that would not be offset by the creation of jobs appears cogent.
>
> Unfortunately, Commonwealth medical officers of the MMCU are prevented by the regulations from considering these wider economic issues when delivering their opinions and the Tribunal's hands are in turn effectively

5 Exhibit 12, 18 August 1992.

tied by those opinions. The result is that no decision maker in this case has yet been able to properly consider Mr Bishay's total circumstances on their merits. It seems that the national interest is poorly served by such a situation, especially given the current unemployment rate in the Albury-Wodonga area.

It is particularly difficult to ascertain a coherent Government policy in regulation 144 (health waiver), which allows primary decision makers to weigh non medical factors in some visa classes but not in the business migration classes. ... Neither are the Minister's residual powers to overrule a review body of much assistance to most business applicants as the powers can only be exercised when there is a right of review. Most business migrants do not have such rights and even when they do the Tribunal's observation is that those rights seem to be rarely exercised. We can only speculate that business migrants are unlikely to want to suffer the delays involved in the appeal process on the 'off chance' that their case may attract the Minister's discretion. They are after all the most mobile of migrants and their business acumen and financial resources are much sought after by other countries.

However, we are bound by the legislation and Mr Bishay's application for review must therefore fail. We can only suggest once again to the Minister that he heed the recommendations espoused in previous decisions of this Tribunal in relation to review of health criteria in visa classes where no waiver is permitted. We would go further in this case and suggest that primary decision makers should be in a position to weigh the national interest against any failure of health criteria, by including the business migration program visa classes in the health waiver provisions under regulation 144.[6]

5.38 On the question of expanding the opportunities for conditional entry, those departments and agencies responsible for administering the health requirement generally were cautious, and tended to favour a limited adjustment to existing avenues for entry or stay. DILGEA, for example, expressed a preference for

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6 *Re Bishay*, decision of 28 October 1991, pp. 11 and 12.

a limited extension of the visa and permit classes covered by the waiver provisions. DILGEA stated:

> It may be appropriate to consider whether a limited extension of the health waiver power to some additional visa classes and its careful use in particularly compelling cases may be more appropriate than a complex and possibly unworkable conditional entry arrangement available for a wider group of cases. This would of course mean that there would continue to be cases where grant of a migrant visa would be precluded on the grounds of undue costs to the Australian community arising from a health condition.[7]

5.39 In its submissions dated 30 November 1989 and 4 September 1991, DSS cautioned that:

> Wide-ranging proposals to allow entry to Australia under Assurances of Support or similar arrangements for people likely to need extensive post-arrival assistance need to be considered very carefully. Particularly in relation to people needing significant health care, the potential impact on Social Security outlays is considerable. The most significant aspect is the likely duration of assistance required, which will correlate closely with the probabilities of breaches of contract for support.[8]

5.40 In its submission, DHHCS indicated that to permit migrants with serious health conditions or disabilities to enter Australia conditionally could impose a cost on or prejudice the access to health care of Australian residents, in spite of any undertakings made. DHHCS stated:

> The justification for this view is that no matter the type of guarantee that is given, or the undertaking that is made, once such persons enter Australia, it is extremely costly and time-consuming to ensure their exclusion from mainstream access to Medicare, which is the universal right of Australian residents.[9]

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7 Submissions Vol. 3, p. 29.

8 Submissions Vol. 1, p. 160.

9 Submissions Vol. 2, p. 13.

Models for a conditional entry scheme

5.41 In its initial submission, and in subsequent evidence, DILGEA argued that a conditional entry scheme would have to adhere to equity principles and avoid the undesirable outcome of favouring applicants who have wealthy sponsors and supporters.[10]

5.42 In a supplementary submission, DILGEA pointed out that there are several possible models for a conditional entry scheme. DILGEA indicated that arrangements involving either up-front payments or payments over time could be contemplated. However, DILGEA noted that to be effective any set of arrangements must:

1. satisfactorily quantify the amount of money that a sponsor has to have or put aside in order to meet assessed liabilities over the life of the migrant;

2. fix liability on any individual to pay those costs over the life of the migrant; and

3. make satisfactory provision for the funds to be disbursed to any Commonwealth, State, private or charitable service provider to the individual.[11]

5.43 DILGEA stated further:

> The system must also ensure, either through reimbursement to service providers or exclusion of the individual from Government funded benefits, that there is no leakage of health and welfare expenditure to the individual concerned. Where payment to providers is through reimbursements, there need to be sanctions against default on payment.[12]

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10 Submissions Vol. 1, p. 86 and Transcript of evidence, 19 February 1992, pp. 150 and 151.

11 Submissions Vol. 3, p. 27.

12 ibid.

5.44 DILGEA indicated that a range of mechanisms are available which could support a conditional entry regime. These include:

- a deed signed by a guarantor under which the guarantor consents to indemnify the Commonwealth, States etc, against costs incurred on behalf on the person covered by the guarantee;
- a contract; or
- a bond, similar to that already provided for under the Assurance of Support scheme.[13]

5.45 However, DILGEA noted that:

> ... all involve a level of complexity in determining the likely level of cost to the community and, if those costs are incurred, difficulty in restoring the funds to a possibly wide range of community organisations over periods which might be up to fifty years or more.[14]

5.46 In this regard, DILGEA noted, upon advice from the Attorney-General's Department, that to be of effect, a signed deed must be delivered to all interested parties. According to DILGEA, this requires the establishment of a complex administrative network to ensure that all parties concerned are aware of the existence of the deed.[15]

5.47 A similar problem can arise in relation to contracts, as all parties to a contract must sign the document. DILGEA noted that this would not be a simple matter, as it is not always known in advance which government agencies or charitable organisations would be affected by conditional entry arrangements. In addition, all parties may have difficulty in reaching agreement on the terms of each contract. This creates the potential for cumbersome and resource intensive administration of the contract conditions.[16]

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13 Submissions Vol. 2, pp. 97-99.

14 ibid., p. 86.

15 ibid., p. 98.

16 ibid.

5.48 Commenting on the feasibility of adopting a conditional entry regime based on any of the above mechanisms, DILGEA stated:

> If such a system were to be contemplated, it may be more appropriate to seek limited one-off settlements to key parts of the health and welfare system based on an estimate of resource usage, rather than more complicated arrangements over long periods.[17]

5.49 In this regard, DILGEA noted that one-off lifetime payments in workers' compensation cases have operated effectively for purposes similar to those envisaged in a conditional entry scheme for migrants. While acknowledging that difficulties may arise, in that people may dispute the amounts required to be paid or the amounts to be paid may vary dramatically from case to case, DILGEA nevertheless commented:

> ... you could, presumably, by such means reach an agreed amount.[18]

5.50 Other agencies, though, warned about the difficulties of estimating an up-front payment. DHHCS, highlighting the problem in relation to disability, stated:

> The costs per individual vary enormously. We have just completed a rather inconclusive census, but that shows that the mean for accommodation support for a person with a moderate to severe disability may be of the order of $35,000 per annum. For that same person with employment support it may be of the order of $7,000 per annum. People with a milder form of disability, whether in a sheltered workshop or in open employment with lesser means of support, generally cost of the order of $2,000 to $2,500 per annum. But that figure varies widely. Of course, many people choose to look after a person with a disability at home, so the accommodation cost can be zero.[19]

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17 ibid., pp. 86 and 87.

18 Transcript of evidence, 19 February 1992, p. 149.

19 Transcript of evidence, 19 February 1992, p. 172.

5.51 AGHS, in a draft paper on intellectual disabilities, stated:

> While all migrants have the potential to become a charge on public funds due to injury and/or old age, the cost of supporting people with intellectual disabilities is usually longer-term and more inevitable. ... The cost of service provision for people with intellectual disabilities varies considerably from one individual to the next.[20]

5.52 Before reaching any conclusions on the possible mechanisms for conditional entry, the Committee approached several commercial organisations to ascertain the commercial viability of establishing arrangements for conditional entry.

5.53 While the response from the Australian Mutual Provident Society (AMP) was somewhat guarded,[21] it nevertheless indicated that a sinking fund structure rather than an insurance-type bond may be the most suitable arrangement for providing the type of cover envisaged in a conditional entry scheme. Under a sinking fund structure, the initial deposit is set aside to accumulate and claims are made for subsequent health care costs. This process stops either when the claimant dies or the fund is exhausted.

5.54 MLC Life Limited (MLC) indicated that the company already markets an investment-linked insurance policy designed to accumulate funds to meet a variety of future needs. Such insurance bonds are usually sold with an initial charge and/or a charge on early draw-down of funds. However, MLC noted that it would be prepared to waive or reduce its usual charges, depending on the specific arrangements made, if such a conditional entry proposal came to fruition.[22]

5.55 Of the health insurance funds, HCF is not currently in a position to assist with an insurance bond arrangement because its operations are restricted to NSW and the Australian Capital Territory and because a special health insurance plan would have to be established, with DHHCS endorsement.[23] Without submitting a formal response to the Committee, Medibank Private also raised a number of difficulties, apart from the need to obtain clearance from DHHCS for undertaking that type of health insurance business. The Committee understands that Medibank Private would not be interested in tendering for such medical/disability cover because initial analysis suggested that the proposal would not be commercially viable due to the anticipated high premium levels and the complexities of managing treatment and benefits over time if specific health/disability conditions are excluded from Medicare access.

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20 Exhibit 8, p. 4.

21 Submissions Vol. 3, pp. 101 and 102.

22 Submissions Vol. 3, p. 103.

23 Submissions Vol. 3, p. 115.

Conclusions

5.56 There is need for greater flexibility in the existing health rules pertaining to migration. The Committee accepts that those who pose a risk to the health of the Australian community should continue to be excluded from entry or stay. However, those who do not fall into such a category, and who are able to demonstrate that they will not become a burden on community resources and facilities should have greater opportunity to be considered for entry or stay. Cond onal entry should be available to such persons.

5.57 The Committee considered a number of mechanisms under which a conditional entry scheme could operate, including a deed, contract, insurance bond or payment of an up-front fee. The Committee discounted the possibility of using a deed or contract on the basis of the evidence it received that there would be particular difficulties in administering a contract or deed over a long time frame, in ensuring that all parties involved were aware of its existence and were agreeable to its terms, and in recovering claims against it.

5.58 The Committee deliberated extensively on the feasibility of implementing either an up-front fee payment system, a bond arrangement, or both. The Committee concluded that the most desirable option would be to implement a system which provides sufficient flexibility to allow decision makers to consider the individual circumstances of those applying for entry or stay, while at the same time ensuring that Commonwealth revenue is protected.

5.59 As a general rule, the Committee agreed that for those who do not meet the health requirement or the existing health waiver provisions, an up-front fee should be payable before entry or stay should be allowed. An up-front fee would operate in a similar way to a tax payable to the Commonwealth prior to the grant of a visa or entry permit. The fee paid would be included in general revenue. The amount of the fee should equal the costs which the applicant is likely to generate over his or her lifetime for treatment, care and assistance arising from the disability or medical condition which is the basis of the original decision to refuse a visa or entry permit. These costs should be determined on an actuarial basis by the Commonwealth Compensation Commissioner, who, in making these calculations, should take into consideration the nature of the disability or medical condition, the age of the applicant and the likelihood of long term survival.

5.60 The Committee recognised that an up-front fee payment system alone could be inequitable, in that it would favour those with substantial capital or assets. Accordingly, the Committee considered the possibility of also introducing an insurance-type bond and/or a loan arrangement. A loan arrangement would be negotiated between the applicant and a financial institution, which would make a payment to the Commonwealth in return for regular instalments or premiums paid by the applicant or a sponsor. A bond also would involve a payment to the Commonwealth, this time by an insurance company or other financial institution, which would require the applicant or a sponsor to pay the instalments or premiums to the company. The difference between a loan arrangement and a bond would be

that in the case of a bond, upon the death of the person covered by the bond, the insurance company could apply to the Commonwealth for a refund of any monies not expended on the care and treatment of that person. The insurance company would insure the person on the basis that there was a reasonable chance that the full amount of the payment, as assessed by the Commonwealth Compensation Commissioner, would not be expended. It should be noted that little interest has been expressed by financial institutions and insurance companies in entering into loan or bond arrangements.

5.61 In considering these options, some members of the Committee expressed reservations about the practicality of a bond system. In particular, some members had concerns about the administrative and monitoring systems which would need to be implemented in order to make a bond system workable. Some members were concerned that the onus for ensuring that the administrative and monitoring arrangements were effective would place an undue burden on the Commonwealth. Other members, however, considered that under an insurance bond arrangement, the onus would be on the insurance company to determine the extent of the risk and, in claiming refunds from the Commonwealth, to provide evidence that the up-front payment had not been fully expended on care and treatment of the person covered by the bond.

5.62 The Committee was unable to reach agreement on the adoption of either a bond or a loan arrangement to supplement the up-front fee proposal. However, in order to ensure that greater flexibility is built into the health rules, the Committee considers that the Government should investigate further the opportunity for establishing an insurance bond and a loan arrangement for those applicants who do not meet the health requirement or the existing waiver provisions and who are unable to pay the up-front fee. In any such arrangements, the need to protect the revenue over the lifetime of the applicant should be a relevant consideration.

5.63 Consequent upon the adoption of either an up-front payment, a bond or a loan arrangement, the Minister should have the discretion to consider the circumstances of the applicant, particularly the likely contribution which the applicant or the applicant's family may be able to make to the Australian community, and either:

> waive any part of the up-front fee payable by the applicant or a sponsor, or any part of the up-front payment to be covered by a bond or loan; or
>
> in particularly compelling cases, waive in total the requirement for the up-front fee payable by the applicant or a sponsor, or up-front payment to be covered by a bond or a loan.

Recommendations

5.64 The Committee recommends that:

15. as a general rule, in cases where an applicant does not meet the prescribed health criteria and does not satisfy the health waiver provisions, before entry or stay may be approved, the applicant or a sponsor pay to the Commonwealth an up-front fee. The amount of the fee should equal the costs, as determined by the Commonwealth Compensation Commissioner, of ongoing treatment, care and assistance, over the lifetime of the applicant, which are likely to arise as a result of the medical condition or disability identified by the Commonwealth medical officer as the reason for the applicant's failure to meet the health requirement;

16. as a supplement to the up-front fee proposed in recommendation 15, the Government investigate the feasibility of implementing an insurance bond system and/or a loan arrangement for applicants who do not meet the prescribed health criteria or the waiver provisions and who are unable to pay an up-front fee to the Commonwealth. In any such arrangements, the need to protect the revenue over the lifetime of the applicant should be a relevant consideration; and

17. consequent upon recommendations 15 and 16, the Minister for Immigration, Local Government and Ethnic Affairs be provided with a discretion to consider the circumstances of the applicant, particularly the likely contribution which the applicant or the applicant's family may be able to make to Australia, and either:

    a) waive any part of the up-front fee payable by the applicant or a sponsor, or up-front payment to be covered by a bond or a loan; or

    b) in compelling cases, waive in total the up-front fee payable by the applicant or a sponsor, or the up-front payment to be covered by a bond or a loan.

Inter-country adoptees

5.65 The special situation pertaining to migrant entry by adopted children was the subject of many submissions to the Committee. A recurring theme in most of these submissions was well expressed by the Australian Society for Inter-country Aid for Children (ASIAC), NSW:

> It is at best insensitive, and at worst morally culpable, for Australia to expect to take from relinquishing countries (which are necessarily among the most needy in the world) only the most healthy orphaned or abandoned children, leaving those countries with the sole responsibility for caring for the less healthy children.[24]

5.66 In a submission from Mr and Mrs Rollings, adoptive parents of a blind Taiwanese boy who was eventually granted entry following appeal to the IRT, that theme was continued. They stated:

> We cannot encourage acceptability of people with disabilities within our own community, and at the same time only allow the adoption of perfect blue-ribbon babies from overseas.[25]

5.67 The general thrust of ASIAC's submission was echoed in submissions and evidence from other organisations such as AICAN, which argued that Australia should be prepared to accept children with a range of health problems at least similar to those found in the Australian community.[26]

5.68 Both ASIAC and AICAN emphasised the relatively small and specialised nature of the migrant intake which comprises intercountry adoptees (less than 0.5 per cent according to ASIAC).[27] In evidence, AICAN indicated that migration statistics showed that '303 children arrived in 1989/90 and probably fewer in 1990/91'.[28]

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24 Submissions Vol. 1, p. 111.

25 Submissions Vol. 1, p. 101.

26 Submissions Vol. 3, p. 3.

27 Submissions Vol. 1. p. 112.

28 Transcript of evidence, 20 February 1992, p. 242.

5.69 AICAN summarised its view of the two main problems associated with administration of the health requirement in relation to intercountry adoptees as follows:

> Firstly, we consider that the disability component of the medical assessment procedures does not work validly or effectively for intercountry adoptees. Secondly, we think that the many costs of administering the current system to intercountry adoptees are not worth the very small benefit, if any, to Australia.[29]

5.70 In AICAN's submissions and illustrative case studies, it was put to the Committee that Australia should take a more humane and consistent approach to assessing the health of prospective intercountry adoptees:

> First, it is not realistic for children living in poorly resourced institutions to be assessed against criteria more appropriate to children living in 'first world' families, especially in terms of weight, height and general development. Children who are underweight and undersized and somewhat developmentally delayed in an institutional setting generally prosper with the care, nourishment and stimulation provided in a family setting.
>
> Second, ... if Australia is to participate in intercountry adoption, it should not adopt more restrictive health criteria than apply in other developed countries. It is morally wrong to exclude those children who would benefit most from intercountry adoption. Australia should be prepared to accept children with a spectrum of health problems equivalent to those occurring in the Australian-born population.
>
> Third, Australia is proud of the humanitarian component of its migration programme. The divisions between the family, skill and humanitarian components are not, in practice, absolutely sharp. A humanitarian element in the intercountry adoption program should be acknowledged and acted upon.[30]

5.71 Accordingly, AICAN recommended that the present Migration Regulations should be amended to create separate health criteria for intercountry adoptees, while retaining the prohibition on infectious diseases. In AICAN's view,

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29 Transcript of evidence, 20 February 1992, p. 241.

30 Submissions Vol 3, pp. 2 and 3.

the considerable complexity and costs involved in the screening program for intercountry adoptees is unnecessary because accurate prognoses in such cases are very difficult and frequently involve extra tests and inevitable delays before the MMCU is able to clear the children from overseas institutions. AICAN made the further point in evidence that the intercountry adoption process is self-limiting. AICAN stated:

> There are very few families who are willing and approved to adopt a child with an ongoing disability of any significance. ... Since in fact we know of no cases which have been directly screened out, we know of no savings, only costs. These costs could be avoided by recognising that the system is self-limiting and by allowing this process of self-limitation to operate.[31]

5.72 In its final submission, AICAN reiterated its solution for the simplest and most cost-effective way to remedy the problems arising in the administration of the health requirement for intercountry adoptees. This solution was to create separate health criteria for intercountry adoptees, for whom health screening should take the form of testing for infectious diseases only. Any further medical checks and safeguards considered necessary should be furnished, in AICAN's view, by the adoption medical tests and the adoption assessment process itself, which effectively limits the number and degree of disabilities present in intercountry adopted children.[32]

Conclusions

5.73 *Recognising the essentially self-limiting nature of the intercountry* adoption program, the Committee was sympathetic towards permitting greater flexibility in interpreting the health rules, to enable consideration to be given to financial and other circumstances which might outweigh the less positive aspects arising from a disability or medical condition. This flexibility should only apply to cases where there is no potential risk to public health, the relevant State welfare authority is satisfied that the intending parents are suited to the task of parenting the particular disabled child, and appropriate guarantees of financial support are provided.

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31 Transcript of evidence, 20 February 1992, p. 246.

32 Submissions Vol. 3, p. 11.

Recommendation

5.74 The Committee recommends that:

18. in determining whether to grant an adoption visa or entry permit to a disabled adoptive child who cannot satisfy the health criteria, the Minister for Immigration, Local Government and Ethnic Affairs consider the financial and other family support able to be provided by the adoptive family and the circumstances of the adoptive child, particularly whether these factors could outweigh any likely costs to the community or access to community resources in short supply. In such cases, the entry or stay should be approved only where appropriate guarantees of support can be provided and where the relevant State welfare authorities have approved the intending adoptive parents as capable of parenting the child.

Chapter Six

ACCESS TO THE HEALTH SYSTEM

Introduction

6.1 As a necessary consequence of its examination of conditional migrant entry, the Committee considered the existing arrangements for accessing Australia's health services. In particular, the Committee focused on the extent to which those entering Australia either on a temporary or conditional basis are able to gain the benefit of Australia's national health insurance system, Medicare, and other health programs, such as the Pharmaceutical Benefits Scheme. The Committee sought to determine the nature and effectiveness of existing control mechanisms for ensuring that those who receive the health benefits actually are entitled to them.

Australia's health system

6.2 Australia's health system is administered jointly by the Commonwealth Government, through DHHCS and the Health Insurance Commission (HIC), and State and Territory Governments, through State and Territory Departments of Health.

6.3 The Commonwealth Government is responsible for those aspects of the health system which have a national focus, including:

- development of national health policies;
- administration of the Medicare system; and
- administration of other national health programs such as the Pharmaceutical Benefits Scheme.

6.4 State and Territory Governments are responsible for the planning, provision and administration of health care services within each State and Territory. In particular, they are responsible for the provision of public hospital services. They also are responsible for the administration of a registration system for health professionals, and the licensing and regulation of private hospitals and private nursing homes.

6.5 The Commonwealth Government retains influence over decision making in the health services area through its financial arrangements with State and Territory Governments, the provision of benefits and grants to organisations and individuals, and the regulation of health insurance.

Access to medical services

6.6 In general, medical services in Australia are delivered by either private medical practitioners on a fee for service basis, or by medical practitioners who are engaged by public hospitals or employed in community health centres. All Australian residents, and some non-residents covered by Medicare, are entitled to free accommodation and treatment in shared wards in a public hospital by doctors nominated by the hospital. Costs incurred by patients who attend private medical practitioners are reimbursed in whole or in part by means of Medicare benefits.

6.7 The *Health Insurance Act 1973*, which established the Medicare system, provides for a Medicare Benefits Schedule, which lists a range of medical services and a standard Schedule Fee applicable to each medical service. The services which attract Medicare benefits and which are listed in the Schedule may be rendered by a range of providers, including:

- legally qualified medical practitioners;
- approved dentists (in certain circumstances for medical services);
- accredited dental practitioners in the treatment of cleft-lip and cleft palate conditions; and
- participating optometrists for optometrical consultations.

Eligibility for Medicare

6.8 Section 10(1) of the Health Insurance Act provides that a benefit is payable to an eligible person for certain medical expenses incurred in Australia on or after 1 February 1984. Benefits are available to certain diplomatic representatives in Australia and to Australian residents, defined under section 3 of the Health Insurance Act as persons who reside in Australia and who are included in one of the following categories:

- an Australian citizen;
- a person within the meaning of the Migration Act who holds a valid permanent entry permit;
- a person with a return endorsement or a resident return visa in force under the Migration Act;
- a New Zealand citizen who is present lawfully in Australia;

- a person who is present lawfully in Australia and whose continued presence is not subject to any limitation as to time imposed by law; and

- certain categories of persons who apply for permanent residency while within Australia (see paragraph 6.15).

6.9 Benefits are not available to members of foreign diplomatic missions or their dependants, unless a reciprocal agreement exists with the country concerned.

6.10 Visitors to Australia who are residents of countries which have reciprocal health care agreements with Australia (currently Italy, Malta, New Zealand, Sweden, The Netherlands and the United Kingdom) are eligible for Medicare benefits. Also eligible are certain temporary residents who have been declared eligible persons by the Minister for Health, Housing and Community Services (for example, persons working in Australia under certain employer-sponsored schemes).

6.11 All other temporary residents and visitors to Australia are responsible for the full cost of their medical and hospital treatment.

6.12 In order to receive a benefit under Medicare, a person is required to enrol on the appropriate form and establish their identity in accordance with the definition of an Australian resident under section 3 of the Health Insurance Act. Documents required for proof of identity are:

a) for Australian citizens, an Australian passport or a birth certificate and citizenship papers if appropriate; and

b) for those holding or applying for permanent residence, a foreign passport with either a residency stamp or acceptable visa and/or entry permit/entry stamp.

6.13 Where a person is an applicant for permanent resident status, the passport must include a temporary entry permit current at the time of enrolling, and application for permanent resident status, and a receipt for the application fee.

Temporary residents

6.14 Since the commencement of Medicare, the Federal Government's position has been that, in general, only permanent Australian residents should have access to the government-supported health system. An exception, though, has been made for certain temporary entrants who fall within the definition of an Australian resident under section 3 of the Health Insurance Act.

6.15 In accordance with section 3 of the Health Insurance Act, a person is defined as an Australian resident, and is therefore eligible for Medicare benefits, if that person has a valid temporary entry permit, has applied for permanent resident status, and is a person with respect to whom it is more likely than not that:

- territorial asylum in Australia may be granted;
- another person, being the person's spouse, parent or child is an Australian citizen or the holder of an entry permit that is not intended to operate as a temporary entry permit under the Migration Act;
- a determination may be made that the person has the status of a refugee within the meaning of the Convention Relating to the Status of Refugees that was done at Geneva on 28 July 1951 or of the Protocol Relating to the Status of Refugees that was done at New York on 31 January 1967;
- there is in force an authorisation to work in Australia and the person is not a prescribed non-citizen within the meaning of section 11ZD of the Migration Act; or
- strong compassionate or humanitarian grounds for the grant of an entry permit may be found to exist.

6.16 During the inquiry, concerns were expressed that some of the temporary residents listed above are able to access Medicare benefits, even though their applications for permanent residence ultimately are unsuccessful. Concerns also were expressed about persons who are able to gain temporary entry permits to Australia, subject to undertakings that any medical costs incurred in Australia would be covered, but subsequently are able to gain access to the benefits of the health system because their spouse has access to a Medicare card.

6.17 DHHCS, for example, noted that some of the persons who have been eligible for entry under the Skills Transfer Scheme have been unable to meet the health standards for entry, or have had dependants with chronic medical conditions. In such circumstances, temporary entry has been permitted, subject to undertakings that any medical costs arising during their stay in Australia will be covered. However, the principal applicant in Australia may have access to a Medicare card, by virtue of falling within the definition of an Australian resident under section 10(1)(e). DHHCS observed that, in such situations, no check is made of the extent to which the dependants of a principal applicant are accessing Medicare.[1]

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1 Submissions Vol. 2, p. 10.

6.18 In other evidence, the NSW Health Department noted that a major Sydney hospital currently has outstanding fees of $249,000 incurred by non-Australian residents and persons who are Medicare ineligible. The NSW Health Department indicated that while some of this amount relates to bills awaiting payment by insurers, on behalf of persons with travel insurance, at least half of the amount, in excess of $100,000, is unlikely to be recoverable. It was suggested that the amount across the health system would involve many millions of dollars.[2]

Misuse of Medicare cards

6.19 During the inquiry, the Committee sought information from the HIC on the misuse of Medicare cards by illegal entrants and ineligible temporary entrants.

6.20 At the public hearing held on 11 March 1992, the HIC noted:

> The evidence that we have had on the misuse of cards is primarily anecdotal.[3]

6.21 In subsequent evidence, the HIC on advised that in 1990/91 approximately 3.5 percent of total identified fraud related to illegal entrants.[4]

6.22 The Committee questioned the HIC on the existing control mechanisms for detecting fraudulent use of Medicare cards. The HIC indicated that, to a large extent, it relies on complaints about fraud being reported to it. The HIC stated:

> When somebody has used somebody else's card ... it has to be identified to us. A complaint has to be made to us by the doctor; by the person who lost his card - he may report it as a lost or stolen card; or by the receptionist at the doctor's surgery. It has to come to our attention.[5]

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2 Transcript of evidence, 11 March 1992, p. 302.

3 Transcript of evidence, 11 March 1992, p. 283.

4 Submissions Vol. 3, p. 68.

5 Transcript of evidence, 11 March 1992, p. 285.

6.23 From the evidence provided by the HIC, it was clear that the HIC regard doctors as the first line of defence against fraud. The HIC, for example, commented:

> If you have stolen or borrowed a card, you cannot go to a doctor that knows you. If you are trying to present yourself using someone else's card, you have to make sure that you go to a doctor that does not know you or the person whose card you took.[6]

6.24 However, the HIC acknowledged the limits of this control when it stated:

> If people borrow a card and go to a different doctor, we have no way of picking that up.[7]

6.25 In terms of other control mechanisms, the HIC indicated that it does not check signatures on claim forms, but does check the names and addresses which are quoted with the card number. The HIC considered that this is a 'fairly safe' mechanism, as Medicare cards do not have addresses imprinted on them.[8]

Debt recovery

6.26 In its evidence to the Committee, the HIC and the NSW Health Department both referred to problems which arise in recovering debts generated by illegal entrants and temporary residents who are ineligible for Medicare but who use Australia's health services. Both organisations highlighted the difficulties arising from the restrictions which the *Privacy Act 1988* places on the sharing of information between themselves and DILGEA. The HIC stated:

> ... we are not in the position to advise Immigration of the amount of benefit that those people will be generating ... the [Health Insurance] legislation and the Privacy Act prohibit us. Quite honestly, we are hamstrung by this particular legislation.[9]

6.27 The HIC referred to the example of an illegal immigrant who had presented fraudulent documentation in order to obtain a small amount of Medicare benefits. The HIC noted that the person was deported by DILGEA, but HIC was

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6 Transcript of evidence, 11 March 1992, p. 283.

7 Transcript of evidence, 11 March 1992, p. 284.

8 Transcript of evidence, 11 March 1992, p. 284.

9 Transcript of evidence, 11 March 1992, p. 291.

unable to advise DILGEA about the debt which had been generated. The HIC commented:

> We had the ludicrous situation of having to wait until this person came back - and he did come back eventually - before we could take him to court to get the money reimbursed to the Commonwealth.[10]

6.28 The NSW Health Department gave the example of a person who had entered Australia on the basis of receiving medical treatment but who still owed $68,000 to the hospital over $50,000 for treatment received. The Department indicated that there were privacy restraints on the information which DILGEA could provide to the hospital seeking to recover the debt. The NSW Health Department suspected that it was given incorrect advice but was having difficulties in pursuing the matter because of privacy restraints on the information which DILGEA was able to share.[11]

6.29 The problems to which the NSW Health Department alluded are worrying, particularly if considered in the context of the criteria for entry set down in the Migration Regulations. The Migration Regulations state that all persons entering Australia must satisfy certain public interest criteria. One such criterion is that the person seeking entry or stay 'does not have outstanding debts to the Commonwealth unless the Minister is satisfied that appropriate arrangements have been made for payment'. If information concerning a person's indebtedness is not or cannot be exchanged between government departments, this hampers or precludes decision makers in their full assessment of this public interest criterion.

Conclusions

6.30 The Committee is disturbed by evidence from Commonwealth and State health agencies that non-citizens who are ineligible for Medicare are accessing Medicare benefits and generating potentially unrecoverable debts when utilising Australia's health services. While some of the evidence is anecdotal, examples provided by the HIC and the NSW Health Department indicate that the potential exists for significant abuse of Australia's health system by illegal entrants and temporary residents ineligible for Medicare benefits.

6.31 The Committee is of the view that the existing control mechanisms for preventing Medicare abuse have significant limitations. The system, to a large extent, relies on medical practitioners and/or their staff identifying fraudulent use of Medicare cards, either by personally knowing the user of the card or the actual owner of the card. As acknowledged by the HIC, there is sufficient opportunity to by-pass this control, simply by attending an alternative medical practitioner.

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10 Transcript of evidence, 11 March 1992, p. 291.

11 Transcript of evidence, 11 March 1992, p. 302.

6.32 To overcome potential and actual abuse in this area, the Committee considers that tighter controls are required for Medicare card distribution and use. For non-citizens, more stringent Medicare enrolment procedures should be introduced, to ensure proof of identity. In addition, signatures should be included on each Medicare card as an immediate means of checking that the person using the card is in effect the person who is entitled to the benefit.

6.33 The Committee is also of the view that, in general, temporary entrants should be excluded from access to Medicare. In this regard, the Committee accepts that there may be specific groups of temporary entrants for whom the Government would wish to provide access to Medicare, for example those granted Extended Eligibility (Spouse) Temporary Entry Permits and asylum seekers granted Domestic Protection Temporary Entry Permits. For such specific groups, specific legislative provisions granting access to Medicare should be required.

6.34 Finally, to assist with debt recovery in the health area, the Committee considers that there should be greater opportunity for exchange of information between DILGEA and both Commonwealth and State health agencies. Clearly, it is not in the public interest if illegal entrants and temporary residents are able to avoid payment of health costs, or if such persons are being readmitted to Australia without any proper scrutiny of their indebtedness to the Commonwealth because privacy considerations prevent organisations such as the HIC from providing DILGEA with relevant information. The Committee is of the view that a debt ought to be recovered or seen to be recoverable before the person who generated the debt is able to remain in or re-enter Australia.

Recommendations

6.35 **The Committee recommends that:**

19. in light of the potential for fraud in the existing procedures for enrolment in Medicare and in the use of Medicare cards, the following changes to the Medicare system be implemented:

(a) the Medicare enrolment procedures for non-citizens be amended to require two original documents as proof of identity, with one of those documents including a photograph; and

(b) the signature of each nominated Medicare card holder be required to be included on the Medicare card, so that every transaction can be verified as a service to the card holder or another authorised family member;

20. the definition of 'Australian resident' in subsection 3(1) of the *Health Insurance Act 1973* be amended to prevent persons with temporary entry permits from gaining access to Medicare, but the Government introduce specific legislative provisions to cover specific groups of temporary residents which the Government considers should have access to Medicare, for example those granted Extended Eligibility (Spouse) Temporary Entry Permits and asylum seekers granted Domestic Protection Temporary Entry Permits; and

21. appropriate legislative amendments be made to ensure that the Health Insurance Commissioner and other appropriate persons be empowered to provide the Department of Immigration, Local Government and Ethnic Affairs with information regarding instances of unlawful access to Medicare by temporary entrants and illegal entrants, and information regarding the extent of indebtedness of temporary residents and/or illegal entrants who have accessed Australia's health system.

Dr Andrew Theophanous, MP
Chairman

December 1992

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APPENDIX A

SUBMISSIONS

Volume 1

No.	Name of person/organisation
1	Karingal Parents and Friends
2	Australian Intercountry Adoption Network
3	Mr Brian Murray
4	Ms Christine Heal
5	Mr Geoff Binkowski
6	Confidential
7	Mr W D Blackshaw
8	KJB Selig Migration Services
9	Confidential
10	Intellectual Disability Services Council
11	Health Department, Western Australia
12	Karingal East Geelong Community Centre
13	Confidential
14	Disabled Peoples International (Australia)
15	Broadmeadows Migrant Resource Centre
16	Western Region Ethnic Disability Services
17	Springvale Community Aid and Advice Bureau
18	National Federation of Blind Citizens of Australia
19	Refugee Advice and Casework Service (Victoria)

20	Migrant Resource Centre, Prahran Inc.
21	Victorian Immigration Advice and Rights Centre Inc., Migrant Resource Centre, Prahran Inc. and Refugee Advice and Casework Service (Vic) Inc.
22	Law Institute of Victoria
23	Australian Migration Consultants Association
24	Reverend Pamela Phillips
25	Mr Noel Nicholson
26	Australian Council for the Rehabilitation of the Disabled (ACROD)
27	Mr Eifion Jones
28	Mr & Mrs Barry and Julia Rollings
29	Authority for Intellectually Handicapped Persons, Perth
30	Mr E R Cope
31	Intercountry Aid for Children (NSW)
32	(Name Withheld)
33	National Council on Intellectual Disability
34	Law Institute of Victoria
35	Mr Cliff Joachim
36	Refugee Council of Australia
37	Department of Social Security
38	L'Arobe Genesaret
39	Redfern Legal Centre
40	Confidential
41	Immigration Advice & Rights Inc
42	Confidential

43	Disability Advisory Council of Australia

Volume 2

44	Confidential
45	Confidential
46	Minister for Multicultural and Ethnic Affairs, Western Australian Government
47	Department of Health, Housing and Community Services
48	National Federation of Blind Citizens of Australia Ltd
49	Premier of Tasmania
50	Illawarra Immigration Interagency
51	State and Territory Members of the Committee of Social Welfare Administrators
52	Department of Immigration, Local Government and Ethnic Affairs
53	Chief Minister, Darwin

Volume 3

54	Australian Intercountry Adoption Network (Supplementary)
55	Australian Migration Program and Investments (Supplementary)
56	Disability Advisory Council of Australia (Supplementary)
57	Department of Health, Housing and Community Services (Supplementary)
58	Department of Immigration, Local Government and Ethnic Affairs (Supplementary)
59	Department of Social Security (Supplementary)
60	Health Insurance Commission
61	National Council on Intellectual Disability (Supplementary)

62	Australian Intercountry Adoption Network (Supplementary)
63	AMP Society
64	MLC Life Limited
65	Brian Murray and Associates (Supplementary)
66	Hospitals Contribution Fund of Australia Ltd
67	Name Withheld
68	ACROD (Supplementary)
69	Department of Immigration, Local government and Ethnic Affairs (Supplementary)

APPENDIX B

EXHIBITS

1	DILGEA: Health Rejections and the Use of the Waiver (formerly Exhibit 'A')[1]
2	DILGEA: Exercise of the Health Waiver (formerly Exhibit 'B')
3	DILGEA: Health Requirements - *Notes for the guidance of doctors and radiologists examining applicants for visa and entry permits*, 1989 (formerly Exhibit 'C')
4	DSS: Assurances of Support - Affected Visa and Entry Permit Classes[2]
5	NCID: Videotape of segment from BBC interview (Family D), screened at the public hearing on 20 February 1992
6	AICAN: Letter from Australia for Children Society, 18 February 1992
7	CONFIDENTIAL
8	AGHS: Discussion paper on intellectual disabilities, February 1992
9	NSW Health Department: *A Review of the NSW Refugee Medical Screening Program*, June 1991
10	Australian Institute of Health and Welfare: *Immigrants in Australia, a health profile*
11	Letter from the Office of the Privacy Commissioner to the Health Insurance Commission, dated 31 March 1992
12	Letter from Senator Margaret Reynolds, dated 18 August 1992

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1 At the public hearing on 19 February 1992. DILGEA tendered Exhibits 'A','B' and 'C' which are now numbered Exhibits 1,2 and 3 respectively

2 Formerly Exhibit 'D' (DSS), public hearing on 19 February 1992

APPENDIX C

WITNESSES APPEARING AT PUBLIC HEARINGS

Witnesses/Organisation	Date(s) of appearance
Individuals	
Dr Brian Dovovan	28-08-91
Mrs Julia Rollings	20-02-92
Australian Council for Rehabilitation of Disabled	
Mrs Helen McAuley Policy Officer	20-02-92
Australian Intercountry Adoption Network	
Ms Rosamond Madden National Co-ordinator	20-02-92
Broadmeadows Migrant Resource Centre and Broadmeadows Ethnic Disability Service	
Mr Nick Michael Project Officer	28-08-91
Department of Health, Housing and Community Services	
Mr Warwick Bruen Senior Adviser Aged and Community Care Division	19-02-92
Mr Mark Burness Director Medicare Eligibility	19-02-92

Mr Brian Corcoran National Program Manager Disability Services Program	19-02-92
Mr Brendon Kelly National Manager Australian Government Health Service	19-02-92
Dr Kathleen King Director Migrant Medical Clearances	19-02-92

Department of Immigration, Local Government and Ethnic Affairs

Ms Linda Barnes Director Migrant Entry and Citizenship Branch	19-02-92
Mr Peter Hughes Assistant Secretary Migrant Entry and Citizenship Branch	19-02-92
Mr David Wheen First Assistant Secretary Migration Division	19-02-92

Department of Social Security

Mr Chris Butel First Assistant Secretary Program Delivery Division	19-02-92
Mr Peter Huta Assistant Director Special Assessments Section	19-02-92
Mr David Tune Acting Executive Manager Program Delivery Division	19-02-92

Disability Advisory Council of Australia

Mrs Vivi Germanos-Koutsounadis	20-02-92

Disability Resources Centre

Ms Elina Dalziel Advocacy/Policy Officer	28-08-91

Disabled Peoples International (Australia)

Mr Frank Hall-Bentick Past President	28-08-91

Health Insurance Commission

Mr Tim Bourke Manager Statistics	11-03-92
Mr Richard Karling Manager Investigations	11-03-92
Mr Graham Mynott Acting Manager Processing	11-03-92
Ms Jacquelyn Wood Acting Manager Health Benefits Division	11-03-92

Illawarra Adoptive Parents Association

Mrs Vicki Osborne Information Officer	20-02-92

Law Institute of Victoria

Mr Paul Baker Chairman Migration Committee	28-08-91

National Council on Intellectual Disability

Mrs Margaret Verick Executive Officer	20-02-92

National Federation of Blind Citizens of Australia

Mr William Jolley President	28-08-91
Mr John Simpson Executive Officer	28-08-91

NSW Health Department

Dr Gavin Frost Deputy Chief Health Officer	11-03-92

Springvale Community Aid and Advice Bureau

Ms Sherron Dunbar Social Worker	28-08-91

Prahran Migrant Resource Centre

Mr George Lekakis Co-ordinator	28-08-91
Ms Jeanette Liebmann Senior Social Worker	28-08-91

Refugee Advice and Casework Service (Vic) Inc.

Ms Roz Zalewski Co-ordinator	28-08-91

Victorian Immigration Advice and Rights Centre

Ms Sarah Fisher Immigration Adviser	28-08-91

APPENDIX D

(1) FORM 26 - MEDICAL REPORT

(2) FORM 160 - RADIOLIGICAL REPORT ON A CHEST X-RAY

Department of Immigration, Local Government and Ethnic Affairs

MEDICAL EXAMINATION OF AN APPLICANT FOR VISA / ENTRY PERMIT TO AUSTRALIA

26

About the information you give in this form. The information you give in this form is needed by the Department of Immigration, Local Government and Ethnic Affairs to carry out its functions and activities. It is also the Department's usual practice to pass on some or all of such information to Commonwealth or State agencies which deal with education, health, community services and social welfare.

Office use only
File number

Name and address of office processing the application

Family Name

Given Names

Address

Sex: ☐ Male ☐ Female

Date of Birth / /19

Photograph
To be attached firmly to the form by staples or other means.

Medical Examiner to certify in writing across the top of the photograph and form (without obliterating the image) that it is a true likeness of the examinee.

Applicant's declaration (All questions must be answered)

1. Intended occupation/activity in Australia

2. Proposed duration of stay in Australia. Permanent (migrant / refugee / resident status) ☐
   OR
   Temporary ☐ For how long ? years months

3. Are you:
   (a) a child for adoption by an Australian resident ? ☐ No ☐ Yes
   (b) an unaccompanied minor refugee child ? ☐ No ☐ Yes
   (c) a refugee who has lived or is living in a camp ? ☐ No ☐ Yes

4. In Australia, will you be:
   (a) attending or teaching classes ? ☐ No ☐ Yes
   (b) involved in health care, food processing or catering, the hospitality or pharmaceutical industries ? ☐ No ☐ Yes

5. Have you ever had:

	No	Yes	If Yes, please provide dates and details
(a) an operation ?	☐	☐ →	
(b) an accident needing hospital treatment ?	☐	☐ →	
(c) tuberculosis or an abnormal chest X-ray, or have you ever coughed up blood or lived with a person with tuberculosis ?	☐	☐ →	

5. (CONT) Have you ever had:	No	Yes	If Yes, please provide dates and details
(d) convulsions, fits or epilepsy ?	☐	☐ →	
(e) anxiety, depression or nervous complaints requiring treatment ?	☐	☐ →	
(f) high blood pressure, heart trouble, breathlessness and/or chest pain ?	☐	☐ →	
(g) pain in the neck, back or any joint ?	☐	☐ →	
(h) stomach pains, indigestion or heart burn ?	☐	☐ →	
(i) a dangerous contagious disease or other serious illness ?	☐	☐ →	
6. Have you had any medical attention during the past year ?	☐	☐ →	
7. Are you currently on any treatment or medication ?	☐	☐ →	
8. Have you ever been addicted to a drug or taken drugs illegally ?	☐	☐ →	
9. Do you take alcohol ? (If so, how much ?)	☐	☐ →	
10. Do you have any physical or mental disabilities which may affect your ability to earn a living or take full care of yourself ?	☐	☐ →	
11. Have any members of your family, particularly your spouse, children, parents, grandparents, brothers or sisters ever suffered from a mental illness, blood disorder, diabetes or any other inherited disorder ?	☐	☐ →	
12. Do you receive a pension for medical reasons ? (If Yes, give details of diagnosis, duration of pension, date last employed, restrictions on ability to work, and prognosis.)	☐	☐ →	

13. Statement
To be signed and dated in the presence of the examining doctor. Examining doctor to ensure that applicant has provided answers to all questions in "Applicant's Declaration". (Parent or guardian should sign on behalf of child under 16 years of age.)

I Certify that the above information is correct.

Signature

Date / /19

Examining doctor's findings

The role of the examining doctor is to examine applicants for visas and entry permits to Australia and to report on their state of health in accordance with the questions below. Recommendations or decisions on whether the health requirements for entry to Australia are met are made by the relevant Australian Government authorities.

To the examining doctor:

- Please answer ALL questions and complete comments in English
- Please write clearly. Illegible forms will have to be returned for clarification
- Wherever the examinee answers "Yes" to questions 5 to 12 in "Applicant's Declaration" please comment fully below
- The questions below are not considered exhaustive; any conditions not covered by the form should be identified and fully recorded
- If, in your opinion, specialist's reports or tests would be desirable, please mention. However, they should be obtained at this stage only as indicated on this form
- For HIV and HBV testing, please ensure that pre- and post-test counselling is carried out in accordance with local arrangements including advice on vaccination for close contacts of those testing HBV positive

	Normal	Abnormal	COMMENTS:
1. Height and weight Centimetres ____ Kilos ____			
2. Cardiovascular system (Record any evidence of cardiac failure, abnormality or irregularity, organic lesions or heart murmurs. Blood pressure readings required for all persons 16 years or over. Where repeat readings after rest exceed the following limits - under 40 years of age - 140/90 - between 40 and 65 years - 150/100 - over 65 years - 170/100 obtain and attach cardiologist's report.)	☐	☐	Blood Pressure: Systolic ____ Diastolic ____
3. Respiratory system. (For current or previous tuberculosis, provide date and duration of treatment and name, strength and dosage of drugs used.)	☐	☐ →	
4. Nervous system mental state intelligence	☐	☐ →	
5. Gastro-intestinal system	☐	☐ →	
6. Locomotor system physical formation (For persons over 60, include information on mobility.)	☐	☐ →	
7. Skin (including evidence of lymphadenopathy)	☐	☐ →	
8. Urogenital system, including evidence of sexually transmitted disease. (Obtain and attach VDRL test results for: - refugees over 16 years who have lived or are living in camps (see question 3(c) of "Applicant's Declaration"). - any other person where clinically indicated	☐	☐ →	
9. Endocrine system	☐	☐ →	
10. Evidence of drug - taking (eg venous puncture marks)	☐	☐ →	
11. Ear / nose / throat / mouth / teeth	☐	☐ →	
12. Hearing Right	☐	☐	
Left	☐	☐	
13. Eyes (including fundoscopy.) (Obtain and attach specialist opthalmologist's report if presence or history of cataract, trauma, trachoma or other eye condition /disease.	☐	☐ →	

	Right	Left	COMMENTS:
14. Visual acuity (Preferably using Snellen's or equivalent.) Uncorrected	/	/	
Corrected	/	/	

(Obtain and attach a specialist opthalmologist's report where corrected visual acuity is worse than 6/12 in either eye. Please provide appropriate comments in lieu of readings for those too young to be tested.)

15. Are there any physical or mental conditions which may affect this person's ability to earn a living, take care of him / herself or adapt to a new environment? — No ☐ Yes ☐

16. Is this person pregnant ? ☐ ☐ → Date of last monthly period / /19

17. Urinalysis
(Complete for all persons over 5, and those under 5 where clinically indicated. Repeat immediately if trace or more of protein or glucose is present. If test still positive with no simple explanation, obtain and attach results of urine microscopy culture and sensitivity, serum creatinine or glucose tests as indicated.)

Albumin ☐ Sugar ☐

18. Hepatitis B antigen blood test — Normal ☐ Abnormal ☐
To be undertaken and results attached for:
- pregnant women
- child for adoption by Australian resident. (see Qn. 3(a) of "Applicant's Declaration")
- unaccompanied minor refugee child. (see Qn. 3(b) of "Applicant's Declaration")

19. Human Immunodeficiency Virus test — Normal ☐ Abnormal ☐
To be undertaken and results attached for:
(a) Persons intending permanent stay in Australia who are 15 years of age and over; also all children under the age of 15 years
  i) who are for adoption by an Australian resident, (see Qn. 3 of "Applicant's Declaration") or
  ii) who have a history of blood tranfusions, or
  iii) where it is otherwise clinically indicated. (see Qn. 2 of "Applicant's Declaration")

(b) Other persons as indicated on clinical grounds.
The test required is:
- ELISA, and if the initial ELISA test is positive
- repeat ELISA, and Western Blot or third ELISA.
  Particle agglutination tests also acceptable: if positive, a confirmatory Western Blot test required.

20. Statement
(to be signed by the doctor who personally performed the examination)

I declare that I have examined the person above and that this is a true and correct record of my findings

Name of examining doctor (please print)

Signature of examining doctor

Date of examination / /19

Place of examination

Australia has no compulsory immunization requirements but parents are strongly encouraged to have their children immunized against Tuberculosis, Pertussis, Diphtheria, Tetanus, Poliomyelitis, Mumps, Measles and Rubella. Please counsel parents accordingly; advise them to have outstanding immunizations done before travelling to Australia and to bring immunization records with them.

THIS ENVELOPE CONTAINS PRIVATE MEDICAL DOCUMENTATION CONCERNING:

Name

Address

IN RELATION TO AN APPLICATION FOR A VISA/ENTRY PERMIT TO AUSTRALIA.

ONCE SEALED, THIS ENVELOPE IS TO BE OPENED ONLY AT THE AUSTRALIAN GOVERNMENT OFFICE PROCESSING THE APPLICATION.

TO THE PERSON TO BE EXAMINED:

Before you attend the medical examination:

- fill in your name and address in the space above
- tick the box below that describes your situation. You must tick EITHER box A or box B.

A. The application to which my medical examination is related has already been submitted to an Australian Government office.

BOX A ☐

Name and address of office concerned

My file number is

(After your examination, the doctor will place all your medical documents into this envelope and send it direct to the office.)

B. The application to which my medical examination is related has not yet been submitted to an Australian Government office.

BOX B ☐

(After your examination, the doctor will place all your medical documents into this envelope and return it to you, at the address you have given above. You must make sure that this unopened envelope accompanies the application for visa/entry permit when it is submitted. If you are not the person submitting the application, make sure this unopened envelope is given to the person or agent who will be submitting the application.)

TO MEDICAL EXAMINER:
Please put the completed Form 26, together with any further reports required, into this envelope. Please seal it and place your signature or rubber stamp over the junction of flap and envelope. Then place the envelope in an outer envelope and return it:

- where Box A is ticked, direct to the Australian Government office indicated at Box A above; otherwise
- where Box B is ticked, to the person examined.

TO MEDICAL EXAMINER. Please detach this envelope from Form 26

TO MEDICAL EXAMINER: Please place your signature or rubber stamp over the junction of the flap and the envelope

Department of Immigration, Local Government and Ethnic Affairs

RADIOLOGICAL REPORT

(for applicants for overseas migrants, students etc. aged 16 or more years)

Form A.180(5-87)1

File Number

Photograph must be signed by the examiner.

NOTE 1: The X-Ray film plate must bear the date of the examination, the applicant's family name and christian or given names and file no.: this information should preferably be automatically inscribed during the photographic process; if not, it should be written in white ink.

NOTE 2: The X Ray film and the report must be sent directly to the Australian Mission and not given to the applicant.

PHOTOGRAPH

Family Name	Christian or Given Names

Address

Date of Birth	Date of X-Ray	Identity Document No.
/ /19	/ /19	

Applicant's Signature (to be signed in the radiographer's presence)

..... / /19

	Normal	Abnormal	Radiologist's observations concerning abnormalities, including degree of pulmonary sclerosis and scar tissue, etc. in the case of disease within the chest.
1. Skeleton and soft tissue			
2. Cardiac shadow			
3. Hilar and lymphatic glands			
4. Heni diaphragms and sinuses			
5. Total pulmonary image			
6. Evidence of old or recent TB			
7. Other abnormalities			

I certify that I have carried out the X-Ray of the person whose photograph and signature are on this form.

.....
(Radiographer's signature)

.....
(Radiologist's signature)

Radiologist's Titles and Address

AUSTRALIAN RADIOLOGIST COMMENT

FINAL RESULT

APPENDIX E

VISA AND ENTRY PERMIT CLASSES TO WHICH AN ASSURANCE OF SUPPORT IS APPLICABLE

(Source: DILGEA. Procedures Advice Manual, Update No 93, *Assurance of Support*, pp. 19-22, 1 June 1992)

3. Assurance of Support

3.1 Classes to which an AOS applies

3.1.1 Schedules 2 and 3 of the Migration Regulations list those visa and entry permit classes for which an AOS is essential, discretionary or can not be obtained. There are no provisions for an AOS to be waived where it is an essential criterion.

3.1.2 The following visa and entry permit classes are those for which an AOS is essential:

Class 103	parent who meets the balance of family test
Class 104	preferential family (aged dependent, special need, orphaned minor and last remaining relatives)
Class 206	Lebanese concession
Class 804	aged parent (after entry)
Class 806	family and other close ties (only aged dependent, special need, orphaned minor and remaining relatives in this class).

3.1.3 For orphaned minor relatives only an AOS and MHSC payment are required. The bond does not apply. This also applies in any other case where the principal applicant in a class where the AOS is an essential criterion is a minor.

3.1.4 The Migration Regulations also provide that an accepted AOS may be a requirement for any other

visa or entry permit class **EXCEPT for the classes listed below:**

Class	Code No	Regulation Reference
resident return A	154	Schedule 3
resident return B	155	Schedule 3
resident return C	156	Schedule 3
resident return D	157	Schedule 3
resident return E	158	Schedule 3
resident return F	159	Schedule 3
refugee	200	Sch 2, Pt 2
in-country special humanitarian	201	Sch 2, Pt 2
global specialhumanitarian	202	Sch 2, Pt 2
emergency rescue	203	Sch 2, Pt 2
woman at risk	204	Sch 2, Pt 2
camp clearance	205	Sch 2, Pt 2
Soviet concession	207	Sch 2, Pt 2
emergency (permanent entry)	302	Sch 2, Pt 3
emergency (temporary entry)	303	Sch 2, Pt 3
restricted passport	431	Sch 2, Pt 3
December 1989 (temporary)	440	Schedule 3
transit	771	Sch 2, Pt 3
border	773	Sch 2, Pt 3
refugee (restricted)	781	Sch 2, Pt 3
territorial asylum	800	Schedule 3
confirmatory	808	Schedule 3
processing	825	Sch 2, Pt 3
statutory visitor	992	Sch 2, Pt 3

3.1.5 Officers may request an AOS for applicant(s) in any other class of visa or entry permit if the officer believes there is a risk of the applicant needing Special Benefit, Job Search or Newstart Allowances paid by DSS.

3.1.6 In determining whether to seek an AOS in these circumstances, the officer should consider relevant social and economic aspects of the case, for example, the person's age, employment prospects

Special Benefit, Job Search or Newstart Allowances paid by DSS.

3.1.6 In determining whether to seek an AOS in these circumstances, the officer should consider relevant social and economic aspects of the case, for example, the person's age, employment prospects (including skills or qualifications), their eligibility for social security benefits and, if sponsored, the ability of the sponsor to provide assistance.

3.1.7 Although temporary resident visa classes do not appear on the list of classes exempt from an AOS, they are ineligible for social security payments. Under these circumstances there is no purpose in requesting an assurance. The exceptions to this are specifically mentioned in 3.1.4.

3.2 **Who can provide an AOS**

3.2.1 It is a matter of policy that in making an assessment of the ability of the assurer to meet commitments under Regulation 164C, the assurer should be:

a) an Australian citizen or permanent resident of Australia;

b) 18 years of age or over;

c) usually resident in Australia; and

d) financially able to meet the commitment.

3.2.2 In order for an AOS to be given in a form that is acceptable to the Minister, it is administrative practice that, for assessment purposes, documentary evidence be provided by the assurer that they have financial resources sufficient to fulfil their legal commitment should that become necessary.

3.2.3 The assurer need not be the sponsor.

3.2.4 It is possible for each spouse in a family to be treated as a separate assurer provided that their separate financial circumstances meet the requirements of the AOS.

3.3 **The form 28B Assurance of Support**

3.3.1 The form 28B "Assurance of Support", which replaced the form 28 on 20 December 1991, seeks detailed and comprehensive information about assurers which is necessary to make an assessment of the assurer's capacity to meet obligations. It encourages would-be assurers to obtain legal advice before signing the form.

3.3.2 The form 28B is a Statutory Declaration which is made and signed in accordance with the requirements in the form. It is to be signed by the person giving the assurance.

3.3.3 The form 28B also provides for assurers and their spouses to sign an authority to DSS, permitting disclosure by that Department to DILGEA of information relevant to the assessment of the assurance.

3.3.4 The form 28B provides for the recording of information by DSS and for the final decision of acceptance or refusal by a DILGEA officer.