

DISCUSSION PAPER

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MIGRATION LAW AND HIV

The case for reform of Australian migration law and policy to ensure that the human rights of people living with HIV are respected and protected

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Glossary of acronyms and terms

ANAO	Australian National Audit Office
CALD	Culturally and linguistically diverse
CRPD	Convention on the Rights of Persons with Disabilities
DIAC	Department of Immigration and Citizenship
UNHCR	Office of the United Nations High Commissioner for Refugees
Asylum seeker	<p>An asylum seeker is someone who makes a claim for asylum in a country other than their own. For some of the world's refugee population it is either impractical or impossible to go first to a neighbouring country and then to seek resettlement from there. In these cases, individuals may choose to try to go directly to a country, such as Australia, where they can seek protection. Such people are called asylum seekers. Those who come to Australia often enter with a visitor, student or other temporary visa. Some arrive with no documents.</p>
Refugee	<p>The 1951 Convention relating to the Status of Refugees defines a refugee as someone who: "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country..."</p> <p>A refugee is someone who is outside their home country because they believe they could be persecuted for the reasons listed above and cannot be protected by their government.</p>

Executive summary

Current Australian migration law and policy discriminates against people living with HIV.

Reform of Australian migration law and policy to remove mandatory HIV testing is required to bring Australia into line with international human rights standards and public health best practice.

Australia's ratification of the United Nations *Convention on the Rights of Persons with Disabilities* (CRPD) should drive reform of Australia's migration law and policy in respect of the Health Requirement generally, and particularly in respect of its application to people living with HIV.

The exemption of the *Migration Act 1958* from the *Disability Discrimination Act 1992* is not supportable.

Given the highly selective nature of the migration program, there should be no Health Requirement except the Public Health Criteria restricting the entry of people with active TB and other highly infectious diseases (or conditions that otherwise pose a threat to public health).

In respect of humanitarian and refugee applicants, no regard should be had to disability or chronic illness in the determination of claims for protection. HIV testing should be voluntary and offered to people from high HIV prevalence communities after their arrival in Australia, and any person granted permanent protection who is HIV positive should be referred to culturally appropriate treatment, care, support and counselling services.

People living with HIV on temporary visas who apply for permanent status should be eligible for Medicare, the Pharmaceutical Benefits Scheme and Social Security income support while they await the determination of their substantive claim.

1 Introduction

This paper aims to inform discussion of options for reform of Australia's migration laws and policies to reduce discrimination against people living with HIV. Australia does not impose travel restrictions on people living with HIV who enter as short-term visitors. This paper relates primarily to policies affecting people living with HIV who apply for permanent visas as migrants or refugees. It also addresses issues affecting people living with HIV on certain temporary visas such as bridging visas or student visas. This paper does not cover the distinct and significant issues that relate to long-term temporary work visas (sub-class 457).

Migration policy is influenced by community attitudes, which in turn are shaped by media representations of migrant and refugee populations and the challenges they face – including, in some cases, living with HIV. Press reporting of cases involving migrants and refugees with HIV has often been sensational and inaccurate – binding together negative stereotypes of refugees and people with HIV that can reappear from time to time. For people who discover their HIV positive status as a result of applying for Australian residence, stigma is just one of many challenges associated with the diagnosis, especially for refugees. There is a risk that media interest in the criminal convictions of African men for offences involving transmission of HIV may also feed into the demonisation of migrants and refugees with HIV.¹ This can undermine health promotion strategies for migrant and refugee communities. Government initiatives that respond to media stereotyping are required.

2 Current law and policy

The *Migration Act 1958* and *Migration Regulations 1994* impose strict rules for people applying for permanent residence, including rules regarding health. These rules are referred to as the 'Health Requirement'. Generally, applicants for permanent visas who have HIV do not pass the Health Requirement, but some applicants may be granted a permanent visa under the 'waiver' provisions.

To pass the health criteria a person must demonstrate that they are:²

- (i) free from tuberculosis;
- (ii) free from any disease or condition that is, or may result in, the person being a threat to public health in Australia or a danger to the Australian community;
- (iii) not a person who has a disease or condition:
 - a. that would be likely to require health care or community services or meet the medical criteria for the provision of a community service, and
 - b. that health care or those community services would result in a **significant cost** to the Australian community in the areas of health care and community services or prejudice the access of an Australian citizen or permanent resident to health care or community services.

There is no definition of what is considered a "significant" cost. Generally any disease or condition which is likely to cost \$20,000 or more over a five year period is considered to be significant. The costs are assessed by a Medical Officer of the Commonwealth (MOC), who provides the Department of Immigration and Citizenship (DIAC) with an opinion as to whether the individual meets the Health Requirement

¹ A. Pearson and C. Newman, 'Making Monsters: heterosexuality, crime and race in recent Western media coverage of HIV' *Sociology of Health & Illness*, Volume 30, Issue 4, pages 632–646, May 2008.

² *Migration Regulations*, Schedule 4 – Public Interest Criteria and Related Provisions

overall. For an HIV-positive person, that opinion includes an assessment of whether the costs associated with their HIV status will be “significant”. DIAC is bound to accept the opinion of the MOC as final.³

Mandatory HIV testing

A test for HIV is a mandatory part of the final health check for all prospective migrants to Australia, for off-shore applicants for refugee and humanitarian visas and for certain temporary visa applicants.

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

HIV testing of children under 15 years is mandatory only where they are to be adopted by an Australian resident, where they have a history of blood transfusions, or where it is clinically indicated. An exception exists for children who are on-shore refugees.

For on-shore non-refugee applicants, the HIV test is taken as part of a medical examination conducted by Medibank Health Solutions (formerly known as Health Services Australia). For off-shore applicants, the HIV test is taken by a DIAC approved “panel doctor”, as part of the final health check.

The Health Requirement as it applies to people living with HIV

The Health Requirement applies to all people applying for permanent visas except to on-shore applicants for permanent protection visas i.e., individuals seeking asylum. The Health Requirement applies to the main visa applicant and also to family members included in the application. Generally, a person and all family members included in a permanent visa application must satisfy the Health Requirement. Where any member of the family fails the Health Requirement, the whole family will be refused permanent residence.

The only disease or condition which currently automatically results in the refusal of a visa for migrant and off-shore refugee applicants is active tuberculosis (TB). Applicants with other diseases or conditions (including diseases and conditions which are disabilities, such as HIV), are potentially eligible for most visa sub-classes, subject to either meeting the Health Requirement or having the Health Requirement waived. Most people with HIV fail the Health Requirement because the cost of treatment and care over a person’s lifetime is generally considered to be “significant”.

AFAO understands that perceived risk to public health is *not* regarded by DIAC as a relevant factor in assessing applicants who have HIV, although health care workers applying for temporary visas can, in limited situations, be deemed to be a public health risk. For migrant and off-shore humanitarian and refugee applicants with HIV (and for the other family members on a visa application), the primary issue is the estimated future cost of treatment and care.

³ Immigration Advice and Rights Centre, *IARC Client Information Sheet: Health*, February 2010, available at: www.iarc.asn.au/LiteratureRetrieve.aspx?ID=40018

Until 2008, the estimate of likely future costs associated with HIV was guided by a standard costing. The future costs associated with HIV were regarded as necessarily “significant” and/or it was considered that the need for health care and community services would necessarily “prejudice” Australians’ access to these services. Permanent visa applications of people living with HIV were generally refused, due to the weight given in the standard costing to the future cost of medications to be borne by the Pharmaceutical Benefits Scheme. In rare cases for certain visa sub-classes, a waiver was granted (see below).

In the light of several appeals⁴ highlighting inadequacies in these assessments, the Medical Officer of the Commonwealth is now required to make an assessment in respect of the individual applicant’s likely future treatment and care costs. Policy regarding the assessment of future cost in relation to HIV is set out in the *Notes for Guidance for Medical Officers (2008)*,⁵ which stipulate that the assessment must include a lifetime estimate of the cost of medication and health-care, including hospitalisations.

There is no evidence that the approach adopted since 2008 has resulted in an increase in the number of visas granted to people living with HIV or in the percentage of applications from people living with HIV that are approved. Despite the introduction of the requirement for individualised assessments, AFAO understands that the Health Requirement still precludes most people living with HIV from obtaining permanent visas unless they are able to secure a waiver.

Waiver of the Health Requirement

For some visa sub-classes, the Health Requirement may be waived where granting of the visa would be unlikely to result in:

- *undue prejudice to the access to health care or community services of any Australian citizen or permanent resident; or*
- *undue cost to the Australian community.*⁶

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

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

The visa classes for which waiver is available include:

- partner (includes de-facto, opposite sex or same-sex) of an Australian

⁴ These appeals notably include the cases of *Seligman (Minister for Immigration and Multicultural Affairs v Seligman (Seligman) [1999] FCA 117)*, *Robinson (Robinson v Minister for Immigration and Multicultural and Indigenous Affairs [2005] FCA 1626)* and *Applicant Y (Applicant Y v Minister for Immigration & Multicultural and Indigenous Affairs [2008] FCA 367)* which were directed to the validity of the report of the Medical Officer of the Commonwealth (MOC). These decisions clarified that the MOC report must give an estimate of costs based on a hypothetical person with the same state or form of the condition as the applicant. Furthermore, the *Bui (Bui v. Minister [1999] FCA 118)* case clarified that considerations in the Department’s decision regarding the waiver should take into account compelling and compassionate factors including social and cultural contributions of the applicant and must not be limited to an economic calculus of the costs/benefits.

⁵ *Notes for Guidance for Medical Officers of the Commonwealth of Australia: Financial implications and consideration of prejudice to access for services associated with infection with human immunodeficiency virus and acquired immune deficiency syndrome (HIV/AIDS)*, 9 July 2008.

⁶ *Migration Regulations*, Schedule 4 – Public Interest Criteria and Related Provisions (4005-07 of Schedule 4).

- citizen or permanent resident;
- fiancé(e);
- dependent child of an Australian permanent resident or citizen;
- refugee and humanitarian visas granted overseas; and
- temporary humanitarian stay.

The *Migration Regulations 1994* also provide for a 'skilled health waiver', which provides more flexibility for certain onshore skilled labour permanent visa sub-classes (e.g. employer nomination).⁷ Where a visa applicant fails to meet the Health Requirement and a skilled health waiver is available, the applicant will be given the opportunity to put forward arguments in support of a waiver – for example, their likely contribution to Australia in terms of skills, their ability to mitigate costs and any compassionate and compelling circumstances. Where potential health and community costs are estimated to be \$100,000 or more and/or prejudice of access of Australian citizens to health care or community services is substantial or excessive, a decision maker will consult the state or territory where the applicant intends to reside for a view on whether or not they support a waiver being exercised. The states/territories then provide a view on whether the health costs/prejudice to access involved in a particular case should be considered to be "undue" when weighed against the skills that the applicant and their family members would contribute to Australia if they were granted permanent residence.

3 The case for reform: permanent visas

Convention on the Rights of Persons with Disabilities (CRPD)⁸

Australia's ratification of the United Nations *Convention on the Rights of Persons with Disabilities* (CRPD) should drive reform of Australia's migration legislation, policies and guidelines in respect of the Health Requirement generally, and particularly in respect of its application to people living with HIV. HIV falls within the Convention as a form of disability.⁹

The Australia's ratification of the CRPD in 2008 represents a substantial commitment, as espoused on the website of the Attorney-General Department:

*Australia has joined other countries around the world in a global effort to promote the equal and active participation of all people with disability.*¹⁰

However, the strength of this commitment was diluted by the Government's submission of an Interpretive Declaration on its ratification of the CRPD. This included the following statement:

Australia recognises the rights of persons with disability to liberty of movement, to freedom to choose their residence and to a nationality, on an equal basis with others. Australia further declares its understanding that the Convention does not create a right for a person to enter or remain in a

⁷ See: <http://www.rrs.com.au/site/files/57544/Skilled%20Health%20Waiver%20Changes.pdf>

⁸ United Nations Convention on the Rights of Persons with Disabilities (adopted 13 December 2006, entered into force 3 May 2008) A/RES/61/106 art. 5(1)

⁹ Article 1 of the CRPD utilises a social model of disability, defining persons with disability to include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others. A person living with HIV clearly has a disability as defined under the CRPD.

¹⁰ Australian Government Attorney-General's Department, 'United Nations Convention on the Rights of Persons with Disabilities' accessed 21 April 2011.

http://www.ema.gov.au/www/agd/agd.nsf/Page/Humanrightsandanti-discrimination_UnitedNationsConventionontheRightsofPersonswithDisabilities

*country of which he or she is not a national, nor impact on Australia's Health Requirements for non-nationals seeking to enter or remain in Australia, where these requirements are based on legitimate, objective and reasonable criteria.*¹¹

The CRPD does not confer any right upon a non-citizen with disability to migrate to a foreign country, nor is such a right available under general international law. During the drafting of the Convention, a draft proposal to extend article 18 (liberty of movement and nationality) to include a right to 'enjoy on an equal basis with others the right to enter and immigrate to a country other than their State of origin' was not accepted.

Article 4 of the Convention imposes a primary obligation:

to ensure and promote the full realization of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disability.

Article 5 of the Convention provides further non-discrimination guarantees:

all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law.

Where a State legislates to provide for the entry and stay of non-citizens, such laws (including Health Requirements) must comply with these non-discrimination obligations and commitments.

The Centre for International Law, University of Sydney, has provided a legal opinion as to whether the operation of the Health Requirement breaches the CRPD.¹² The key points of the legal opinion on this issue are as follows:

- (i) Health requirements imposed by migration law are in principle permissible under international law to safeguard scarce medical resources.
- (ii) However, the Health Requirement of Australia's *Migration Regulations* may give rise to unjustifiable discrimination against refugees and migrants with disabilities, in breach of the equal protection obligation under Article 5 of the CRPD.
- (iii) Indirect discrimination may occur because the threshold of the health test is set too low to adequately balance the interests of non-discrimination against people with disability with the preservation of scarce health resources. Thus, in some cases the health assessment may lead to discrimination that is not proportionate to the policy objective of preserving health resources for all Australians.
- (iv) Indirect discrimination may occur because the evidentiary requirements are not sufficiently strong, for example in relation to accurately quantifying the future costs to the community of illness or disability.
- (v) Indirect discrimination may occur by inadequate procedures to take into account an applicant's ability to pay for the costs attributable to their own disability or illness.

¹¹ *Australia's Declaration upon ratification of the United Nations Convention on the Rights of Persons with Disabilities* (adopted 13 December 2006, entered into force 3 May 2008) A/RES/61/106 (CRPD Declaration).

¹² Dr Ben Saul, *Advice on the UN Convention on the Rights of Persons with Disabilities*, 15 May 2008. See:

http://www.neda.org.au/files/refugees_and_migrants_with_disability_and_un_crpdc_july_2008_final_1.pdf

In 2007 the Australian National Audit Office (ANAO) reported on its assessment of the Health Requirement. The ANAO found that DIAC complied with the intent of the *Migration Act* and the health criteria but found that DIAC's administration was deficient. One effect of these deficiencies was:

*DIAC could not determine the effectiveness of its implementation of the Health Requirement in protecting Australia from public health threats, containing health costs and safeguarding access of Australians to health services in short supply.*¹³

The deficiencies identified by the ANAO undermine the whole basis of the Health Requirement and its rationale. The fundamental nature of these deficiencies is such that it cannot be said that the Health Requirement is based on "legitimate, objective and reasonable criteria", as required by Australia's Interpretive Declaration.¹⁴

DIAC faces an impossible task attributing potential future costs for an individual in respect of a condition such as HIV, especially given that the effectiveness of antiretroviral drugs means enhanced quality of life and life expectancy for people with HIV. It seems that this difficulty has resulted in what is still effectively a blanket policy that migrants and refugees with HIV fail the Health Requirement in the first instance on cost grounds (i.e. before any waiver consideration). The Health Requirement contravenes the equal protection guarantee of Article 5(1) of the CRPD because, in practice, application of the Health Requirement generally results in the refusal of a permanent visa to a person with HIV in the first instance.

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

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

DIAC may have improved the way it conducts its waiver decisions since the ANAO investigation and the 2009 Inquiry into the Migration Treatment of Disability but fundamental issues raised in submissions to the Inquiry have not been addressed. However, given the imprecise nature of the requirement to estimate future costs to the health care system associated with a person's disability, it is unlikely that either Health Requirement or waiver decisions will be consistently applied over time. In this respect Australia's Interpretive Declaration on the CRPD is relevant, the Government having indicated that any requirements would be "based on legitimate, objective and reasonable criteria."

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

¹³ *Administration of the Health Requirement of the Migration Act 1958*, Australian National Audit Office, Commonwealth of Australia 2007, p. 18

¹⁴ CRPD Declaration (n. 5)

Public health risk assessment

The 2007 ANAO report referred to potential issues with regard to HIV in terms of DIAC's capacity to identify potential public health risks posed by migrants from high-prevalence countries. HIV does not represent a direct threat to public health given the manner in which it is transmitted. This is reflected in the United Nations *International Guidelines on HIV/AIDS and Human Rights*, which state that:

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

Apart from the fact that restricting the migration of people with HIV on public health grounds would contravene the UN Guidelines, such a policy would also be counterproductive to efforts to de-stigmatise HIV. A 2008 International Organisation for Migration study found that exclusion of migrants and refugees from countries with high HIV prevalence served to compound the stigma and discrimination experienced by people living with HIV.¹⁶ This both adversely affects quality of life of people living with HIV and is damaging to broader health promotion efforts among communities most-at-risk of HIV.

AFAO does not believe that introducing restrictions relating to HIV based on public health grounds (rather than on cost grounds) is under consideration by the Government. However, the fact that the ANAO saw fit to refer to potential public health risks posed by migrants from high HIV prevalence countries points to issues regarding perceptions of the nature of HIV and its transmission. There needs to be clear delineation of what can and cannot constitute a public health risk, particularly given widespread and at times racist and xenophobic misconceptions in the community, fed by some elements of the media, regarding the risks that newly arrived migrants and refugees pose to Australian society.

Violation of Australia's treaty obligations to refugees

Article 14 of the 1948 *Universal Declaration of Human Rights* states: "*Everyone has the right to seek and to enjoy in other countries asylum from persecution.*"

International law obliges States to admit persons who satisfy the criteria for refugee status, and to accord such persons the rights specified by the 1951 *Convention relating to the Status of Refugees*. These rights include the right to enjoyment of the protections offered by the Refugee Convention without discrimination, and the right to freedom from expulsion, save on grounds of national security or public order.¹⁷

Article 3 of the Refugee Convention requires States to apply the provisions of the Convention to refugees without discrimination as to race, religion or country of origin. This list of factors is non-exhaustive and the principle of non-discrimination must be

¹⁵ UNHCR and UNAIDS, 'International Guidelines on HIV/AIDS and Human Rights', (2006) HR/PUB/06/9, available at: <<http://www.unhcr.org/refworld/docid/4694a4a92.html>> para 127.

¹⁶ International Migration Organisation, 'Comparative Study of the Laws for Legal Immigration in the 27 EU Member States' (2008).

<http://www.iom.int/jahia/webdav/shared/shared/mainsite/law/legal_immigration_en.pdf>, p. 44.

¹⁷ Article 32 (1) of the Refugee Convention.

observed in relation to all factors save those for which exceptions are expressly made.

Under international law, the right to access, and remain in, a country of asylum, is not dependent on the health status of the applicant, save where that status may present a risk to national security or public order. This principle is observed in the treatment accorded by Australia's migration legislation and regulations to onshore applicants for 'protection' visas.

It is of concern that this principle is not presently observed by Australia in its consideration of resettlement, or 'offshore' humanitarian cases. AFAO cannot understand why this principle is not applied by Australia in respect of resettlement and offshore humanitarian cases.

In its submission to the 2009 Inquiry of the Joint Standing Committee on Migration, the Office of the United Nations High Commissioner for Refugees (UNHCR) stated:

Although the waiver is theoretically available, it is very rarely granted. Automatic rejection of HIV+ refugees is the norm. Subsequent application of the principle that 'one fails, all fail' means that the resulting effects are felt by all family members. The Health Requirement is discriminatory in effect. Australia presently falls short of its international obligations.

UNHCR recommended:

1. *That refugee and offshore humanitarian visa applications be made exempt from the operation of the Health Requirement.*
2. *In the alternative, that a prima facie presumption in favour of the granting of Ministerial waivers for refugee and offshore humanitarian cases be instituted.*
3. *That mandatory HIV testing be discontinued as an element of medical screening prior to resettlement.*

The 2010 Report of the Joint Standing Committee on Migration did not accept these recommendations. Instead, the report recommended that the Australian Government amend the *Migration Regulations 1994* to provide access to consideration of a waiver to offshore refugee visa applicants involving disability or health conditions on compelling and compassionate grounds.

AFAO disagrees with the Joint Standing Committee recommendation. AFAO supports the UNHCR recommendation that refugee and offshore humanitarian visa applications be made exempt from the operation of the Health Requirement. Indeed, AFAO would prefer that the Government go a step further and remove the Health Requirement as it affects people with disabilities altogether (retaining only criteria relating to public health risk) (see Recommendations, below).

AFAO questions why Australian migration law and policies recognise the absolute unacceptability of discriminating against people on the grounds of ethnicity or race but discrimination on the grounds of disability remains firmly in place.

Application of the Health Requirement in respect of off-shore refugee applicants is clearly contrary to the Government's stated policy that consideration of a claim for Permanent Protection should involve no issues other than the person's need for protection. AFAO is strongly of the view that a person's disability is irrelevant to their claim for protection. The fact that a person with HIV may require antiretroviral medications, hospitalisation and access to community programs is irrelevant to the

context of their need for asylum and resettlement, whether their application is lodged off-shore or on-shore.

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

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

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

If there is to be mandatory HIV testing of refugees, the test should be *after* permanent protection is granted, and only once the person has arrived in Australia – thereby effectively treating off-shore humanitarian and refugee applicants the same as on-shore applicants. The rationale for HIV testing should relate to the health of the applicant, and preferably should only occur voluntarily, with fully informed consent and culturally appropriate counselling.

**UNHCR's call for removal of the discriminatory Health Requirement
as it affects refugees living with HIV¹⁸**

The current application of the Health Requirement is broader than is necessary to ensure the protection of the Australian community and to achieve the relevant policy objectives.

In the processing and health screening which are necessary to implement the health requirement, there is a danger of the infringement of some human rights norms. The availability of a Ministerial waiver of elements of the Health Requirement goes some way to addressing these concerns, however it does not address the underlying issue of principle. Additionally, reliance on a discretionary and non-reviewable avenue of intervention as a response to the protection of human rights remains less than ideal. A more appropriate response is to address the underlying structures which give rise to discriminatory results.

¹⁸ UNHCR, *Submissions to the 2009 Joint Standing Committee on Migration Inquiry into the Migration Treatment of People with a Disability*.

Although the waiver is theoretically available, UNHCR's experience in practice suggests that it is very rarely granted and, effectively, automatic rejection of refugee cases which fail the Health Requirement is the norm. Subsequent application of the principle that 'one fails, all fail' means that the resulting effects are felt by all family members included in the given case.

...it should be recalled that the numbers of refugee and humanitarian entrants remain a very small proportion of the overall migration program. Although the theoretical demand upon health services may be significant when calculated on the basis of hypothetical persons calling upon every service available to them, the actual demand exerted by a small group of entrants is unlikely to significantly prejudice the Australian community or present an untenable cost.

Perhaps most significantly, the present operation of the Health Requirement is discriminatory in effect and endangers a number of other human rights norms. To that extent, Australia presently falls short of its international obligations.

The effective exclusion of refugees who are disabled or who have significant health concerns from resettling to Australia has a very real impact on the lives of already vulnerable refugees. Resettlement is intended as a protection tool, but its linkage to health status significantly undermines the protection component and can lead to the separation of families and the creation of additional protection problems.

Ultimately, the underlying principle of non-discrimination should apply in all cases.

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

The Government is still considering the recommendations of the Joint Standing Committee on Migration Inquiry for assessing the economic and social contribution that a potential resident, and their family, would make if granted residence. The Government is considering whether a new Health Requirement should be introduced that would attempt to balance these economic and social benefits against any cost associated with the applicant's (or a member of their family's) disability.

A new cost/benefit test may not make any substantive difference for most applicants living with HIV. The issues outlined above that relate to ascribing HIV-related treatment and care costs would remain. Formulating a cost/benefit test regarding HIV which genuinely assessed an individual's circumstances would need to involve complex actuarial projections taking into account the person's age, co-morbidities, past HIV treatment and adherence, potential changes in treatment costs (especially regarding the cost of antiretroviral drugs), cultural issues (including health literacy), family situation, and their employment prospects.

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

Where a person with HIV is either a member of a family seeking residence, or seeking to join family in Australia, a benefit test would also need to take into account the attributes of each member of the family and their role within the family, so as to incorporate a proper assessment of the potential benefits to society of keeping the family together.¹⁹

Due to the effectiveness of antiretroviral drugs, many migrants and refugees with HIV now have long and productive working lives, making significant tax and other economic contributions, and potentially self-funding retirement and medical insurance. These contributions, tangible or otherwise, would need to be balanced against potential medical and health care costs, and also against less tangible benefits migrants make to community and cultural life. For people applying as carers, costings would need to take into account the significant economic contribution made by carers, and health care costs potentially saved by Commonwealth and State/Territory service providers. Similarly, potential carer roles met by people applying for residence as partners, or under the Family Reunion Program would need to be factored into the analysis, as would the effect of family reunions in the context of the Government's Social Inclusion Agenda.

Selectivity of migration program

Current policies regarding people living with HIV appear to give no consideration to the nature of the visa sub-class for which the person is applying until the issue of whether the Health Requirement should be waived comes into play. This not only makes the system costly, but also gives grounds for criticisms such as those made by the ANAO (outlined above).

Given the nature of Australia's Migration Program with its highly defined sub-classes for which eligibility criteria include cost/benefit considerations, AFAO questions the need for a prescriptive over-arching Health Requirement. The Public Health Criteria restricting the entry of people with infectious diseases (or conditions that otherwise pose a threat to public health) provide sufficient protection of the public health.

Selectivity has been built into Australia's migration and refugee programs – with a plethora of visa sub-classes with complex eligibility criteria focussing on the applicant's business acumen and wealth, or their professional skills, or the needs of Australian family for family reunion, or whether they are joining a partner or adoptive parent, or whether they will meet the personal care needs of an Australian.

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

4 The case for reform: temporary visas

The application of the Health Requirement in respect of temporary visas can ultimately be counter-productive to the effectiveness of Australia's domestic and

¹⁹ The submission to the Joint Standing Committee Inquiry into the Migration Treatment of Disability made by Professor Ron McCallum AO and Professor Mary Crock provides an analysis of the minimum components of a test which seeks to balance costs and benefits.

international HIV response.

Health check requirements for applicants for temporary visas generally depend on the applicant's proposed length of stay in Australia, the purpose of the proposed stay, the prevalence of TB in their country of origin, and other discretionary factors. Most people applying for a temporary visa do not have to undergo a medical examination. However, certain visas and types of people will require additional assessment. Applicants intending to come to Australia to work as, or study to become, a doctor, dentist, paramedic or nurse are required to have HIV, Hepatitis B and Hepatitis C tests.²⁰

Applying the Health Requirement in respect of students seeking temporary visas can be counter-productive to Australia's international development commitments. Under the Development Scholarship Program of the Australian Agency for International Development (AusAID), overseas students can obtain qualifications at Australian universities and colleges. If a student visa applicant is required to be tested for HIV as part of their health check, and they are found to be positive, they will generally fail the Health Requirement – with no waiver available for student visas.

Fundamental issues for people on temporary visas such as bridging visas and student visas who apply for permanent status are flow from their ineligibility for Medicare, the Pharmaceutical Benefits Scheme and Social Security income support while they await the determination of their substantive claim. Whether or not a person with a bridging visa or student visa proceeds to permanent residence, such policies compromise the effectiveness of cross-portfolio policies targeting HIV in culturally and linguistically diverse (CALD) communities.

5 Inquiry into the Migration Treatment of Disability

In 2010, the Joint Standing Committee on Migration tabled its report on the Inquiry into the Migration Treatment of Disability.²¹ A number of important recommendations relevant to applicants with HIV were made by the Committee, none of which has been implemented by Government to date. The Committee's recommendations include:

Recommendation 1: that the Australian Government raise the 'significant cost threshold' (which forms part of the Health Requirement) to a more appropriate level. The Committee also recommends that the Department of Immigration and Citizenship quickly complete the review of the 'significant cost threshold'.

Recommendation 2: that the Australian Government adopt a contemporary Health Requirement for prospective permanent and temporary migration entrants under the Migration Act 1958. The Committee recommends changes to the Health Requirement include changes to the assessment criteria, processes and waiver options. These are outlined in subsequent recommendations.

Recommendation 3: that the Australian Government amend Schedule 4 of the

²⁰Immigration Advice and Rights Centre, *IARC Client Information Sheet: Health*, February 2010, p.2, available at: www.iarc.asn.au/LiteratureRetrieve.aspx?ID=40018; Department of Immigration and Multicultural Affairs, *Health requirement for temporary entry to Australia*, p.2, available at: <http://www.immi.gov.au/allforms/pdf/1163i.pdf>

²¹Joint Standing Committee on Migration, *Enabling Australia: Inquiry into the Migration Treatment of Disability*, June 2010.

Migration Regulations 1994 to allow for the consideration of the social and economic contributions to Australia of a prospective migrant or a prospective migrant's family in the overall assessment of a visa.

Recommendation 8: that the Australian Government remove from the Migration Regulations 1994 the criterion which state that costs will be assessed 'regardless of whether the health care or community services will actually be used in connection with the applicant'. The Committee also recommends that the Australian Government revise the approach which assesses visa applicants' possible health care and service needs against 'the hypothetical person test'. This test should be revised so that it reflects a tailored assessment of individual circumstances in relation to likely healthcare and service use.

Recommendation 11: The Committee recommends that the Australian Government review the operation of the 'one fails, all fails' criterion under the Migration Regulations 1994 to remove prejudicial impacts on people with a disability.

6 The Disability Discrimination Act exemption is not justifiable

The *Migration Act 1958* is currently exempt from the *Disability Discrimination Act 1992*. Given the Australian Government's ratification of the CRPD and the global effort in recent years to further the human rights of people with disability, the ongoing validity of this rationale must be re-examined.

The rationale for exempting migration legislation from the *Disability Discrimination Act 1992* was that it was necessary in order to retain the Health Requirement, and so allow certain sub-classes of visa applications to be refused if the main applicant, or a member of their family included in the application, has a "disease or condition" which constitutes a "disability" under the *Disability Discrimination Act 1992*.

If not for the exemption of migration law from the *Disability Discrimination Act 1992*, the policy to test all permanent visa applicants for HIV and to generally refuse visas to people with HIV would be unlawful discrimination under this domestic law.

An issue of fundamental importance is whether the *Migration Act 1958* should continue to be exempt from the *Disability Discrimination Act 1992*. Australia cannot meet its international commitments to prevent discrimination on the grounds of disability while the exemption remains in place.

Section 29 of the *Disability Discrimination Act 1992* prohibits direct and indirect disability discrimination in the administration of Commonwealth laws and programs. However, discrimination is not unlawful if it would impose an unjustifiable hardship on the discriminator. In determining whether hardship is unjustifiable, all relevant circumstances should be taken into account, including (among others):

- (a) the nature of the benefit or detriment likely to accrue to, or to be suffered by, any person concerned;
- (b) the effect of the disability of any person concerned;
- (c) the financial circumstances, and the estimated amount of expenditure required to be made, by the first person; and
- (d) the availability of financial and other assistance to the first person; and
- (e) possible advancements in medicine and assistive technology which would impact upon costs.

The burden of proving that something would impose unjustifiable hardship lies on the person claiming unjustifiable hardship. Section 52 provides an exemption from the requirements of the Act to the provisions of the *Migration Act 1958* and regulations, and to those things permitted or required to be done under those instruments. The *Disability Discrimination Act 1992* would not prohibit consideration of the costs associated with the grant of a visa to a person with a disability. However, this issue cannot be determinative and other considerations should be considered, for example:²²

- (i) the contribution of people with disabilities to social and economic life;
- (ii) the contribution of people with disabilities to cultural diversity and social cohesion;
- (iii) the contribution of individuals towards meeting the costs associated with their disability;
- (iv) decreased costs associated with disability as barriers to participation in social and economic life are removed (in accordance with Australia's obligations under the CRPD); and
- (v) advancements in medicine which would impact upon cost.

The United Nations Committee on Economic, Social and Cultural rights has reviewed Australia's compliance with the *International Covenant on Economic, Social and Cultural Rights* and commented on the issue of disability and migration, stating:²³

The Committee regrets that insufficient measures have been taken by the State party to ensure an adequate standard of living for persons with disabilities. In particular, it notes with concern that section 52 of the Disability Discrimination Act 1992 exempts migration laws, regulations, policies and practices, from the effects of the Act, leading to negative immigration decisions based on disability or health conditions. The Committee expresses concern at the fact that this situation has had a particularly negative impact on the families of asylum seekers. (art.2.2 and 10 and 11)

The Committee encourages the State party to strengthen its efforts towards the adoption of concrete measures to enable persons with disabilities to fully enjoy the rights guaranteed by the Covenant. It recommends that the Migration Act 1958 and the Disability Discrimination Act 1992 be amended to ensure that the rights to equality and non-discrimination apply to all aspects of migration law, policy and practice.

7 Mitigating the harms associated with mandatory HIV testing

If Australia is to continue mandatory HIV testing of refugees and prospective migrants as part of the application process, the Government has a moral responsibility to people found to be HIV positive who are refused a visa. Australia must acknowledge the flow-on personal family and community effects of the policy to test for HIV.

Where there are no HIV treatment, care, support and counselling programs in place in the country concerned, Australia's international aid programs need to address

²² See: Human Rights Law Centre, *Disability, Migration and Human Rights, Submission to the Joint Standing Committee on Migration's Inquiry into Immigration Treatment of Disability*, October 2009. <http://www.hrlrc.org.au/files/Migration-and-Disability-HRLRC-Submission.pdf>

²³ Committee on Economic, Social and Cultural Rights, 42nd Session, Geneva, 4 to 22 May 2009 *Consideration of Reports Submitted by States Parties under Articles 16 and 17 of the Covenant, Concluding Observations of the Committee on Economic, Social and Cultural Rights – Australia (E/C.12/AUS/CO/4)*.

such unmet need in advising those countries regarding the development of best practice clinical and community-based health programs.

Australia is in no position to chest-beat regarding the need to recognise, respect and protect the human rights of people living with HIV in those countries, when our migration policies effectively discriminate against people from those countries who are diagnosed with HIV in the course of applying to migrate to Australia.

8 The need for targeted settlement programs

Researchers have identified a number of common stressors for people with HIV from culturally and linguistically diverse (CALD) communities.²⁴ These may include:

- the need to simultaneously deal with an HIV diagnosis and the rejection of the claim for permanent residence, and then await a waiver decision;
- limited access to treatment, Medicare, Social Security income support, and care services, depending on the visa sub-class;
- delayed diagnosis of HIV, which can result in poor health prospects due to reduced benefits from treatment. Between 1998 and 2007, between 60% and 80% of people from Africa, the Middle East, Asia, South America and Europe (excluding UK) who were diagnosed with AIDS had a late HIV diagnosis, compared to around 40% of Australian born diagnoses;²⁵
- additional barriers to accessing health care services for HIV positive women from some CALD communities, due to power relationships within the family, e.g., a controlling husband refusing to allow engagement with services;
- HIV-positive people with limited English experiencing difficulty negotiating various health and support services; and
- due to the stigma associated with HIV in their country of origin, people with HIV from some CALD communities can fear that their community will discriminate against them. This means that a person with HIV may not trust service providers or interpreters from their community.

All of these issues are relevant to people with HIV who were born in high HIV prevalence countries. Since systematic collection of data about country of birth of people living with HIV in Australia began in 2002, the highest estimated incidence of HIV²⁶ has consistently been among people from sub-Saharan Africa.²⁷ These issues are also typical of the kinds of difficulties people from high prevalence countries face in other western countries.^{28 29 30}

²⁴ H. Korner, M. Petrohilos, D. Madeddu, 'Monograph 4: Living with HIV and Cultural Diversity in Sydney' (2005) National Centre in HIV Social Research (NCHSR); Annual Surveillance Report 2008 National Centre for HIV Epidemiology and Clinical Research (NHECR) figure 45, p.30.

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

²⁶ The number of diagnoses per 100,000 of the population group, in terms of region of birth.

²⁷ Annual Surveillance Report 2009, NCHSR, Table 1.1.5, p.37

²⁸ M. Duckett, 'Migrants right to Health' (2001) UNAIDS; and see African Black Diaspora Global Network, *Universal Access to HIV treatment, prevention and care for migrant/mobile populations including Black and other ethnic minorities*: June 2011, UN High-Level Meeting on Comprehensive Review on HIV/AIDS, available at: http://www.abdgn.org/files/UA_position-final-ABDGN-Apr16-2011.pdf.

²⁹ Avert, 'HIV and AIDS amongst Africans in the UK' accessed 21 October 2009 <<http://www.avert.org/aids-africans-uk.htm>>

³⁰ A. Prost, J. Elford, J. Imrie, et. al. 'Social, Behavioural, and Intervention Research among People of sub-Saharan African Origin Living with HIV in the UK and Europe: Literature Review and Recommendations for Intervention' (2008) 12 (2) AIDS Behaviour pp. 170 – 194

The importance of developing appropriate, well-targeted settlement and ongoing community services for new migrants and refugees with HIV is recognised under Australia's *Sixth National HIV/AIDS Strategy*. Community health services need to be better resourced so as to provide effective ethno-specific HIV counselling, treatment and education targeted to CALD community needs, having regard to the complex treatment, interpersonal and disclosure issues for a person recently diagnosed with HIV settling in a new country.

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

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

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

The Immigration Advice and Rights Centre's submission to the Inquiry into the Migration Treatment of Disability noted that many clients are bewildered by the immigration process. When attending for health checks, many have no knowledge that they are going to be tested for HIV and they complete the process having no idea that their blood is to be tested for HIV. The psychological effect of a positive result in this situation is inevitably devastating and as acknowledged by the UNHCR, the flow-on effects can be tragic.

9 Developments in comparable countries

United Kingdom

The United Kingdom does not impose mandatory HIV testing for those entering the country as visitors or immigrants, nor does it require a declaration of HIV status. In rare circumstances, an individual's conditions of employment may require testing, for instance, where a healthcare worker is moving to the UK to work for the National Health Service, they may be asked to test for HIV if the job role carries a high risk of exposure. Those who seek asylum are routinely offered a voluntary health

³¹ This discrepancy is alluded to in the discussion of the study carried out by NCHSR/MHAHS - "CALD Periodic Survey" available at http://nchsr.arts.unsw.edu.au/media/File/1_CALDperiodicsurvey.pdf

assessment.³²

European Union

The European Union has removed discretion on the basis of disability from its migration law in keeping with the EU's *Charter of Fundamental Rights*. The Charter precludes all discrimination against people with a disability. For example, Germany does not treat people with a disability differently to other visa applicants and has abolished the health assessment as part of the visa procedure altogether.³³

New Zealand

New Zealand's *Immigration Act (2009)* does not include health criteria for entry but provides for screening for threat or risk to security, public order or public interest.³⁴

Canada

People seeking to enter Canada as refugees are required to have a medical examination, including an HIV test, but HIV status is not a barrier to entering Canada. Refugees are exempt from the 'excessive demands' provisions of the *Immigration and Refugee Protection Act*. The only consideration is whether there is any danger to public health or safety. Since 1991, it has been Canadian government policy that people living with HIV do not represent a danger to public health or safety due to their HIV status.

For other visa categories, Canada generally only excludes people living with HIV if they can be expected to place an "excessive demand" on publicly funded health and social services. This compares to Australia imposes a lower threshold of 'significant cost' to Australia, or prejudice to the access of an Australian to health services. Exclusion is permitted only where a disabled person's needs impose 'excessive' demands rather than merely 'significant' costs (which may not amount to an 'excessive' demand). The Canadian health test is accordingly more likely theoretically to satisfy the CRDP requirement of an objective and reasonable justification for interference with equal protection, which provides the means for balancing the competing interests of non-discrimination against people with disability and the preservation of health resources.³⁵

United States of America

Until January 2010, the United States *Immigration and Nationality Act* stated that any foreign national with a "communicable disease of public health significance" was inadmissible.³⁶ Since 2010, mandatory testing for HIV has not been required, and people living with HIV are allowed to migrate if they meet all other conditions of admissibility.³⁷ An economic model was developed by the US Government to calculate the impact of the change in policy on health care costs.³⁸ The rationale

³² KWP Factsheet 2: HIV and Immigration 2010. <http://kwp.org.uk/files/kwp-briefing2.pdf>

³³ Joint Select Committee on Migration (2010) *op. cit.* p.40.

³⁴ Joint Select Committee on Migration (2010) *op. cit.* p.40.

³⁵ See: Dr Ben Saul, Centre for International Law *op. cit.* However, advocates argue that assessments are not transparent and thus it is difficult to establish to what extent the Canadian health test actually satisfies the CPRD requirement. They also raise the issue of using outdated reference tools for assessment. See: Coyte, P., Thavorn, K, 'When Does an Immigrant with HIV Represent an Excessive Demand on Canadian Health or Social Services?' *Aporia* Volume 2, Issue 3, pages 6-17, 2010

³⁶ Immigration Equality, 'HIV Ban: the End Is in Sight' accessed 21 October 2009

<<http://immigrationequality.org/template.php?pageid=5>>.

³⁷ US CDC, *Revision of 42 CFR Part 34 (Medical Examination of Aliens) Removal of Human Immunodeficiency Virus (HIV) from Definition of Communicable Disease of Public Health Significance – Final Rule*, 2010.

³⁸ US CDC, HIV Economic Model: <http://www.cdc.gov/immigrantrefugeehealth/laws-regs/hiv-ban-removal/hivecon-model.html>.

behind the U.S. reforms was that while HIV remains a serious health condition, maintaining HIV on the list of communicable diseases is no longer valid based on scientific knowledge and public health best practice. The reforms were also presented as a means of reducing the stigma and discrimination associated with HIV. It was acknowledged that exclusion did not provide a significant public health benefit and was at odds with human rights considerations.³⁹

10 Recommendations

Continuing to apply the Health Requirement in respect of disabilities (other than infectious diseases that pose a demonstrable threat to the public) is inconsistent with Australia's commitments under the CRPD. A case may be made for retention of the Health Requirement for infectious diseases that pose a threat to the public. However, HIV should not be considered an infectious disease for these purposes.

AFAO acknowledges that costs would flow from exempting disabilities from the Health Requirement, but this would be partly balanced by administrative savings. Most importantly, although abolishing the Health Requirement for disabilities would predictably result in more people with HIV being accepted for permanent residence, the number would in all likelihood be very small.

In 2007-2008 the number of permanent visa holders taking up residence in Australia was 205,940 and a total of 1,532 temporary and permanent visa applicants were refused a visa on health grounds. Of these 1,532 refusals, only 244 were on the grounds of applicants failing the Health Requirement on cost/prejudice grounds, and of these 244 refusals, only 71 were on the grounds of some form of disability.⁴⁰

AFAO agrees with the National Ethnic Disability Alliance that the reform of Australian migration law must form part of the Government's implementation plan for the CRPD.⁴¹ There would be financial outlays flowing from such reform, but these must be balanced against the potential financial and social contribution that would be made by the relatively small number of people with disabilities who would otherwise be refused residence or entry.

- (i) AFAO recommends that the Health Requirement in respect of disabilities be withdrawn.
- (ii) AFAO recommends that the exemption of the *Migration Act* from the *Disability Discrimination Act 1992* be repealed.
- (iii) AFAO recommends that Australia's Interpretive Declaration in respect of the *UN Convention on the Rights of persons with Disabilities* be withdrawn.
- (iv) AFAO recommends that mandatory testing for HIV should cease as it undermines the domestic and international HIV response, and is out of kilter with policies in place in comparable countries.
- (v) AFAO recommends that people living with HIV on temporary visas who apply for permanent status be eligible for Medicare, the Pharmaceutical Benefits

³⁹ US Department of Health and Human Services Federal Register Vol. 74, No. 126 /Thursday, July 2, 2009 / Proposed Rules, <<http://edocket.access.gpo.gov/2009/pdf/E9-15814.pdf>>

⁴⁰ Department of Immigration and Citizenship, 'Immigration Update: 2007-2008', p.8.

⁴¹ *Refugees and Migrants with Disability and the United Nations Convention on the Rights of Person with Disabilities*, National Ethnic Disability Alliance, Harris Park NSW, July 2008, p.7-8.

Scheme and Social Security income support while they await the determination of their substantive claim.

Pending institution of the above reforms, AFAO proposes that there is an urgent need for:

- a. the removal of the 'one fails, all fail' policy, whereby if one member of a family fails the Health Requirement other members of the family also fail;
- b. specified classes of person to be made exempt from the Health Requirement (e.g., partners, carers, natural or adoptive children of Australian citizens or residents).

AFAO believes that there is a pressing need for reform of migration laws affecting humanitarian and refugee applicants with disability. AFAO recommends:

- c. that refugee and offshore humanitarian visa applications be made exempt from the operation of the Health Requirement. The Health Requirement should not apply to such applicants, whether their claim is made off-shore or on-shore, and no regard should be had to disability or chronic illness in the determination of claims for protection;
- d. that in the alternative, waiver of the Health Requirement be made available to all offshore applicants and that a prima facie presumption in favour of the granting of waivers be instituted; and
- e. That mandatory HIV testing be discontinued as an element of medical screening of refugees prior to resettlement. HIV testing should be voluntary and offered to refugees from high HIV prevalence communities after their arrival in Australia, and any person granted permanent protection who is HIV positive should be referred to culturally appropriate treatment, care, support and counselling services.