REVIEW AND RECOMMENDATIONS FOR REFORM OF AUSTRALIAN LAWS AND POLICIES RELATING TO ENTRY, STAY AND RESIDENCE FOR PEOPLE LIVING WITH HIV

July 2014

REVIEW AND RECOMMENDATIONS FOR REFORM OF AUSTRALIAN LAWS AND POLICIES RELATING TO ENTRY, STAY AND RESIDENCE FOR PEOPLE LIVING WITH HIV

Prepared by Alexandra Stratigos, Mary Crock, Indraveer Chatterjee and Ron McCallum AO[1]

With the assistance of John De Wit, David Fowler, Hannah Martin, Raunak Vallabhji and Melissa Woodroffe[2]

This paper was commissioned by the Joint United Nations Programme on HIV/AIDS (UNAIDS) in the context of global efforts to support the elimination of HIV-related restrictions on entry, stay and residence. The views expressed in this paper are those of the authors and do not necessarily reflect the views, opinions and policies of the UNAIDS Secretariat or its co-sponsoring organizations. UNAIDS does not warrant that the information published in this publication is complete and correct and shall not be liable for any damages incurred as a result of its use.

Executive Summary

This report was commissioned to review and analyse Australia's migration framework and how it affects people living with HIV and their opportunities for entry, stay and residence.

The authors outline the health requirements in Australian migration law (the *Migration Act 1958* and *Migration Regulations 1994*) and policy (the Procedure Advice Manual – PAM3). They evaluate Australia's compliance with obligations assumed in becoming party to the major international human rights instruments, including the *Convention on the Rights of Persons with Disabilities* (CRPD), and the *International Covenant on Civil and Political Rights* (ICCPR). Australia's laws and policies are also assessed against the findings and recommendations of the International Task Team on HIV-related Travel Restrictions ('Task Team').

Australia's current migration legislation and policies are assessed in three parts:

I. the legislative power of migration officials to deal with matters of health;
II. the circumstances in which an applicant or an applicant's family members will be required to undergo an HIV test; and
III. the impact of an HIV positive test on visa applications.

Where a visa applicant has a chronic health condition, Australian law requires that an assessment be made as to whether the applicant will be a significant cost to the Australia community in terms of health care and community services. Policy and practice suggests that all applicants for permanent visas living with HIV will be considered to represent a significant cost. Most applicants with HIV seeking longer stay, or applicants who have dependant family members with HIV, will fail the health-

[1] Alexandra Stratigos is a solicitor at the HIV/ AIDS Legal Centre Inc (Sydney) (HALC); Mary Crock is Professor of Public Law, University of Sydney and Accredited Specialist in Immigration Law; Indraveer Chatterjee is Principal Solicitor, HALC; and Ron McCallum AO is Professor Emeritus, University of Sydney and Vice-Chair of the UN Committee on the Rights of Persons with Disabilities.

[2] Professor John De Wit is Director of the National Centre in HIV Social Research at University of New South Wales; David Fowler is Board member Australasian Society of HIV Medicine and Secretary and Director AusAID's HIV Regional Capacity Building Program; Hannah Martin is Research Associate, University of Sydney and Solicitor, Ashursts (Sydney); Melissa Woodroffe is a solicitor and Raunak Vallabhji is a volunteer, both at HALC.

related cost criteria and their visa will be refused. A 'health waiver' is available for a limited number of close family, humanitarian and business visas. Applicants must show compelling and compassionate reasons and that the costs associated with them are not 'undue'. Waiver is discretionary. Temporary visa applicants may face a visa refusal because of costs associated with healthcare.

The report notes that recent changes to immigration policies and practices in Australia have generally improved the process from the perspective of people with chronic health conditions, including people living with HIV. Notably, the increase in the significant cost threshold has resulted in greater temporary visa opportunities. The change means that the majority of HIV-positive applicants will now qualify for a visa of at least 2 years, and in some cases even longer. However, there is still considerable scope for improvement. The report details the detrimental impact of immigration policies and procedures on individuals, using 'on the ground' data and practical examples provided by the HIV/AIDS Legal Centre. The case studies demonstrate that in addition to the risk of a visa refusal, HIV positive applicants face a variety of other challenges. These include additional costs, lengthy processing times and breaches of privacy. The case studies also highlight the detrimental impact to the wider Australian community where HIV positive migrants are not permitted to enter or remain in Australia.

Though the report concludes that Australia complies with the core recommendations of the International Task Team on HIV-related Travel Restrictions, in that HIV is not singled out and people living with HIV are assessed against criteria applying to anyone with a chronic health condition, these recommendations are viewed as a "low threshold" and not reflective of the evolution in international norms and standards related to disability. The authors argue that Australia's migration framework discriminates against persons with disabilities and must be reformed. The discriminatory treatment of migrants with disabilities – including migrants living with HIV – is provided for in the caveats created both under Australia's domestic legislation and in relation to international law. The *Disability Discrimination Act 1992* (Australia) (DDA) exempts decisions made under migration law and policy from full compliance with that Act. Australia has also lodged an interpretative declaration with respect to Article 18 of the CRPD, which addresses liberty of movement. Both of these caveats allow for the government and decision makers to engage in discriminatory treatment of migrants with disabilities.

The report also examines changes that have been proposed to Australia's migration law and policy. These include an expansion in the circumstances in which migrants with HIV could obtain a health waiver and the adoption of a health waiver process that provides more certainty for applicants. While such changes would benefit people with disabilities and chronic health conditions, including people living with HIV, the report finds that Australia would continue to fall short of meeting its international obligations. The authors argue that there is no real justification or need for either the interpretative declaration of the CRPD or the exemption under the DDA.

This report compares and contrasts Australia's migration framework, and its approach to applicants living with HIV, with a series of other states, notably Canada, New Zealand, the United States and countries in the European Union. While Canada and New Zealand overall have similar approaches to Australia, there are some small but significant differences. The authors note that HIV is no longer a barrier to entry, stay or residence in the United States. They further note that EU countries with comparable or better publicly-funded health care (relative to Australia) place no restrictions on the admission of non-citizens with HIV despite the potential cost to the public purse.

For Australia to comply fully with its international obligations, the authors recommend removal of the health criteria with respect to migrants with HIV and comparable conditions; and withdrawal of

the interpretative declaration to Article 18 of the CRPD. Based on past responses to calls for reform in this area, the authors are not confident that a complete removal of the health-related cost criteria with respect to migrants is achievable in the near term. In part this is because such a decision would be politically unpopular, exposing a government to criticisms about cost implications and 'scarcity of public healthcare facilities'.

To build political support and foster greater transparency, the authors recommend that the Government of Australia undertake a cost-benefit analysis of its migration program with the cost of healthcare as the focus, taking into account the overall economic and other benefits associated with migration to Australia. Based on this review, steps should be taken to substantially narrow the health criteria (i.e. focus exclusively on highly contagious conditions threatening public health).

The following recommendations are made for reform to Australian law and policy so as to encourage better alignment with international law and international policy on travel by migrants with HIV:

Recommendation 1: The principles and protections under the *Disability Discrimination Act,* and the *Convention on the Rights of Persons with Disabilities*, must be applicable to Australia's migration laws, policies and processes;

Recommendation 2: Positive reforms that have been made at a policy level should be given the force of law;

Recommendation 3: Eligibility for waiver of the significant cost threshold in relation to health should be expanded to all visa applicants, regardless of the class of visa;

Recommendation 4: A more contemporary and individualised health assessment for visa applicants, and consideration of their social and economic benefits to Australia, should be put in place to reduce barriers faced by people living with HIV and other health conditions;

Recommendation 5: Mandatory HIV testing of temporary, humanitarian and family formation visa applicants, as well as non-migrating dependants, should be removed immediately as it is unnecessary and wasteful, violates human rights norms, does not contribute to good health outcomes, and adds red tape to the visa application process;

Recommendation 6: Procedures for applying the significant cost test should be revised so that all applicants are assessed based on a five-year period, rather than having some applicants – including people living with HIV – subject to assessment for 'lifelong costs';

Recommendation 7: The 'undue cost burden' associated with applicants who fail the health requirement should be put in the broader context of migration's overall economic and social benefits for Australia;

Recommendation 8: Consideration should be given to removing all migration restrictions based on an applicant's disability or health status (barring those conditions that are medically assessed to be a threat to public health). The current health undertaking should be replaced with a new undertaking that requires a person to submit to an 'overall health assessment' after entry, the result of which is confidential and not shared with the Department of Immigration, but is used by state and local health authorities to ensure that the persons receive appropriate treatment and has access to services.

Contents

This paper was commissioned by the Joint United Nations Programme on HIV/AIDS (UNAIDS) in the context of global efforts to support the elimination of HIV-related restrictions on entry, stay and residence. The views expressed in this paper are those of the authors and do not necessarily reflect the views, opinions and policies of the UNAIDS Secretariat or its co-sponsoring organizations. UNAIDS does not warrant that the information published in this publication is complete and correct and shall not be liable for any damages incurred as a result of its use.

I. Introduction

It is a common feature of immigration laws across the world that states reserve the right to exclude or expel non-citizens who pose a threat to the public health. Indeed, quarantine regulations represent some of the oldest forms of immigration controls. Although Australia is not unique in regulating the entry of persons with health conditions, including people living with HIV, Australian laws and policies governing the treatment of so-called 'health concern non-citizens' stand out for their stringency. The Australian Government justifies the restrictions that prevent the entry, stay and residence of some persons living with HIV on the grounds that they are necessary to protect the public purse and to ensure that medical and community services are not overstretched.

This report examines current and proposed Australian health criteria in relation to entry, stay and residence and considers how they apply to people living with HIV. It will illustrate how the 'health rules' in immigration have not kept pace with medical advances that have reduced the impact of and risks associated with HIV as a condition. As a result, it appears that an unnecessarily burdensome framework is being applied to non-citizens living with HIV who may wish to enter or remain in the country. Not only are restrictive approaches unnecessary from the perspective of the public health and the public purse, the health criteria in their current form are also inconsistent with Australia's international obligations, found in a range of human rights instruments, particularly the United Nations Convention on the Rights of Persons with Disabilities (CRPD).

This report begins by considering the position of international law on entry, stay and residence of persons with HIV, giving closest consideration to the most recent of the international human rights treaties, the CRPD. The CRPD applies equally to persons with HIV as it does to persons with any other disability, and it represents a revolution in the way that international law requires disability to be conceptualised and accommodated.

This report then reviews the current laws, regulations and policies in Australia in which HIV status features as a factor in determining entry, stay, residence and work. The health criteria for visa applicants are set out in the *Migration Act 1958 (Cth)* (the Act) and the *Migration Regulations 1994 (Cth)* ('the Regulations'). The Act and Regulations are supplemented by Ministerial Directions and by a policy manual, the Procedures Advice Manual 3 (PAM3). Unless there is good reason to do otherwise, decision makers are expected to follow PAM3. As explained below, in many instances decision makers both at primary level and review stage are required to accept as correct the health assessments made in respect of visa applicants. It should be noted that this report has been written without the benefit of full statistical information from the Department of Immigration and Border Protection (DIBP). Where statistics are on the public record, this report includes analysis of those statistics. However, further statistical information would enable a clearer picture of how the health criteria operate in practice. Statistical information sourced from the casework of the HIV/AIDS Legal Centre is set out in Annex 1.

The health rules contained in the Act and the Regulations were amended in 1989 and 1999 and have been most recently been altered in a series of changes in 2011. Further changes to the health rules, including the adoption of a 'Net Benefit Approach', have been proposed. Part XI of this report compares these proposed changes with international standards and criteria on the elimination of restrictions against persons living with HIV.

In light of Australia's international obligations and the findings and recommendations of the International Task Team on HIV-related Travel Restrictions (established in 2008), this report provides recommendations on how Australia's migration framework could be revised to better meet Australia's international obligations. It also suggests measures for streamlining the immigration

health assessment process in ways that advance national interests (e.g. reduced transaction costs) and increase opportunity and transparency for applicants. Part IX of this report deals specifically with how the Task Team recommendations apply to Australia, and Part XII makes a series of specific recommendations for amendments and modifications to Australian laws and policies.

II. International law and the human rights framework

A. Australia's international human rights obligations

In contrast to comparator countries including the Canada, New Zealand and the United Kingdom, Australia has neither a regional nor a domestic bill of rights. Australia is, however, a party to all the major international human rights treaties, many of which contain provisions relevant to the rights of persons living with HIV.

Perhaps the most fundamental right to which persons living with HIV are entitled under international law is the right to non-discrimination on the grounds of HIV status. In its General Comment on the right to non-discrimination under Article 18 of the International Covenant on Civil and Political Rights (ICCPR)[1], the United Nations Human Rights Committee did not specifically mention HIV status, but made it clear that the list of grounds in article 18 ('race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth') is not exhaustive. The prohibition on discrimination based on 'other status' certainly prohibits any form of discrimination based on HIV status which has the effect of 'nullifying or impairing the recognition, enjoyment or exercise by all persons, on an equal footing, of all rights and freedoms.'[2] Each of the other human rights treaties contains a similar anti-discrimination provision that, in effect, prohibits states parties from denying to a person any of the rights in that treaty based on their HIV status.[3] The Committee on Economic, Social and Cultural Rights has noted that states must not use 'health status', specifically including HIV status, as a barrier to realizing the human rights of the International Convention on Economic, Social and Cultural Rights (ICESCR).[4] The imperative to eliminate HIV-related discrimination is also a central tenet of the *Political Declaration on HIV/AIDS* which was endorsed by all Member States at the June 2011 High Level Meeting of the United Nations General Assembly.[5] It should be noted that the 2011 *Political Declaration* furthermore encourages Member States to "consider identifying and reviewing any remaining HIV-related restrictions on entry, stay and residence in order to eliminate them".[6]

As well as a general protection against discrimination, international law creates specific rights and obligations which must also guide national immigration control. The ICCPR, the ICESCR[7] and the Convention on the Rights of the Child (CRC)[8] all give persons, including persons living with HIV, rights to protection of their family life. The equivalent European Convention on Human Rights, which does not apply in Australia but is similar to other international protections of family life, has been interpreted in a way that privileges the right to family life over the state's right to control entry and stay of non-citizens.[9]

B. The health criteria and the UN Convention on the Rights of Persons with Disabilities

As a party to the United Nations Convention on the Rights of Persons with Disabilities (CRPD),[10] Australia has undertaken to abide by the terms of the Convention and to amend its laws and policies accordingly. HIV and AIDS constitute disabilities within the meaning of the CRPD because they are chronic conditions that invoke discriminatory responses.[11] Article 1 of the Convention states that

persons with disabilities include those who have long-term physical …impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

The significance of the CRPD definition of disability is that it abandons the old 'medical' approach to disability that relies heavily on the categorisation of persons according their impairment. The CRPD in contrast recognises that it is not only a person's impairment that creates disability. It is also the way they are treated within a society – most particularly the extent to which reasonable accommodations are made for any impairment. Interestingly, Australia's Federal Court has confirmed that disabilities for the purposes of Australia's immigration health rules should be assessed in a way that does more than simply label a person as having a disease or condition. The ruling in *Robinson v Minister for Immigration and Multicultural and Indigenous Affairs*[12] forces the adoption of a 'functionality' approach to the assessment of disability insofar as each applicant must be assessed according to their specific impairments and/or disease or difficulty.[13] In practice this means that any assessment of an HIV positive applicant must involve consideration of the person's age; CD4 count; viral load; the treatments (if any) the persons is receiving; and whether the person has ever had an AIDS defining illness.

Australia did not make any reservations to the CRPD. It did, however, lodge an 'interpretative declaration' with respect to Article 18 of the Convention. This is the provision most relevant to immigration. Article 18(1) reads:

1. *States Parties shall recognize the rights of persons with disabilities to liberty of movement, to freedom to choose their residence and to a nationality, on an equal basis with others, including by ensuring that persons with disabilities:*
    - *Have the right to acquire and change a nationality and are not deprived of their nationality arbitrarily or on the basis of disability;*
    - *Are not deprived, on the basis of disability, of their ability to obtain, possess and utilize documentation of their nationality or other documentation of identification, or to utilize relevant processes such as immigration proceedings, that may be needed to facilitate exercise of the right to liberty of movement;*
    - *Are free to leave any country, including their own;*
    - *Are not deprived, arbitrarily or on the basis of disability, of the right to enter their own country.*

Australia's Interpretative Declaration states that:

Australia recognises the rights of persons with disability to liberty of movement, to freedom to choose their residence and to nationality, on an equal basis with others. Australia further declares its understanding that the Convention does not create a right for a person to enter or remain in a country of which he or she is not a national, nor impact on Australia's health requirements for non-nationals seeking to enter or remain in Australia, where these requirements are based on legitimate, objective and reasonable criteria.

The caveat was considered necessary due to the discriminatory nature of migration policy and procedure with respect to people with disabilities. The Department of Immigration and Border Protection (the Department) has sought to justify its discriminatory health policies and practices on the basis that they apply the same criteria to everyone and they are not concerned with the disability itself but with the impact upon the Australian community. However, this rationale does not change the fact that the health criteria predominantly affect applicants with disabilities and applicants who have family members with disabilities, resulting in either visa refusal or the imposition of visa conditions that differ from those imposed on other applicants.

The CRPD also requires Australia to prohibit discrimination on the grounds of disability. Australia's domestic laws recognise that people living with HIV or AIDS have a disability. Section 4 of the *Disability Discrimination Act 1992* states that: ***'disability'**, in relation to a person, means: …*

> *(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;*[14]

This means that unless a lawful exemption exists, it is unlawful to treat a person differently or harass a person on the basis of their HIV status in such areas as the provision of goods and services, employment, sport, and education. The prohibition on discrimination is common to both state and federal laws. People with disabilities who experience discrimination have a right to take action against the perpetrator. They may receive financial or other compensation for loss or damage. There are only a limited number of exemptions that identify when it is considered lawful to discriminate against a person with a disability. One such relates to the entry, stay and residence of non-citizens. The *Disability Discrimination Act*[15] (the DDA) contains a specific provision exempting the migration legislation from its operation. The exemption means that decisions made by the Minister and delegates under the *Migration Act* or the *Migration Regulations* are considered exempted from action under the DDA. It can be argued that the existence of such an exemption is acknowledgement from the Federal Government that current laws and practices amount to discrimination against people with disabilities.

The Committee on the Rights of Persons with Disabilities (CRPD Committee), the body of independent experts which monitors implementation of the Convention by the States Parties, has called for the removal of Australia's interpretative declaration. In its Concluding Observations on Australia made at the 10th session of the CRPD Committee held in September 2013, the Committee stated (at paragraphs 8 and 9 of the Concluding Observations):[16]

> The Committee is concerned that despite the adoption of the National Disability Strategy, the State Party has not to the full extent enacted legislation that corresponds to the contents of the Convention. It is further concerned about the existence of interpretive declarations to articles 12, 17 and 18 of the Convention.
> The Committee recommends the state party to incorporate all rights under the Convention into domestic law and to review the interpretive declarations on art.12, 17 and 18 in order to withdraw them.

The current political and social context in Australia makes it unlikely that law and policy will be amended sufficiently so as to allow for removal of the interpretative declaration in the near future. However, it is seen as feasible to make changes that would bring Australia more within the spirit of the CRPD.

III. Application of the health criteria to persons living with HIV

The most significant aspects of Australia's health rules are set out in Schedule 4 of the Migration Regulations.[17] This schedule contains what are referred to as the 'Public Interest Criteria' (PIC) that must be met by every applicant for an Australian visa. These (and other schedules) are divided into paragraphs that are referenced by a four-digit number. These numbers are used as a short-cut reference to the criteria contained in the various PICs in the various visa subclasses contained in Schedule 2 of the Regulations. There are three main Health PICs that apply to almost all visa subclasses. Exceptions apply for Onshore Protection visas and some subsets of Medical Treatment Visas (MTV). Onshore protection visas require applicants to undergo a medical assessment, however they will not face any detriment if they test HIV positive.[18]

PIC 4005 - the first and most common test - applies to almost all temporary and most permanent visa subclasses and is known as the 'non-waivable' health test. As explained in Part V below, concessions are made for certain family members, business migrants and temporary workers under PIC 4007 and 4006A with provisions that allow the Minister to waive the requirements of the health rules, in essence where the applicant will not pose an undue burden on the Australian community and or where an employer provides an undertaking that they will meet any costs which arise.

The common feature of the tests is that the applicant must be:

> *(a) …free from tuberculosis; and*
>
> *(b) …free from a disease or condition that is, or may result in the applicant being, a threat to public health in Australia or a danger to the Australian community[19]; and*
>
> *(c) free from a disease or condition in relation to which:*
>
> > *(i) a person who has it would be likely to:*
> >
> > > *(A) require health care or community services; or*
> > >
> > > *(B) meet the medical criteria for the provision of a community service;*
> >
> > *during the period described in subclause (2); and*
> >
> > *(ii) the provision of the health care or community services would be likely to:*
> >
> > > *(A) result in a **significant cost**[20] to the Australian community in the areas of health care and community services;[21] or*
> > >
> > > *(B) **prejudice the access** of an Australian citizen or permanent resident to health care or community services[22];*
> >
> > *regardless of whether the health care or community services will actually be used in connection with the applicant.*
>
> *(d) if the applicant is a person from whom a Medical Officer of the Commonwealth has requested a signed undertaking to present himself or herself to a health authority in the State or Territory of intended residence in Australia for a follow-up medical assessment — has provided the undertaking.*

The PAM3 correctly states that HIV/AIDS is not a risk to public health in relation to the movement of people across borders.[23] However, sub-paragraph (c) of the PICs operates to use the putative cost of treating HIV/AIDS as a ground for excluding visa applicants. The statistics provided by the Department of Immigration indicate that in the 2011-12 financial year, 164 visas were refused on the basis of an applicant's failure to meet the health requirement in relation to cost or prejudice to access. This included 20 HIV-positive applicants. In the same year, 4,442,694 visas were granted. Though the statistics suggest that very few people living with HIV are screened out in the immigration health assessment process, they do not reveal the extent to which Australia's health rules may discourage people living with HIV from applying for a visa to enter and stay in the country. Overall, however, one may conclude that a negligible number of persons present each year as 'health concern non-citizens' relative to the overall benefit that more than 4 million migrants bring to the Australian community.

IV. When HIV testing is required

Section 60 of the Act provides that where the health of an applicant is relevant to the grant of the visa, the Minister may require the applicant to undergo a medical examination as a precondition to the grant of certain subclasses of visa. It states:

> *(1) If the health or physical or mental condition of an applicant for a visa is relevant to the grant of a visa, the Minister may require the applicant to visit, and be examined by, a specified person, being a person qualified to determine the applicant's health, physical condition or mental condition, at a specified reasonable time and specified reasonable place.*

(2) An applicant must make every reasonable effort to be available for, and attend, an examination.[24]

Because every visa class specifies one of the health criteria as a PIC, Section 60 will always be activated and therefore a person can always be required to submit to a health examination. For all permanent visas and many temporary visas this assessment includes an HIV test. For permanent visas, non-migrating dependants ('NMD') (including dependent children and partners) also have to undergo an HIV test.

Section 65 of the Act states that if the health criteria have not been met the Minister is to refuse to grant a visa.[25] Failure to undergo a medical examination when requested to do so would mean that the Minister could not be satisfied that the applicant meets the health criteria and will result in a visa refusal. Under s.496 the Minister does not need to act personally but can delegate this power to any other person (a 'delegate').[26] As explained below, the scheme also imposes duties on applicants to provide information on their health status in the course of applying for a visa. As a result, most HIV-positive applicants will have their status revealed if they follow the correct procedures.

If a delegate identifies that an applicant or NMD needs to undergo a medical examination or chest x-ray the applicant will have to so with a Panel Physician, if offshore, or Medibank Health Solutions, if onshore. There are very limited circumstances in which exceptions are granted and an applicant can provide alternate information from their treating doctor or attend a different doctor.[27] These exemptions exist only under policy and are therefore not an absolute right.

The type of medical examinations that an applicant or NMD is required to undertake are substantially determined by policy. Considerations as to the examinations required include:

- the visa subclass sought
- information provided by the applicant to the Department
- country of origin
- purpose of stay
- *adverse* information known to the Department about the applicant.

The 'Health Matrix'[28] comprises two documents[29] that identify the health checks required for applicants. Applicants will have to undergo an HIV test in the following circumstances:

1. permanent visa applicants 15 years and over; and
2. temporary visa applicants intending to work as, or study to be, a doctor, dentist, nurse or paramedic.

In practice, however, many more people already diagnosed as HIV positive are required to undergo HIV testing, including:

1. All applicants and NMD of permanent applicants known to the Department to be HIV positive, regardless of age;
2. All applicants and NMD of permanent applicants who the Department knows to have an HIV positive mother;
3. Permanent visa applicants under 15 years who have been adopted;
4. Temporary applicants staying more than 12 months from 'medium risk' or 'high risk' countries who know that they are HIV positive; and
5. Visitor visa applicants over 75 who know that they are HIV positive.

All temporary visa applications include a question about medical costs and treatment. The question on most application forms is:

During your proposed visit to Australia, do you expect to incur medical costs, or require treatment or medical follow up for:

- *Blood disorder;*
- *Cancer;*
- *Heart disease;*
- *Hepatitis B or C and/or liver disease;*
- *HIV Infection, including AIDS;*
- *Kidney disease, including dialysis;*
- *Mental illness;*
- *Pregnancy;*
- *Respiratory disease that has required hospital admission or oxygen therapy;*
- *Other?*

  No □

  Yes □ → *Give details*

Many HIV-positive applicants believe that they would have to answer in the affirmative to this question regardless of the period of stay, particularly if they are on antiretroviral medication (ARVs). The Department has indicated through informal guidance that where an HIV-positive person is visiting Australia for a short time (less than 3 months), most would reasonably be able to answer in the negative, as they would be travelling with their ARVs. However, once an applicant indicates that they are HIV positive then regardless of the type of visa or proposed duration of stay, the applicant will be required to undergo an HIV test.

Even if a known HIV-positive applicant is not specifically asked to undergo an HIV test, but is required to undergo a limited medical examination, the department will learn of their HIV status due to disclosure requirements. When a visa applicant is asked to undergo a medical examination, even if the case officer does not specifically identify that an HIV test is required, they will have to provide a detailed medical history. This includes, but is not limited to, answers to the following questions:

> *Have you ever been admitted to hospital and/or received medical treatment for an extended period for any reason (including for a major operation or treatment of a psychiatric illness)?*
>
> *Have you ever been told you are HIV positive? …*
>
> *Are you taking any prescribed pills or medication (excluding oral contraceptives, over-the counter medication and natural supplements)? If yes, please list these.*

As a result of this health declaration the delegate along with the Panel Doctor or Medibank Health Solutions will then become aware of a person's HIV-positive status and proceed to conduct an HIV test when the applicant attends their medical examination. PAM3 states that if the applicant's answer in a health declaration is the only reason for requesting a health examination, those:

> *additional health examinations may not be necessary in all circumstances. For example, if a minor health condition is declared and the applicant is intending to travel to Australia for a short period only. In some cases, additional health examinations (for example, an HIV test) may also be required if the applicant has certain serious conditions.*[30]

In PAM3, a case involving an HIV-positive person is deemed to be 'a complex case'. HIV is considered to be a 'serious condition'. Under policy, an applicant who identifies that they are HIV positive would not only have to undergo a medical examination but also a chest x-ray due to their TB risk rating, even if according to the matrix that would not normally be required. In this context, HIV is classified alongside applicants who have had cancer in the last 5 years, cystic fibrosis, or received an organ transplant.[31] HIV is treated similarly to other health conditions that an applicant discloses on an application form or health declaration. PAM3 itemises the medical examinations required where temporary visa applicants are known to have certain health conditions.[32] In the case of temporary visa applicants under 40 years of age who disclose that they have diabetes, the policy allows them to

provide a treating summary from their doctor. The case officer can then email the Global Health section and obtain advice on whether further examinations are necessary.[33]

The Australian approach is generally similar to that taken by Canada and New Zealand. In contrast, in most European countries, HIV tests are not required for entry or stay, but are often offered as a part of a 'suite' of services for new migrants. As noted, testing for HIV in Australia is mandatory for the migration process because applicants who refuse to be tested cannot obtain a permanent visa. This is in breach of international norms around HIV testing and at odds with the general position in Australian for HIV testing. Mandatory testing is otherwise only allowed in very specific situations. For further details on the differences in these policy approaches, please see below at Part XI.

Temporary Visa Applications for HIV-positive delegates to the International AIDS Conference 2014

A medical examination that includes an HIV test will only determine whether or not a person is HIV positive. If further assessment is necessary (for instance, to determine eligibility for the visa), the applicant will then have to provide further information from a treating specialist. Applicants who declare their HIV positive status on immigration forms are automatically directed to a Panel Physician. This results in unnecessary duplication of services, as the only medical information the applicant will receive from the migration medical is confirmation of their HIV positive status. It also results in unnecessary cost for applicants, as they are required to meet all costs of migration medical assessments, and may result in unnecessary disclosure of the applicant's HIV positive status, particularly for short-term visas where a person's HIV positive status is unlikely to have any bearing on their visa eligibility. The practice is likely to have negative impacts upon HIV-positive conference delegates at the International AIDS Conference in 2014 (Melbourne, 20-25 July).

Some advocates have noted that there is considerable discretion granted to officials in the health assessment process, and further highlighted the risk that conference attendance in itself could be perceived as grounds for more stringent health screening. The PAM3 indicates that:

> *Officers should be aware that although routine levels of evidentiary requirements are described in this instruction, these are the minimum health examinations required. They may, with good reason, request additional examination(s) for any visa applicant.*
> *The HAP allows officers to add additional health examinations provided a reason is given – see section 104 The Health Assessment Portal (HAP).*[34]

One potential reason an official could give for requesting additional health examinations would be that applicants entering for a special event may be perceived as being at higher risk of particular health issues.

> *18.2 Special events*
> *Case officers should seek advice from Health Policy Section regarding groups of people entering Australia for special events which may be higher risk in terms of health issues (for example, groups from countries of medium or higher risk in terms of tuberculosis, individuals with HIV, homeless people, individuals with a history of drug abuse). Health Policy will liaise with a Senior MOC as to whether additional health examinations are appropriate for a particular group.*[35]

Thus, applicants planning to attend the conference could be required to undergo HIV testing, notwithstanding that their HIV status is unlikely to have any impact on their visa eligibility. Further, applicants who disclose their HIV-positive status will be required to attend a panel physician and complete medicals, which could require significant travel, and the related time and cost, depending on the applicant's location.

V. The assessment process

If an applicant or NMD attends a medical examination and tests HIV positive, the Medical Officer of the Commonwealth (MOC) must then form an opinion as to whether or not the applicant meets the prescribed health criteria, taking into account the health PIC set out earlier. Section 65 of the Act requires that a delegate rely upon the medical opinion provided by the MOC.[36] If, according to the MOC, an applicant fails to meet the health criteria then the delegate must refuse the visa. For applicants for permanent visas, all migrating applicants and NMD are subject to the health criteria. If the primary applicant or a member of their family unit (whether or not they are migrating) fails the health criteria then the whole application will fail. This is known as the *one fails, all fail* rule.

There have been few occasions in which applicants in Australia have challenged visa refusals for failure to meet the health criteria. In *Minister for Immigration & Multicultural Affairs* v *Seligman*[37] the Full Federal Court determined that applicants could not challenge the accuracy of the costs estimate or the opinion provided by the MOC provided the assessment was made lawfully. Thus the MOC report is determinative and a Section 65 delegate must take the MOC opinion to be correct.[38]

The impact of the *Seligman* case is that applicants cannot proffer alternative cost calculations related to their health status. They can provide documents and information to the MOC. However, once the MOC forms an opinion it is of no utility to try to persuade the *delegate* that the cost calculations are incorrect. The delegate only has the power to make a determination on the basis of the MOC opinion.

A MOC opinion, presented by way of a Form 884, is valid provided that the costing:

- relates to the length of time the applicant proposes to be in Australia;
- cites the correct visa subclass;
- cites the information relied upon in forming the opinion; and
- if considering a refusal, was made within the previous 12 months.[39]

In *Applicant Y* v *Minister for Immigration and Citizenship*[40] the HIV-positive applicant successfully challenged the MOC costing on the basis that it was more than 12 months old. Given that the applicant was seeking a permanent partner visa she would still have failed the health criteria. In fact the court ruling meant that she was able to go on and obtain a health waiver (as described below).

As noted earlier, in making the assessment the MOC must take into consideration all relevant information about the applicant's medical condition. In *Robinson* v *Minister for Immigration and Multicultural and Indigenous Affairs*[41] the Court held that the MOC opinion must be formed on the basis of a hypothetical person with the same specific condition as the applicant.[42] The applicant is able to put forward any medical reports or other information demonstrating that they may meet the health criteria and the MOC must take that information into consideration.

PAM3 states that:

> *In Australia, HIV/AIDS is not regarded as a public health risk, unlike TB, and consequently, visa applicants with HIV/AIDS may still be granted a visa.*[43]

An HIV-positive person may be considered a potential risk to public health if they intend to work as, or study to become, a doctor, dentist, nurse or paramedic. In these circumstances the applicant is required to provide a letter from their employer that they will not engage in exposure prone procedures. The requirement that HIV positive people not perform exposure prone procedures is the same standard required of Australian nationals; however, the requirement that migrants provide indication of same from their employer prior to taking up employment does go beyond what is

required of Australian citizens.

The significant cost test

The biggest hurdle for applicants with HIV is the requirement in the health PICs that their disease or condition not pose the risk of 'significant cost' to the Australian community. Any cost estimate of more than $40,000 is deemed to be significant.

Significant costs for *temporary visas* will usually be based upon proposed period of stay.[44] Significant costs for permanent visas differ depending upon the medical condition. The significant costs for permanent visa applicants are calculated over a five year period, unless the applicant is:

- *is aged 75 or older. In this circumstance the applicant will be assessed for a three year period or*
- *has a condition that is permanent and the course of the disease is reasonably predictable beyond the five year period. In these circumstances, the applicant would be assessed for 'lifelong' costs. When assessing 'lifelong' costs, the MOC will include estimated costs over the applicant's remaining life expectancy*
- *has an inevitable or reasonably predictable (>65% likelihood) reduced life expectancy due to their health condition or disease. In this case, the applicant will be assessed on the reduced life expectancy*.[45]

In the case of applicants for temporary visas, there is a list of exclusions as to what will be 'costed' for the purpose of determining 'significant cost'. These exclusions are contained in Gazette Notice *IMMI 11/073*.[46] The cost of ARVs will always be included in the 'costing'. Cost is calculated on the assumption that the person will use public services, regardless of whether or not they are entitled to or will actually access those services.

For HIV-positive applicants for *permanent visas* the significant cost is based upon the person's life expectancy and projected costs over this period. HIV is considered to be a permanent condition and the course of the disease is deemed reasonably predictable.

The MOCs are not specialists in all areas of medicine. To make their determinations, they draw upon the 'Notes for Guidance for Medical Officers of the Commonwealth of Australia: Financial implications and consideration of prejudice to access for services' (Notes for Guidance) for the specific condition.[47] The Notes for Guidance do not take into account HIV-positive applicants who may be considered to be 'long-term non-progressors' or 'elite controllers' (i.e. will not develop AIDS or require HIV treatment), the likelihood that drug costs will reduce or advances in medicine. For many conditions, including HIV, they will also request specialist reports.

The legislative framework and the assessment process places the MOC in the role of independent arbiter, limiting potential legal disputes over medical costs estimates. An applicant cannot make arguments to the Department that they can pay for their medication or have sufficient private health insurance and will therefore not be a 'significant cost'. Anecdotally, temporary visas applicants on drug trial programs, or who can demonstrate that they possess treatment for the duration of stay, and thus are able to prove that no costs will arise, can avoid being estimated as being a 'significant cost'. This is not possible for permanent visas as the MOC does not accept that an applicant will be on a trial program, or will independently access medication for their lifetime. It is also not accepted that a 'long term non-progressor' or 'elite controller' will not require treatment indefinitely.

VI. The health waiver

A limited number of visas have a mechanism whereby an applicant considered to be a 'significant cost' can nonetheless meet the health criteria (referred to in this paper as a 'health waiver'). Delegates may consider material other than the MOC costing for these visas. Depending upon the visa subclass, there may be available a *waiver* of the health criteria for those who fail on the basis of 'prejudice to access' or 'significant cost'. No waiver is available for applicants who have active TB or are considered to be a threat to public health. However, processing will often be delayed until the applicant has undergone treatment for such conditions.

The health waiver is available for a select number of permanent visas. A separate and differently structured health waiver is available for one type of temporary business visa, the 457 visa.

Schedule 4 PIC 4006A[48] of the Regulations is applicable to subclass 457 visas. These are temporary employer sponsored business visas with a maximum term of 4 years. The 457 visa has a number of different visa streams and has strict criteria around base rate of pay, skills, occupation and employer obligations. PIC4006A allows for a waiver of the 'significant cost' provisions if the employer/sponsor provides an undertaking to meet costs associated with the condition for the duration of the visa.

There is no requirement placed upon an applicant to disclose to the employer the specific medical condition for which the Department seeks the undertaking. In practice, employers will not provide such undertakings without some knowledge of the applicant's health situation. The choice to obtain an undertaking is left to the applicant and the delegate cannot under privacy laws contact the employer and disclose personal medical information.

A different health waiver is applicable to certain permanent visas. The PIC 4007(2) allows a waiver if:

> *(b) the Minister is satisfied that the granting of the visa would be unlikely to result in:*
>
> *(i) undue cost to the Australian community; or*
>
> *(ii) undue prejudice to the access to health care or community services of an Australian citizen or permanent resident.*[49]

In determining whether or not the condition would be unlikely to result in undue cost or undue prejudice to access, the impact upon the Australian community is weighed against the compelling and compassionate factors that are applicable to the applicant.[50] This includes the ability for the applicant or any other person to offset the costs on a fiscal level, social and cultural contributions of the applicant, as well as any detriment that the applicant or any other person might suffer as a result of a visa refusal. It is not limited to an economic calculus of costs/benefits.

An HIV-positive applicant will always fail to meet the health criteria for a permanent visa as the estimate lifetime 'costing' will typically be upwards of $175,000.[51] This means that if no health waiver is available the visa will be refused.

Until 2009, the health waiver was only available for certain 'family formation visas' and onshore protection visa applicants.[52] There was no avenue for skilled migrants who failed the health test to obtain a permanent visa, though in theory an avenue existed in the form of a permanent employer sponsored visa (visa subclass 856/857) that allowed applicants residing in 'participating States' and Territories access to a health waiver.

From 2009 until 2010 the various State and Territories were gazetted as 'participating States' under the Employer Nomination Scheme, the Labour Agreement Nomination Scheme, the State/Territory Regional Established Business Visa and the Regional Sponsored Migration Scheme. This meant that

onshore skilled applicants could seek a health waiver to obtain a visa for themselves and members of their family unit. From 1 July 2012 the options have been narrowed reducing availability of the waiver to only those skilled visa applicants who have been nominated for and apply under the *Temporary Residents Transition Stream* of the Employer Nomination Scheme (visa subclass 186) and Regional Sponsored Migration Scheme (visa subclass 187).

The *Temporary Residents Transition Stream* of the 186 and 187 visas is only open to applicants who have been on a 457 visa, under a *'standard business sponsorship'* and with the sponsoring employer for 2 years in the previous 3 years.

There is no waiver provision for any temporary visa apart from the 457 visa (as described above); therefore, if the MOC determines that the applicant will be a significant cost (greater than $40,000 for the term of the visa) or will prejudice access to services, then the visa will be refused.

VII. Infringement of civil liberties

In addition to the potential restrictions on the entry, stay and residence of people living with HIV, Australia's migration law and policy interferes with an HIV-positive person's liberty in that it requires disclosure of confidential health information and mandatory HIV testing. The Australian Government has justified such practices by characterising the act of applying for a visa to Australia as a choice. The *International Guidelines on HIV/AIDS and Human Rights*, however, has highlighted that migration laws and policies can deprive people living with HIV of their liberty, specifically through mandatory HIV testing and the requirement of 'health undertakings'.

Mandatory HIV testing

Mandatory HIV testing has long been acknowledged as an infringement of civil liberties. This is identified in the *International Guidelines on HIV/AIDS and Human Rights,* published by the Office of the United Nations Commissioner for Human Rights and UNAIDS. The Australian Government asserts that HIV testing is not mandatory, stating people choose to apply for a visa to Australia. If a person wants a visa to enter or remain they must satisfy certain criteria and provide certain information, including submitting to an HIV test. As indicated previously the published policies state that the concern is not with the condition itself but with the financial impact upon the Australian community. A person's HIV status has the potential to affect all visa applications with the exception of a Medical Treatment visa and an onshore Protection Visa.

Applicants for a Medical Treatment visa who are seeking to obtain medical treatment in Australia have to provide evidence of their financial capacity to cover the costs of the medical treatment sought. Accordingly, the cost implications to the Australian community are removed.

In accordance with Australia's obligations under the UN Convention relating to the Status of Refugees (the *Refugee Convention*), applicants for onshore Protection Visas are not disadvantaged if they or their family members are HIV positive. As such, there is no practical reason for requiring a protection visa applicant to submit to an HIV test. These are vulnerable people who are asserting that they fear persecution in their country of origin, within the meaning of the *Refugee Convention,* or would be at risk of significant harm if returned, in accordance with the *International Covenant on Civil and Political Rights*, and fear returning to their country of origin. Accordingly, there is little 'choice' for such applicants but to comply with the request for them to submit to an HIV test, therefore depriving them of their liberty.

A different policy approach has been adopted by most countries within the European Union, based

on a human rights approach to HIV testing and promotion of access to HIV information and services. Thus, migrants to most countries within the EU are not required to undergo HIV testing prior to entry, but rather encouraged to undertake testing voluntarily, and with informed consent.

It is to be noted that there are a number of problems with mandatory testing, particularly where such testing takes place offshore. HIV testing and counselling serve a number of highly useful public health functions, including education, promotion of behavioural change, and uptake of treatment and medical services. There has not been any investigation into the efficacy or public health benefits of the Australian approach to HIV screening in the context of the immigration health assessment. However, studies have been conducted on the Canadian approach which is similar.[53] A number of criticisms have been made of such a mandatory testing model, and in particular its lack of utility in delivering better public health outcomes. For instance, education and behavioural change are rooted in the proper and culturally-appropriate provision of pre- and post-test counselling. However, Bisaillon cites numerous instances where counselling was either entirely absent, or provided extremely badly.

The situation is exacerbated where testing takes place offshore, and in circumstances where the applicant does not have access to, or the ability to uptake treatment. It would be entirely foreseeable for an offshore applicant to be diagnosed with HIV, resulting in an inability to receive a visa to Australia, and furthermore left without the counselling and support that would link that individual to treatment in their country. The situation is complicated by the complexity of the Australian migration system. Case studies in Annexure 1 document incorrect advice from doctors, migration agents and the Department itself regarding visa options. Such experience demonstrates that mandatory testing can result in extremely poor individual and community outcomes. Additionally, such an approach has been criticised in perpetuating stigma around HIV and increasing apathy towards testing within the country (on the basis that people living with HIV are 'kept out'). The International Labour Organization, in conjunction with the International Organization for Migration, performed a similar analysis[54] of mandatory HIV testing for migration purposes, stating that:

> *Mandatory HIV testing, therefore, creates a two-tiered system of rights, with dignity, integrity and work afforded to those without the virus, and deprivation and exclusion forced upon those living with the virus. This violates the state's responsibility and accountability for human rights, 'not only for the direct or indirect violation of rights, but also for ensuring that individuals can realize their rights as fully as possible'.* (citations removed)

Health undertaking

Even if an HIV-positive applicant is granted a visa, they may still be asked to complete a 'Health Undertaking'.[55] PIC4005/4006A/4007(1)(d) operate in the following terms:

> *Applicants to whom a health undertaking applies undertake to contact the HUS (see section 6.4 Health Undertakings Service (HUS)), or present themselves to a health authority in the State/Territory of intended residence in Australia for a follow-up medical assessment and undergo any course of treatment or investigation that the State/Territory health authority directs.*[56]

The health undertaking also gives permission for an applicant's HIV status to be disclosed to other agencies, including border control, education, health, community services and social welfare.

Failure to provide the undertaking if requested to do so would result in a visa refusal. Failure to

contact HUS may impact upon the grant of future visas.

The requirement for applicants to provide such an undertaking is contrary to the *International Guidelines on HIV/AIDS and Human Rights.* By signing the undertaking, applicants are waiving their right to freely *'choose amongst all available drugs and therapies, including alternative therapies.'* [57] The signing of this undertaking also takes away an HIV-positive person's right to privacy. A more appropriate and human rights-based approach would provide information and support to visa applicants, so that they know how to access available HIV-related and other health and social services in the country.

VIII. Changes to the health criteria in 2012

Despite the caveats to the CRPD and the exemption under the DDA, the Federal Government appeared in 2012 to be looking for ways to ensure that Australia's immigration laws were appropriately aligned with Australia's obligations under international conventions including the CRPD. Whether or not the conservative coalition Government elected in 2013 will continue the work that was initiated remains unclear at time of writing.

In an effort to meet obligations under the CRPD, the Joint Standing Committee on Migration of the Parliament of Australia conducted an *'Inquiry into the Migration Treatment of Disability'* in 2009. In June 2010, as a result of this inquiry, the Joint Standing Committee report made 18 recommendations for improvements to the health criteria and Senators Hanson-Young and Boyce made a further two recommendations.[58]

A number of changes occurred in response to the recommendations. However, many of these are of limited practicable value to people living with HIV seeking longer stays in Australia.

1. The 'significant cost' threshold has now been raised. The threshold was previously $21,000 and had been in place since 2000. From 1 July 2012 the 'significant cost threshold' was increased to $35,000, and this figure will be reviewed annually ensuring that it reflects contemporary costs of health care and community services (**Recommendation 1**). As at November 2013 the 'significant cost threshold' is $40,000.

This change has been beneficial for HIV-positive temporary visa applicants whose estimated pharmaceutical costs might now be under the 'significant cost' threshold for a short stay (i.e. 2 years or less). However, the change will still not have any benefit to HIV-positive permanent visa applicants as pharmaceutical and medical services costs over a lifetime will always be projected greater than $40,000.

2. The Department has now made the current 'Notes for Guidance' publicly available (**Recommendation 5**).

Although the Notes for Guidance are said to be 'publicly available', this is via LegendCom, which can only be accessed by those with a subscription. Accordingly, they are essentially only available to applicants who obtain assistance from a migration agent/solicitor.

While there had been advocacy for greater transparency in the MOC opinion process, including making public the Notes for Guidance, applicants still lack a means of challenging MOC opinions by providing an alternative calculations or assessments of costs. As explained above, the structure of the legislation protects the MOC role as an 'independent arbiter', ostensibly to avoid the potential

for interminable legal dispute over such estimates. Without the possibility of review or appeal, access to the notes for guidance is of limited practical value.

3. The MOC now provides each applicant with a detailed breakdown of their assessed costs associated with the disease or condition under the Health Requirement (**Recommendation 7**).

Though the increase in transparency is laudable, similar to the reforms in response to Recommendation 5, the provision a statement of assessed costs has limited practical benefit to applicants. With an HIV-positive applicant the costs are usually broken down vis-à-vis two line items: costs of pharmaceuticals and cost of medical services. Only pharmaceutical costs are considered in relation to temporary visas.

Case Study 1: MOC cost breakdown

Jessica applied for a 4 year 457 visa. The MOC assessment stated:

The applicant is a 44 year old person with:
- Significant HIV infection
This condition is likely to be permanent.

I would consider that a hypothetical person with this disease or condition, at the same severity as the applicant, would be likely to require health care or community services during the period specified above. [period specified being 4 years]

These services would be likely to include:

Pharmaceuticals

Provision of these health care and/or community services would be likely to result in a significant cost to the Australia community in the areas of health care and/or community services.

It was identified that the likely cost to the Australian community would be $93,508.

The costing was surprising high given that the applicant was receiving medication via ATRAS. ATRAS is a study where 'Medicare Ineligibles' were receiving ARVs from the major pharmaceutical companies free of charge and at no cost to the Australian community. The applicant would be on that programme for more than 2 years. Due to the high cost estimate a request was made for a breakdown of the costs. The following response was received:

As requested, the breakdown of the estimated cost to the Australian community is as follows:

Pharmaceuticals - $23,377 x 4.0 years = $93,508

No indication was provided as to what HIV treatment regimen was used for the basis of the calculation. Such a general figure is of limited assistance to the applicant.

4. As of 1 July 2012, the 'significant cost' test has been removed from all offshore humanitarian visas. Therefore, applicants with conditions such as HIV and intellectual disabilities will most likely pass the health criteria. (**Recommendation 14**)

While implementation of this change is obviously beneficial to HIV-positive applicants, it is worth

noting that the change has only been incorporated into policy. Policy can change quickly with limited consultation and can be relatively hidden from the general public. When agents are advising an HIV-positive applicant seeking an offshore humanitarian visa, the applicant will need to be informed that although under policy there is an automatic waiver vis-à-vis the significant cost test, the ability to obtain that visa is overall still only discretionary.

When consulted on the rationale for removing the significant cost test through policy change rather than legislative change, Department officials have stated that:

> *'a policy change was preferred to legislative change so that the Department could determine if the change resulted in perverse outcomes such as altering the composition of the offshore humanitarian cohort.'*[59]

Such statements suggest that the Department may not be fully committed to implementing Recommendation 14 over the long-term, and furthermore indicate that the reform not likely to become a fixture in migration laws. For the Department to create certainty about the ongoing application of recommendation 14, and full respect for the provisions of the *Refugee Convention,* the health criteria in the Regulations for the offshore protection visa subclass should be amended to reflect the Regulations for the onshore protection visa.

IX. Criteria for removal of restrictions as identified by the International Task Team on HIV-related Travel Restrictions

In its report, the International Task Team on HIV-related Travel Restrictions ('Task Team') referred only to restrictions on entry, stay and residence where:

- HIV is a *formal and explicit* part of the law or regulations;
- HIV is referred to *specifically*, apart from other comparable conditions; and
- Exclusions or deportation occurs because of *HIV positive status only.*

As outlined above, Australian law contains no HIV *specific* travel restrictions, but rather HIV is included along with other chronic health conditions. However, the PAM3 do contain specific commentary in relation to HIV, among other conditions.

The Task Team made two primary recommendations directed at governments, namely for the removal of HIV-specific restrictions on entry, stay and residence, and for States to ensure the protection of human rights for people living with HIV in the context of mobility.

Australia is generally aligned with these recommendations by not including HIV-specific restrictions; however, the findings of the present review do suggest that immigration health criteria and processes could be improved from the perspective of people living with HIV. This report concludes that Australia could better respond to the findings of the Task Team by taking additional steps to ensure the protection of human rights for people living with HIV in the context of mobility, in particular by eliminating unnecessary HIV screening for certain groups of visa applicants. More on this last point can be found below.

The Task Team found no evidence that HIV-related restrictions on entry, stay and residence protected the public health and was concerned that they may in fact impede efforts to protect the public health. In particular:

> *the Task Team found that ensuring the access of mobile populations – nationals and non-nationals – to HIV prevention, treatment, care and support would likely be more effective in*

> *preventing HIV transmission and protecting the public health than are HIV-related restrictions on entry, stay and residence. Such access would empower all people, national and non-nationals, in the context of travel and migration, to be able to avoid becoming infected with HIV and to avoid infecting others. Furthermore, increased access to treatment would maintain productivity, avoiding the need for costly health care, while likely reducing infectiousness if taken under optimal conditions. Thus, the Task Team found that much greater efforts should be made to expand access to evidence-informed HIV programmes and services that have proven to be effective to travellers and migrants; in contrast to application of ineffective and discriminatory measures to deny entry or stay based on HIV status.*[60]

It is recommended that Australia's immigration health policy framework include specific reference to the aim to achieve positive health outcomes for individuals in the context of migration. At present, nowhere in Australia's Act, Regulations or in the PAM3 is it suggested that HIV testing or any other testing is carried out to promote positive health outcomes for applicants.

The Task Team findings noted that it is not inappropriate for States to exclude people on the basis of being an undue burden/excessive demand on public monies/services, provided that such exclusion is not based only on one's HIV-positive status, and is not limited to HIV-positive individuals but is inclusive of others with chronic health conditions.[61] The Task Team recommended the use of individual assessments as a more rational means by which to identify potential "public charge" cases, and less restrictive than blanket exclusions. The Task Team further noted that:

> *Such an assessment should ascertain that the person requires health and social assistance; is likely in fact to use it in the relatively near future; has no other means of meeting such costs (e.g. through private or employment-based insurance, private resources, support from community groups); "and that these costs will not be offset through benefits that exceed them, such as specific skills, talents, contribution to the labour force, payment of taxes, contribution to cultural diversity, and the capacity for revenue or job creation."* [62]

Australia complies with this requirement to the extent that certain visas have the possibility of allowing the costs associated with that applicant's medical condition to be balanced by relevant humanitarian circumstances, as well as the economic benefits that the applicant brings. It should be noted, however, that the Australian costing mechanism utilises a 'lifetime cost' approach, based on a 'hypothetical applicant', resulting in no practical difference between an applicant who is a long-term non-progressor and one who is currently on treatment or has advanced HIV infection. Further individualisation of the assessment process would ensure, for example, that long-term non-progressors are not inadvertently screened out due to generic assumptions about costs associated with hypothetical disease progression.

The Task Team also found that *'the implementation of restrictions on entry, stay and residence to avoid potential costs to public funds should not prevail over national obligations to protect individual human rights and address humanitarian concerns.'*[63] Such humanitarian concerns or state obligations to protection of human rights extends beyond *non-refoulement* obligations but also incorporates rights of the child, rights of women, rights of the family, right to seek asylum, and rights to life, privacy, work, and the highest attainable standard of health.

While Australia's approach to 'costing' applicants and assessing undue burden appears to comply with the Task Team's recommendations, it is noted that not all visa classes have a mechanism to consider humanitarian and other relevant matters that could justify the waiving of the cost criteria. A more complete response to the Task Team's findings could be achieved through the extension of the PIC 4007 to all visa subclasses, and removal of restrictions on all family formation visas.

X. Proposed changes to the health criteria

In October 2012, the then Minister for Immigration and Citizenship, Chris Bowen MP, announced that:

> *The government will now take into account all of the circumstances when assessing prospective visa applicants against the visa health requirement… A 'net benefit' approach will allow decision makers to consider the social and economic benefits an applicant and their family bring to Australia compared to the cost of their health care.*[64]

The following assessment of the proposed net benefit model is taken from the Key Stakeholders Brief from December 2012. It should be noted that the present Government has not provided their opinion as to how the proposed 'net benefit' model will operate, or if it will be adopted. If the proposal is modified, further assessment will be necessary.

Under the proposed model, where the MOC finds an applicant to be a significant cost or likely to prejudice access to services to the Australian community, the "net benefit" of those applicants will be assessed; if an applicant is still found to be a significant cost then they will have the ability to present compelling and compassionate reasons for why a waiver should be granted.

It is proposed that all visas would utilise this health criteria, barring the following:

- Transit visas, carer visas and medical treatment visas – these will proceed directly to 'health waiver' stage without application of the net benefit model; and
- Onshore protection – the current criteria will continue; an applicant's HIV status is not an impediment to the grant of the visa (see above).

In considering the net benefit of an applicant, the Department will take into account a wide range of factors.

Those factors against the applicant meeting the health criteria may include:

- *The MOC costing*
- *Any pension, allowances or payments (based primarily on age and Australian average usage);*
- *Average health and education costs based on age;* and
- *Any likely user charges.*

Those factors in favour of the applicant meeting the health criteria may include:

- *GST that is likely to be earned from their spending in Australia;*
- *Income tax that is likely to be paid based on occupation or skill level;*
- *Likely fiscal contributions to industry such as international student fees to educational institutions or support of the tourist industry.*

The determination of such figures will be based upon averages considering age, gender, visa subclass/purpose of stay, occupation, skill level, period of stay, family composition and intention to be a primary carer. For temporary visas these figures would be calculated for the duration of the visa; for permanent visas it is unclear over what period these figures will be calculated although has been some suggestion that the figures be calculated over a 10 year period.

While this framework will benefit some applicants, it appears that others will remain disadvantaged. In particular, families with young children, unskilled applicants and applicants with advanced HIV infection or multiple health conditions are unlikely to be greatly assisted by the proposed changes.

For example:

1. A permanent skilled visa application involving a two parent family, where both parents are HIV positive, with three children aged 4, 6 and 10 would have only the fiscal contributions of the parents to be offset against such costs as the MOC costing x 2 as well as schooling for 32 years (being 12 years + 12 year + 8 years) and average health care costs for a family of five. It is therefore unlikely that this family would be seen to be of net benefit.
2. Conversely, a permanent skilled visa application involving a two parent family, where both parents are HIV positive, with three children aged 17, 19 and 23 would have the fiscal contributions of the parents as well as the two adult children which could reasonably offset such costs as the MOC costing x 2 as well as schooling for 1 year (for the 17 year old) and average health care costs for a family of five. This family are likely to demonstrate that they are of net benefit.

Both families are essentially the same, however the costing mechanism will not consider young children as potential future income earners but rather as costs to the public schooling system.

Though greater individualisation of the assessment process and opportunity to offset costs with benefits is generally seen as an improvement over the present approach, it should be noted that there is broader concern that proposed framework maintains discrimination toward applicants with disabilities. Such a costing mechanism is triggered when health and disability issues are identified in the immigration process. Yet, it is entirely foreseeable that some applicants without disabilities, if required to undergo the net benefit assessment, would be unable to demonstrate that their fiscal benefits to the community outweigh their likely costs to the public purse over their lifetime or the duration of the visa.

XI. Health criteria in other jurisdictions

Australia, Canada and New Zealand are alone among high-income Anglo-Western States – and are in a distinct minority when compared to all States – to have mandatory HIV testing and restrict the entry, stay and residence of people living with HIV and other chronic health conditions due to so-called 'undue cost'.[65] Their approach can be contrasted with countries such as Japan, Switzerland, the United States, and most countries within the European Union, which do not maintain restrictions on entry, stay and residence, nor require applicants to be tested for HIV.

Australian, Canadian and New Zealand's migration laws and policies related to the entry, stay and residence of HIV-positive people all have a common theme – the cost implications upon the community. In many instances, the failure to meet a set 'cost threshold' results in a refusal.

The United States previously classified HIV as a "communicable disease of public health significance" in the context of migration, and thus non-nationals living with HIV were considered to be a threat to public health. Since 4 January 2010, the United States no longer classifies HIV as a communicable disease of public health significance, and accordingly, once that classification was removed from the immigration framework, so were the restrictions on entry, stay and residence for HIV-positive people.[66]

Australia, Canada and New Zealand have all put in place immigration health criteria and cost assessments which may identify a person living with HIV as a "significant cost to the community". Though Australia, Canada and New Zealand's standard of publicly-accessible health care is greater than that found in the United States, it is comparable to that available in many Western European countries. It is worth emphasising that most European Union countries do not have entry, stay or

residence restrictions for people living with HIV. They do not test for HIV or assess potential costs that an HIV-positive person may represent for the country. The policy approach taken in the EU countries to migration and mobility for people with HIV is significantly different to that adopted by Australia, Canada and New Zealand, with the European model underpinned principally by human rights considerations.

HIV has been a political priority for the European Union, which has issued a number of important declarations over the past decade, the most relevant of which have been the 2004 Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia, the 2004 Vilnius Declaration on Measures to Strengthen Responses to HIV/AIDS in the European Union and in Neighbouring Countries, the 2007 Bremen Declaration on Responsibility and Partnership – Together Against HIV/AIDS and the European Parliament resolution of 20 November 2008 on HIV/AIDS: early diagnosis and early care. However, these declarations and resolutions for the most part mirror the ethos of the international declarations committing to universal access to HIV prevention, treatment, care and support, and upholding human rights in the context of the response. The European Parliament in its 2008 resolution noted that the *'full protection of human rights is essential in every aspect of the response to HIV'* and (relevantly to migration) called on member States to:

(at 3) *commit substantial political, financial and human resources to support the implementation of such a strategy;*

(at 4) *ensure access to testing, which must remain free and anonymous;*

(at 8) *enact provisions which effectively outlaw discrimination against people living with HIV/AIDS, including restrictions that impact on their freedom of movement within their jurisdictions;*[67]

The approach taken by European countries is consistent with such a human rights and public health focus. For instance, Italy, Norway, Sweden and the United Kingdom provide anti-retroviral treatment to all migrants who are in need of the same, including visitors. These countries provide a comparable level of healthcare to Australia, with a comparable level of services and GDP spend.[68] As noted by the International Task Team on HIV-related Travel Restrictions, ensuring the access of mobile populations to HIV prevention, treatment, care and support is more effective in preventing HIV transmission and protecting the public health than are HIV-related restrictions on entry, stay and residence.

As the above-mentioned countries do not have restrictions on the entry, stay or residence of people living with HIV, this report does not consider their migration legislation. However, the Canadian and New Zealand approaches have a few salient differences to Australian legislation which are examined below.

Canada

Power to restrict entry on health criteria can be found in s.38 of Canada's *Immigration and Refugee Protection Act*[69], which states:

> *(1) A foreign national is inadmissible on health grounds if their health condition*[70]
>
> *(a) is likely to be a danger to public health*[71]*;*
>
> *(b) is likely to be a danger to public safety*[72]*; or*
>
> *(c) might reasonably be expected to cause excessive demand on health or social services*[73]*.*

Cost-related restrictions are deemed justified on the basis that permanent residents have access to publicly-funded medication and services. HIV testing of migrants is required for some applicants

seeking to enter Canada temporarily for more than 6 months and for all permanent resident visa applicants.

The health criteria are not applicable to certain applicants. Specifically, s.39 notes that the criteria do not apply to *[…] a foreign national who:*

> *(a) has been determined to be a member of the family class and to be the spouse, common-law partner or child of a sponsor within the meaning of the regulations*[74]*;*
> *(b) has applied for a permanent resident visa as a Convention refugee or a person in similar circumstances*[75]*;*
> *(c) is a protected person; or*[76]
> *(d) is, where prescribed by the regulations, the spouse, common-law partner, child or other family member of a foreign national referred to in any of paragraphs (a) to (c)*[77]*.*

Unlike in Australia, where only onshore protection visa applicants and medical treatment visa applicants are exempt by law from the relevant health criteria, a larger list of certain migrants, including sponsored partners and/or children, and refugee or humanitarian (both off and onshore) entrants, do not need to meet the health criteria.

The Canadian system also differs from the Australian system in that there appears to be greater discretion in the determination of whether or not a migrant will be a significant cost. Additionally, costs are not calculated on a lifetime basis and certain migrants are not required to meet the health criteria.

'Excessive demand' is defined as a demand on health services for which the anticipated costs would likely exceed average Canadian per capita health services usage over a period of five consecutive years. This is determined after the most recent medical assessment required under paragraph 16(2)(b) of the Act. The period can extend up to 10 years for conditions such as HIV. The threshold is set at CAN$ 6,285 per year.[78]

Unlike in Australia, where the estimated costs for permanent visa applicants are projected over a life time, in principle in Canada an HIV-positive applicant in good health who will not require treatment in the medium term would satisfy the health criteria if their cumulative cost to health or social services is less than $62,850 over the next 10 years. Elite controllers, long-term non progressors, and people infected with HIV-subtype 2 are thus more likely to meet Canadian health criteria.

Because of the high cost of treatment, individuals who are on treatment are likely to be assessed as causing excessive demand. Similar to Australia, the general position appears to be that applicants will be assessed as needing services regardless of whether or not they will actually use them over their lifetime. Applicants on treatment with private health insurance may fail the health criteria on the basis that publicly-funded health benefits are available to permanent residents, and having private insurance does not guarantee that the applicant will not use public benefits. However, the Canadian courts have noted several exceptions to this general principle, suggesting that applicants in particular circumstances may meet the health criteria. In December 2009, the Canadian Federal Court held in *Companioni* v *Canada (Minister of Citizenship and Immigration)*[79] that permanent resident applicants with HIV should have an opportunity to demonstrate their ability to bear the costs of their medication in order to avoid being determined medically inadmissible. Since, without consideration of an applicant's ability and intention to pay for social services, it is impossible to determine realistically what 'demands' will be made, medical officers are required by the Courts to take into account both medical and non-medical factors such as an applicant's net assets and the likelihood of finding employment that will provide private health insurance. The threshold to be

applied in the assessment (described in the cases of *Hilewitz v. Canada*[80] and *De Jong v. Canada*[81]) is "reasonable probability", not remote possibility. In both these cases, applicants possessed considerable assets that made them extremely unlikely to need to rely on public health care.

Canada has been able to demonstrate that HIV testing within the context of the immigration health assessment process has not had the effect of preventing people living with HIV from obtaining entry, stay or residence. According to government data, of the 2,567 immigration applicants who tested positive for HIV between January 2002 and December 2006, only 126 (less than 5%) were reportedly denied entry, stay or residence. An official of Citizenship and Immigration Canada has been quoted in the Canadian media on this subject, noting that, for the most part, applicants living with HIV are not considered a public health risk nor an excessive burden on the medical system, and that "the medical cost considered during a five to 10-year period generally isn't considered untoward".[82]

New Zealand

New Zealand's immigration framework is set out under the *Immigration Act 2009*[83] and the health requirements are further detailed in the Immigration New Zealand (INZ) Operational Manual ('Manual').[84]

The Manual holds that visa applicants must have an acceptable standard of health (ASH) unless they are applying for a medical treatment visa or have been granted a medical waiver. Applicants for resident class visas are considered to have an acceptable standard of health if they are:

i. *unlikely to be a danger to public health; and*
ii. *unlikely to impose significant costs or demands on New Zealand's health services or special education services, and*[85]
iii. *able to undertake the work on the basis of which they are applying for a visa, or which is a requirement for the grant of the visa.*

There is a list of medical conditions that are deemed to impose significant costs and/or demands on New Zealand's health and/or education services. If an applicant is found to have one of these medical conditions, which includes HIV infection, they may be assessed as not having an acceptable standard of health.[86]

Applicants for residence class visas will be seen not to have an acceptable standard of health if there is a relatively high probability that the applicant's medical condition will require health services in excess of NZ$ 41,000[87] over the predicted course of the condition (chronic, recurring medical conditions),[88] which would include all HIV-positive applicants. To ensure fairness to applicants, in determining whether there is a high probability that the applicant's medical condition will require use of health services in New Zealand, an INZ medical assessor must consider all relevant information.[89]

Temporary applicants will be seen not to have an acceptable standard of health if there is a relatively high probability that the *applicant will need publicly funded health services during their period of stay in New Zealand including, but not limited to:*

- *hospitalisation;*
- *residential care;*
- *high cost pharmaceuticals;*
- *high cost disability services.*[90]

However, INZ does not generally test people seeking a visa or entry permission for shorter periods of time (visitors, students, short-term workers), and they are much less likely to be considered to not meet an acceptable standard of health as their likelihood of incurring costs to the publicly-

funded health system is also very low. The one exception to this is the Recognised Seasonal Employer work category, where HIV testing is mandatory for people from countries with an HIV prevalence rate greater than one per cent; people who are found to be HIV positive are not eligible for a visa.

Similar to Australia, the applicant's ability to access publicly-funded health care or to mitigate the costs, either personally or through a third party such as insurance, family or friends, is not taken into consideration.[91]

HIV-positive applicants can seek a waiver. There are two groups of HIV-positive people who are very likely to be granted a waiver of the ASH requirement. One is refugees: asylum seekers who test HIV positive are very likely to be granted a waiver, though Cabinet has approved an annual cap of up to 20 HIV-positive quota refugees. The other is HIV-positive partners of New Zealand citizens and permanent residents.

The immigration officer must consider the compelling circumstances in favour of granting a medical waiver.

> *Factors that officers may take into account in making their decision include, but are not limited to, the following:*
>
> *a. the objectives of Health instructions (see A4.1) and the objectives of the category or instructions under which the application has been made;*
> *b. the degree to which the applicant would impose significant costs and/or demands on New Zealand's health or education services;*
> *c. whether the applicant has immediate family lawfully and permanently resident in New Zealand and the circumstances and duration of that residence;*
> *d. whether the applicant's potential contribution to New Zealand will be significant;*
> *e. the length of intended stay (including whether a person proposes to enter New Zealand permanently or temporarily).*[92]

HIV-positive applicants who are partners or dependent children of a New Zealand citizen or permanent resident, who would have met the criteria for residence under a partnership or dependent child visa, or assessed as having refugee or protection status, are automatically granted a medical waiver, unless an exception applies. The exception to the automatic medical waiver is where the applicants:

> *ii. are applying for residence under one of the Family Categories; and*
> *iii. were eligible to be included in an earlier application for a residence class visa (or a residence visa or residence permit issued or granted under the Immigration Act 1987) as the partner of a principal applicant or the dependent child of a principal applicant or their partner; and*
> *iv. were not declared in that earlier application; or*
> *v. were not included in that earlier application; or*
> *vi. were withdrawn from that earlier application.*[93]

Accordingly, INZ differs significantly from Australia with respect to the waiver process, in that all applicants appear to have the ability to obtain a medical waiver, and some will automatically be granted a waiver thus reducing stress and processing times for such applicants.[94]

XII. Conclusions and Recommendations

Recent changes to immigration policies and practices in Australia have improved the process from the perspective of people living with HIV. Notably, the increase in the significant cost threshold has resulted in greater temporary visa opportunities. The change means that the majority of HIV-positive applicants will now qualify for a visa of at least 2 years, and in some cases even longer. Under the earlier rules, many temporary visas over 12 months duration were refused. Offshore humanitarian entrants who are living with HIV, and who would otherwise fail the significant cost test, have benefited from the introduction of an automatic waiver of the health requirements. It is noted that this change has only occurred at a policy level, with no move foreseen to alter the legislation to give the measure formal legal standing.

Australian migration laws with respect to the entry, stay and residence of people with disabilities fall short of obligations the country has assumed under international law. As noted in submission of the UN High Commissioner for Refugees to the Joint Standing Committee undertaking a review of migration and disability in Australia:

> *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.*[95]

If the present Government were to adopt a 'net benefit' approach to assessing visa applicants, as recommended by the Joint Standing Committee on Migration, Australia would move one step closer to meeting obligations it has assumed under the Convention on the Rights of Persons with Disabilities. Such reforms would also further individualise the immigration health assessment process and provide greater opportunity to offset potential costs, in line with the findings and recommendations of the International Task Team on HIV-related Travel Restrictions. However, even if this important change is made, further reform will be needed to ensure the migration framework is disability-inclusive.

The main conclusions and recommendations of the present report are the following:

1 The principles and protections under the *Disability Discrimination Act,* and the *Convention on the Rights of Persons with Disabilities*, must be applicable to Australia's migration laws, policies and processes;

The International Task Team on HIV-related Travel Restrictions acknowledges that States have the right to control their borders and to consider undue costs as a matter of national interest. However, the Task Team also considered that States must be mindful of their international human rights commitments and obligations, including those relating to non-discrimination and equality before the law. In the case of Australia, removing the exemption in the Disability Discrimination Act (DDA) related to immigration matters and the Interpretive Declaration to Article 18 of the CRPD, would be actions that reflect the country's international commitments and obligations. At present, the recommendation of the Joint Standing Committee on Migration that the DDA and the impact of Section 52 of the DDA upon people with disabilities be reviewed is not supported by the Federal Government.

This report argues that the only way to ensure full compliance with obligations under the CRPD is to drastically narrow the health criteria used in reviewing visa applicants, focusing exclusively on conditions considered to be a threat to public health. Removal of such overly broad health criteria would ensure that disability and health status does not prejudice the success of visa applications,

and furthermore would put Australia in line with the human rights-based practices of many states, including those that provide substantial publicly-funded health care and social services (e.g. France, the Netherlands, Sweden, Switzerland and the United Kingdom).

2 Positive reforms that have been made at a policy level should be given the force of law;

Important progress has been made vis-à-vis the consideration of protection visa applications, notably to ensure that people living with HIV or any other health condition are not denied a visa on the basis of their HIV or health status; however, these changes have been made only at the level of policy and have not been given the force of law.

3 Eligibility for waiver of the significant cost threshold in relation to health should be expanded to all visa applicants, regardless of the class of visa;

At present, only a limited subset of visa applicants is eligible to be considered for a waiver of the significant cost threshold. It is recommended that this be expanded so that all applicants can benefit equally from consideration of compelling or compassionate circumstances related to their application, thereby reducing the barriers to entry, stay and residence for persons with disabilities, including people living with HIV and other chronic health conditions.

The expansion of waivers and flexibilities to all visa subclasses, both temporary and permanent, should include the following features:

1. Waivers should be automatic where there are humanitarian concerns or there is a national obligation to protect the applicant's (or another person's) human rights;
2. Where 1 has not been met, the applicant has the ability to demonstrate other compelling and/or compassionate reasons why a waiver should be granted.

4 A more contemporary and individualised health assessment for visa applicants, and consideration of their social and economic benefits to Australia, should be put in place to reduce barriers faced by people living with HIV and other health conditions;

Although the number of persons refused entry, stay and residence each year on health grounds appears to be very small, it is of concern that Australia's health rules and processes may risk mischaracterising or over-estimating the future health needs of some applicants living with HIV (e.g. long-term non-progressors) and fail to capture the social and economic benefits that would offset the cost considerations. It has furthermore been noted that the Procedures Advice Manual has not necessarily kept pace with an evolving clinical context for HIV, whereby HIV has become a manageable, chronic health condition, with people living with HIV increasing living long, healthy, productive lives. Management of HIV infection may typically only require two or three visits to the doctor each year, and the cost of HIV management and treatment has improved. It is recommended that the guidance be continuously updated to reflect latest developments in costs and clinical management, and that applicants be given greater opportunity to have the specificities of their health status taken into account in the assessment process.

The Joint Standing Committee on Migration of the Australian Parliament has recommended that the *Migration Regulations* be amended to allow for "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". The proposed adoption of such a 'net-benefit approach' to assessing visa applicants would reduce barriers and increase opportunities for people living with HIV. Not only would such reforms be in line with the Task Team recommendations, they would generally be in the national interest by ensuring that Australia is facilitating entry, stay and residence for all those who

have important contributions to bring to the country.

5 Mandatory HIV testing of temporary, humanitarian and family formation visa applicants, as well as non-migrating dependants, should be removed immediately as it is unnecessary and wasteful, violates human rights norms, does not contribute to good health outcomes, and adds red tape to the visa application process;

HIV testing remains a mandatory requirement for all permanent visa applicants and many temporary visa applicants. This includes onshore protection visa applicants where the health criteria are not relevant to the grant of the visa and 'significant costs' of health care or community services are not considered. As noted above, recent increases to the 'significant cost threshold' have resulted in most people living with HIV, who otherwise meet the criteria for the granting of a visa, being able to receive a visa of up to two years, if not longer.

HIV is not considered a general threat to public health in Australia, and never has been. Despite this, mandatory testing requirements in circumstances where a person's HIV status would not impact upon the grant of the visa suggests that HIV is treated in the same manner as conditions which are a threat to public health.

It is recommended that HIV testing requirements be immediately removed for all temporary visa applicants seeking to stay for up to two years, for humanitarian entrants (both onshore and offshore), for family formation visa subclasses – including but not limited to partner, child, orphan relative, adoption, parent and remaining relatives – as well as non-migrating dependants. Mandatory HIV testing presents an unnecessary financial imposition on applicants and leads to the waste of resources (including the current practice of re-testing where the applicant already has an HIV-positive diagnosis). Unnecessary HIV testing furthermore adds red tape to the visa application process and is associated with delays for applicants and additional transaction costs for the Department.

Removal of mandatory HIV testing is consistent with the recommendations and findings of the United Nations. A health assessment offered for the benefit of the applicant (including to ensure their access to services) would also be consistent with the approach recommended by the Task Team, in that it would increase access to HIV prevention, treatment, care and support. (More is said on this voluntary approach below.) It is of concern that quality pre- and post-test counseling is not consistently accompanying HIV testing carried out in the immigration health assessment process, particularly where applicants are attending medical examinations offshore. A voluntary health assessment could be offered to migrants either upon arrival in Australia or when applying for a visa onshore. It would need to be made clear to applicants that the outcome of any medical examinations will not impact upon their or their family's ability to remain in Australia.

Testing of non-migrating dependants is of concern because of privacy implications. These tests are particularly problematic where the non-migrating dependants and other family might be unaware of their family member's HIV status; where counselling and support is lacking, this has been reported to lead to the splitting of the family.

6 Procedures for applying the significant cost test should be revised so that all applicants are assessed based on a five-year period, rather than having some applicants – including people living with HIV – subject to assessment for 'lifelong costs';

The current practice of assessing applicants with permanent, "reasonably predictable" conditions according to lifelong costs results in all HIV-positive applicants for permanent residency exceeding

the significant cost threshold. As such, HIV-positive status effectively bars an application for permanent residency, unless there are compelling or compassionate circumstances that lead to the granting of a waiver. The consideration of five-year costs for some applicants, and lifelong for others, also makes potentially false distinctions and fails to acknowledge the uncertainty related to future health needs or the development of a disabling condition by those applicants being assessed on a five-year basis.

7 The 'undue cost burden' associated with applicants who fail the health requirement should be put in the broader context of migration's overall economic and social benefits for Australia;

In order to build political support for more disability-inclusive migration policy, as well as to promote transparency, it is recommended that the Department of Immigration and Border Protection conduct an analysis of the overall economic benefit of migration to the Australian community, and place the potential cost of those migrants who would fail the health criteria under current laws in that broader context.

8 Consideration should be given to removing all migration restrictions based on an applicant's disability or health status (barring those conditions that are medically assessed to be a threat to public health). The current health undertaking should be replaced with a new undertaking that requires a person to submit to an 'overall health assessment' after entry, the result of which is confidential and not shared with the Department of Immigration, but is used by state and local health authorities to ensure that the persons receive appropriate treatment and has access to services;

A voluntary and confidential health assessment that does not prejudice the overall visa application would protect people living with HIV, as well as others with health conditions or disability, from discrimination. The focus of such a health assessment process would be supporting new migrants and their integration into the community, including access to health and social services. The health assessments could offer not only HIV testing but also other tests currently required for permanent migration to Australia, as well as those routinely recommended by Australian health departments (e.g. pap smears, mammograms, prostate examinations, bowel screening, Hepatitis A, B and C testing). Conducting such medical examinations in Australia will ensure that people can be immediately linked with services and necessary counselling, including counselling related to the rights and obligations of people living with HIV, and circumstances requiring disclosure of their HIV status to another party. Such obligations vary across Australia's states and territories.

In the context of this recommendation, the Department of Immigration and the Department of Health should conduct joint community consultations that identify how access to HIV prevention, treatment, care and support can be strengthened among migrant communities. Such consultations should also address HIV-related stigma, discrimination and xenophobia faced by migrants coming to Australia from countries with high rates of HIV prevalence.

Taking forward the recommendations

Implementation of the recommendations outlined above will have important positive implications not only for people living with HIV, but all persons with disabilities. As such, advocacy and dialogue with Government officials regarding the recommendations should include a broad range of stakeholders from both the HIV and disability sectors. An important component of any such advocacy is overcoming stigma and negative public perceptions of migrants living with HIV. Recent high-profile cases of people charged with criminal transmission of HIV – some of whom have been migrants – will have negative implications for public support for reforms that are perceived as 'less

restrictive'. Broader advocacy for removal of restrictions in relation to people with other disabilities may be met more favourably by the public. Australian States also need to be engaged regarding possible reforms as Australian health care is funded by the States. In the review carried out by the Joint Standing Committee on Migration, States put up significant opposition to the possibility of changes that would increase the costs related to providing health and social services for migrants with disabilities. The cost/benefit analysis proposed above may assist in alleviating States' concerns with respect to the potential financial implications of a more disability-inclusive migration policy. The International AIDS Conference in Melbourne is an opportunity to promote discussion about restrictions on the entry, stay and residence of people living with HIV, as well as the broader challenges of promoting migration frameworks that are inclusive of persons with disabilities.

Annex 1: Case studies and problems with the health criteria

Due to the health criteria, HIV-positive visa applicants are still often placed in difficult circumstances beyond that of other migrants, including migrants with other disabilities.

From July 2010 until June 2013, the HIV/AIDS Legal Centre has assisted over 500 people in HIV-related migration matters. Sixty-three of those HIV-positive people had applied for or were intending to apply for permanent visas without health waivers. Thirty-seven people were advised that applications that had already been lodged would certainly be refused. If it were not for their or their family member's HIV status, 246 people could have applied for permanent skilled visas other than those skilled visas with health waivers.

Thirty-two applicants had no options other than applying for a protection visa or seeking Ministerial Intervention. Ministerial Intervention is a mechanism where a person who has had their visa refused by both the delegate and the Migration Review Tribunal or the Refugee Review Tribunal can then request that the Minister for immigration intervene and grant them a visa. The Minister only intervenes in rare circumstances where it is in the public interest to do so.

The difficulties that HIV-positive migrants face can most aptly be highlighted through case studies. It is worth noting that these difficulties have implications upon not only the individual applicants but also upon others including the Australian Government, employers and the Australian community.

a. Incorrect information and advice

Due to complexity surrounding the health criteria, most HIV-positive applicants are going to need advice and assistance with applying for a visa in circumstances where HIV-negative applicants would not. Due to the complexities involved even experienced migration agents provide incorrect advice to applicants. In some circumstances this can lead to dire consequence for an applicant where this misinformation is not corrected.

Case Study 2: Incorrect advice from an agent

Kevin was a highly skilled surveyor and he and wife and three small children had come from Zimbabwe. Kevin was diagnosed with HIV during health checks for his 457 visa application. His sponsoring employer gave a health undertaking to cover costs associated with his HIV condition. The employer later informed Kevin that they wanted to sponsor him and his family for a permanent visa.

A health waiver was available for the visa although it was only recently available in that state. With the assistance of an agent the employer put in a nomination, which was approved, and Kevin and his family submitted their application with the assistance of the same agent. The agent was from a large well-reputed firm. The agent, who was acting for both the employer and Kevin, advised the employer that the visa while a health waiver was available, the chances of successfully applying was poor.

The employer contemplated the agent's advice and said that due to the high cost of the undertaking for a 4-year 457 visa they were not prepared to continue with the permanent nomination as they were concerned about how much the undertaking would be for a lifetime.

The employer clearly misunderstood the difference in the health waiver process between the permanent visa and the 457. As described above, the permanent visa requires no participation from the employer.

The agent who received the information from the employer passed it onto Kevin and did not correct the employer on their misunderstanding. The agent told Kevin that he and his family had to withdraw their visa application and put in an application for a 457 because they couldn't get a permanent visa. Kevin was not advised about the health waiver process. Kevin accepted the advice given and gave permission to withdraw the permanent visa and apply for a new 457.

The employer then said that they didn't want to give an undertaking in relation to health because they were worried about 'risks associated', despite having previously given an undertaking for the first 457. The employer told Kevin and his family that they would pay for their plane tickets to leave Australia and return to Zimbabwe.

Throughout the entire process Kevin was paying for all the migration agent fees associated with their application and the application fees.

Kevin was concerned about returning to Zimbabwe so he sought a second opinion on the advice given. Kevin was advised that he could apply for the visa he had originally applied for and about the health waiver process. It was also noticed that the MOC costing and opinion were incorrect and didn't take into consideration all relevant information, namely the fact that he was a long-term non-progressor and wasn't going to need treatment for at least 5 years. The 457 was granted without the need for an undertaking. Kevin then moved to a new employer on the 457 and applied for a permanent visa with the new employer.

The incorrect advice caused significant added costs for Kevin and his family, as well as the employer. Since that time the previous employer has been contacting the applicant on a regular basis asking that he come back to work for them and offering a significant pay increase well above what the initial 4 year undertaking was.

The entire process from when the first permanent visa was withdrawn until grant of the second permanent visa took close to three years. Had he been applying under the current migration laws an additional two years would have been added to that, as he would have needed to be with the new employer for at least 2 years before becoming eligible to even apply for the permanent visa with a health waiver.

Providing incorrect information is not limited to migration agents; the Department also risks providing incorrect information. Incorrect or misleading information or direction by the Department can have cost implications and may also lead to people not making an application when they might have been entitled to do so.

Case study 3: Incorrect directions by the Department

Lulu left her husband, Daniel, and daughter, Precious, in sub-Saharan Africa and came to Australia. When in Australia, Lulu applied for and was granted a protection visa as she feared persecution due to political affiliation.

A short time later, Daniel and Precious then applied for a partner visa so they could join Lulu in Australia. This was more than 2 years ago. During the medical examinations for this visa application Daniel was diagnosed with HIV. Lulu is not HIV positive.

Daniel also has three other children from a previous relationship who are not included on the

application. Recently the case officer wrote:

> *'It is a requirement that all non-migrating family members undertake a medical examination. HIV tests will also be required for all secondary applicants and non-migrating family members because of the diagnosed condition of the Primary Applicant.'*

All children, including Precious, are under 15 years of age and would not normally have to undergo an HIV test.

The migration agent responded to the case officer stating:

> *'With respect to* [the children] *being required to undergo an HIV test, given* [their] *age and that there is nothing to suggest that* [they are] *HIV positive is this necessary? Although* [Daniel] *is HIV positive* [Lulu] *is not and transmission of HIV from the father to a foetus without passing HIV onto the mother is medically improbable.'*

The case officer stated that she had discussed the matter with her supervisor and that the children did have to undergo HIV tests. Consequently the applicants arranged to undergo medical examinations including an HIV test, which resulted in additional costs for the family.

Two weeks later an email was received stating:

> '*I have just been advised that the children are no longer required to do HIV testing. Apologies for any inconvenience caused by this request.'*

The family had already expended money on the requested medical examinations.

Case study 4: Misleading information from the Department

Peter is a skilled diesel fitter/mechanic from Southern Africa, and came to Australia on a 457 visa. His wife Patience, and two children Petunia and Patrick, remained abroad so he could establish a home for them first. Patience and Peter are both HIV positive. Peter was not required to undergo an HIV test as part of the application

When Patience and the children applied to be included on the 457 visa, Patience was required to undergo a medical examination. Due to the length of time remaining on the visa and Patience's health, she did not reach the significant cost threshold.

The MOC still required Patience to sign a health undertaking indicating that she would present to Health Undertaking Service upon arrival in Australia. The delegate also requested that Patience and Peter acknowledge:

> *that just because* [Patience] *was being granted a 457 visa on this occasion it does not mean they will meet the requirements for any visa, either temporary or permanent, in the future; and that the success of the application is contingent upon meeting the relevant Migration Legislation, including meeting the relevant health criteria, at the time of any future application.*

Patience and Peter gave that acknowledgement, however, the requirement for them to provide same places an obligation above and beyond every other applicant.

It is true with all applicants that the success or failure of any future application would be dependent upon meeting relevant migration legislation. Yet in this matter the delegate required that the acknowledgment be provided as a condition of granting this visa. This acknowledgement gave Patience and Peter the impression that they would not be granted any visas in the future. Had the family not had access to sound migration advice they may have never tried to reapply for any visa in the future.

b. Disclosure

Laws in Australia required HIV-positive people to disclose their HIV status only in very limited circumstances, however the health criteria often leads to applicants being placed in the difficult position where they are forced or coerced into disclosing their HIV status to a variety of people to be able to obtain a visa. Unlike most other medical conditions, HIV continues to be highly stigmatised throughout the globe including in Australia and for this reason many people living with HIV do not want to disclose their HIV status to others.

Employers
Due to the structure of the health waiver for 457 visas, skilled applicants are often put in the position where they have to disclose their HIV status to their employer; due to concerns around stigma and discrimination they may not wish to do so.

Case Study 5: Fear of disclosing to an employer

Agnes, Justice and their two teenage children Diego and Jemma are from sub-Saharan Africa. Both Agnes and Justice are highly skilled, and have skills which are in high demand. The family came to Australia in 2000 on a 457 visa. Agnes, Justice and Diego are all HIV positive, they were diagnosed shortly after arrival in Australia.

In 2004, knowing that they could not obtain a permanent visa due to their HIV status, they applied for a new 457 visa. They had a private migration agent who stressed them about the process in order to pressure them to pay more money. They came to the HIV/AIDS Legal Centre in 2007 when they were on a bridging visa for the 457 and when the department were requesting that they obtain an undertaking from the employer.

The undertaking would have most likely involved disclosure of their HIV status to the employer, which they were not willing to do. They decided to take the less certain route of proceeding to request Ministerial Intervention, over risking disclosure to the employer. The visa was refused in 2008 (four years after lodgement) and then the matter had to be appealed to the Migration Review Tribunal (MRT) so that they could eventually request Ministerial Intervention. The MRT refused the visa in January 2011.

The family were concerned about returning to their home country due to their HIV status, including their teenage son's HIV status, and also because they had been affiliated with the opposition government and were at risk of and had experienced persecution as a result of that. The Minister intervened and granted the family permanent visas in August 2012.

Had the family not felt forced to disclose their HIV status to the employer they would have been able to obtain a 457 visa which could have led to the permanent employer nomination scheme visa with

a health waiver, this would have resulted in less stress and costs for the family, and less expenditure on time and resource of the Department, the Migration Review Tribunal and the Minister. It is also useful to note that, but for the health criteria, *both* Agnes and Justice would have satisfied the criteria for permanent unsponsored skilled visas.

As indicated previously:

> *In Australia, HIV/AIDS is not regarded as a public health risk, unlike TB, and consequently, visa applicants with HIV/AIDS may still be granted a visa.*[96]

Although HIV is not considered to be a risk to public health in Australia, where an applicant intends to work as, or study to become, a doctor, dentist, nurse or paramedic, the MOC may question whether they are a risk to public health. In these circumstances the MOC can require an applicant to provide a letter from their employer that they will not engage in exposure prone procedures. The delegate will also ask such temporary visa applicants to undergo an HIV test.

In all states in Australia, an HIV-positive person is not permitted to perform exposure-prone medical procedures. This standard applies to both nationals and non-nationals. There is no requirement for Australian nationals, however, that a medical student or practitioner living with HIV disclose their HIV status. People performing exposure-prone procedures have a duty to know their HIV status and not perform exposure-prone procedures if they are HIV positive. The requirement placed upon visa applicants, intending to work as, or study to become, a doctor, dentist, nurse or paramedic, to approach their employer and obtain a letter that they will not engage in exposure-prone procedures, places an obligation above and beyond that of other HIV-positive doctors, dentists, nurses or paramedics in Australia, and other visa applicants, to disclose their HIV status to their employer.

Migration Agents

Many applicants elect to enlist the assistance of a migration agent to support them in their migration matter. Commonly applicants will engage agents who they may have cultural connections to, have been recommended by friends or are the same as the agent used by their employer.

Anecdotally, from the HIV/AIDS Legal Centre, it is not uncommon for applicants to be diagnosed with HIV during the visa application process. When this occurs, disclosure of their HIV status to a person who is part of their community or has connections to their associates is problematic.

Case Study 6: Breach of privacy – migration agents

In mid-2011, Poornima, a baker, applied for an 857 Regional Sponsored Migration Scheme visa with the assistance of a Registered Migration Agent/solicitor recommended to her by a friend.

Poornima was diagnosed with HIV when she undertook her visa medicals. She told her husband, her doctor and her migration agent about her HIV diagnosis.

Soon afterwards, Poornima's employment with the sponsoring employer ended. However, she found alternative employment with an employer who was willing to sponsor her. On advice from her migration agent, she withdrew the 857 application. The migration laws had changed at that time and the 857 visa no longer existed, accordingly based upon advice received she lodged a 187 application with her new employer. The migration agent failed to advise her that there was no health waiver available for direct entry via the 187 visa, and that she would be required to first hold a 457 visa for at least two years to be able to access the health waiver.

Poornima sought a second opinion from another migration agent and decided to end the appointment of the first migration agent.

Shortly after this, Poornima's employer received a call from a person purporting to be from Medibank Health solutions. This person told Poornima's employer about her HIV diagnosis and warned him to ensure that all his staff were trained about dealing with HIV. Medibank confirmed that no such call had been made to Poornima's employer. Poornima believes it was the migration agent who disclosed her HIV status to her employer without her consent, as this was the only person who knew other than her husband and doctor. Poornima was suspended from her employment whilst her employer sought further advice.

Poornima was unable to satisfy the requirements of the visas she applied for and despite engaging a professional to assist her with the process, her migration agent, upon learning of her HIV status, disclosed this information to her employer without her consent. The second migration agent also never advised her that the visa for which she applied couldn't be granted due to her HIV status.

The Department

Delegates should be well aware of privacy obligations surrounding an applicant's personal information, including personal health information. However, as the following case study demonstrates, delegates can be complacent with the sharing of information to other sources that they may feel that they can legally do. The following case study is one of two almost identical scenarios that have resulted in disclosure of an applicant's HIV status to a third party.

Case Study 7: Breach of privacy – the delegate

Brenda is from Papua New Guinea and is married to Bruce. On a visit to Australia she was diagnosed HIV positive and immediately commenced treatment. Brenda had witnessed how HIV-positive people from her village were treated and feared disclosing her HIV status to family. Brenda immediately lodged a partner visa so she could remain in Australia with Bruce, her sole support person.

Brenda also has a 13 year old daughter in PNG, Bernadette. Although Bernadette couldn't be included in the application because she wasn't also in Australia, Bernadette was required to undergo a medical examination as a non-migrating dependant (NMD). The medical examination included an HIV test because Brenda is HIV positive. The panel doctor in PNG required a letter from the case officer in Australia confirming what medical examinations need to be conducted. The case officer wrote in an email sent directly to the clinic:

> *'It is policy that all non-migrating dependents undergo a medical examination, and, if a biological parent is HIV+, regardless of age or whether or not they are migrating, they must also have a HIV test.'*

The Panel doctor informed Brenda's family of this when they took Bernadette for the medical examination, thus disclosing Brenda's HIV status to her family.

Information about when an HIV test is required can found on the Department's website and is available in multiple languages. Accordingly, even if the scenario as described above had not occurred, given the framework of the migration laws, it would have been possible for family members to deduce the reason why a non-migrating dependent child needed to undergo an HIV test.

c. Impact upon the community

Although the grant of a visa is often beneficial to the applicant, there are often benefits to the Australian community also. Despite assertions that limitations upon entry, stay and residence of people living with HIV is due to economic reasons, the health criteria can put obstacles in place that are of economic or other detriment to the community.

Case Study 8: Detriment to the criminal justice system

Dario is from Germany and was in a relationship with Garry and lodged a partner visa application. During the course of the application the Department was made aware of Dario's HIV status.

The relationship between Garry and Dario broke down and Dario notified the Department of this change in his circumstances and indicated that he wished to withdraw the application. Dario returned to Germany.

When Dario was living in Australia he witnessed someone being assaulted. The New South Wales State police asked Dario to attend and give evidence in court. Police told Dario to apply for a visitor visa to come to Australia, which he did. The Department informed Dario that he would have to undergo a medical examination because they were aware that he was HIV positive as a result of the previous partner visa application.

Due to the additional time taken to process Dario's application this resulted in the charges against the defendant in the criminal proceedings being dismissed, as Dario was not present to give evidence.

Case Study 9: Detriment to the community

Ted is a highly skilled Rail Engineer from the United Kingdom. His skills are recognised as being in short supply in Australia, and as a result of this he was offered employment by the NSW Government in 2006. He was unable to obtain permanent residency as NSW was not a *participating state* for the 856 visa program at the time.

Ted was offered a job in Victoria in 2010 and the new employer sponsored him for a 856 visa; Victoria was a *participating state* for the purpose of the health waiver. The application remained pending for a further two years; due to conditions on Ted's visa he was required to continue to work for the NSW employer and was unable to commence work with the sponsor unless and until his 856 visa was granted. During this period, Ted's police and health checks expired, necessitating further delays (and costs) in the process as he was forced to re-apply for these checks.

Subsequently, the sponsoring employer became frustrated that he hadn't yet commenced employment and terminated the contract. At that point for Ted to have been able to remain in Australia he would then have had to try to obtain a new 457 and be on that visa for 2 years before being eligible to apply for the permanent visa from the beginning.

Ted was frustrated with the experience and the expenses due to the delays as a result of the health criteria and elected to return to the UK. As a result of this the Australian community has missed out on the benefit of Ted's skills and expertise.

Case Study 10: Detriment to other Australian citizens and cost implications for the community

Ms Nguyen is an Australian citizen who was widowed in 2010. She has 3 young children under the age of 6 years. Since her husband's relatively sudden death from liver cancer, she has struggled with severe depression. Her late husband's family provide her with as much support as they can. Her parents, who still live in Vietnam, visited Australia on visitor visas on a number of occasions to support their daughter during this difficult time. However, over time it has become apparent that she requires more long-term care. Her parents applied for a carer visa so that they could provide longer-term care to her and the three children. When they undertook the visa medicals, her father tested positive for HIV.

There is no health waiver available for the carer visa. Ms Nguyen has been assessed as in need of care and there is on one else that can provide that. The family's only option will be to apply for Ministerial Intervention.

d. Processing Times

Due to the structure of the health criteria, applicants often face lengthy processing times that can have adverse consequences. The processing times can have a detrimental impact upon family relationships, employment relationships and financially.

Lengthy processing times often mean that there are changes to an applicant's circumstances. Such changes can have impact upon the capacity of the applicants to obtain the visa for which they initially applied for. Although applicants might no longer satisfy the criteria for the grant of the visa, that does not detract from their skills or expertise which the applicant and their family may bring to the Australian community.

Case Study 11: Change in circumstances - impact upon family

Cynthia was a highly skilled nurse. In 2004 she came to Australia from Zimbabwe on a skilled 457 visa to create a better life for herself, her husband Terrence and two children. Cynthia had come to Australia ahead of her husband and children to earn money to pay for their flights and to set up a home. Four months after Cynthia arrived in Australia her one year old son died of what she believed to be gastroenterological complications. Cynthia's husband and ten year old daughter came to Australia after the baby's funeral.

Cynthia and Terrence were diagnosed as being HIV positive in Australia in 2006; their daughter is negative. The family had not been aware of their HIV status when they made the application and did not have to undergo an HIV test when applying to come to Australia.

No health waiver was available for any permanent skilled visas at that time so when their visa was expiring in 2008 they had to apply for another 457 visa. This required the family to disclose their HIV status to the employer which caused them significant stress and at times the family lost hope of ever giving their daughter the life they had dreamed for her. It took approximately 2 years for Cynthia and her daughter's visa to be granted, and then a further 12 months for Terrence's visa to be granted. They were granted a visa until mid-2012.

In 2010 health waivers had become available on a limited basis for skilled applicants. Accordingly, discussions then took place with the employer for them to sponsor the family for a permanent visa.

In March 2012 the family applied for a permanent visa. The letter acknowledging that the

application has been validly lodged states:

> *As a guide, it is expected that most applications will be finalised within five to seven months when all appropriate documents are provided with an application. When applications are more complex or documents are not provided quickly, the application may take longer to finalise.*

All necessary documents to process the visa were lodged at time of application. In June 2013, being 15 months after lodgement, the family were notified that due Cynthia and Terrence's HIV condition the Medical Officer of the Commonwealth had found that they would likely be a significant cost to the Australian community in terms of health care and community services. As the visa had a health waiver they were invited to demonstrate compelling and compassion reasons for why the estimated costs were not undue. The family were able to provide strong reasons for why a health wavier should be granted and put forward a large volume of information in support of this.

On 2 September 2013, Cynthia passed away suddenly.

Terrence and their daughter are left with limited visa options. Under current legislation, Terrence would have to find an employer to sponsor him for a 457 and then be with that employer for at least 2 years before being eligible to apply.

An HIV diagnosis of one party in a relationship can be significant for a couple to deal with, but that coupled with the impact of that diagnosis upon the couple or family's migratory future is often too much. Although in the outset the couple may be able to work though this together, the lengthy processing times contribute significantly to the family's capacity to cope with the situation.

Case Study 12: Relationship breakdown

Quanda and his wife, Qelhatat, originally migrated to Australia in 2002 from South Africa. Qelhatat was the primary applicant, being a qualified nurse. Quanda is a fire and safety inspection officer. Qelhatat and Quanda then lodged an application for permanent residency in 2005. At that time, Quanda was diagnosed as HIV positive. There were no options for them to obtain a permanent visa at that time, due to Quanda's HIV-positive status. The couple proceeded to try and obtain a visa from the Minister on compassionate grounds.

In 2010, Quanda learnt that the relationship broke down, in part due to the stress of the ongoing migration process, via notification from the Minister. Qelhatat had, unbeknown to Quanda, notified the Minister that she had left her husband and was subsequently granted a permanent visa on her own. The Minister refused to intervene for Quanda.

From that time on, he had no work rights and was forced to rely upon friends and charity for ongoing financial support. He applied for a protection visa in 2010, on the basis of the risk to his health and life due to the then position on HIV of the South African Government, and lack of familial support. He was recognised as being owed obligations under the Refugee Convention and was granted a permanent visa in late 2011. He remained without work rights for the entirety of this process.

Qelhatat (and Quanda) were – barring Quanda's HIV positive status – eligible for the grant of a permanent visa in 2005. It would be reasonable to expect that process to have ordinarily not taken over 12 months and should have resulted in the grant of a permanent visa by 2006 at the latest.

Case Study 13: Detriment to health and integration

Adaeze is a qualified Aged Care Nurse from Zimbabwe. Adaeze, her husband, Temitope, and their three children originally applied to migrate to Australia in 2003 at which time Temitope was diagnosed with HIV. The family decided to split, with Temitope remaining in Zimbabwe, as they were advised they would not be granted the visa otherwise. Adaeze and the children have been residing in Australia since on a 457 visa, with Temitope visiting on visitor visas over the intervening years.

In 2009, Temitope was diagnosed with renal failure and an AIDS-defining condition during a visit to Australia. He had been unable to obtain treatments or employment in the intervening period in Zimbabwe, and had been financially supported by Adaeze. The family applied for a permanent employer sponsored visa, which had only recently had a health waiver available. Temitope was given Departmental permission to join that application. The application was complicated by the fact that – in 2010 – Adaeze was older than the age cut off. She had been unable to apply earlier for a permanent visa due to the lack of options available, as even if Temitope was not on the application his health would have prevented the family being granted a visa.

Due to the length of time, Adaeze also had to change employers. The family currently remain on a bridging visa as the permanent application has not yet been processed. The family has expended significant sums of money on the education for the children, as they have to pay international school fees and do not have access to governmental assistance. The two older children have been unable to start university due to the costs associated. The length of delay may also impact on the ability of the older children to obtain the visa, as they are approaching the age cut-off for dependent applicants. The delays in the processing of the application also result in increased process fees for the family. As the family's character and health checks expired, new checks from Zimbabwe and Australia had to be obtained resulting in further delays and significant cost that had to be met by charitable organisations as the family no longer had the resources to meet these costs. The cost of new police and medical checks cost roughly $1,400 and to date they have been repeated three times. The family are under significant emotional and financial pressures. Temitope faces a genuine risk to his health should he be forced to return.

Adaeze was – barring her husband's HIV-positive status – eligible for the grant of a permanent visa on the basis of her skills in 2003. Her skills are highly valuable and recognised by the Government as being in short supply. Had she obtained residency in 2003, Temitope would have been able to access medications then and would likely have been in significantly better health. It is likely that the family will be granted their visa, however had this occurred in 2003 the Australian community would not now be having to bear the burden of Temitope's deteriorated health. He is currently unable to work and dependent financially on Adaeze. There is a disincentive for the children to enter the workforce as, if they are not financially dependent on the primary applicant (Adaeze), they may become ineligible for the grant of the visa. The family has been unable to properly integrate into the community due to these set-backs.

e. No options

As highlighted in other case studies there are many circumstances in which HIV positive applicants have no options as a result of their HIV status. Such visas as orphan relative, sole remaining relative, parent, carer and all independent skilled visa categories do not have any provision for a waiver of the health criteria; many of these people have no option.

Lack of visa options can often lead to such applicants applying for visas with the knowledge that they will be refused and then seeking Ministerial Intervention. The process of seeking Ministerial Intervention is lengthy and results in expenditure of time and resource not only of the applicant but also the department, the MRT or RRT and the Minister. Many of these applicants are in a position to demonstrate that it is in the public interest for the Minister to intervene and grant a visa. Thus, had the applicants' HIV status not been an impediment to the grant of a visa, the expenditure of much time and resources could have been avoided.

Case Study 14: Remaining relative visa

Zola is from South Africa. Her mother, Racheal, migrated to Australia in 2003. Her two younger sisters joined Rachael in 2004 but Zola and her child, Qhikiza, were unable to join them as Zola was diagnosed HIV positive during the migration process.

During the period 2003 – 2010, Zola and Qhikiza remained in South Africa and were financially supported by Racheal due to the difficult economic circumstances in South Africa at the time. They had no other family remaining in South Africa. Zola was unable to access medication due to the policies of the South African Government during much of this period. While visiting Racheal in 2010, Zola was diagnosed with AIDS and a severely depleted immune system. Ordinarily, she would qualify for a *Remaining Relative* visa but this has no *health waiver*. An application was lodged, in the knowledge that Zola would be refused the application, and subsequently appeal to the Migration Review Tribunal, and then to the Minister of Immigration.

Zola remains awaiting a determination on her application. Her son, Qhikiza, has been unable to go to university as he is not eligible for government assistance and would have to pay high international student fees. Zola is now the primary income earner for her extended family.

Case Study 15: Skilled visa

Lee is a gay man from Malaysia. He is a highly qualified chef. He originally entered Australia in 2003. He was ineligible for the grant of any permanent visa, as there were no skilled visa options for HIV-positive migrants at the time, and was forced to return to Malaysia where he is at significant risk of harm due to his sexuality. Following reforms to the migration process he has attempted to obtain employer sponsorship from 2010 onwards, offshore from Malaysia, but has been unsuccessful. Barring his HIV-positive status, he would have been eligible for the grant of an independent skilled visa on his original entry to the country.

Case Study 16: Skilled visa

Bahadur first came to Australia in 2004 on a student visa. He completed a Bachelor's degree in Business, majoring in Accountancy.

In 2008, following graduation, Bahadur applied for a skilled migrant visa on the basis of his accountancy qualifications, skills highly sought after in Australia. As part of the visa application process, he undertook medical tests and was diagnosed with HIV. There was no health waiver available for the skilled visa options at this time so he was advised to withdraw the application.

The health diagnosis came as a significant shock to Bahadur. He was also in a relationship with Nila, who he had been seeing since 2004. He told Nila about his diagnosis. She tested negative for HIV. After the initial shock of Bahadur's diagnosis, they had many discussions with medical professionals about the implications for them of Bahadur's diagnosis. They learnt that it was still possible for them

to have a family, with appropriate medical treatment and intervention to prevent transmission of HIV from Bahadur to Nila or to their children.

The couple applied for a partner visa later in 2008, having been advised of the availability of a health waiver for this visa.

In around mid-2010, the relationship between Nila and Bahadur broke down. The couple explained that the stress of living with the diagnosis, and the stigma and discrimination they feared if any of their family or friends were to find out about Bahadur having HIV took its toll on their relationship and they decided to separate.

The partner visa application was subsequently refused and resulted in an automatic bar on Bahadur making any further onshore applications. There were in any event no other skilled visas he could apply for at the time which had a health waiver available. His only option was to proceed to the Minister to request that he intervene in accordance with s351 of the Act. As of December 2013, over five years since he first applied for a visa and was diagnosed with HIV, he is still awaiting a decision on his application.

Bahadur is a well-educated, highly skilled and ambitious young man with excellent employment prospects. He has already made significant contributions to Australia, having worked full-time since graduation. He has engaged in further study, embarking upon a Masters Degree in Supply Chain Management on a part-time basis whilst working full time. His treating doctor confirms that he is in excellent health and his HIV is not affecting his ability to work or live a normal life.

Were it not for Bahadur's HIV-positive status, he would have likely been granted in the first instance a skilled migrant visa. The submissions that could be made in support of a health waiver are strong and compelling.

As it stands, Bahadur remains in limbo, five years since he first applied for a skilled visa to remain in Australia. He faces an uncertain future, and has significant concerns for his wellbeing if he has to return to Nepal and face significant stigma and discrimination, as well as barriers to accessing appropriate treatment for HIV.

---

[1] *International Covenant on Civil and Political Rights*, opened for signature 19 December 1966, 999 UNTS 171 (entered into force 23 March 1976).

[2] United Nations Human Rights Committee, 'General Comment 18: Non-discrimination', UN HRC, 37th sess, 1989, UN Doc HRI/GEN/1/Rev.1 (11 October 1989). The United Nations Commission on Human Rights has also adopted numerous resolutions on human rights and HIV which, *inter alia*, confirm that discrimination on the basis of HIV/AIDS status, actual or presumed, is prohibited by existing international human rights standards and clarify that the term "or other status" used in the non-discrimination clauses of such texts "should be interpreted to include health status, such as HIV/AIDS".

[3] *International Covenant on Economic, Social and Cultural Rights*, opened for signature 19 December 1966, 993 UNTS 3 (entered into force 3 January 1976) art 2; *Convention on the Rights of the Child*, opened for signature 20 November 1989, 577 UNTS 3 (entered into force 2 September 1990) art 2(2).

[4] International Committee on Economic, Social and Cultural Rights, 'General Comment No 20: Non-discrimination on Economic, Social and Cultural Rights (art 2 para 2), ICESCR 42nd sess, UN Doc E/C/12/GC/20 (10 June 2009).

[5] United Nations General Assembly, 'Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS', UN GAOR, 65th sess, 95th plen mtg, Agenda item 10, UN Doc A/RES/65/277 (8 July 2011).

[6] Ibid at 79

[7] *International Covenant on Economic, Social and Cultural Rights*, opened for signature 19 December 1966, 993 UNTS 3 (entered into force 3 January 1976) art 10.

[8] *Convention on the Rights of the Child*, opened for signature 20 November 1989, 577 UNTS 3 (entered into force 2 September 1990).

[9] *ZH (Tanzania) v Secretary of State for the Home Department* [2011] UKSC 4.
[10] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 Mar 2007, 2515 UNTS 3 (entered into force 3 May 2008) ('CRPD'); *Optional Protocol to the Convention on the Rights of Persons with Disabilities*, opened for signature 30 Mar 2007 (2007) 46 ILM 443 (entered into force 3 May 2008). Australia ratified the Convention on 17 July 2008 and ratified the Optional Protocol on 21 August 2009.
[11] See, for example, OHCHR, WHO and UNAIDS (2009), Disability and HIV policy brief. Available on-line at http://www.who.int/disabilities/jc1632_policy_brief_disability_en.pdf
[12] [2005] FCA 1626
[13] *Robinson v Minister for Immigration and Multicultural and Indigenous Affairs* (2005) 148 FCR 182. See the discussion in Mary Crock and Laurie Berg, *Immigration, Refugees and Forced Migration: Law, Policy and Practice in Australia* (Sydney: Federation Press, 2011), 162.
[14] Annexure 2
[15] Annexure 3: *S.52 Divisions 1, 2 and 2A do not: (a) affect discriminatory provisions in: (i) the Migration Act 1958 ; or (ii) a legislative instrument made under that Act; or (b) render unlawful anything that is permitted or required to be done by that Act or instrument.*
[16] Committee on the Convention on the Rights of Persons With Disabilities, Concluding Observations on Australia, CRC, 60th session, 28 August 2012, UN Doc CRC/C/AUS/CO/4.
[17] Annexure 4: Schedule 4 of the Regulations 4005, 4006A or 4007 depending upon the visa subclass.
[18] Medical examinations are only supposed to be assessing threat to public health and TB. MTV applicants in need of medical treatment excludes considerations under PIC4005(1)(c), therefore essentially only needing to demonstrate that they don't have TB or any other condition that could be considered a threat to public health.
[19] By way of example this includes such conditions as R1N1, H1N1 and Ebola
[20] Significant cost is any cost of $40,000 over the life of the visa for a temporary visa or in the case of a permanent visa either 5 years or a life time
[21] The 'significant cost test' is applicable to such conditions as HIV, and intellectual disabilities.
[22] Conditions, which might be considered to cause 'prejudice to access', may include a person in need of a liver transplant or someone in need of dialysis.
[23] Annexure 9.4: PAM3: Sch4/4005-4007 - The health requirement, at 47.1
[24] Annexure 5
[25] Annexure 6
[26] Annexure 7
[27] Annexure 8: Regulation 1.16AA - *The Minister may, by writing signed by the Minister, appoint a medical practitioner to be a Medical Officer of the Commonwealth for the purposes of these Regulations.* See also *Annexure 9.4: PAM3: Sch4/4005-4007 - The health requirement, at 52.2 - Using non-panel physicians & 52.4 - Acceptable non-MHS health examinations.*
[28] Annexure 10: Australian Government – Department of Immigration and Border Protection, *Health Requirement for temporary entry into Australia,* form 1163i.
[29] Annexure 11: *Legislative Instrument IMMI 13/079 - Commonwealth of Australia Migration Regulations 199, REQUIRED HEALTH ASSESSMENT (Clauses 4005, 4006A and 4007)*
[30] Annexure 9.2: PAM3: Sch4/4005-4007 - The health requirement, at 17
[31] Ibid
[32] Ibid
[33] Ibid
[34] Annexure 9.1: PAM3: Sch4/4005-4007 - The health requirement, at 7.4
[35] Annexure 9.2: PAM3: Sch4/4005-4007 - The health requirement, at 18.2
[36] Annexure 6
[37] (1999) 85 FCR 115
[38] *Minister for Immigration & Multicultural Affairs v Seligman* (1999) 85 FCR 115
[39] *Applicant Y v Minister for Immigration and Citizenship* [2008] FCA 367
[40] [2008] FCA 367
[41] [2005] FCA 1626
[42] Robinson v Minister for Immigration and Multicultural and Indigenous Affairs [2005] FCA 1626
[43] Annexure 9.4: PAM3: Sch4/4005-4007 - The health requirement, at 47.1
[44] Annexure 12: Exemptions to this rule are listed in Gazette Notice *IMMI 12/02, Federal Register of Legislative Instruments F2012L01291*. The temporary visas listed in the Gazette are those that likely lead to the grant of a permanent visa and therefore the assessment is on a permanent basis.
[45] Annexure 9.6: PAM3: Sch4/4005-4007 - The health requirement, at 72.2

[46] Annexure 13: *Federal Register of Legislative instruments F2011L02242* – exclusions to the 'costing' are *(a) Social Security payments; (b) costs associated with issuing a Health Care Card or Pensioner Concession Card; (c) Pharmaceuticals listed under the PBS that, if ceased, would not be seriously detrimental to the applicant's life or wellbeing.*

[47] Annexure 14

[48] Annexure 4

[49] Ibid

[50] *Bui v Minister for Immigration and Multicultural Affairs* (1999) 85 FCR 134

[51] Anecdotal evidence from HALC

[52] 'Family formation visas' included partner, child, adoption, New Zealand Relative and offshore sponsored Humanitarian visas - remaining relative, orphan relative and parent visas are not included – this is highlighted in *schedule 2* of the Regulations.

[53] See for instance Klein, A., *HIV/AIDS and Immigration: Final report. Montreal*, Canadian HIV/AIDS Legal Network (2002), and Bisaillon, L., *Human rights consequences of mandatory HIV screening policy of newcomers to Canada*, Health and Human Rights Journal (2013) accessed at: http://www.hhrjournal.org/2013/08/26/human-rights-consequences-of-mandatory-hiv-screening-policy-of-newcomers-to-canada-2/

[54] *Mandatory HIV testing for employment of migrant workers in eight countries of South-East Asia: From discrimination to social dialogue* (2009), ILO Subregional Office for East Asia and International Organization for Migration

[55] Annexure 15: Form 815 Health Undertaking

[56] Annexure 9.7: PAM3: Sch4/4005-4007 - The health requirement, at 91.3

[57] *International Guidelines on HIV/AIDS and Human Rights of the United Nations Commissioner for Human Rights* at 145.

[58] Annexure 16: 'Australian Government response to the Joint Standing Committee on Migration report: Enabling Australia Inquiry into the Migration Treatment of Disability'

[59] Advice provided by health policy

[60] Report of the International Task Team on HIV-related Travel Restrictions, Finding and Recommendations, December 2008, page 22 at 44

[61] Ibid at page 23 at 48

[62] Ibid at page 24 at 51

[63] Ibid at page 24 at 52

[64] *A fairer approach to migration for people with disability*, 31 October 2012 accessed at http://www.minister.immi.gov.au/media/cb/2012/cb191379.htm

[65] UNAIDS Human Rights Law Team, *HIV related restrictions on entry, stay and residence* (2012) <http://www.unaids.org/en/media/unaids/contentassets/documents/factsheet/2012/20120724CountryList_TravelRestrictions_July2012.pdf>. See also The Global Database on HIV-Specific travel and residence <http://www.hivrestrictions.org/>.

[66] Explanatory Memorandum, Public Law and Inadmissibility Due to Human Immunodeficiency Virus (HIV) Infection, 110-293, 42 CFR 34.2(b).

[67] European Parliament resolution of 20 November 2008 on HIV/AIDS: early diagnosis and early care, OJ C 16E, 22.1.2010, page 62

[68] See for instance the comparison between the healthcare systems between, relevantly, Australia, the UK, Italy, Sweden, France and Germany conducted by the National Audit Office, United Kingdom: *International Health Comparisons: A compendium of published information on healthcare systems, the provision of healthcare and health achievement in 10 countries*

[69] *Immigration and Refugee Protection Act 2001* (Canada).

[70] Ibid s38.

[71] Ibid s38(a).

[72] Ibid s38(b).

[73] Ibid s38(c).

[74] Ibid s39(a).

[75] Ibid s39(b).

[76] Ibid s39(c).

[77] Ibid s39(d).

[78] Canadian HIV/AIDS Legal Network, *Canada's immigration policy as it affects people living with HIV* (2013) <http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=2117>.

[79] *Companioni v. Canada (Minister of Citizenship and Immigration)*, [2009]F.C.J. No.1688 (Federal Court) (QL).

[80] *The Minister of Citizenship and Immigration v. David Hilewitz* 2003 FCA 420.

[81] *Dirk De Jong v. The Minister of Citizenship and Immigration* 2003 FCA 422.

[82] B Kaufmann, "Canada welcomes HIV immigrants: Sun learns thousands who have the virus causing AIDS allowed to come to Canada". *Calgary Sun*, 20 March 2008.

We thank Sandra Chu from the HIV/AIDS Legal Network, Canada, for her assistance in reviewing the Canada section of this report.

[83] *Immigration Act,* 2009 (New Zealand).

[84] *Immigration New Zealand (INZ) Operational Manual,* (2013).

[85] Ibid, A 4.10 (a).

[86] Ibid, A 4.10(c).

[87] Ibid, A4.10.2 (b).

[88] Ibid, A10.2.

[89] Ibid A1.5. and *BJ v Immigration and Protection Tribunal New Zealand*, [2012] NZIPT 200703.

[90] *Immigration New Zealand (INZ) Operational Manual,* (2013) A4.15

[91] Ibid, A4.10.2.

[92] Ibid, A4.70.

[93] Ibid, A4.60 (b)

[94] We thank Antoinette Tanguay, Immigration New Zealand, for her assistance in reviewing the New Zealand section of this report.

[95] UNHCR 'Submission No 82 to the Joint Standing Committee on Migration Inquiry into the Migration Treatment of People with a Disability' *Inquiry into Migration Treatment of People with a Disability*, 2009.

[96] Annexure 9.4: PAM3: Sch4/4005-4007 - The health requirement, at 47.1