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Health and Immigration Control: The Case of Australia's Health Requirement

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Afrasian Research Centre, Ryukoku University
Phase 2

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Health and Immigration Control:
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Akihiro Asakawa*

Introduction

Immigration control linked to the health condition of migrants is incorporated into migration legislation in a number of developed countries. In these countries, migrants are prevented entering a country if they have a communicable disease. In Australia, the potential cost incurred by medical and social services, due to particular health conditions of migrants, are always taken into consideration. This is partly seen as a means to protect the universal health care system from additional costs. The Australian system includes mechanisms to ensure potential migrants have medical examinations and to calculate the potential cost of accepting migrants with certain health conditions.

This article discusses the management of immigration policy, and in particular, explores the significance of assessing the health condition of potential migrants and the fiscal costs associated with health issues. The international movement of people is controlled by many factors and those factors are incorporated into the immigration legislation as selection criteria used to asses migrants' visa applications. Criteria are mainly composed of family, skill, or humanitarian concern.

The health condition of migrants is one of the factors to which immigration control is applied. Countries such as the United States and Australia require migrants to undergo a health examination to assess whether they should be admitted or not. Therefore, there is a clear and important relationship between the health of migrants and immigration control. Australia's policy, known as the Health Requirement, focuses on the fiscal cost caused by migrants in addition to public health concerns. It is very important to understand the nature of immigration control in relation to the health condition of migrants, and how this affects its management.

To date, research in this area has focused on the health condition of migrants within the

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public health context, and has not look at the cost or fiscal implications of admitting migrants with health conditions. For instance, Martin and Donna (2006) and Keane and Gushulak (2001) look at the health screening of migrants in relation to infectious disease; Gushulak and Pottie et al. (2011) compare the health situation between the immigrant population and the general population in Canada; Hofmann (2011) also analyses the health conditions of immigrants from the former Soviet Union to the United States. In addition, Bashford and Howard (2004), Bashford and Power (2005) extensively surveyed how the Australian government historically prevented the entry of migrants with certain kinds of diseases due to public health concerns. However, none of this work has focused on the cost aspect. It is true that some research has focused on the medical cost of migrants, but most of this work is concerned with the cost incurred by migrants, and not the cost incurred by governments through universal health care and social security systems. Kik et al. (2009) analyze medical spending by migrants with tuberculosis in the Netherlands. Steel et al. (2005) also analyses disability and health service use by Vietnamese refugees in Australia. Mohanty et al. (2005) analyze the health care spending by migrants in the US and concludes that personal spending on health by migrants is lower than the general population. Similarly, Stimpson et al. (2010, 544) finds that "the cost of providing health care to immigrants is lower than that of providing care to U.S. natives" but these results deal with migrants accepted both legally and illegally by the US, and is not concerned with how to control the entry of migrants based on their associated health costs.

There is virtually no research that directly analyses the relationship between the immigration control mechanism and the cost incurred due to health conditions of migrants in the context of public policy management. This article, focusing on the example of Australia's immigration policy, seeks to start readdressing the balance by analyzing those mechanisms evident in immigration policy that impose health-related entry restrictions, and the potential cost of admitting migrants with health problems to the host country. First, Australia's the Health Requirement that migrants are expected to meet is explained and an international comparison is made. Following this, an analysis is done of how the cost aspect of the Health Requirement is applied. Finally, the policy challenges associated with the implementation of this policy are discussed in the context of "significant costs" and their subjective nature is interpreted.

1. Australia's Health Requirement

As with other major countries, Australia imposes what is known as the Health Requirement to prevent migrants with certain health conditions from entering the country. Under the current Migration Act, Section 60 says that, "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."

In addition, the Migration Regulations 1994 have a "Public Interest Criteria" (PIC), which is applied as part of the conditions for granting a visa to migrants. Failure to meet any of these criteria means a visa will not be granted, and the applicant will not be admitted. This PIC has 22 criteria, some of which are related to the health condition of prospective migrants. For example, PIC 4005 prohibits potential migrants if they cannot meet one of the following criteria:

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

(2) The applicant is free from a disease or condition in relation to which;
(ii) the provision of the health care or community services would be likely to;
(A) result in a *significant cost* to the Australian community in the areas of health care and community services; or
(B) *prejudice the access* of an Australian citizen or permanent resident to health care or community services

In essence, a migrant is prohibited from being admitted if he or she; (1) is a threat to public health (tuberculosis is one of the actual diseases legislated); (2) has a condition that would result in significant cost to health care and community services; (3) has a condition that would prejudice the access of Australian citizens to health care. In short, *public health, significant cost*, and *prejudice access*, are the three components of the Health Requirement.

2. Comparison with the United States

International comparison shows the peculiarity of Australia's Health Requirement with its focus on the cost associated with treating migrants. In other countries, public health concerns are the primary reason for the control of immigration on health grounds. For example, the United States' Immigration and Nationality Act (INA) Section 212(a)(1)(A) specifically and directly legislates that "any alien who is determined to have a *communicable disease of public health significance*" are "ineligible to receive visas and ineligible to be admitted to the United States." The diseases specifically listed are tuberculosis, syphilis, chancroid, gonorrhoea, granuloma inguinale, lymphogranuloma venereum, and Hansen's disease (leprosy). In addition, any alien who "has failed to present documentation of having received vaccination against vaccine-preventable diseases" or "who is determined to have a physical or mental disorder and behavior associated with the disorder that may pose, or has posed, a threat to the property, safety, or welfare of the alien or others" are also ineligible to be admitted. Fifteen diseases, including polio and hepatitis B, are defined as "vaccine-preventable diseases."

The United States' rules are primarily concerned with the fact that the health condition of potential migrants might cause direct public health or related threats to the people of the United States. This means that the existence or physical admission of a migrant is *itself* considered a threat. As mentioned earlier, the US immigration legislation specifies a number of diseases that result in exclusion. In the case of Australia, only tuberculosis is listed. At first sight, this might appear to mean that Australia's immigration policy, on the grounds of health, is less stringent than that of the US.

The fundamental difference between the Australian and US policies is grounded in the way the potential costs associated with a migrant's health condition are taken into consideration. US immigration law states that any alien who is likely "to become a public charge is inadmissible" (INA 212(a)(5)); however, there is no direct link between the health condition itself and the potential medical costs related to the condition. In the case of Australia, if a potential migrant has "a disease or condition in relation to which result in a *significant cost* to the Australian community in the areas of health care and community services," he or she will not receive a visa. Rather than just focusing on direct public health concerns, this approach looks at the *indirect* influence caused by the health conditions by taking into account the medical and social welfare system. The presence of migrants with health conditions "which results in a significant cost" does not necessarily cause a direct public health concern unless that condition is a communicable disease. However, the issue in Australia relates to the demands lawfully admitted migrants will place on medical and social care services. In short, US immigration policy is far more concerned with the issue of public health and concerns over how potential migrants may affect this, while Australia's immigration law only lists tuberculosis as a disease, which justifies exclusion. The cost of accepting migrants with certain health conditions is taken into consideration more heavily than public health threats are.

This contrast in approach relates to the differences in the social security systems of both these countries. For instance, the US does not have universal health cover and people are required to have health policies with private insurance companies. Goldman et al. (2006, 1700) indicates that foreign-born members of the population do not generally create costs for the whole system, stating that "the foreign-born (especially the undocumented) use disproportionately fewer medical services and contribute less to health care costs in relation to their population share, likely because of their better relative health and lack of health insurance." This is also strongly related to the presence of a health insurance system; Goldman points out that "uninsurance rates for the foreign-born were twenty-four percentage points higher than those for natives" and that "the foreign-born are also less likely than the native-born to use public funds, so their impact on public spending is even smaller" (*ibid*., 1705, 1710). In other words, because health care is not universal and therefore largely provided by private insurance companies in the US, the existence of immigrants with certain

health condition does not necessarily result in other taxpayers having to pay more. In contrast, in a country like Australia, where health care is universal and the cost is shared by all the residents and taxpayers, the issue of whether prospective migrants require medical and social services becomes an important selection criterion for immigration control.

In summary, public health concerns for migrants are rather common in immigration policy. However, concern over the medical costs associated with migrants is not common, largely because countries, such as the US, do not offer universal healthcare, and so the cost of directly treating migrants' health problems is not such a pressing concern. This is reflected in both the US and Australia's immigration policy, and in particular, through the fact Australia takes the potential health care cost of potential migrants seriously, while the US does not.

3. Implementation of Australia's Health Requirements

As has become clear, the costs associated with the health needs of migrants are important selection criteria within the context of Australia's immigration policy, and as such, the actual implementation of this particular policy is very important. Implementation involves a rather complicated process of calculating the potential cost. In the case of immigration policies that focus on public health concerns, policies can be easily implemented simply by preventing migrants with designated diseases from entering the country. Such policies require migrants to undergo medical inspections to check whether they have any of the designated diseases. When policy calls for a cost assessment of the healthcare requirements of migrants, not only is the identification of a particular health condition necessary, but also calculating the cost required to treat that particular health condition. It is important to take a closer look at how Australia implements this policy.

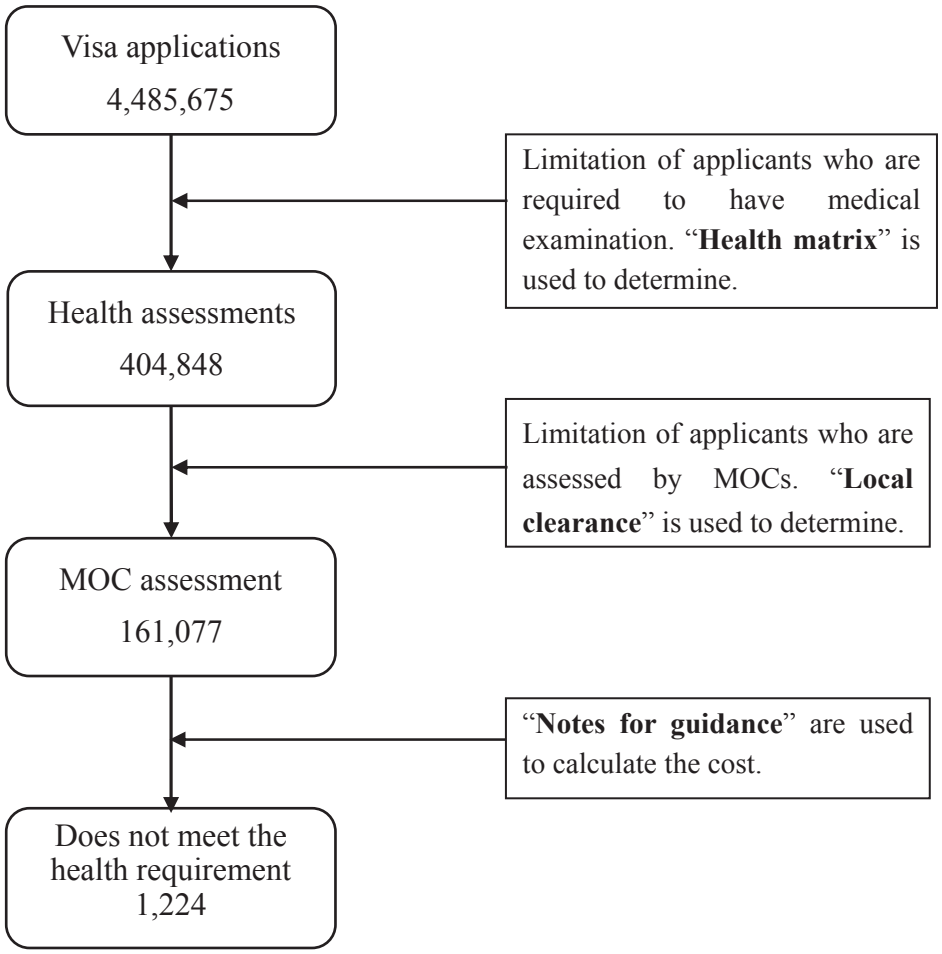
Under the current policy, it is true that the Health Requirement is applicable to all the visa subclasses, but the actual requirement of a health examination is differently applied, depending on the different type of visa being applied for. This is because it is unrealistic to require all entrants to undergo a medical examination, especially if people are only visiting for a short period. Therefore, it is necessary to limit the number of applicants who actually have to undergo a medical examination. For this purpose, there is "the health matrix" that determines which applicants are required to undergo a medical examination. All applicants for permanent visas are required to undergo a medical examination. Applicants for temporary visas are divided by lower, medium, and higher risk countries. They are also divided by "stays of up to and including 12 months" and "more than 12 months."

It is quite logical that all applicants for permanent residency need to undergo a medical examination, regardless of the level of risk. This is because permanent residents are eligible for Australia's universal health care (Medicare) and for other social security benefits. It is true

that migrants with temporary visas are not eligible for Medicare or social security benefits, but a medical examination is necessary for some temporary visa applicants as well. The health matrix guides implementation covering both public health and cost concerns caused by potential migrants. For temporary applicants, the main health related issue that may halt their application is the presence of tuberculosis. However, it is unrealistic to have a medical examination for all migrants, regardless of their intended period of stay, even though public health issues are involved. As a result, both the public health risk of countries of origin and the period of stay are taken into consideration.

For example, for the financial year 2004–2005, 404,848 applicants out of a total of 4,485,675 were required to undergo medical examinations (Australian National Audit Office 2007, 17). This is about 9% of the total (See Figure 1).

Figure 1: Actual Numbers on the Operation of the Health Requirement (2004–2005)



Source: Australian National Audit Office 2007, 17.

4. Assessment of Medical Examinations

After the number of potential migrants required to have a medical examination is determined, the next point should be how the medical condition of the potential migrants is assessed. Applicants seeking permanent residence are required to undergo a medical examination, a chest x-ray, and an HIV test (if 15 years old or over). Those living overseas are required to go to a panel doctor appointed by the Department of Immigration and Citizenship (DIAC), while those people staying in Australia on temporary visas are examined by Medibank Health Solutions (MHS). This means that, regardless of the

location of potential migrants, they have to undergo health examinations at medical institutions designated by the Australian government. Doctors responsible for conducting the necessary tests in the respective medical institutions use designated forms for these examinations (Form 26) and radiological reports (Form 160). This means the Australian government determines the actual items designated for testing. After examining these items, doctors are required to classify applicants as A or B on the Form 26. "A" means "no significant history or abnormal findings are present. For applicants 11 or more years of age, the chest x-ray must also be taken into account." "B" means that "significant history or abnormal findings present."

Following this is a stage of how to assess those medical examinations. As mentioned above, under migration legislation, the Minister can require applicants to undergo medical examinations (Section 60 of the Migration Act). In such cases, the Minister is obliged to seek the opinion of "a Medical Officer of the Commonwealth (MOC)" to judge whether an applicant satisfies the criteria for the grant of a visa on health grounds (Migration Regulations 1994, 2.25A). MOCs are medical practitioners appointed by the Minister. However, this does not mean that all the medical examinations undertaken by visa applicants are referred to MOCs. This is because a referral to the MOCs is exempt for temporary visa applications or permanent visa applications submitted in certain countries (Migration Regulations 1994, 2.25A). Therefore, before referring applicants to MOCs, immigration officers follow a process called "local clearance" to decide the cases that should be referred.

There are guidelines for "local clearance," and these are found in the Procedures Advice Manual (PAM3) created for immigration officers to help them perform their duties. First, local clearance in terms of the location of applications has a limitation. Local clearance for both temporary and permanent applications is only available in 76 designated countries, including Australia. This means that if applications are filed outside of these countries, all medical examinations must be referred to MOCs. A further 24 countries are designated as eligible for local clearance only for temporary visas; 66 countries are designated as ineligible for local clearance for both permanent and temporary visas. In addition, local clearance is not

applicable for any applications for refugee and humanitarian visas (Department of Immigration and Citizenship 2012b, 75). This application of local clearance is probably governed by the potential health risk of each country and region, as well as the quality of medical services in terms of their reliability.

As immigration officers are not medical practitioners and do not have the required knowledge to assess the details of a medical examination, there is criteria to guide whether local clearance can be exercised or not. The PAM3 lists three types of conditions that should be referred to a MOC: "most significant," "significant for all applicants," and "significant for permanent applicants only." "Most significant" includes "TB, HIV, intellectual disability (including but not limited to Down syndrome, autism, cerebral palsy, and old-age dementia), kidney failure, organ transplant." "Significant for all applicants" includes "diabetes, heart disease, cancer, and major psychiatric illness (examples include schizophrenia, bipolar disorder, and anything that has required past hospitalization)." "Significant for permanent applicants only" includes "physical disability (including very poor vision and very poor hearing)." PAM3 also mentions why physical disability is significant for permanent applicants only, as "temporary applicants are not eligible for disability support" (*ibid*., 84).

During the financial year 2004–2005, 161,077 out of 404,848 health assessments were referred to MOCs (Australian National Audit Office 2007, 17). This means that about 60% of the cases were "locally cleared" (see Figure 1). The next stage is the actual calculation of the cost of medical treatment by MOCs.

5. Calculating Medical Condition into Costs

To help MOCs to quantify the cost, Notes for Guidance for Medical Officers of the Commonwealth of Australia have been developed. This is a manual explaining specific medical conditions and disabilities, and outlining a method and the basis for calculating costs. As of September 2012, the following fourteen "Notes for Guidance" have been developed by the Australian government in close cooperation with medical practitioners:[1]

1. Alcohol and other drug dependence
2. Disability services
3. Endocrinology conditions
4. Gastroenterological conditions
5. Hematological conditions
6. Hearing conditions
7. Human immunodeficiency virus and acquired immune deficiency syndrome

[1] Interview with Public Officers of Detention Health Branch, Department of Immigration and Citizenship on 5 September 2012.

(HIV/AIDS)
8. Nephrological conditions
9. Ophthalmological conditions
10. Psychiatric disorders
11. Rheumatological conditions
12. Supported care
13. Tuberculosis
14. Viral hepatitis

For example, the notes for guidance on "psychiatric disorders" include schizophrenia, major depression, bipolar disorder, and eating disorders. In the section on bipolar disorder, the following points are mentioned:

1. Definition and brief description of bipolar disorder
2. Prognosis, factors affecting progression, including rate of progression
3. Information required
4. Diagnostic tests and baseline assessments
5. Currently accepted treatments
6. Financial considerations
7. Prejudice to access and scarcity of resources
8. Effect on applicant's ability to work

In the section on "financial considerations," detailed information on calculating costs is shown; there are also lists relating to the cost of "commonly prescribed medications," "inpatient episodes: public hospitals; 2008–2009," and "MBS (Medicare Benefits Schedule) and other medical costs." MOCs use this information to calculate the actual cost associated with the specific medical conditions of applicants. In the section relating to "prejudice to access and scarcity of resources," it says, "prejudice to access does not apply to services related to the treatment of bipolar depression." In the section on "effect on applicant's ability to work," the following is mentioned:

> Patients responding to treatment are able to function normally including in the workforce. Bipolar disorder though is more disabling even than major depressive disorder. The evidence based treatments detailed above, increase the likelihood of return to prior functioning, however, many patients are unable to return to prior functioning levels (Department of Immigration and Citizenship 2011).

The same structure is applied to other "notes for guidance." These give detailed information the calculation of medical costs for various health conditions.

Interestingly, some "notes for guidance" include examples of actual cost calculations for hypothetical cases. The notes for guidance on "disability support services in Australia" contain a scenario of an adolescent with moderate disability. The applicant is "an 18 year old with an acquired brain injury who lives with her mother. She has some difficulty in communicating with people who are not familiar with her. Her mother has difficulty supporting all of her needs. She has been working in a supported environment and with support could do so again." The total cost of care for the first year for this individual is calculated at $71,774. This includes $28,961 for disability services, $7,388 for education services, and $35,425 in pensions and allowances. Next, the cost of the second to the fifth years is calculated at $209,797. This includes disability services of $115,843 and pensions and allowances of $93,954. Therefore, the total cost for five years in this case comes to $281,571 (Department of Immigration and Citizenship 2010). This calculation is based on the State governments' spending relating to this specific disability as well as the federal government's disability payments.

Another hypothetical example is of "a 28 year old female refugee from Sudan who in applying for a subclass 200 refugee visa was found to be HIV-seropositive. She is currently asymptomatic and has a CD4+ T-cell count of 270 cells/mm^3 and viral load of 50,000 copies/mL." The calculation of the cost for the first year is $18,314, composed of medical services, diagnostic tests, and pharmaceutical agents. The cost for the second and subsequent years is calculated at $17,615 (Department of Immigration and Citizenship 2008). The basis for these costs for medical and pharmacy services is based on a predetermined price under a universal pricing system within the medical insurance system. As the cost for specific medical services and medications are set by the government, it is possible to calculate the cost of potential migrants who would require medical services and medication.

Calculating the cost of certain visa applicants' medical condition for the Australian health and welfare system begins with a detailed method of calculation directed by several "notes for guidance" for major medical conditions, which have been developed with the cooperation of medical practitioners. The examples mentioned above of actual calculations show that the calculation itself is fairly objective. There is no room for discretion in the MOCs' calculations. The Migration Regulations 1994 Section 2.25A(3) requires that the Minister must take the opinion of the MOCs to be correct. This means that migration officers cannot question or alter the MOCs' calculation of the cost itself.

Given this calculation is based on detailed criteria and is done by medical practitioners and not immigration officers, this process is "legitimate, objective, and reasonable," as per the DIAC.[2]

[2] Interview with Public Officers of Detention Health Branch, Department of Immigration and Citizenship on 5 September 2012.

6. Statistics of the Health Requirement

Table 1 shows the number of visa refusals owing to failure in meeting the Health Requirement. Statistics on the Health Requirement are not regularly published, although these statistics have appeared in several government and parliamentary reports. During the financial year 2004–2005, 1,224 applications were refused, representing about 0.76% of applications that were referred to MOCs (161,077). This also represents about 0.30% of applications that were required to have medical examinations (Australian National Audit Office 2007, 17; Figure 1). It is true that the Health Requirement seems strict, especially on the grounds of cost. However, the actual number of refusals based on this requirement is relatively small.

Further, these refusals against the Health Requirement do not mean that all applicants failed on the grounds of cost. During the financial year 2008–2009, 1,586 applications were refused, the details of which have been made public. Of these, 864, or 54.5%, failed to take the required health assessment tests and hence were refused visas; 360, or 22.7%, failed to meet the Health Requirement on the grounds of cost or prejudice of access; 282, or 17.8%, had a family member who failed to meet the Health Requirement on the grounds of health costs/prejudice of access. This latter figure reflects what is called the "one fails, all fail" rule, which requires all family members of visa applicants to meet the Health Requirement,

Table 1: Number of Visa Refusal on Health Grounds

Financial Year	Number
1986–1987	396
1987–1988	763
1988–1989	895
1989–1990	762
2004–2005	1,224
2008–2009	1,586

Source: Australian National Audit Office 2007, 17; Joint Standing Committee on Migration 2010, 14; Joint Standing Committee on Migration Regulations 1992, 8.

regardless of his or her actual migration to Australia.[3] Of the total, 36, or 2.7%, failed to meet the Health Requirement on public health concerns. Therefore, during the financial year 2008–2009, at least 642, or about 40%, were actually refused visas on the grounds of cost. This makes the proportion of rejection on the cost component of the Health Requirement even smaller in the case of overall visa applications. However, the Australian government estimates that "$70 million health and community service costs would have resulted if these visas had been granted" (Department of Immigration and Citizenship 2009, 42).

In the Australian system, the projected cost attached to a migrants' health condition is taken into consideration because of the existence of a universal health care system. Therefore, a system is in place that requires certain applicants to have a medical examination and includes a detailed method of calculation of the projected cost by MOCs based on "notes for guidance." Therefore, it is quite reasonable to say that this system should be "legitimate, objective, and reasonable."

However, even if that is the case, there arises the very important issue of how to determine if the calculated cost is "significant." Quantification of the cost might be an objective process, but how to assess the cost is very much subjective. There are ongoing discussions on this point.

7. The Significant Cost Threshold

First, legislation never determines a specific threshold for "significant costs," and the actual threshold is determined by the Minister and the government. The discussion on the appropriateness of the threshold tends to center on this issue.

In June 2010, the Joint Standing Committee on Migration of the Australian parliament tabled a report on the Health Requirement. This report stated that, "the review of significant cost threshold is priority as the Committee considers that the threshold is too low" and recommended that, "the Australian Government raise the 'significant cost' threshold to a more appropriate level" (Joint Standing Committee on Migration 2010, 37–38). The government accepted this recommendation and raised the threshold from $21,000 to $35,000, starting July 1, 2012. This new threshold includes health and welfare costs, plus a 20% loading. This cost assessment is based on a five-year duration for permanent visa applicants and covers the entire period of stay for temporary visa applicants (Department of Immigration and Citizenship 2012b, 85).

[3] This rule is explained as follows: if a migrant to Australia decides after a period of time that they want to sponsor to Australia a family member who remained offshore, difficulties can arise if the family member has a major health concern that could lead to significant costs being incurred (Department of Immigration and Citizenship 2012b, 37–38).

This modification is partly because of the recommendation by the parliamentary committee and partly because of the adjustment of medical prices to the current level. At the Committee hearing, a DIAC official outlined that, "On the whole, the MOCs have been using a costing that was applied way back in 2000 and has not actually been escalated or changed since that time […] that costing was done in the 2002–2003 financial year. There has been no formal annual review process for that" (Joint Standing Committee on Migration 2010, 33).

This implies that the concept of "significant cost" is subjective, in that, it requires modifications to match the current medical cost. It also invites discussion over what actually *is* significant because there is no perfectly determined objective threshold to be "significant cost." In relation to this, the US immigration law has a provision that prevents the admittance of migrants on "public charge" (INA 212(a)(4)). This requires family-sponsored migrants to have an "affidavit of support" given by their sponsors. This requires sponsors to have an income level of more than 125% of the federal poverty line (INA 213A).

However, unlike in the US, there are no reliable statistics for the "significant cost" threshold in Australia and this invites ongoing discussions of how to determine the threshold of the "significant cost" itself. This is a significant challenge for the effective implementation of the Health Requirement.

8. The "Waiver" System

In addition to the difficulties in determining the threshold of "significant cost," there have been discussions on whether the application to this requirement is appropriate or not in the context of compassionate or humanitarian concern. A particular mechanism exempts certain visa applicants from having to meet this threshold. The application of this system is subjective and invites further discussion.

This feature is called the "waiver" system, and is legislated in the Public Interest Criteria 4007 as follows:

> (2) The Minister may *waive* the requirements of paragraph (1)(c) if;
> (a) the applicant satisfies all other criteria for the grant of the visa applied for; and
> (b) the Minister is satisfied that the granting of the visa would be unlikely to result in:
> (i) *undue* cost to the Australian community; or
> (ii) *undue* prejudice to the access to health care or community services of an Australian citizen or permanent resident.

This means that if this "waiver" is applied, even if the applicant's health costs are calculated as "significant," visas can be granted, unless it leads to *undue* costs. This waiver is mostly applied to offshore humanitarian visa applicants, or third country resettlement refugees. It is easily anticipated that refugees would have diseases or disabilities because of the poor public health conditions in their countries of origin. Further, it is reasonable to accept refugees who would cause "significant costs" because the acceptance of refugees itself is in the humanitarian context. This is why the "waiver" system is applied mainly to refugees.

Even so, this waiver system itself is open to the discretion of the Minster and immigration department and the regulation does mention that the acceptance of those migrants should not result in "undue cost." Given the discretionary nature of this regulation, this means that it is still possible for a visa to be refused on the grounds of the "significant cost" requirement.

The Joint Standing Committee on Migration recommended that "the Australian Government amend the Migration Regulations 1994 to provide access to consideration of a waiver to offshore refugee visa applicants involving disability or health conditions on compelling and compassionate grounds" (Joint Standing Committee on Migration 2010, 134). The government accepted this recommendation and made the following arrangements: "a humanitarian visa processing officer will not consider any costs for health or community care services undue." However, the government did not intend to change the regulation itself. This means that the "waiver" is nearly automatically applied to humanitarian visa applicants at the discretion of the government. Consequently, visas could be granted even if the costs exceed $35,000, which means that "significant" health costs could be accepted for humanitarian entrants.

For example, the cost for the example of "a 28 year old female refugee from Sudan" mentioned above should be around $106,530, based on the calculation. Hence, this applicant will be refused a visa because the cost exceeds $35,000, if the "waiver" is not applied. However, this should not be a basis for refusal in this example because the "waiver" is nearly automatically applied to refugees.

Another type of subjectivity is evident in relation to "significant costs" and the setting of exceptions for different groups of prospective migrants.

9. How to Consider "Contributions"

There have been a number of ongoing and important discussions to suggest that the "contribution" of migrants should also be taken into consideration. Current practice is based on the determination of costs and applying the "significant cost" threshold, then refusing visas to applicants whose costs exceed the threshold. There is no consideration given to the

positive aspects of accepting migrants who are refused entry under the current practice. The argument is that the cost of accepting these migrants could be offset if these migrants can make economic and social contributions.

The Joint Standing Committee on Migration argued this point and said that "countering cost concerns is the argument in relation to the possible social and economic benefit gained by Australia by the entry of disabled migrants" (Joint Standing Committee on Migration 2010, 46). The Committee also mentioned that, "most noteworthy of the criticisms regarding the current application of the Health Requirement is its inflexible nature. There was a perceived failure to account for the social and economic contributions that could be made by individuals with a disability or condition" (*ibid*., 55). Based on this understanding, the committee recommended the legislation should be amended "to allow for the consideration of the social and economic contributions to Australia of a prospective migrant or prospective migrant's family in the overall assessment of a visa" (*ibid*.).

The issue of recognizing such contributions has been discussed for a long time. In 1992, the Joint Standing Committee on Migration Regulations of the Australian Parliament tabled a report titled *Conditional Migrant Entry: The Health Rules*, and stated that "the Committee has emphasized the need to take into consideration the likely contribution which individuals and families will make to the Australian community, as well as their ability to meet the cost of treatment and care arising from a medical condition or disability" (Joint Standing Committee on Migration Regulations 1992, iii).

The Committee then recommended that, "the applicant or a sponsor pay to the Commonwealth an up-front fee. The amount of the fee should equal the costs" (*ibid*., 83). However, this recommendation was not accepted by the government at the time because "the introduction of an up-front fee as recommended by the JSC revealed significant practical and conceptual difficulties in developing a scheme that could be integrated and operate effectively with the current health requirement" (Australian Government 1995).

However, in 2012 the Australian Government principally accepted the recommendation to consider contributions and indicated that it would introduce a "net benefit approach." This approach is where "any applicant who is found to have their, and their family's likely contributions to the Australian community considered. This would involve an economic assessment of the applicants' likely net fiscal contributions coupled with an expansion of the health waiver scheme so that social contributions and compassionate and compelling circumstances could also be considered" (Australian Government 2012, 4). It also states that DIAC "intends to report the outcome of the feasibility study and inter-departmental committee views to the Government in 2013" (*ibid.*) and that this "will dramatically change the way in which health requirement is applied to visa applicants" (*ibid*.).

Following the debate about the implementation of the Health Requirement, a new approach will be implemented that sees the intended economic contributions that prospective migrants could make "calculated," in addition to the already established method of "calculating" the medical cost. This should be an interesting approach because the economic contribution of migrants is calculated as a whole. For example, the "migrant fiscal impact model" calculated the fiscal impact of permanent migration at $721.4 million in the first year (Department of Immigration and Citizenship 2012, 167).

Therefore, this approach includes important implications not only in the implementation of the Health Requirement, but also in the management of immigration policy based on the *individual* fiscal and economic costs and the potential contribution of migrants. This point is clearly mentioned by the Australian Government: "A Net Fiscal Benefit Model which, based on some characteristics of the applicants, would calculate and model into the future the likely fiscal net contributions of the family unit to all levels of the Australian Government. The health costs would be included as an input in this model" (Australian Government 2012, 5).

Conclusion

In this article, the management of immigration policy in relation to the health condition of migrants was discussed in the context of Australia. Restricting the entry of potential migrants with certain health conditions is incorporated into migration legislation by many countries. There are two main approaches to restrict entry—public health concern and cost concerns. Restrictions based on public health concerns are widely implemented in the immigration laws of countries like the US. The actual implementation of these policies is rather easy, because it requires the designation of particular diseases and the detection of these diseases. On the other hand, cost concerns are closely related to the medical and social security system in individual countries such as Australia that have a universal health care system, are very concerned about the cost aspect, and therefore implement the Health Requirement.

A detailed analysis of the actual implementation of the Health Requirement involves several difficult issues. The first issue is how the intended cost of potential migrants with certain health conditions is calculated. On this point, the Australian Government has established a mechanism of medical examination systems for migrants, including the appointment of MOCs, who calculate the costs based on "notes for guidance." However, the second issue relating to assessing the calculated cost contains ongoing and complicated discussions owing to the very subjective nature of deciding what the "significant cost" is. More recently, there has been a prospective change in how the cost itself is calculated, and now includes the fiscal contribution of individuals. This change adds to the issue of calculating individual costs and benefits not only in the health aspect but also in overall activities.

There must be a safeguard to protect the country from the health conditions of potential migrants, based on either public health or on cost concerns. At the same time, this process must be "legitimate, objective, and reasonable" and should not discriminate against those who could make financial contributions. This implies that the nature and the mission of immigration policy are based on striking a good balance between inclusion and exclusion of migrants. Australia's practice of following the Health Requirement gives us important clues that will help us in managing immigration policy as well as in the actual implementation of this mission.

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