

Counting the cost: the social construction and human rights conceptualisation of the disabled child migrant through Australia's migration processes

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Abstract

Children living with a disability who seek to migrate to Australia are currently subject to the health requirement, which excludes applicants on the basis of their cost to Australia's health systems. While subject to seemingly objective processes of quantification, these children are in fact incorporated into a set of structures that order belonging and citizenship in classed, raced and ableist terms. In so doing, migration systems construct a static and disempowering social category, that of the disabled child migrant. In this paper we explore this construction within technical and administrative processes; we then discuss the possibilities of an alternative, human rights based approach. The paper concludes that for people living with a disability to become visible and to claim worthiness, capacity and advocacy in this system as opposed to silent, helpless burdens, human rights discourse itself will require transformation.

Keywords: Disability, Migration, Children, Citizenship, Quantification

Introduction

Fears centred on disability, ethnicity and citizenship are a constitutive theme of Australia's contested and imagined national identity. Particular categories of migrants were – and are – accepted into the nation based on conformity to the ideal of 'the good citizen embodied as male, white, active, fit and able, in complete contrast to the unvalued, inactive, disabled other' (Meekosha and Dowse 1997 50). Ethnicity and ability, as separate and intersecting structures, continue to be the basis of excluding people from the nation state. This exclusion has been underpinned by the desire for

economic and demographic growth, believed to be most effectively achieved through genetically, morally and physically 'strong' citizens (Meekosha 2006).

The early framework for assessing potential citizens was referenced to medical models of biological superiority, which were presented as a rational basis for decisions (Meekosha 2006). While the language has changed, rationality, now referenced to economics and medicine, continues to be presented as the key logic of migration decisions. In light of the current migration framework, Soldatic and Fiske claim 'the primacy of 'rational decision-making' remains unexamined and unchallenged' (2009:298).

This paper furthers existing accounts of Australia's migration systems through a critical reading of the 'health requirement' and its application to children who are living with a disability and applying for Australian residency. This discussion centers on children because to date children have been marginalised in legal and conceptual analysis of migration (e.g. Jakubowicz and Meekosha 2002, Meekosha and Dowse 1997), even though they are disadvantaged within Australia's migration processes and have not enjoyed the protections promised by human rights discourse (Bessell and Gal 2009: 283).

We explore two questions: How do Australia's migration systems construct children living with a disability?; and can rights discourses be used as a tool to counter these constructions? Our analysis focuses on quantification – the increasingly common and expected process of translating the characteristics of any social phenomenon into numbers. The resultant data are afforded a high degree of authority: they are understood as the outcome standardized and universalised rules that are a defence against the biases of decision makers (Espeland and Nelson 1998). We argue that quantification, as a symbol rather than a practice of rationality, is a key process in the

construction of a static and disempowering social category – that of the disabled migrant child. The international human rights system offers an alternate process of construction, that of inherent dignity, social worth and participation rights, which should allow disabled non-citizen children to claim non-discrimination rights from the destination state. In practice, this process often echoes the presumption that underpins the quantification process of migration decisions, conceptualising the child only as dependent and incompetent, a cost rather than a contributor to society.

Our analysis in this paper is rooted in a social model of disability that foregrounds power and the meanings that attach to bodies as core components of social and institutional marginalization of people living with a disability. We explicitly reject a deficit model of disability (Goggin and Newell 2005). In light of the limited word count, we acknowledge the importance of corporeal experience, but do not engage with broader debates over the importance of the body in disability studies (see Gabel and Peters 2004).

Australia's health requirement: creating the disabled migrant child

On its face, Australia's migration system no longer explicitly excludes on the basis of ethnicity or ability. When people apply to reside in Australia, they must meet the 'health requirement', which requires the applicant to be free of any disease or condition that creates a threat to public health or the Australian community, is likely to require health or community services, and would likely result in a significant cost to the community or limit access of citizens or permanent residents to health care of community services¹. These processes play out at three levels of decision making: an initial assessment by a Medical Officer of the Commonwealth, a Ministerial waiver (for some visa sub-classes) and Ministerial discretion, exercised with no formal

guidelines. In this paper we focus on the first two levels. The provisions are justified as protecting the public health and safety of the Australian community, containing public expenditure on health and community services and ensuring the priority of Australian residents in access to those services (DIAC 2009).

In the initial decision making process, medical authority legitimates exclusion. After a written application, a health matrix, based on tuberculosis (TB) rates in the country of origin, is used to assess the risk of an applicant. A Medical Officer of the Commonwealth (MOC) assesses those living in 'high risk' countries –primarily countries in the developing world – for disease and physical impairment. If a physical impairment is identified, the opinion is taken as correct (DIAC 2009), affording primacy to medical definitions of disability at the expense of applicants' accounts of impairment and (dis)ability.

Medical diagnosis seems to impose a rational and scientific structure on migration processes but the emphasis on TB, a disease more commonly found in developing countries, acts as a filter. As a result, disability, ethnicity and age are linked to systematically disadvantage the same social groups that were explicitly excluded in earlier times: 80% of people with disabilities live in developing countries; and children constitute about a quarter of all disabled people (UN Enable 2006).

A MOC finding of physical impairment triggers quantification, and the transformation of impairment into disability. The MOC makes an economic assessment of the cost of any condition, referenced to actuarial tables. Refusal of a visa occurs when a person is diagnosed with a condition that would impose a 'significant cost' in treatment. This is currently defined any costs over a threshold value of \$21,000 over five years to treat (calculations are referenced to annual per capita health and welfare expenditure for Australians).

The actuarial tables to which treatment costs are referenced are, as Simon (1988) argues, an example par excellence of the ideals of rationality and standardization (Simon 1988). However, the use of the tables and associated data in this process reflects the symbolic nature of quantification. Following Carruthers and Espeland (1991), we argue processes of quantification are symbols of rationality and may function to legitimate particular outcomes even when the decision making process is de-coupled from technique. This is evident in two characteristics of the tables used in migration processes: the quality of the data used and the sole focus on the costs of disability.

On the first point, the Australian National Audit Office has highlighted deficiencies in the actuarial tables, finding them to incorporate costings that are incomplete and out-of-date, and with an ad hoc rather than systematic inclusion of items and services (ANAO 2007:23). On the second point, children living with a disability in markets are treated solely as a consumer within health and community care markets. There is no attempt to offset costs with potential contributions – either social or fiscal. Further, care markets are reified. The costs of care are presented as the result of the needs of particular categories of disability; there is no space within the process for an acknowledgement that health care is the outcome of intersecting institutions, cultural expectations and the structural position of individuals. The inclusion of only costs, regardless of their accuracy, highlights the connection between impairment and deficit. The inaccuracies and omissions are significant less for their inaccuracy in calculating costs than as reminders that they are primarily symbols of rationality and objectivity in a systematically discriminatory migration system.

In certain sub-classes of visas, including refugee and humanitarian visas, an applicant who has failed the health requirements may be able to apply for a waiver to be

exercised by the Minister or his or her delegate. Consideration is to be given to the potential for an applicant's health to deteriorate, their need for medical and community care, educational and occupational services, the charge on public funds and prejudice to access, the availability of any private care and support, whether minor children will be affected, location of family members and sponsors, and compassionate or humanitarian considerations. The long list of issues suggests that the discretionary waiver may under some circumstances mitigate the implications of the initial, medically referenced quantification.

Despite the promise of discretion, quantification remains a barrier to migrant children living with a disability. Most directly, the considerations remain referenced to numbers: if the estimated health expenditure will exceed the 'undue cost' of \$200 000 or when there will be substantial prejudice to citizens' access, the discretion to exercise the health waiver is in effect withdrawn – many children are effectively priced out of the waiver.

The list of considerations also continues to reflect a deficit model of disability, in its emphasis on costs rather than productive labour. The expectation of on-going dependency is explicit in the focus on the availability of private care and support. This positions applicants in relationships of dependency within the private sphere – there is no conceptual space for disabled people to inhabit public sphere. Thus, the disabled migrant child is conceptualized as dependent and familialised.

The use and relevance of the waiver are structured by ethnicity and class. Consideration of the waiver is not automatic, and people must pay specialists to argue the case. Further, the emphasis on family care of a disabled person benefits applicants who have qualifications, financial resources and earning capacities, that is, those from middle or upper class backgrounds. Class position also intersects with ethnicity –

those without the necessary resources are more likely to be moving from developing countries (NEDA undated). Thus, the most vulnerable – people with limited resources and opportunities, and particularly refugees – are the least likely to be granted the protections and opportunities available in Australia.

Australia's migration systems have unique implications for how children are conceptualised as a social category. Processing child applicants with reference to costs reflects and reinforces a conceptualisation of disability as a deficit and as largely unproductive. Disability is seen as an individual lack, rather than the outcome of social processes and power relationships that define impairment in negative ways (Goggin and Newell 2005). Able-bodied children are presumed to be in the process of developing (intellectually, physically, emotionally) into productive citizens (Prout 2005), but this expectation is denied to children living with a disability, whose potential engagement in the labour market is denied (cf. AIHW 2008), as are any present or future contributions to the social good (Gothard 1998). Denying the possibility of productivity in turn denies an independent future. The provisions within the waiver power clearly conceive of children living with a disability as appropriately dependent upon their family and removed from the public realm.

This model places children in a particularly precarious position. Empirically, they face greater barriers to residency when costs are calculated over a lifetime. Further, the health requirement is designed so that it 'one fails, all fail' – children may be left behind to allow other family members to migrate (particularly in refugee cases, where the decision is more markedly forced and options limited). This limits the child's (and their family's) emotional, physical and social well being (NEDA undated). These disadvantages are also structured by ethnicity: children from developing countries are more likely to be screened in to the health matrix, and more likely to be living with a

disability, compared to children from developed countries. Thus, the workings of the migration system impact most negatively upon a group who stands in particular need of the protections and opportunities that may be available in Australia.

Intersectional human rights analysis: liberation and chain

Human rights law might provide a source of counter-argument to the current imagining of the disabled migrant child under Australian migration policy. The needs and best interests of children are an increasing focus of international law. The most ratified human rights instrument is the *Convention of the Rights of the Child*. One of the other most fundamental and agreed human rights is the right to family life and family unity, even for non-citizens, set out in the *International Covenant on Economic Social and Cultural Rights*. Additionally, Australia is a signatory to the *1951 Refugee Convention* and although there is no specific requirement to provide family reunion to refugees, there is a wealth of ‘soft’ law².

Moreover, human rights can potentially provide an alternative methodology and framework to assess the worth of disabled non-citizen children, one that emphasises personal narrative and individual worth on the grounds of innate dignity and equality of that individual, impervious to market ideology and technical citizenship (Weissbrodt 2008). The health requirement is prima facie contrary to the social model of disability as reflected in the *Convention on the Rights of Persons With Disabilities* (the *Disability Convention*) which emphasises the holistic contribution of a person with a disability, their inherent equality and their human worth beyond an economic assessment of the cost of their disability.

However, the transformative potential of human rights discourse for disabled migrant children is limited. They sit at an intersection of human rights ‘black spots’ within

legal frameworks that correspond to the social construction of disabled migrant children, set out above. Migration is the last bastion of sovereignty, heavily linked to the labour market (Dauvergne 2008) and exercised largely within the Executive power. The negation of the rights of aliens is endemic and structural. There is no right to migrate and even such rights as are bestowed by the 1951 Refugee Convention or the new UN Migrant Workers Convention are narrowly prescribed and restrictively applied. Where challenged, there is little recourse to the courts or parliament. The Australian Government's right to legislate in regards to aliens and govern over matters of immigration is constitutionally protected³.

In terms of disability rights, advocates argue that even those people living with a disability who have full technical citizenship of a state endure a state of invisibility and 'defective' citizenship (Meekosha 2006). Thus, the Health Requirement is by nature discriminatory, but such discrimination is explicitly legalised by section 52 of the *Disability Discrimination Act 1992 (Cth)*; Australia has signed but also entered a broad reservation to the *Disability Convention*, which states that the Convention does not impact on the health requirement.

The weakness in the human rights framework around disability and migration can be explained by quantification logic. With declining birth rates, most first world countries now need migrants, to help them maintain their national living standards and to provide services and care for the aging population. Entry to Australia is highly competitive, described by Dauvergne as 'the pursuit of the best and the brightest' (2008: 12), an expectation that is referenced to ableist definitions of labour market contributions. Margaret Somers (2008: 1) warns that the growing authority of the market is distorting the non-contractualism of citizenship; that rights, inclusion and moral worth are increasingly dependent on contractual market value. Accordingly,

non-citizens who cannot display market value are arguing for ‘the right to have rights’.

The weakness also lies in human rights discourse itself. Martha Minow suggests that rights rhetoric is often interpreted as offering two separate tracks – one track to freedoms and civil rights, granted to those who are identified as autonomous, rational and capable of making independent decisions; and a second track to protection and social provision. The benefits provided by the second track often come at the price of exclusion and disempowerment for those labelled dependent, incompetent and irrational (Minow 1995) – the characterisation of children living with a disability.

Conclusion

Discrimination against disabled migrant children seems inevitable under the current quantification process, but is in fact the product of a series of societal definitions of worth. Children subject to Australia’s migration decisions about health are subject to the control and planning of society and nature through quantification with its implications of rational and ‘scientific’ knowledge. Denying residency to children living with a disability is rooted in technical and administrative processes, but these are not objective – they are explicitly and latently structured by class, ethnicity, ability and age. These intersect within the migration system to create a static and disempowering social category: the disabled migrant child. An yet an alternative human rights discourse does not fulfil its potential to make non-citizen children with a disability visible and allow them to claim worthiness, capacity and advocacy. Dismantling the impact of Australia’s migration processes and more general human rights approaches requires a re-conceptualisation of the possibilities and potential of people living with a disability.

Notes

- 1 The process is specified in three key documents: *Migration Act 1958 (Cth)* s60(1); *Migration Regulations 1994 (Cth)* reg. 2.25A; Department of Immigration and Citizenship, *Procedures Advice Manual 3* (14/04/2009) Sch4/4005-4007 – The Health Requirement [4].
- 2 See further UNHCR EXCOM Conclusions 9(XXVII)-1977; 24 (XXXII) – 1981 and 88(L)-1999.
- 3 *Commonwealth Constitution*, s51(xix), s51(xxvii); *Robtelmes v Brenan* (1906) 4 CLR 395, 400.

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