

# MEDICAL WAIVERS

**LexisNexis Conference 16 July 2009  
AUCKLAND**

**David Ryken**  
Ryken and Associates  
Barristers & Solicitors  
P O Box 501, DX CP20540  
AUCKLAND 1140  
TEL: 09 356 7370  
FAX: 09 356 7372  
EMAIL: [David@rykenlaw.co.nz](mailto:David@rykenlaw.co.nz)  
WEBSITE: [www.rykenlaw.co.nz](http://www.rykenlaw.co.nz)

## **Disclaimer**

While the author has taken all research steps to ensure that the information in the paper is accurate at the time of printing it cannot be substituted for diligent enquiry to be made by any person intending to rely on its content. There is no substitute for direct reference to the relevant legislation, departmental policy and case law.

Enquiries in relation to any aspect of this paper concerning a particular case may be referred to the author for an opinion.

## **Brief Biography of the Author**

David Ryken is a graduate of the University of Auckland where he first obtained a Master of Arts (Russian) and then an LLB. He was admitted to the Bar in 1989. After an internship with Marsden Woods Barristers and Solicitors in Whangarei he practised with Haigh Lyon Barristers and Solicitors (1991-1995) before practising on his own account. Ryken and Associates practises principally in immigration, family, employment, criminal and civil litigation, primarily judicial review.

David has also prepared a number of papers and is a regular speaker at conferences in New Zealand and internationally (International Bar Association). He has appeared in a number of leading cases both in the High Court and the Court of Appeal, and before each of the four New Zealand immigration tribunals. Although David is a sole practitioner, he is assisted by a team of eight including Isabel Chorao (Associate), Lloyd Vivera (Consultant Solicitor), Eve Thajudeen (Senior Immigration Consultant) and Law Clerk Somang You. Somang has greatly assisted in the preparation of this paper.

## INTRODUCTION

As a starting point, New Zealand immigration policy requires all applicants to have an 'acceptable standard of health.' If Immigration New Zealand (INZ) is not satisfied of this, an assessment is then made of the applicant's entitlement to a medical waiver. This preliminary stage is followed by the medical waiver assessment proper, and a medical waiver may be granted in certain cases prescribed by policy

The rules relating to the preliminary stage, which differ for residence and temporary applications, are outlined in Part I. These are followed by the rules relating to the medical waiver assessment proper. A more detailed discussion about the issues arising from the medical waiver assessment is contained in Part II.

## PART I – Operational Policy

### 1. Temporary Entry

- 1.1 The health assessment for temporary applications generally involves more discretion because the requirements are less prescribed. The operational policy is as follows:

#### **A4.15 Acceptable standard of health (applicants for temporary entry)**

- a. Applicants for temporary entry to New Zealand must have an acceptable standard of health, unless they have been issued or granted a visitor's visa for the purpose of obtaining medical treatment (see V3.40) or have been granted a medical waiver (see A4.65).
- b. Applicants for temporary entry to New Zealand 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 during their period of intended stay in New Zealand; and
  - iii. (if they are under 21 years of age and are applying for a student visa or permit) unlikely to qualify for Ongoing and Reviewable Resourcing Schemes (ORRS) funding during their period of intended stay in New Zealand; and
  - iv. able to undertake the work or study on the basis of which they are applying for a visa or permit, or which is a requirement for the issue or grant of the visa or permit.

#### **A4.15.1 Assessment of whether an applicant for temporary entry is unlikely to impose significant costs or demands on New Zealand's health services**

- a. Assessment of whether an applicant for temporary entry is likely to impose significant costs or demands on New Zealand's health services will take into account whether 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.

1.2 Medical waivers are generally not granted for temporary entry applications unless they fall under one of the exceptions listed in A6.65:

**A4.65 Medical waivers (applicants for temporary entry)**

Applicants for temporary entry will not be considered for the grant of a medical waiver unless:

- a. they are applying for work visas or permits as seconded business personnel (see A4.65.1 below); or
- b. they have submitted a claim for refugee status in New Zealand; or
- c. they are the partner\* or dependent child\* of a New Zealand citizen or resident; and
  - i. the purpose of their stay in New Zealand is to be with that New Zealand citizen or resident; and
  - ii. if they applied for residence in New Zealand they would meet the criteria for residence under the Partnership policy (see F2.5 (a)) or Dependent child policy (see F5.1 (a)).

---

**Note:** The grant of a medical waiver for the purpose of temporary entry to New Zealand does not confirm that the applicant has an acceptable standard of health for the purposes of residence in New Zealand or that a medical waiver would be granted if a residence application were made. This does not prevent a visa or immigration officer considering whether or not an applicant is likely to be granted a medical waiver for the purpose of residence in New Zealand.

---

## 2. Residence

2.1 Compared to temporary applications, residence applications involve a more careful and heavily prescribed assessment of the applicant's future medical prognosis.

2.2 Medical conditions that indicate a potential for high cost or hospitalisation may result in refusal to grant residence. Operational policy states:

**A4.10 Acceptable standard of health (applicants for residence)**

- a. Applicants for residence visas and permits must have an acceptable standard of health unless they have been granted a medical waiver. An application for residence must be declined if any person included in that application is assessed as not having an acceptable standard of health and a medical waiver is not granted (see A4.60).
- b. Applicants for residence 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
  - iii. (unless the applicant is sponsored for residence by a person who holds refugee status in New Zealand) able to undertake the work on the basis of which they are applying for a visa or permit, or which is a requirement for the issue or grant of the visa or permit.

- c. The conditions listed in Appendix 10 are considered to impose significant costs and/or demands on New Zealand's health and/or special education services. Where a visa or immigration officer is satisfied (as a result of advice from an Immigration New Zealand medical assessor) that an applicant has one of the listed conditions, that applicant will be assessed as not having an acceptable standard of health.
- d. If a visa or immigration officer is not initially satisfied that an applicant for residence has an acceptable standard of health, they must refer the matter for assessment to an Immigration New Zealand medical assessor (or the Ministry of Education as appropriate).

**A4.10.1 Assessment of whether an applicant for residence is unlikely to impose significant costs on New Zealand's health services**

- a. The requirement that an applicant for residence must be unlikely to impose significant costs on New Zealand's health services is not met if, in the opinion of an Immigration New Zealand medical assessor, there is a relatively high probability that the applicant's medical condition or group of conditions will require health services costing in excess of \$25,000.

---

**Note:** Assessment will be in terms of current costs with no inflation adjustment.

---

- b. In the case of acute medical conditions, the medical assessor will provide an opinion on whether there is a relatively high probability that the condition or group of conditions will require health services costing in excess of NZ\$25,000 within a period of four years from the date the assessment against health requirements policy is made.
- c. In the case of chronic recurring medical conditions, the medical assessor will provide an opinion on whether, over the predicted course of the condition or group of conditions, there is a relatively high probability that the condition or group of conditions will require health services costing in excess of NZ\$25,000.

**A4.10.5 Assessment of whether an applicant for residence is unlikely to impose significant costs on New Zealand's special education services**

The requirement that an applicant for residence must be unlikely to impose significant costs on New Zealand's special education services is not met if the Ministry of Education (MoE) has determined that there is a relatively high probability that the applicant's physical, intellectual, sensory or behavioural condition or group of conditions would entitle them to Ongoing and Reviewable Resourcing Schemes (ORRS) funding.

**A4.10.10 Assessment of whether an applicant for residence is unlikely to impose significant demands on New Zealand's health services**

The requirement that an applicant must be unlikely to impose significant demands on New Zealand's health services is not met if, in the opinion of an Immigration New Zealand medical assessor, there is a relatively high probability that the applicant's medical condition or group of conditions will require health services for which the current demand in New Zealand is not being met.

- 2.3 Some medical conditions are prescribed in A4.10(c) as having a high cost presumption. They are listed in Appendix 10 of the Operational Manual. At the time of publication Appendix 10 contains the following:

**Medical conditions**

- HIV infection

- Hepatitis B surface antigen positive, with abnormal liver function
- Hepatitis C, RNA positive, with abnormal liver function
- Malignancies of solid organs and haematopoietic tissue, including past history of, or currently under treatment

Exceptions are:

- a. treated minor skin malignancies (not melanoma)
  - b. malignancies where the interval since treatment is such that the probability of cure is > 90%, e.g.: early stage (I & IIA) breast cancer at 5 years; low risk prostate cancer at 5 years; early stage (Dukes A & B1) colorectal cancer at 5 years; childhood leukaemia at 5 years
- Solid organ transplants, excluding corneal grafts more than 6 months old
  - Chronic renal failure or progressive renal disorders
  - Diseases or disorders such as osteoarthritis with a high probability of arthroplasty in the next four years
  - Central Nervous System disease, including motor neurone disease, complex partial seizures, poorly controlled epilepsy, prion disease, Alzheimer's and other dementia, and including paraplegia and quadriplegia
  - Cardiac disease including ischaemic heart disease, cardiomyopathy or valve disease requiring surgical and/or other procedural intervention
  - Chronic obstructive respiratory disease with limited exercise tolerance and requiring oxygen
  - Genetic or congenital disorders: muscular dystrophies, cystic fibrosis, thalassaemia major, sickle cell anaemia if more than one sickle crisis in 4 years, severe haemophilia, and severe primary immunodeficiencies
  - Severe autoimmune disease, currently being treated with immunosuppressants other than prednisone
  - In a person up to the age of 21 years, a severe (71-90 decibels) hearing loss or profound bilateral sensori-neural hearing loss
  - In a person up to the age of 21 years, a severe vision impairment with visual acuity of 6/36 or beyond after best possible correction, or a loss restricting the field of vision to 15-20 degrees
  - In a person up to the age of 21 years, a severe physical disability, where they are unable to stand and walk without support, and cannot independently dress, eat, hold a cup, or maintain their stability when sitting.

2.4 Where a residence application is filed and one of the applicants suffers from one of the matters listed in Appendix 10, or there is a determination that hospitalisation or high cost is likely for conditions not listed, the applicant is given the opportunity to seek a medical waiver subject to the limitations in A4.60. Among others, the general requirement is that the applicant(s) meets all other relevant Government residence policy requirements.

#### **A4.60 Medical waivers (applicants for residence)**

- a. Applicants for residence in New Zealand who are assessed as not having an acceptable standard of health and whose applications meet all other requirements for approval under the relevant Government residence policy may be considered for the grant of a medical waiver unless:

- i. they require dialysis treatment, or an Immigration New Zealand medical assessor has indicated that they will require such treatment within a period of four years from the date of the medical assessment; or
  - ii. they have active pulmonary tuberculosis; or
  - iii. they have severe haemophilia; or
  - iv. they have a physical incapacity that requires full time care.
- b. Medical waivers will also not be granted to people:
- i. who are applying for residence under Family category policy; and
  - ii. who were eligible to be included in an earlier application for residence as the spouse or partner of a principal applicant or the dependent child of a principal applicant or their spouse or partner; and
  - iii. were not declared on that earlier application.
- c. People who:
- i. were eligible to be included in an earlier successful application for residence as the spouse or partner of a principal applicant or the dependent child of a principal applicant or their spouse or partner; and
  - ii. who were declared in that application but were not included in that application as non-principal applicants; and
  - iii. whose application for residence under Family category policy is sponsored by a person included in the application for residence referred to in (i) above
- will be assessed for the grant of a medical waiver as if they had been included in the earlier application and as if the sponsor was not resident in New Zealand.
- d. Applicants (and dependants included in their application) who have been recognised as refugees may be granted medical waivers.

### 3. Medical Waiver

- 3.1 Having determined that the applicant is eligible for a medical waiver under A4.60 or A4.65, the factors the immigration officer must consider in determining whether to grant a medical waiver for all cases are set out in A4.70:

#### **A4.70 Determination of whether a medical waiver should be granted (residence and temporary entry)**

- a. Any decision to grant a medical waiver must be made by an officer with schedule 1 delegations (see A15.4).
- b. When determining whether a medical waiver should be granted, visa and immigration officers must consider the circumstances of the applicant to decide whether they are compelling enough to justify allowing entry to, and/or a stay in New Zealand.
- c. Factors that officers may take into account in making their decision include, but are not limited to, the following:
  - iv. the objectives of Health requirements policy (see A4.1) and the objectives of the policy or category under which the application has been made;
  - v. the degree to which the applicant would impose significant costs and/or demands on New Zealand's health or education services;

- vi. whether the applicant has immediate family lawfully and permanently resident in New Zealand and the circumstances and duration of that residence (unless the limitations on the grant of medical waivers set out at A4.60(c) apply);
  - vii. whether the applicant's potential contribution to New Zealand will be significant;
  - viii. the length of intended stay (including whether a person proposes to enter New Zealand permanently or temporarily).
- d. An applicant who is the partner or dependent child of a New Zealand citizen or resident, may generally be granted a medical waiver unless there are specific reasons for not granting such a waiver or the limitations on the grant of medical waivers to such persons set out at A4.60 (c) apply.
  - e. Officers should consider any advice provided by an Immigration New Zealand medical assessor on medical matters pertaining to the grant of a waiver, such as the prognosis of the applicant.
  - f. Officers must record decisions to approve or decline a medical waiver, and the full reasons for such a decision.

## **PART II – Issues Arising from the Medical Waiver Assessment**

### **4. Appeal to the Residence Review Board (the Board)**

- 4.1 An appeal to the Board in practice involves something more than a full merits review. The two jurisdictions of review are prescribed under section 18C(1) of the Immigration Act 1987, these being (1) correctness of Immigration New Zealand's decision (section 18C(1)(a)), and (2) consideration of special circumstances that warrant an exception to policy (section 18C(1)(b)).
- 4.2 The special circumstances jurisdiction involves a full consideration of all the circumstances of the appellant and is inherently unfettered by policy due to its objective as an exception to policy jurisdiction. This has resulted in an appeal that is over and above a standard full merits review. See *Martin v Chief Executive of the Department of Labour*, HC, 4 November 1998, Cartwright J.
- 4.3 The Board's jurisdiction is not only supervisory but further has a de novo recommendatory power to make exceptions. This power is not fettered by the policy itself, but clearly the Board does not exercise its discretion to make a recommendation without good reason.

### **5. Partners and dependent children**

- 5.1 There is a general presumption in favour of a medical waiver for partners and dependent children (A4.70(d)). The partner or dependent child must not have been a person who could have featured in an earlier application when the sponsor was applying for residence, thus creating the application of the presumptions at a later time (A4.60(c)).

- 5.2 Generally speaking it is a mistake to argue presumption cases under the special circumstances jurisdiction of the Board (*Residence Appeal 14848*, 23 May 2006, V Vervoort).<sup>1</sup>
- 5.3 Partnership in and of itself would not normally be a special circumstance though of course there may be cases where employment or skills create a ground for special circumstances.

## 6. Presumption – A4.70(d)

- 6.1 Only available: Partners  
Dependent child
- 6.2 Not available: Where partner or dependent child is the principal applicant only because they were “peeled off” on a previous application. Applies to persons with Appendix 10 conditions
- 6.3 Query: Does the A4.70(c) balancing exercise apply? If so, what then is the purpose of the exception in A4.70(d)?
- 6.4 Query: What is the meaning to be given to the words “unless there are specific reasons for not granting...”? It is suggested that it must mean that there must be something significant and identifiable (the use of the word “specific”). Perhaps a partner with HIV who is non-compliant with medication (and is likely to develop AIDS) might be such an example.
- 6.5 The presumption is frequently overlooked by both INZ and the Board (see *Residence Appeal 16025*, 23 December 2008, P Millar).<sup>2</sup> When INZ do apply it, there is a tendency to return to the weighing up of A4.70(c) factors rather than identify A4.70(d) “specific reasons” (if any) other than those in A4.70(c). By returning to the weighing up exercise the presumption is made meaningless. Obviously the “specific reasons” cannot be the condition itself because otherwise the presumptive statement in A4.70(d) is redundant.
- 6.6 In the author’s view the reason why decisions are so often flawed in this category is also because of the use of templates. The same template is being used for both A4.70(c) cases and A4.70(d) cases. In fact there is no template for an A4.70(d) case and some officers do not seem to be aware of the policy’s existence (see for example *Residence Appeal 14848*, cited above in paragraph 5.2 and *Residence Appeal 16038*).

---

<sup>1</sup> Partner with HIV. NZIS does not appear to have considered relevance of A4.70(d) nor did the Board pick up on this oversight in its assessment of the NZIS decision. However, the case was appealed only on the grounds of special circumstances (although the Board went on to briefly assess the NZIS decision), the possible result being that simply no-one thought of the partner presumption and that arguably the decision was wrong in law.

<sup>2</sup> Dependent child by adoption with cardiac disease. No explicit consideration of A4.70(d). However, reason for dismissing the appeal was that there was no evidence as to the background of the adopted child’s relationship with his adopted parents and whether he was emotionally dependent on them in any way. Further, child could apply for visitor’s visa to enter New Zealand if surgery, which is unavailable in home country, was necessary. Appeal unsuccessful, no special circumstances.

## **7. The Partner Presumption and HIV**

- 7.1 HIV positive applicants have little to no chance of being granted a medical waiver in skilled migrant category or business category cases. Decisions of the Board in exercising its preference to refer matters back have so far focused on overall procedural flaws in the decision rather than give due weight to the partner presumption in a substantive decision.
- 7.2 *Residence Appeal 15519*, 28 September 2007, S Pearson: Partner with HIV on anti-retroviral. Decision was flawed due to several factual errors by INZ. Little weight was given to the appellant's relationship since 2003. Meaning of "specific reasons" not examined. Referred back (later granted residence, from the author's practice, 2008).
- 7.3 *Residence Appeal 16038*, 18 February 2009, M Poole: Partner with HIV not yet on anti-retrovirals. There was little consideration given to the "presumption." "Specific reasons for not granting" is left for the individual officer to determine on a case by case basis, but must be clearly articulated. No determination as to whether these reasons could be A4.70(c) reasons. Referred back due to procedural flaws (decision pending).
- 7.4 One would expect that if the Board were prepared to refer the case back for a failure to clearly articulate the "specific reasons," they could have given some guidance as to what these "specific reasons" may be. The result being that INZ may again go through the A4.70(c) balancing exercise and again find that they should not grant a medical waiver because the applicant has a high cost condition. Applicants are then compelled to seek legal representation to argue their case in a way that addresses the misunderstanding without being caught up in or put off by the bureaucratic process.
- 7.5 The point is that A4.70(d) is frequently misapplied and sometimes even overlooked completely, (see *Residence Appeal 16038* above) when it should clearly operate as a presumption that bypasses the balancing exercise in A4.70(c) and shifts the burden onto INZ to articulate why exactly a medical waiver should not be granted. The policy's presumptive intention in support of reunification of the immediate family unit (a valuable asset in economic terms) is obvious, yet it has so far been devoid of any effective power.

## **8. Fairness**

- 8.1 In the course of the medical waiver process INZ must ensure that the rules of fairness are met, that the applicant has the opportunity to address the cost to the state, and that the information provided by the applicant is carefully considered (see A4.40). Appeals where there has been a procedural or substantive breach of fairness involving a medical condition

will normally involve a referral back accompanied by directions of the Board.

*Procedural vs substantive unfairness, what's the difference?*

- 8.2 The distinction between procedural and substantive unfairness is blurry at best and the distinction itself is generally not of great importance. It is useful to note however that procedural unfairness can arise without there necessarily being a corresponding incorrect decision. Occasionally the Board will find that there were breaches of a procedural nature but will conclude that these flaws did not render the decision incorrect (see *Residence Appeal 14848*, cited in paragraph 5.2). Nevertheless, they are to be avoided because of the increased risk of a more serious substantive breach.
- 8.3 What is more correctly characterised as substantive unfairness usually arises when the assessor (be it the case officer or consultant physician), for whatever reason, has arrived at an incorrect conclusion or made a determination that was not open to them on the evidence available. This may or may not have flowed on from a procedural flaw.
- 8.4 Very often cases will involve a series of procedural flaws that have the combined effect of rendering a decision invalid. Some examples of procedural fairness issues are as follows:
  - 8.4.1 Not properly going through the assessment process, i.e. from determination whether applicant has acceptable standard of health to eligibility for medical waiver then onto consideration of factors for grant of medical waiver (*Residence Appeal 14816*, 20 March 2006, S Joe);
  - 8.4.2 However, a failure to adhere strictly to this process will not necessarily be fatal on appeal (see *Residence Appeal 14848*, cited in paragraph 5.2);
  - 8.4.3 Using a templated decision-making process to come to a desired result, i.e. without a meaningful and open consideration of the factors. See below in paragraph 8.5.2;
  - 8.4.4 Not advising the applicant of the waiver rules (otherwise how does the applicant know what information may assist) (see *Residence Appeal 15462*, 20 August 2007, P Millar);
  - 8.4.5 Not advising the reasons behind a medical assessor's assessment (this type of breach may reach back to the assessor's response itself);
  - 8.4.6 Cryptic and/or markedly brief responses from case officer or medical assessor (*Residence Appeal 16035*, 23 January 2009, S Pearson);

- 8.4.7 Not providing relevant information to the medical assessor (*Residence Appeal 15431*, 16 August 2007, E Riddiford);
- 8.4.8 Not advising of the partner presumption *Residence Appeal 16038*, supra 7.3;
- 8.5 Cases:
  - 8.5.1 *Residence Appeal 15951*, 21 November 2008, V Vervoort: Parent with bladder and prostate cancer. Errors in medical and medical waiver assessments.
  - 8.5.2 *Residence Appeal 16035*, 23 January 2009, S Pearson: Medical waiver assessment template had incorrect information. Parent with cardiac problems. Board found the practice of using templates attracts mistakes.
- 8.6 Other issues that arise, perhaps more correctly characterised as substantive unfairness:
  - 8.6.1 Ignoring information provided by the applicant;
  - 8.6.2 Simply adopting the decision of the medical referee (*Residence Appeal 15431*, 16 August 2007, E Riddiford);
  - 8.6.3 Consideration of irrelevant factors (see *Residence Appeal 15065*, 19 December 2006, A Clayton);
  - 8.6.4 Failure by medical assessor to identify actual health services and costs pertaining to appellant (*Residence Appeal 16050*, 23 January 2009, V Vervoort);
  - 8.6.5 Lack of sound evidential basis in classification of relevant category for medical waiver consideration (*Residence Appeal 14890*, 12 May 2006, V Vassiliadis);
  - 8.6.6 Lack of properly reasoned opinion of relevant medical waiver factors (*Residence Appeal 14906*, 30 June 2006, P Millar);
  - 8.6.7 Wrong statement of facts. *Residence Appeal 15519* supra at 7.2.

## **9. Medical Referee v Immigration Officer**

- 9.1 There is general confusion over the role that the medical referee plays. This is apparent because of the way in which officers continue to thrust cases back to the medical referee when the application provides new information, but where the medical status (e.g. as an Appendix 10 person) remains much the same. Back it goes for another two to four month delay. Back comes the reply. Still an Appendix 10 person. We knew that.

9.2 It is clear when dealing with medical issues that a large number of officers are simply not equipped to make the evaluative decisions required. This first process for non-Appendix 10 cases is to determine the facts and the likelihood of future hospitalisation or costs. Often these are evaluative issues and there may be a range of medical opinion, not always definitive in terms of future prognosis. Then comes the question of the medical waiver process and whether during that process new information has been obtained that sheds light on the likelihood of future costs. However, where the information provided is not information that goes to the issue of future costs or the likelihood of future treatment, there seems little point in sending the waiver information back to the medical referee, given that the medical waiver proper is an immigration decision.

## 10. Is the Medical Condition Permanent?

10.1 In some cases a person can take remedial action to either remove themselves from Appendix 10 or from a categorisation of unacceptable standard of health. For example, an individual with an enlarged heart that needed an artificial heart valve. After having cardiac surgery privately, his future prognosis was practically the same as the rest of the population (from the author's practice, 1992). An interferon course for hepatitis is another process that can reduce the future risk of the sequelae, and the high cost of the interferon itself. With obese clients, especially at the lower end, improving their health status may not be a bad idea (several cases from the writer's practice). Of course, any further assessment will have to take into account risk factors etc arising out of the previous period of obesity and how stabilised the person's health or weight has become. Put bluntly, it may be in some applicants' interests to lose some weight!

10.2 In some cases the fact that the applicant has taken steps to reduce the risk of becoming a high cost to the New Zealand taxpayer is factored into a consideration of special circumstances. This is found in cases where the appellant is not entitled to be granted a medical waiver, but has other factors in his or her favour that, when considered cumulatively, would warrant an exception to policy. See *Residence Appeal 15877* in paragraph 10.3.1 below.

### 10.3 Cases:

10.3.1 *Residence Appeal 15877*, 12 January 2009, B Slane: Skilled migrant, morbidly obese. Although there were obvious identifiable health risks, the appellant recognised risks and took steps to address them. This, considered cumulatively with the fact that she is highly qualified and both she and her husband have the capacity to contribute to New Zealand, warranted exception to policy.

10.3.2 *Residence Appeal 15945*, 17 October 2008, S Pearson: Parent with autoimmune hepatitis and osteoarthritis. She could have undergone knee replacement surgery to address her osteoarthritis, which was

financially possible as her family and church had pledged financial support for this surgery. However, in this case the appellant's remaining conditions would continue to pose a high cost to the New Zealand taxpayer.

## 11. Hepatitis Cases

11.1 *Residence Appeal 16005*, 27 November 2008, M Poole: Parent category. Child with hepatitis C (note this is not a case where the dependent child is the primary applicant and the child presumption applies as per A4.70(d)). Applicant had hepatitis C with genotype 3A, the type that responds well to interferon treatments. Appeal unsuccessful.

11.2 Comment: Why not complete the interferon treatment before applying for residence?

## 12. Mental Capacity

12.1 *Residence Appeal 15906*, 20 October 2008, V Vervoort: Adult Sibling: Mild mental retardation and some physical disability. Special circumstances accepted. Compelling nature of family support and coherent nature of plan for his care and support. Vulnerable in the home country (Philippines).

## 13. Special Circumstances

13.1 The Board weighs factors cumulatively when considering whether there are special circumstances to warrant referral of a case to the Minister as an exception to policy. A different approach is to look for "special" circumstances where "special" means there is something unique or exceptional about the case.

13.2 In some cases, the Board's approach seems to be that "special circumstances" arise when the factors in favour of the appellant collectively outweigh the factors against. See *Residence Appeal 16078*, 24 March 2009, where A Clayton found cumulatively that there were special circumstances.<sup>3</sup> See *Residence Appeal 16075*, 27 March 2009, where the same member found there were no special circumstances when factors were considered cumulatively, despite there being "special" or exceptional circumstances in the normal sense when considered individually.<sup>4</sup>

---

<sup>3</sup> Adult sibling with multiple sclerosis. Factors in favour of appellant such as stable current condition, "relatively straight forward" management of disease, strong family ties in New Zealand, family's wish and ability to care for her (possibly reducing negative effects on New Zealand's health system), security concerns in home country of Lebanon and the psychiatric health of appellant and her New Zealand family members when considered cumulatively outweighed the negative effects on New Zealand health system. Board found only compassionate course was to reunite the appellant with family, therefore special circumstances.

<sup>4</sup> Skilled migrant with morbid obesity. Appellant had employment offer in New Zealand as a nurse, which was on LTSSL. Board also noted appellant's evident seniority and experience in nursing. However, negative effect on New Zealand health system plus no nexus to New Zealand outweighed factors in favour, therefore no special circumstances.

- 13.3 Medical waivers of high cost conditions are not normally granted under the Skilled Migrant Category unless there are special circumstances. High cost conditions factor heavily against the appellant in the weighing exercise performed by the Board in the special circumstances jurisdiction. The standard for finding special circumstances is high:
- 13.3.1 *Residence Appeal 15930*, 8 October 2008, V Vervoort: Skilled migrant with hepatitis B. Qualification and work experience in information technology insufficient to outweigh medical condition and no family nexus to NZ. Appeal unsuccessful, no special circumstances.
  - 13.3.2 *Residence Appeal 15788*, 26 August 2008, A Clayton: Skilled migrant with heart condition. Appellant was possibly skilled in area of skill shortage but this was unproven. No family nexus to NZ. Appeal unsuccessful, no special circumstances.
  - 13.3.3 *Residence Appeal 15828*, 31 July 2008, V Vervoort: Skilled migrant with metabolic syndrome resulting in obesity and related conditions. Appellant's negative health status outweighed skilled employment, qualification, and potential employability in area of skill shortage. No family nexus to NZ. Appeal unsuccessful.
- 13.4 But see *Residence Appeal 15898*, 16 July 2008, S Pearson: Skilled migrant with chronic myeloid leukaemia. Special circumstances accepted considered cumulatively: applicants highly qualified, treatment underway and leukaemia under control, interruption to treatment could have major implications on long term health, partner was pregnant.
- 13.5 Further cases:
- 13.5.1 *Residence Appeal 16004*, 10 December 2008, S Pearson: Parent with chronic liver disease and hypertension. Strong nexus to New Zealand. Three adult children and all family members had left home country permanently. Unwilling to undergo medical procedures for religious reasons. Exception to policy.
  - 13.5.2 *Residence Appeal 16007*, 5 January 2009, B Slane: Skilled migrant. Morbidly obese. Appellant's attempts to reduce weight insufficient to establish special circumstances.
  - 13.5.3 *Residence Appeal 15877*, 12 January 2009, B Slane: Skilled migrant. Morbidly obese. Senior employment position. Appellant and spouse capable of high economic contribution to New Zealand. Appellant had taken steps to reduce health risks. Special circumstances.
  - 13.5.4 *Residence Appeal 15216*, 16 January 2007, D Plunkett: Special Policies (Residual Pacific Access Category Places, Tonga).

Applicant's child aged 4 severely disabled with cerebral palsy, completely dependent on carers (mainly parents). Board held life would not only be shortened but quality of life would be significantly decreased should family return to Tonga. Appeal successful, exception to policy.

#### 14. Australia: A Brief Comparison

14.1 "Health" and "character" of persons are commonly referred to as the "Public Interest Criteria" set out in Schedule 4 of the Migration Regulations 1994 (Cth).

14.2 There are essentially three hurdles. The first is the applicant must be free from tuberculosis. The second is the applicant must not be a threat to public health or a danger to the Australian community. The third relates to particular diseases or conditions (discussed below) and concerns researching costs and access to healthcare (cf. our high cost to New Zealand exclusion and Appendix 10).

14.3 Cost and Access item 4005(c) in Schedule 4 of the Regulations is as follows:

The applicant is not a person who has a disease or condition to which the following subparagraphs apply:

- (a) the disease or condition is such that a person who has it would be likely to:
  - (i) require health care or community services; or
  - (ii) meet the medical criteria for the provision of a community service;during the period of the applicant's proposed stay in Australia;
- (b) provision of the health care or community services relating to the disease or condition would be likely to:
  - (i) result in a significant cost to the Australian community in the areas of health care and community services; or
  - (ii) prejudice the access of an Australian citizen or permanent resident to health care or community services;regardless of whether the health care or community services will actually be used in connection with the applicant.

14.4 The Australian position is that care is "likely" (on the balance of probabilities). Apparently the "cost" is not quantified but departmental guidelines (PAM) in the late 1990s and early 2000s spoke of "significant" cost being a total of \$15,000 over 5 years with 65 % certainty with costs beyond that initial 5-year term being included if the costs were at least 50% certain to flow.<sup>5</sup> Currently after some recent changes the figure is \$21,000.

---

<sup>5</sup> See David Prince, *Deal Breakers – Complex Health and Character Cases*, 3<sup>rd</sup> Annual CPD Immigration Law Conference 20-21 March 2009.

14.5 The assessment as to likely costs must be the specific circumstance of the applicant: *Robinson v Minister of Immigration and Multicultural and Indigenous Affairs* [2005] FCA 1626.

14.6 Historically waivers have only been available in family sponsored cases. As a result of some controversial cases the Migration Regulations 1994 were amended in 2006 to enable consideration of exercising a waiver in certain onshore visa subclasses (846, 855, 856 and 857) where it may be in the best interests of the Australian community to do so. These can only be considered however where the state or territory in which the applicant resides is designated as a participating jurisdiction as designated by the Minister of Immigration and Citizenship (the Minister). Apparently by late 2008 no states or territories had joined up. On 5 June 2009 Victoria, the Australian Capital Territory and Western Australia had formally agreed to participate. The Minister has intervened using his personal intervention powers (Dr Moeller with a Downs Syndrome child).

## **15. Advocacy: Conclusion**

15.1 In dealing with medical cases it is important to assess what exactly are the costs and to look carefully at the whole case. For example, is a child who has a cochlear implant (which has improved her hearing) an Appendix 10 person? Is the cost assessment made by the medical referee correct? What is the likelihood of future costs and can this or has this been reduced? The offer to pay costs is usually insufficient, but what if the individual does have private and portable private insurance or a career that will provide for an ability to pay for private insurance?

15.2 The challenge is to work with medical specialists to obtain a clear articulation and to address the specific treatment costs and likelihood issues. At an early stage (and perhaps before filing and then filing to be postponed) practical steps can sometimes be taken to reduce the future costs analysis. Appropriate submissions then need to address the costs and waiver issues. Ideally this should all be prior to filing. It is not intelligent to wait for the PPI letter. Medical specialists are not always available at short notice. Furthermore, once the case is filed the opportunity to address some issues may be reduced given time constraints. It is always preferable also to present the information at the time of filing so that the medical referee has the material when the matter is referred to him or her on the first occasion.

DAVID RYKEN