Brief to the Standing Committee on Citizenship and Immigration regarding Medical Inadmissibility under IRPA

Witnesses: Michael Battista & Adrienne Smith, Barristers & Solicitors, Jordan Battista LLP

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Introduction and Background

As immigration lawyers with substantial experience and expertise in representing clients at risk of being determined medically inadmissible, we welcome the Committee's study into Canada's laws and policies regarding the application of s. 38(1)(c) of the *Immigration and Refugee Protection Act* (the "Act").

Our experience with health based inadmissibility developed through decades of representation of clients based within the LGBTQ (lesbian, gay, bisexual, transgender, queer) community, some of whom are living with HIV. It is also based upon our work with HIV organizations across the country, who consult us as they try to mitigate the extent to which medically inadmissibility presents a barrier for immigrants and newcomers to Canada.

Over the years, however, our experience base in advocacy for applicants to Canada with health issues has broadened to cover almost every type of health condition, including conditions such as Alzheimer's, mental health conditions, heart conditions, developmental issues in children, diabetes, and cancer. Clients seek us out for this expertise and for the most part we are successful in assisting them to overcome medical inadmissibility concerns.

Based on our experience, we believe that section 38(1)(c) of the Act should be repealed. This section does not meet its stated goal of preventing excessive costs from being imposed on Canada's health care system, it imposes an unfair financial and emotional cost on persons with health challenges, it leads to the refusal of applications from immigrants who may otherwise greatly contribute to Canadian society, and perpetrates discrimination toward applicants with disabilities and treatable health conditions.

1. Section 38(1)(c) is not effective in preventing excessive health care costs

Unlike other inadmissibility sections within the Act, the effectiveness of section 38(1)(c) relies entirely upon predicting future events, specifically, the development of a health condition, whereas the sections of the Act that deal with criminal or misrepresentation are based upon what has happened in the past. For example, s. 38(1)(c) is based almost entirely upon what is expected

to occur in the future – i.e. will excessive costs result if a foreign national is granted permanent residence within 5 to 10 years?

Furthermore, this predictive exercise is undertaken in relation to a situation which is for the most part out of the control of an applicant, specifically, the applicant's health condition, as compared with other inadmissibility sections which focus on an applicant's conduct.

We believe that the assessment of future "excessive" costs on Canada's health system does not achieve its intended results for the following reasons:

- *Health conditions are highly variable and individualized, depending on a variety of factors personal to an applicant*

By their nature, the progression of health conditions varies depending on age, gender, genetics, and environment. Advances in medical treatment and technology change quickly and are not always within the expertise of panel physicians and regional medical officers who provide the health information listed in the IRCC's "procedural fairness" letters. Finally, obtaining updated information from provinces regarding the cost of treatment is a challenge and a burden that results in inefficient immigration processing.[1]

For these reasons, the "procedural fairness" letters which applicants receive after their immigration medical examinations are frequently cast in exaggerated terms reflecting outdated information regarding diseases. For example, as recently as 2014 our office has received procedural fairness letters that describe HIV as a disease that progresses to inevitable deterioration to palliative care and eventually death within 5 to 10 years. While this may have been accurate decades ago, currently HIV is considered a chronic but entirely manageable disease that is effectively controlled by medication. Studies regarding the likely prognosis of people with HIV in industrialized countries like Canada indicate that life expectancy for people living with HIV approaches that of the general population.[2]

In our experience, many clients are successful in challenging the information contained in procedural fairness letters based on their inaccuracy alone. When we retain health specialists to provide an opinion on the accuracy of the health information in procedural fairness letters, they regularly express surprise at the generalized, inaccurate manner in which diseases are described in the letters. They are also regularly able to provide opinions contradicting the assessment of diagnosis (particularly in the case of developmental disabilities) and prognosis.

[1] 2011 Report of the Auditor General of Canada, para. 2.72: 2.72 "We examined the systems and practices in place to provide visa officers with timely and reliable information on whether an applicant might cause excessive demand on health or social services. CIC medical officers are required to assess the anticipated costs of providing health care and social services related to the health conditions of applicants. We found, however, that there are limits to their ability to accurately estimate these costs because information on provincial/territorial health care expenditures and wait times in Canada for the numerous health conditions that exist may not be available to them."

[2] Dr. Hasina Samji, British Columbia Centre for Excellence in HIV/AIDS, PLoS One, 2013, https://www.healio.com/infectious-disease/hiv-aids/news/online/%7Bc55dea6a-eccc-4632-ae8a-ec10c0bec93d%7D/life-expectancy-of-hiv-positive-adults-approaching-that-of-general-population

The result of these inaccurate or outdated procedural fairness letters is that applicants are required to pay thousands of dollars in additional medical and legal costs defending themselves against inaccurate allegations. Even if they are ultimately successful, they are put to additional expense, lengthy wait times and stress which are not placed on other applicants.

- *The requirement for an individual to provide an individualized plan to mitigate costs is ineffective in predicting future costs because there is no mechanism for tracking an individual's commitment as described in the plan.*

In *Hilewitz*, the Supreme Court of Canada cautioned against a "cookie cutter" approach to assessing health conditions and their associated costs, warning against assigning a cost to the health condition rather than its particular manifestation in the individual.[3] As a result of the Court's decision, applicants at risk of refusal on the grounds of s. 38(1)(c) are routinely invited to construct an "individualized plan" to mitigate anticipated costs.

Despite the time-consuming and expensive process of developing an individualized plan, and government resources dedicated to assessing such plans, there is no monitoring of such plans after a person becomes a permanent resident.[4] An applicant who develops an individualized plan promising not to access public health services may, after becoming a permanent resident, access those health services freely as is the right of any permanent resident.

From a public policy perspective, this "individualized plan" process is contradictory. It requires applicants with health conditions to construct an individualized plan as a condition of being approved, then completely disregards the plan as a tool in evaluating whether the person will present an excessive demand in the future. It is designed to achieve what is ostensibly an important goal – the mitigation of excessive costs on the health care system – but the goal is undermined because no efforts are made to investigate whether a plan is ultimately implemented.

From an individual perspective, the expense, effort and additional stress involved in constructing a plan then waiting for a decision on the realistic nature of the plan is an additional burden which is not placed on healthy applicants. This burden is placed on applicants in the name of saving costs in the health care system. But the lack of follow through leads many applicants to wonder if the goal is genuine, or whether it is in fact a disguised way of discouraging people with health challenges from coming to Canada. From this perspective, and given the small numbers who are ultimately refused on medical grounds, this emotional and financial burden risks being perceived as a "head tax"[5] on the unhealthy.

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[3] *Hilewitz v. Canada (Minister of Citizenship and Immigration)* 2005 SCC 57, para. 45

[4] 2011 Report of the Auditor General, supra, para. 2.73: "Visa officers explained to us that it is very difficult to assess the intent or capacity of an individual to pay. Concerns also exist about the unenforceable nature of an applicant's commitments once the person is residing in Canada."

[5] From 1885 to 1948, Canada collected a head tax on Chinese citizens with the goal of discouraging them from entering Canada.

It is not our recommendation that a system be established to enforce the implementation of individualized plans. Such a system would be complex and expensive in relation to the relatively small number of people who are approved based on an individualized plan. It would require a significant expenditure of government administration resources for monitoring and enforcement, and create prolonged uncertainty for the person who is admitted to Canada on the basis of the plan. It would also lead to legal challenges to enforcement decisions at the investigation, determination and appeal levels, adding backlogs to an already overburdened tribunal system.

The use of the misrepresentation section (s. 40) of the Act to enforce individualized plans is also not recommended. Most plans would likely not be implemented by permanent residents due to a change in circumstances, such as the loss of a job or a change in health conditions, rather than through deception. To subject these permanent residents to loss of status and removal given their health challenges and establishment in Canada would not be humane and would likely encourage lengthy legal challenges.

To conclude, our opinion is that the individualized plan process is almost completely ineffective in furthering the intended goal of section 38(1)(c). It imposes extra costs, stress and processing times on applicants with health issues, in addition to significant government resources being used to monitor medical inadmissibility. The implementation of an enforcement system would require significant government resources and would in effect nullify the intention of avoiding costs to an overburdened public system.

- *The definition of "excessive demand" is vague, subjective and likely based upon a cost threshold that is artificially low*

The primary factor in determining whether an anticipated cost is "excessive" concerns whether it would likely exceed the average Canadian per capita health and social services cost over a 5 to 10 year period.[6] The excessive demand cost threshold effective December 1, 2016 is $6,655 per year.

The published average per capita health cost of Canadians may be artificially low because it doesn't consider all social service spending. A Global News investigation released in August 2017 found that as much as $40 billion in annual social service spending was not included when calculating the excessive demand figure.[7]

The law on medical inadmissibility also does not provide guidance regarding how much in excess of the average Canadian per capita cost of health and social service care is required in order for a cost to be classified as "excessive". It would seem contrary to the plain meaning of "excessive" to determine that a health care cost of any amount. from $1 to a few hundred dollars

[6] IRPR, R. 1(1)

[7] Global News, Andrew Russell and Brian Hill, August 29, 2017, "Immigration Canada 'breaking the law', when denying some disabled applicants, say legal experts", see: https://globalnews.ca/news/3685104/immigration-canada-breaking-the-law-when-denying-some-disabled-applicants-say-legal-experts/

over the average Canadian per capita cost of health care, could be determined excessive. This is particularly the case given the fact that the current threshold of $6,655 is an average cost, meaning that there is a significant portion of Canadians with health care or social service costs exceeding the average threshold.[8]

2. s. 38(1)(c) thwarts the objectives of the Act by refusing applicants who could otherwise contribute greatly to Canadian society

The objectives of Canadian immigration policy are social, cultural and economic. Applicants who meet these objectives are currently rejected on the basis of s. 38(1)(c) without any consideration of whether their potential contributions outweigh the projected demand on health or social services.

An example from our legal practice is an American temporary worker employed in the tech industry in British Columbia. He was important to the local economy and received a provincial nomination based on his importance to the local economy. In his individualized plan, he undertook to set up a private health savings plan to cover the cost of his HIV medication, and provided evidence that he had the personal wealth to do so. Nevertheless, he was refused on medical grounds based on the cost of his medication. No consultation was made with the province regarding its interest in absorbing the cost of his health condition in exchange for his contribution to the local economy.

Another example is an investor with significant assets who, after receiving a positive selection decision, was refused because of the cost of his spouse's medication, which only exceeded the annual excessive demand threshold by $700. No assessment was made regarding whether this applicant's investment or contribution to the Canadian tax base would outweigh the relatively small amount by which the cost of medication exceeded the average Canadian per capita cost of health care.

While economic contributions are obvious omissions from the excessive demand calculation, the neglect of social contributions (a parent who needs hip surgery but provides child care for her professional Canadian children) and cultural contributions (an internationally known dancer who requires knee surgery) also undermine the goals of the Act.

3. s. 38(1)(c) perpetrates discrimination of applicants with treatable health conditions and persons with disabilities

[8] See Coyte, Peter et al, "The economic burden of immigrants with HIV: When to say no?*" in Journal for Business Advancement, April 2010 which recommends $14,581.43 as an appropriate excessive demands cost threshold.

The discriminatory history of inadmissibility on the basis of health was recognized by the Supreme Court of Canada in *Hilewitz*.[9] While the Supreme Court of Canada in *Hilewitz* did not analyze the constitutionality of the medical inadmissibility provision, there are grounds to believe that a challenge to s. 38(1)(c) based on s. 15 of the Charter would be successful.

The dubious constitutional status of s. 38(1)(c) is based upon:

- The historical discrimination against persons with disabilities, which stereotypically views them as societal "burdens" and ignores their contributions;

- The fact that the "excessive demands" analysis under s. 38(1)(c) ignores an applicant's potential contributions, and therefore perpetrates the historical stereotypes applied to persons with disabilities;[10] and

- The individualized assessment of an applicant's plan to mitigate costs, which is purportedly a tool designed to minimize the discriminatory impact of s. 38(1)(c), is ineffective due to the absence of a monitoring mechanism, rendering the process of determining who is admitted to Canada despite s. 38(1)(c) arbitrary.

An illustration of discrimination on the basis of disability perpetrated by s. 38(1)(c) is the case of Jazmine Talosig, a 14 year old high school student who was found medically inadmissible because she is deaf.[11] Jazmine intended to enroll in a British Columbia public school which caters to deaf students at no additional costs beyond standard public school education costs. Nevertheless, she was deemed an excessive demand and the cost of her disability was estimated to be $92,000. The decision was eventually reversed after the involvement of media, Members of Parliament, and the B.C. Education Minister. While this is a positive result, a fair application of admissibility should not depend on access to the media and political clout.

4. Relief from medical inadmissibility is arbitrary and discretionary

It is acknowledged that the Act contains exemptions from medical inadmissibility criteria, but these exemptions are arbitrary. For example, a protected person is exempted from medical inadmissibility, whereas an applicant who demonstrates compelling circumstances to remain in Canada on humanitarian and compassionate grounds can be found medically inadmissible. An additional example is a seriously-ill sponsored spouse in a six month marriage with a Canadian is exempted from medical inadmissibility but a parent who has dedicated their life to raising a Canadian permanent resident can be refused because of the need for knee replacement surgery.

A request for exemption from medical inadmissibility criteria under s. 25 of the Act is a possible form of relief from medical inadmissibility, as is a request for a temporary resident permit.

[9] *Hilewitz*, supra, para. 41-53.
[10] *Hodge v. Canada (Minister of Human Resources Development)* 2004 SCC 65
[11] Toronto Star, "Deaf teen deemed 'medically inadmissible' can now join mother in Canada", June 25, 2015.

However, these forms of relief are highly discretionary and do not address the fundamental unfairness resulting from the application of medical inadmissibility criteria.

Conclusion

Despite recent efforts to mitigate the discriminatory impact of s. 38(1)(c), the process remains arbitrary, ineffective and discriminatory. Further, the financial and emotional toll resulting from s. 38(1)(c) assessments on both the applicant and the government's side are extensive and disproportionate to cost savings. For these reasons, we recommend the repeal of s. 38(1)(c).