HOUSE OF COMMONS
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CANADA

Report of the Standing Committee on Citizenship and Immigration

BUILDING AN INCLUSIVE CANADA: BRINGING THE *IMMIGRATION AND REFUGEE PROTECTION ACT* IN STEP WITH MODERN VALUES

Chair
Robert Oliphant

DECEMBER 2017

42nd PARLIAMENT, 1st SESSION

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Reports from committee presented to the House of Commons

Presenting a report to the House is the way a committee makes public its findings and recommendations on a particular topic. Substantive reports on a subject-matter study usually contain a synopsis of the testimony heard, the recommendations made by the committee, as well as the reasons for those recommendations.

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has the honour to present its

FIFTEENTH REPORT

Pursuant to its mandate under Standing Order 108(2), the Committee has studied federal government policies and guidelines regarding medical inadmissibility of immigrants and has agreed to report the following:

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SUMMARY

Canada, prior to ratifying the United Nations *Convention on the Rights of Persons with Disabilities* in 2010, reviewed its laws and policies to ensure that the Convention could be implemented in conformity with the Canadian constitution. One of the laws that must reflect this new international commitment is the *Immigration and Refugee Protection Act.* Currently, section 38(1)(c) of the Act, which excludes certain people admission to Canada based on medical or disability grounds, is out of touch with Canadians' values.

Broadly, the medical inadmissibility provision based on what is termed "excessive demand", section 38(1)(c), has two components. Excessive demand is understood as a higher than average estimated cost to the health and social services systems or a demand that would add to existing wait lists which could result in the inability to provide timely services to Canadian citizens or permanent residents. Human rights and disability advocates, lawyers, immigration organizations as well as individuals argue that this provision does not respect basic human rights and is discriminatory. This provision dates from before Confederation and has lingered despite numerous legislative changes to Canada's immigration system. Although it is no longer explicitly discriminatory, the provision still has adverse effects on people with disabilities who apply to become permanent residents in Canada. Others have argued that the burden placed on the administrative system as well as the potential economic loss to Canada by the exclusion of certain people or their family members could outweigh the cost savings in medical and social services, although data on this is difficult to find. There are broadly held concerns that, without repeal, section 38(1)(c) of the *Immigration and Refugee Protection Act* and the accompanying regulatory provisions related to excessive demand, our immigration laws unjustifiably violate human rights of certain would-be newcomers to Canada and this is inconsistent with the modern values Canadians associate with contemporary human rights protections.

Faced with these concerns, the House of Commons Standing Committee on Citizenship and Immigration decided to study the federal government's policies and guidelines regarding medical inadmissibility, in particular the excessive demand on health and social services provision. Immigration, Refugees and Citizenship Canada and witnesses provided detailed information and data to help the Committee understand the current medical inadmissibility policies and its challenges. This report provides a number of recommendations based on the issues heard during the course of the study. Foremost, the Committee would like to bring the *Immigration and Refugee Protection Act* in line with Canadian principles, and recommends repealing section 38(1)(c) of the Act. The Committee also acknowledges that such legislative change can take time, involves conversations with the provinces and

territories, and thus emphasizes the need to immediately improve the application of the excessive demand provision in the meantime.

The Minister of Immigration, Refugees and Citizenship, in collaboration with its provincial and territorial counterparts also recently undertook a fundamental review of the medical inadmissibility provision based on excessive demand to ensure it is in line with Canada's commitments and principles. The Committee welcomes the ongoing consultation between the federal, provincial and territorial governments on this issue, as it is of multi-jurisdictional interest.

Canadians value diversity and inclusiveness and it should be mindful of all the abilities and contributions of its citizens, newcomers and potential immigrants as it moves forward with reviewing the medical inadmissibility.

To these ends, the Committee broadly recommends the repeal of section 38(1)(c) of the *Immigration and Refugee Protection Act* and the relevant regulatory provisions. In the intervening period, the Committee recommends implementing certain interim measures to, among other things, increase the cost threshold for excessive demand inadmissibility and modify the calculation criteria for this threshold. Furthermore, the Committee recommends that Immigration, Refugees and Citizenship Canada follow the ruling of the Supreme Court of Canada decision in *Hilewitz v. Canada* when training staff, determining and evaluating excessive demand on a case by case basis.

LIST OF RECOMMENDATIONS

As a result of their deliberations committees may make recommendations which they include in their reports for the consideration of the House of Commons or the Government. Recommendations related to this study are listed below.

Bringing the *Immigration and Refugee Protection Act* in Step with Canadian Values

Recommendation 1

That section 38(1)(c) of the *Immigration and Refugee Protection Act* and the exemptions to it be repealed; that the Governor in Council repeal all corresponding regulations; and that Immigration, Refugees and Citizenship Canada repeal all corresponding policies and guidelines. 40

Consulting with Provinces and Territories

Recommendation 2

That the Minister of Immigration, Refugees and Citizenship continue to consult and negotiate with the provinces and territories on a repeal of section 38(1)(c) from the *Immigration and Refugee Protection Act*. 41

Collecting Data for Better Decision-Making

Recommendation 3

Until such time as section 38(1)(c) of the *Immigration and Refugee Protection Act* is repealed, that Immigration, Refugees and Citizenship Canada report to the House of Commons annually on the use of excessive demand by the department, including comprehensive data on: (i) the number of applications for which the estimation for which the estimation of excessive demand exceeds the threshold for any stage of the application; (ii) the medical cost estimates; (iii) the number of such applications delayed by duration delay; (iv) the number of such applications refused; (v) the number of such applications abandoned; (vi) the number of family members whose applications are also delayed, refused or abandoned as a result of the implication of an excessive demand process; (vii) the full costs of implementing excessive demand and appeals; and (viii) such other information as the department, provinces or territories determine to be relevant in negotiating the repeal of excessive demand. 41

Interim Measures

Recommendation 4

Pending repeal of section 38(1)(c) of the *Immigration and Refugee Protection Act,* in accordance with recommendation 1, that the following interim measures be implemented to the excessive demand regime: 42

Proper Training for Immigration/Visa Officers and Medical Officers

Recommendation 4(a)

That Immigration, Refugees and Citizenship Canada ensure that the final decision-makers on a permanent residence application are properly trained in assessing the reasonableness of the medical officers' recommendations; and that medical officers are properly trained to evaluate the individual's entire application. 42

Calculating the Cost Threshold for Excessive Demand

Recommendation4(b)

That Immigration, Refugees and Citizenship Canada fundamentally review how it calculates the cost threshold for excessive demand on health and social services by eliminating from current definitions those services that are not publicly funded. 42

Recommendation 4(c)

That Immigration, Refugees and Citizenship Canada ensure that the cost threshold for excessive demand on health and social services is calculated by economists based on provincial, territorial and federal data. 42

Expanding the Categories of Exemptions to the Excessive Demand Provision

Recommendation 4(d)

That Immigration, Refugees and Citizenship Canada expand the list of exempted persons from the excessive demand provision to include economic applicants that are already working in Canada and their family members. 43

Providing Clear and Comprehensive Information

Recommendation 4(e)

That Immigration, Refugees and Citizenship Canada provide applicants with timely decisions and procedural fairness letters that are written in plain language and are comprehensive in nature, including rationales, in order fully to inform applicants of the findings they must address to overcome a finding of excessive demand. 43

Recommendation 4(f)

That Immigration, Refugees and Citizenship Canada publish on its website, in plain language, all operation manuals and guidelines regarding health to help applicants understand the evidence they need to provide during their application process.. 43

Parliamentary Review

Recommendation 5

That should, after a thorough consultation with the provinces and territories and analysis of all relevant data, Parliament repeal section 38(1)(c) of the *Immigration and Refugee Protection Act,* a full parliamentary review of the impact of these changes be undertaken within three years of its implementation and that such a review include its impact on the provinces and territories.. 43

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BUILDING AN INCLUSIVE CANADA: BRINGING THE *IMMIGRATION AND REFUGEE PROTECTION ACT* IN STEP WITH MODERN VALUES

PREAMBLE

On 16 October 2017, the House of Commons Standing Committee on Citizenship and Immigration (the Committee) decided to undertake a study of the federal government's policies and guidelines regarding medical inadmissibility in the *Immigration and Refugee Protection Act*. The Committee examined medical inadmissibility through the lens of excessive demand on health and social services provision, including the exercise of discretion.[1]

During the period of 24 October to 23 November 2017, the Committee heard from 25 witnesses and received 24 written submissions.[2] The Committee wishes to thank all witnesses who took the time to appear and share their expertise or heart-wrenching stories with respect to the inadmissibility of persons based on medical grounds. The Committee also expresses its thanks to the Minister of Immigration, Refugees and Citizenship, the Honourable Ahmed Hussen, and to officials from Immigration, Refugees and Citizenship Canada (IRCC) for making themselves available to appear before the Committee.

INTRODUCTION

Since Confederation, Canada's laws and regulations governing the admission of newcomers have evolved and were shaped by the country's changing social, political and economic climate. The current *Immigration and Refugee Protection Act*[3] (IRPA) came into force in 2002 and sets out the core principles and concepts that govern Canada's immigration and refugee protection programs, including provisions relating to requirements and selection, examination and inadmissibility.

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1 House of Commons Standing Committee on Citizenship and Immigration [CIMM], *Minutes of Proceedings*, 1st session, 42nd Parliament, 16 October 2017.

2 CIMM, *Federal Government Policies and Guidelines Regarding Medical Inadmissibility of Immigrants*.

3 *Immigration and Refugee Protection Act* [IRPA], S.C. 2001, c. 27.

This report discusses one type of inadmissibility to Canada, based on health grounds. The objectives of this medical inadmissibility provision are to ensure Canada's population is not: a) likely to be affected by potential danger to public health; b) likely to be affected by potential danger to public safety; or c) likely overburdened by costs to health and social services. During its study, the Committee focused on how medical inadmissibility is applied to people who want to become permanent residents in Canada. The Committee heard specifically from two individuals who shared their experience of hardship and highlighted that, even though they could work in Canada, they could not successfully apply for permanent residency for themselves and their families due to the medical condition of one of their family members.

Part 1 of this report provides an overview of the current application of the excessive demand provision in Canadian law, whereas Part 2 discusses the provincial perspectives on this provision. Part 3 highlights domestic and international human rights law in the context of medical inadmissibility and Part 4 analyzes the issues and specific impact of the provision on individuals. Part 5 recommends a variety of options for reforming medical inadmissibility provisions based on potential excessive demands on health and social services in Canada.

PART 1: MEDICAL INADMISSIBILITY – CURRENT DEFINITIONS AND POLICIES

There are several steps to a finding of medical inadmissibility by IRCC officers as well as options to appeal. To be allowed to enter or remain in Canada, an individual must submit to an examination which includes, for permanent residence applicants, a medical examination. IRPA and its regulations set out a limited number of reasons that render a person inadmissible to Canada.[4] Of note, if an individual is accompanying a family member that is inadmissible, that individual also becomes inadmissible.[5] The inadmissibility based on health grounds is provided for at section 38 of IRPA:

> **38 (1)** A foreign national is inadmissible on health grounds if their health condition
>
> **(a)** is likely to be a danger to public health;

4 IRPA, section 34 to section 42. There are 11 grounds for inadmissibility: security, violation of international human rights, serious criminality, criminality and organized criminality, health grounds, financial grounds, misrepresentation, cessation of refugee protection, non-compliance with the Act and accompanying a family member who is inadmissible.

5 IRPA, section 42.

> **(b)** is likely to be a danger to public safety; or
>
> **(c)** might reasonably be expected to cause excessive demand on health or social services.

Ms. Dawn Edlund, Associate Assistant Deputy Minister at IRCC, explained to the Committee that, while there are many potential reasons for inadmissibility, there also exist ways for these to be waived: "Individuals can have their cases accepted on humanitarian and compassionate grounds…or be provided with a temporary resident permit."[6] In 2016, for example, there were 21 temporary resident permits issued to overcome medical inadmissibility out of 995 applications deemed inadmissible.[7]

Per section 38(2) of the *Immigration and Refugee Protection Act*, section 38(1)(c) does not apply in the case in the case of a foreign national who:

> **(a)** has been determined to be a member of the family class and to be the spouse, common-law partner or child of a sponsor within the meaning of the regulations;
>
> **(b)** has applied for a permanent resident visa as a Convention refugee or a person in similar circumstances;
>
> **(c)** is a protected person; or
>
> **(d)** is, where prescribed by the regulations, the spouse, common-law partner, child or other family member of a foreign national referred to in any of paragraphs (a) to (c).[8]

A. Medical Examinations

Ms. Edlund informed the Committee that "[h]ealth admissibility is determined through a two-stage process."[9] Immigration applicants undergo a medical examination performed by a physician designated by IRCC. These doctors are referred to as panel physicians.

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6 CIMM, *Evidence*, 24 October 2017, 0855 (Dawn Edlund, Associate Assistant Deputy Minister, Operations, Department of Citizenship and Immigration).

7 Immigration, Refugees and Citizenship Canada [IRCC], Response to requests for information made by the Standing Committee on Citizenship and Immigration on 24 October 2017 [Response], *Question 12: Negative Decisions Overturned;* IRCC, Response, *Question 1: Medically Inadmissible Applicants.*

8 IRPA, section 38(2).

9 CIMM, *Evidence*, 24 October 2017, 0845 (Dawn Edlund).

Ms. Edlund stated: "We do quality assurance and various checks on those medical professionals to make sure they're going to do the immigration medical exam under the standards we set out for them."[10] These physicians are not necessarily accredited in Canada.

Dr. Arshad Saeed, Director, Centralized Medical Admissibility Unit at IRCC, explained the next stage: "Once the medical is done, it is sent to one of the four regional medical offices that we have in Ottawa, New Delhi, Manila, and London. It's reviewed by the medical officers… Only the complicated cases are … sent to the specialized unit in Ottawa, which is called the [C]entralized [M]edical [A]dmissibility [U]nit. We look at the file again and then make our recommendation to the visa officer."[11] The Centralized Medical Admissibility Unit was created in May 2015 to allow for the development and maintenance of a centre of expertise on the procedures and content for such cases, to ensure standardization.[12]

B. Inadmissibility Based on Health Grounds or Medical Inadmissibility

Under IRPA, a person may be found inadmissible to Canada for three reasons with regards to their health, as stated above.[13] The first reason is that they may have a health condition that "is likely to be a danger to public health." Ms. Dawn Edlund of IRCC told the Committee that this refers to highly communicable diseases such as active tuberculosis or untreated syphilis.[14]

The department provided to the Committee further information on treatments available to those found with active tuberculosis or syphilis. Most individuals accept treatment and will be able to resume their permanent residence application. Syphilis is treated with antibiotics, usually requiring three visits to a clinic over a two-week period. There have been no recent refusals because of this condition. For tuberculosis, there is a six-month course of treatment and the medical officer must be satisfied that the person is

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10 Ibid., 0905.

11 CIMM, *Evidence*, 24 October 2017, 1005 (Dr. Arshad Saeed, Director, Centralized Medical Admissibility Unit, Migration Health Branch Department of Citizenship and Immigration).

12 IRCC, Response, *Question 8: Processing of Medically Inadmissible Cases*.

13 IRPA, section 38.

14 CIMM, *Evidence*, 24 October 2017, 0845 (Dawn Edlund). IRCC states that the classification of medical conditions is based on the International and Statistical Classification of Diseases (ICD) 9/10 established by the World Health Organization. (Response, *Question 20: Autism Cases*).

no longer infectious to others.[15] As of 27 October 2017, there were 435 cases on hold pending completion of the treatment of tuberculosis.[16] Once such individuals are admitted to Canada, they are referred to their provincial authority for medical surveillance. From 2014 to September 2017, there were a total of 1,934 cases of treated inactive pulmonary tuberculosis in persons applying to come to Canada. There were a total of 23 refusals for permanent residence based on danger to public health for the period between 2013 and 2016.[17] It should be noted that none of the witnesses called for the repeal of section 38(1)(a).

The second reason that an individual may be found medically inadmissible is that they may have a health condition that "is likely to be a danger to public safety". Ms. Edlund stated that "this may include certain health conditions that could result in unpredictable or violent behaviour."[18] It should be noted that none of the witnesses called for the repeal of section 38(1)(b).

The third reason that triggers a finding of medical inadmissibility is if the person's health condition "might reasonably be expected to cause excessive demand on health or social services."[19] There are many elements to this particular finding of inadmissibility, which are discussed in detail below.

C. Excessive Demand on Health and Social Services

The *Immigration and Refugee Protection Regulations*[20] define excessive demand as well as health and social services for the purposes of medical inadmissibility. Ms. Edlund informed the Committee that the total number of medical recommendations of potential excessive demand represent, in any given year, 0.2% of all applications (between 900 to 1000 individuals).[21] This represents savings of at least $135 million over five years, for each year of decision,[22] not including modeling for those who already self-deselect. The number of final refusals is even lower because the applicant may withdraw

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15 There are strains of tuberculosis for which appropriate treatment can last two years or longer. IRCC, Response, *Question 17: Active Tuberculosis and Syphilis*.

16 IRCC, Response, *Question 18: Tuberculosis Cases on Hold*.

17 IRCC, Response, *Question 17: Active Tuberculosis and Syphilis*.

18 CIMM, *Evidence*, 24 October 2017, 0845 (Dawn Edlund).

19 IRPA, section 38(1)(c).

20 *Immigration and Refugee Protection Regulations* (IRPR), section 1.

21 CIMM, *Evidence*, 24 October 2017, 0855 (Dawn Edlund).

22 Ibid., 0850.

their application; the visa officer may choose to accept the mitigation plan proposed by the applicant; the applicant may be accepted under humanitarian grounds; or the visa officer may refuse the applicant on another, non-health-related, ground.[23]

It should be noted that, under section 38(2) of IRPA, Convention refugees[24] and protected persons, as well as spouses and children part of a family sponsorship application, are exempted from medical inadmissibility based on excessive demand.[25] It applies only to economic applicants and their family members, including live-in caregivers, provincial nominees, parents and grandparents, students, foreign workers and temporary residents.

1. Basic Definitions to Excessive Demand

The *Immigration and Refugee Protection Regulations* set out two types of potential excessive demand: one is based on "the cost threshold" to access health and social services and the other on "wait lists" for life saving treatments.

First, applicants are deemed inadmissible if the predicted five-year cost of the health and social services required to treat their specific health condition would likely exceed "the cost threshold" understood to be the average Canadian per capita cost which in 2017 was $33,275 over a five-year period.[26] The cost threshold is calculated by using the latest per capita national expenditure on health and social services reported by the Canadian Institute for Health Information (CIHI) plus a per capita supplement for "other social services" not included in CIHI's report that was determined in 2004 by the Medical Branch of IRCC, updated annually to reflect inflation.[27]

Second, applicants are inadmissible if their health could place a demand on health services or social services that would add to existing wait lists and could potentially increase the rate of mortality and/or morbidity in Canada as a result of an inability to

23 IRCC, Response, *Context and definitions to explain IRCC data and responses.*

24 A total of 26,172 Syrians were resettled in Canada between 4 November 2015 and 29 February 2016. Data provided by IRCC on their use of the Interim Federal Health Program (IFHP) for their first year showed that dental care (40%), drugs (28%) and medical care (11%) were the services most accessed. The total cost to the federal government for all the health care services accessed by those individuals during their first year in Canada was $22.3 million. IRCC, Response, *Question 25: Syrian Initiative—IFHP Utilization.*

25 IRPA, section 38(2).

26 IRCC, Response, *Question 21: Inadmissibility Based on Costs versus Wait Times.*

27 CIMM, *Evidence*, 24 October 2017, 0915 (Dawn Edlund); IRCC, Response, *Questions 5, 11, 12—Cost Threshold and Supplemental Social Services Amount.*

provide timely services to Canadian citizens or permanent residents. At this time, IRCC medical officers only have data on wait lists for dialysis and some transplantation services.[28] Health services that are publicly funded services include hospital care, laboratory services and drugs, services of family physicians, specialists, nurses, chiropractors and physiotherapists. Social services for the purposes of determining admissibility include services such as home care, specialized residence and residential services, special education services, social and vocational rehabilitation services, personal support services and the provision of devices related to those services for which the majority of the funding is through government or publicly funded agencies.[29]

2. Next Steps after Medical Officers Advise Visa Officers of Excessive Demand

When an individual's case is reviewed by medical officers in Ottawa in the Centralized Medical Admissibility Unit, "a medical officer assesses the severity of the illness and the degree of service that would be required to treat it."[30] Medical officers must list the anticipated social services and/or outpatient medication required, based on a detailed assessment, recommendations provided by a recognized specialist in the field and the experience and knowledge of the medical officer.[31] Medical officers are instructed to identify the estimated costs for the health and social services related to an individual's medical diagnosis, generally for the five years following the medical examination.[32]

Upon receiving the medical officer's opinion, the visa officer then sends a "Procedural Fairness" letter to the applicant. The letter's content must include the relevant sections of IRPA, the right to challenge the findings, and the specific social services and outpatient medication that were identified and were the basis of the finding of medical inadmissibility. The letter must also indicate that the applicant may provide a plan to obtain all the services and manage the costs personally or provide an alternative plan.[33]

The plan provided by an applicant deemed inadmissible because of excessive demand is called a "mitigation plan." Dr. Saeed explained that "[i]f they have a detailed plan, we look at the feasibility, the practicality, and the applicability of the plan in a Canadian

28 IRCC, Response, *Question 21: Inadmissibility Based on Costs versus Wait Times.*

29 IRPR, section 1.

30 CIMM, *Evidence*, 24 October 2017, 0855 (Dawn Edlund).

31 IRCC, *Instructions related to Procedural Fairness (Excessive Demand)*, "Instructions for medical officers".

32 IRCC, Response, *Question 3: Avoided Costs.*

33 IRCC, *Instructions related to Procedural Fairness (Excessive Demand)*, "Instructions for visa/immigration officers".

context. That is done, and then we provide our opinion to the visa officer to make the final decision."[34] Ms. Edlund told the Committee that IRCC, however, has "no authority to enforce that mitigation plan once someone becomes a permanent resident."[35]

3. Cost-Benefit Analysis

Officials from IRCC told the Committee that using the data from 2014, which is the first year when health data was consistently captured by IRCC under its new Global Case Management System,[36] "the excessive demand provision results in avoided costs for provincial-territorial health and social services [in] the order of $135 million over five years, for each year of decision."[37] For example, this amount would represent 0.1% of all the provincial and territorial health spending in 2015.[38] IRCC uses findings from medical officers, rather than final decisions by visa officers to establish the savings to the province of destination.[39] Actual savings are not known and were not provided to the Committee. However, the Committee notes that anecdotal evidence provided by the Government of New Brunswick,[40] and no other province, highlights the dearth of evidence to the potential increase of cost due to the repeal of the excessive demand provision.

In response to questions from the Committee, Ms. Edlund indicated that the evaluation process does not consider the economic benefit of having the family in Canada as permanent residents and the contribution to the economy that would be lost should the family be denied.[41] Australia had attempted to undertake such an evaluation.
Mr. Michael Mackinnon, Senior Director, Migration Health Policy and Partnerships at IRCC, explained that "[Australia] found it was unworkable because it involved too many unsupportable assumptions as to what the individual's employment trajectory or income

34 CIMM, *Evidence*, 24 October 2017, 0920 (Dr. Arshad Saeed).

35 CIMM, *Evidence*, 24 October 2017, 1040 (Dawn Edlund).

36 IRCC, Response, *Context and definitions to explain IRCC data and responses.*

37 CIMM, *Evidence*, 24 October 2017, 0850 (Dawn Edlund).

38 Ibid.

39 IRCC, Response, *Question 3: Avoided Costs.*

40 The Government of New Brunswick stated that, in 2014, it had "fewer than five cases constituting an excessive burden [which] would have resulted in costs totalling $297,000 if the individuals had been admissible to Canada." Government of New Brunswick, *Letter*, 20 November 2017, p. 1.

41 CIMM, *Evidence*, 24 October 2017, 0925 (Dawn Edlund).

would be over the years following their arrival, so they abandoned this approach."[42] Additionally, IRCC provided the Committee with an estimated cost of $800,000 to $1,100,000 per year to run the entire administrative process related to the application of section 38(1)(c) of IRPA, especially in regards to determining excessive demand.[43]

PART 2: EXCESSIVE DEMAND: A MULTI-JURISDICTIONAL ISSUE

As per Canada's Constitution*,* health care and social services are under provincial jurisdiction,[44] whereas immigration is a shared competency.[45] In October 2016, the Minister of Immigration, Refugees and Citizenship and the department began a "fundamental review of the excessive demand provision" by consulting with their provincial and territorial counterparts.[46] There was an initial teleconference among all federal, provincial and territorial ministers responsible for immigration that introduced the review. This allowed provincial and territorial ministers to consult with their colleagues responsible for health, education and social services on the impact of the excessive demand provision.[47] Subsequently, the Minister of Immigration, Refugees and Citizenship met again with his provincial and territorial counterparts who were given an opportunity to raise specific concerns.[48]

IRCC told the Committee that the department is considering a "range of possible changes" under this review, but "has not provided provincial officials with specifics."[49] Ultimately, IRCC has "shared potential areas of change with provinces and territories [which include] possible adjustments to the cost threshold, changes in the groups exempted from the provision, redefining the services under consideration, or

42 CIMM, *Evidence*, 24 October 2017, 0855 (Michael MacKinnon, Senior Director, Migration Health Policy and Partnerships, Migration Health Branch, Department of Citizenship and Immigration).

43 The estimated cost includes assessments, litigation of cases and policy work related to the provision. It does not include visa officers' costs given the relatively small volume of cases these represent relative to overall file volumes. IRCC, Response, *Question 26: Processing Costs.*

44 *Constitution Act, 1867*, section 92(7).

45 *Constitution Act, 1867*, sections 91(25) and 95. The federal law supersedes the provincial law, in case of conflict. CIMM, *Evidence*, 20 November 2017, 1905 (Lorne Waldman, Barrister and Solicitor, Lorne Waldman and Associates, as an individual).

46 CIMM, *Evidence*, 24 October 2017, 0850 (Dawn Edlund); CIMM, *Evidence*, 22 November 2017, 1220 (Hon. Ahmed Hussen, Minister of Immigration, Refugees and Citizenship, House of Commons).

47 CIMM, *Evidence*, 22 November 2017, 1300 (Hon. Ahmed Hussen).

48 Ibid., 1230; Government of British Columbia, *Letter*, 22 November 2017.

49 IRCC, Response, *Question 9: Exempt Groups Expansion.*

enhancements in how wait lists are considered."[50] These consultations allow the provinces and territories to evaluate the impact of these possible changes on their health care and social services systems.[51] The Minister emphasized that "consultations with provinces and territories have been ongoing" and that "provinces and territories were very supportive of the review." According to the Minister, "some provinces are little apprehensive about the costs they think they'll have to incur, but they do agree with the general premise that we need to bring this provision in line with our other accepted policies with respect to moving towards an inclusive approach towards people with disabilities."[52]

A. Provincial and Territorial Perspectives

As part of its study, the Committee invited the provinces and territories to hear their perspective on the excessive demand provision and its impact on their health and social services. At the time of writing, British Columbia, Saskatchewan, New Brunswick, Newfoundland and Labrador, Nunavut and Yukon wrote to the Committee to highlight their concerns and recommendations.

The Government of Saskatchewan cautioned against any changes to the excessive demand policy because it would "transfer a large and growing risk to provinces and territories and the services they deliver."[53] For example, there will be additional costs for health, education and social services that would have to be borne by taxpayers and employers.[54] These increased costs could impact the level and quality of services; wait times; health, economic and social outcomes of all individuals; and difficulty in meeting existing commitments as well, including for persons with disabilities and those with additional needs.[55] As such, the Government of Saskatchewan recommended "maintaining the current policy related to medical inadmissibility" because it "is the best option for ensuring that Canadians continue to have timely and quality access to health, education and social services."[56] The Government of Saskatchewan considered that excessive demand cases could increase with a change in policy and that public support for Canada's immigration system could decrease if the excessive demand provision was

50 CIMM, *Evidence*, 22 November 2017, 1220 (Hon. Ahmed Hussen).

51 Ibid., 1220.

52 Ibid., 1230.

53 Government of Saskatchewan, *Letter*, 20 November 2017, p. 2.

54 Ibid.

55 Ibid., p. 1.

56 Ibid.

repealed.[57] The Government of New Brunswick also considered that excessive demand cases could increase with a change in policy.[58]

By contrast, the Government of Newfoundland and Labrador recognized that the excessive demand provision is an unfair and unjust assessment of all the immigrant applicants' long-term contributions to Canada.[59] The province indicated its support for removing the provision, but called for the federal government to take all financial impacts into account and collaborate with provinces and territories to address them.[60]

The Government of Nunavut informed the Committee that "there is little risk of excessive demand on health and social services" from immigrants to the territory.[61] Newcomers to Nunavut come from elsewhere in Canada "having already secured employment" in the territory or are already Canadian citizens.[62] In addition, the territorial government does not foresee an increase in immigration to the territory in the near future. The Government of Yukon echoed those comments.[63] It added that the territory recently eliminated the wait period for refugees to access health care insurance and extended health care insurance to Syrian refugees immediately upon their arrival to the territory.[64] This has not resulted in excessive demands to the territory's health and social services, but the Government of Yukon has seen the benefits of immigration through the contributions of newcomers in the health and social service workforce.[65]

The Government of British Columbia informed the Committee that they had "had the opportunity to share [British Columbia]'s position in writing with department officials and in-person at the Forum of Ministers Responsible for Immigration" and, as of 27 November 2017, had "no additional comments on this matter."[66]

The four provinces and two territories emphasized the importance of consultation and collaboration on the fundamental review of the excessive demand provision led by the

57 Ibid., pp. 2–3.

58 Government of New Brunswick, *Letter*, 20 November 2017, p. 1.

59 Government of Newfound and Labrador, *Written submission*.

60 Ibid.

61 Government of Nunavut, *Letter*, 14 November 2017.

62 Ibid.

63 Government of Yukon, *Letter*, 15 November 2017

64 Ibid.

65 Ibid.

66 Government of British Columbia, *Letter*, 22 November 2017.

federal government. The Government of Newfoundland and Labrador acknowledged that the review and consultation are "key to the development of a constructive solution that supports the interests of all current and future Canadians."[67] Mr. Lorne Waldman, Barrister and Solicitor at Lorne Waldman and Associates, reiterated the importance of collaboration because immigration is a shared responsibility and medical expenditures are under provincial jurisdiction.[68]

B. Costs of Health and Social Services

In order to ensure fairness among provinces, the federal government, through equalization payments, attempts to guarantee that the standards of health, education and welfare are the same for everyone in Canada.[69] The Canadian Institute for Health Information (CIHI) reported that health care

> expenditures per person vary across the country from $7,378 in Newfoundland and Labrador and $7,329 in Alberta, to $6,367 in Ontario and $6,321 in British Columbia [as shown in Figure 1]. This variation across the country occurs for many reasons, including differences in population demographics and health status, prescribing practices, public program design, and other factors.[70]

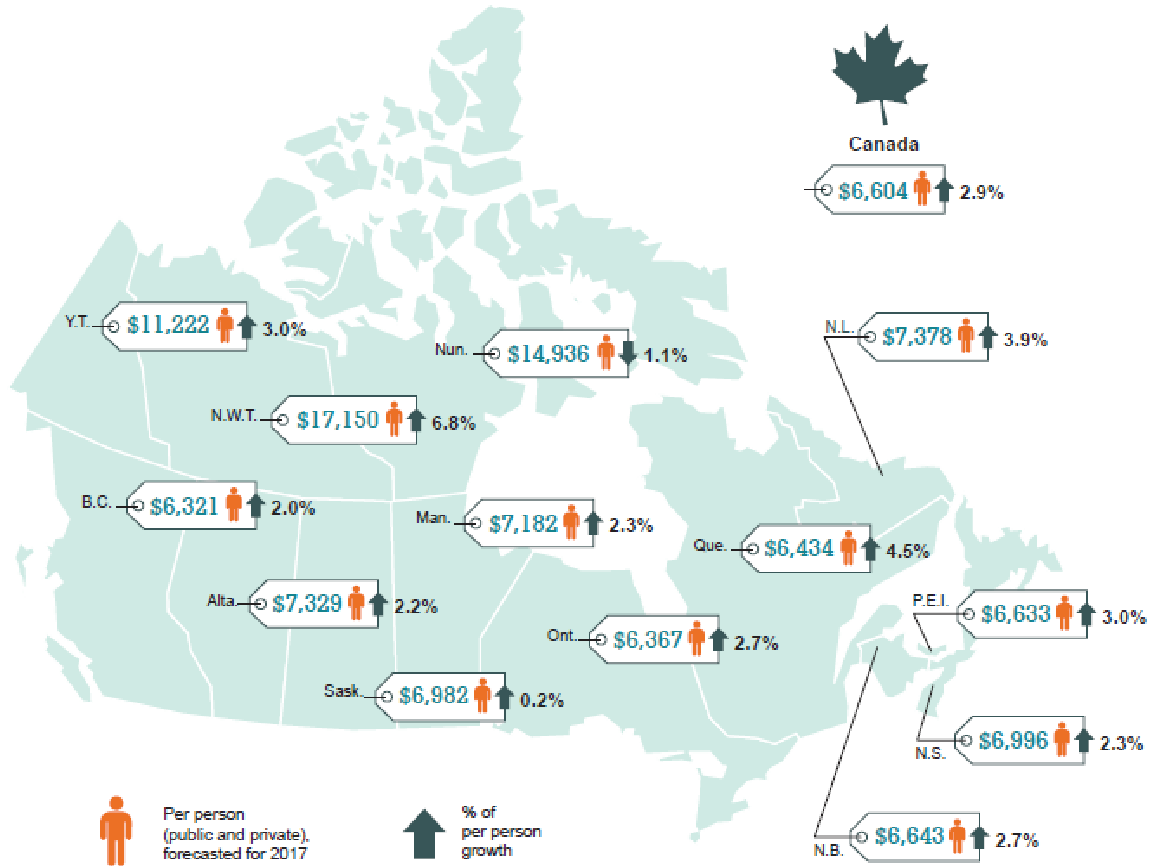
67 Government of Newfound and Labrador, *Written submission*.

68 CIMM, *Evidence*, 20 November 2017, 1905 (Lorne Waldman).

69 *Constitution Act, 1982*, section 36.

70 CIMM, *Evidence*, 20 November 2017, 1845 (Brent Diverty, Vice-President, Programs, Canadian Institute for Health Information).

Figure 1: Health expenditure in Canada in 2017, by province and territory



Source
National Health Expenditure Database, Canadian Institute for Health Information.

Source: Canadian Institute for Health Information, *National Health Expenditure Trends, 1975 to 2017*.

CIHI identified hospitals, drugs, and physician services as the three main drivers of health expenditures,[71] whereas inflation, population growth and population aging are the three main health cost drivers.[72] Of note, the share allocated to hospital spending has been decreasing, whereas the share allocated to drug spending has increased in

71 According to the report *National Health Expenditure Trends, 1975 to 2017* produced by the Canadian Institute for Health Information [CIHI], hospitals (28.3%), drugs (16.4%) and physician services (15.4%) account for more than 60% of total health spending. CIHI estimates that in 2017 there will be a growth of 3% in hospital spending, a 5% growth in drug spending and a 4% growth in physician spending.

72 CIMM, *Evidence*, 20 November 2017, 1845 (Brent Diverty).

recent years.[73] CIHI also reported that even though health spending is higher for seniors than any other demographic group, population aging is a modest cost driver.[74]

Nevertheless, Professor Arthur Sweetman from McMaster University pointed out to the Committee that there are “no good measures of actual demand or costs for such [health and social] services by the sub-set of potential immigrants who are at risk of being adjudicated as excessive cost or risk.”[75] He encouraged the federal government to track the cost of its decisions and, if there are increases in costs borne by provincial governments, to fund those increases.[76] Essentially, his comments echo some provinces’ concerns in regards to funding those potential additional costs.[77]

Professor Sheila Bennett from Brock University also emphasized that the education system distributes costs differently than the health system.[78] She pointed out that within each province school boards distribute costs differently; some self-contain the cost, while others extrapolate it over the entire school population.[79] According to her, “some provinces extrapolate it across the entire province.”[80] She argued that it is important that all children with diverse physical, cognitive, social, or emotional abilities have access to differentiated learning and opportunities support systems. This can lead to additional costs for particular schools but it also is an added social benefit to the entire population.[81]

C. Provincial Engagement

Mr. Waldman informed the Committee that, in the past, at least some provinces covered the costs of an individual’s needs that were deemed to create an excessive demand on

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73 Ibid.

74 More specifically, “the share of public-sector health care dollars spent on Canadian seniors has not changed significantly over the past decade—from 44.3% in 2005 to 46.0% in 2015. During the same time period, the percentage of seniors in the population grew from 13.1% to 16.1%.” Canadian Institute for Health Information, *National Health Expenditure Trends, 1975 to 2017*, p. 27.

75 CIMM, *Evidence*, 21 November 2017, 0905 (Arthur Sweetman, Professor, Department of Economics, McMaster University, as an individual).

76 Ibid.

77 Government of Saskatchewan, *Letter*, 20 November 2017, p. 2; Government of Newfound and Labrador, *Written submission*.

78 CIMM, *Evidence*, 21 November 2017, 0920 (Sheila Bennett, Faculty of Education, Brock University, as an individual).

79 Ibid.

80 Ibid.

81 Ibid.

health care and social services.[82] He gave the example of Manitoba, which "had a scheme where you could pay an amount of money as a bond for future expenditures."[83] Manitoba no longer has that bond program, but Mr. Waldman suggested it was possible to "look for compromises in terms of people offering to pay bonds or provinces agreeing to allow people to come into Canada."[84] Ms. Edlund also informed the Committee that provinces could, through an ad hoc process, support an individual that has an application deemed inadmissible due to a finding of excessive demand through the Provincial Nominee Programs.[85] She explained that the provinces can write a letter to IRCC recognizing the excessive demand, but stating that they support the applicant.[86] The letter is then taken into consideration by IRCC's

> decision-making officers. Frequently at that point the family ends up with a temporary resident permit. Once they're on a temporary resident permit for three years running, they can be granted permanent residency, with no further look at the medical admissibility.[87]

Ms. Edlund further noted that IRCC does not share "individual cases with the provinces" for privacy reasons.[88] The provinces can only "become aware that there is an excessive demand angle to the file" of its provincial nominees through the applicants themselves, at which point they can turn to IRCC for collaboration.[89] In this context, Mr. Michael Battista and Ms. Adrienne Smith, from Jordan Battista LLP, provided to the Committee the example of a provincial nominee in British Columbia that was refused based on excessive demand grounds. The province was not consulted "regarding its interest in absorbing the cost of his health condition in exchange for his contribution to the local economy" before the final decision was rendered.[90]

Ms. Meagan Johnston, from HIV & AIDS Legal Clinic Ontario, was also concerned with the "unfairness of the [excessive demand] provision" and the "unworkability of the

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82 CIMM, *Evidence*, 20 November 2017, 1905 (Lorne Waldman).

83 Ibid.

84 Ibid.

85 CIMM, *Evidence*, 24 October 2017, 0940 (Dawn Edlund).

86 Ibid.

87 Ibid.

88 Ibid., 1035.

89 Ibid.

90 Michael Battista and Adrienne Smith, *Written submission*, p. 5.

system."[91] According to her, provinces should not have "additional mechanisms to sort of circumvent [the] discrimination" created by the excessive demand provision because these will not be fairly applied throughout the country.[92] Mr. John Rae, First Vice-Chair of the Council of Canadians with Disabilities, also warned the Committee that such schemes "could set up a patchwork of eligibility province to province."[93]

PART 3: A HUMAN RIGHTS PERSPECTIVE ON MEDICAL INADMISSIBILITY

Section 3(3) of IRPA states that the Act is to be applied in a manner "consistent with the *Canadian Charter of Rights and Freedoms*, including its principles of equality and freedom from discrimination"[94] and in compliance "with international human rights instruments to which Canada is a signatory".[95] Nevertheless, many witnesses who appeared before the Committee or who provided written submissions argued that IRPA's medical inadmissibility provision based on excessive demand violated basic domestic and international human rights.[96]

The *Canadian Charter of Rights and Freedoms*[97] applies to everyone physically present in Canada.[98] Section 15 states that every individual has the right to equal benefit of the law

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91 CIMM, *Evidence*, 20 November 2017, 2010 (Meagan Johnston, Staff Lawyer, HIV & AIDS Legal Clinic Ontario).

92 Ibid.

93 CIMM, *Evidence*, 20 November 2017, 1905 (John Rae, First Vice-Chair, Council of Canadians with Disabilities).

94 IRPA, section 3(3)(d).

95 IRPA, section 3(3)(f).

96 CIMM, *Evidence*, 21 November 2017, 0850 (Roy Hanes, Associate Professor, School of Social Work, Carleton University, Council of Canadians with Disabilities); CIMM, *Evidence*, 21 November 2017, 0925 (Sheila Bennett); Ibid., (Arthur Sweetman).Felipe Montoya *Written submission*, p. 5; Michael Battista and Adrienne Smith, *Written submission*, p. 6; Canadian HIV/AIDS Legal Network and HIV & AIDS Legal Clinic Ontario [Legal Network and HALCO], *Written submission*, pp. 3-5; Joshua Goldberg, *Letter*, 13 November 2017, p. 2; Community Living Kingston and District and PooranLaw Professional Corporation [CLKD and PooranLaw], *Written submission*, pp. 1-3; Disability Positive, *Written Submission*, p. 2; Canadian Association for Community Living, *Written submission*, p. 2; Macdonald Scott, Carranza LLP, *Written submission*, pp. 1-2 ; Council of Canadian with Disabilities, *Written submission*, pp.8-9; Claire Kane Boychuk, *Written submission*, p. 24; OCASI-Ontario Councils of Agencies Serving Immigrants, Chinese and Southeast Asian Legal Clinic and South Asian Legal Clinic of Ontario [OCASI, CSALC and SALCO], *Written Submission*, pp. 3,6; Migrant Workers Alliance for Change and Caregivers' Action Centre [MWAC and CAC], *Written Submission*, p. 1; A.J. Withers with Alex Tufford, *Written Submission*, pp. 5-7; Repeal 38(1)c Coalition, *Written Submission*, p. 1.

97 *Canadian Charter of Rights and Freedoms*, Schedule B to *the Constitution Act 1982*, Part 1.

98 *Singh v. Canada (Minister of Employment and Immigration)*, [1985] 1 SCR 177.

without discrimination based on mental or physical disability. While our immigration system is selective, discrimination only occurs when a distinction is made in relation to personal characteristics of an individual or a group of individuals, based on protected grounds,[99] which imposes obligations or disadvantages that are not imposed on others.

Within this context, witnesses gave the Committee two examples where discrimination is apparent in the immigration policies. In the first, they highlighted that individuals found to be inadmissible on health grounds are not treated equally: they may challenge IRCC's findings, however an individual who cannot afford medical experts to produce additional evidence will not be successful.[100] In the second, discrimination is seen in access to the immigration programs. Individuals with disabilities or medical conditions cannot put forward their application through Express Entry like most other economic applicants. This intake system does not allow for applications based on humanitarian grounds, which a person with a medical inadmissibility finding would need to present to overcome the decision.[101]

Mr. Felipe Montoya, professor at York University on a temporary work permit who faced medical inadmissibility because of his son's disability when he applied for permanent residence for him and his family, also referred the Committee to the *Canadian Human Rights Act.*[102] Among the prohibited grounds of discrimination are disability and genetic characteristics. It is particularly relevant to Mr. Montoya's application as his son with Down syndrome had triggered a finding of medical inadmissibility for the entire family.

Witnesses' human rights concerns also extended to violations of international human rights law. In particular, they referenced the United Nations *Convention on the Rights of Persons with Disabilities* (CRPD),[103] which is different from other UN human rights conventions in that it outlines key steps and actions that Canada should take to promote and protect the human rights of people with disabilities.[104] Professor Roy Hanes of the School of Social Work at Carleton University highlighted to the Committee that the

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99 *Canadian Charter of Rights and Freedoms.* Section 15(1) lists these grounds of discrimination: race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

100 OCASI, CSALC and SALCO, *Written Submission*, p. 4 ; Macdonald Scott, Carranza LLP, *Written submission*, p. 2; A.J. Withers with Alex Tufford, *Written Submission*, p. 3.

101 Macdonald Scott, Carranza LLP, *Written submission*, pp. 1-2.

102 *Canadian Human Rights Act*, R.C.S, 1985, c.H-6; CIMM, *Evidence*, 21 November 2017, 0955 (Felipe Montoya, as an individual).

103 The United Nations Convention on the Rights of Persons with Disabilities (CRPD) was ratified by Canada in 2010. It is binding, creating obligations for Canada.

104 Julian Walker, *The United Nations* Convention on the Rights of Persons with Disabilities: *An Overview*, Publication No. 2013-09-E, Library of Parliament, Ottawa, 27 February 2013, p. 1.

Preamble offered the only definition of disability in the Convention: "disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others." Witnesses[105] referred to Article 3 which outlines the key principles of the CRPD such as non-discrimination; full and effective inclusion in society; respect for difference and acceptance of persons with disabilities as part of human diversity and humanity; and equality of opportunity. They also referred to Article 4 that lists the obligations that Canada has undertaken "to ensure and promote the full realization of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disability." These include adopting legislation and policies, or abolishing those that are discriminatory, as well as to refrain from engaging in any act or practice that is inconsistent with the Convention. Ms. Claire Kane Boychuk pointed to Article 5 on equality and non-discrimination that specifically applies to non-citizens engaging with the immigration system. It captures indirect discrimination, such as a decision based on costs, as in reality persons with disabilities are disproportionally impacted by such legislation.[106] Mr. Maurice Tomlinson, of the Canadian HIV/AIDS Legal Network, told the Committee that the UN has a formal mechanism to monitor Canada's progress in implementing the CRPD[107] and the Committee expresses its support for Canada's full implementation of the CRPD.

In the United Nations *Convention on the Rights of the Child*[108] the principle of non-discrimination on the basis of disability is provided for at Article 2, while it is specified that the best interest of the child must be a primary consideration in all state actions (Article 3). Witnesses focused on Article 9, which states that children should not be separated from their parents, whereas IRPA's caregiver program and temporary foreign worker program often create this situation.[109] Witnesses also underlined Article 24, which enshrines the right for children to attain the highest standard of health, and not to be deprived access to health services.[110]

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105 Disability Positive, *Written Submission*, p.2; Legal Network and HALCO, *Written submission*, pp. 3-5.

106 Claire Kane Boychuk, *Written submission*, pp. 24-26.

107 Maurice Tomlinson, Senior Policy Analyst, Canadian HIV/AIDS Legal Network , *Speaking Notes*, p. 1; UN Committee on the Rights of Persons with Disabilities, Concluding observations on the initial report of Canada, 8 May 2017, CRPD/C/Can/CO/1. In relation to Article 5 on equality and non-discrimination, the UN Committee suggests Canada include legislation with remedies for migrants with disabilities.

108 The *Convention on the Rights of the Child* was ratified by Canada in 1991.

109 A.J. Withers with Alex Tufford, *Written Submission*, p. 6.

110 Ibid.

Mr. Macdonald Scott, of Carranza LLP, also emphasized that Article 12 of the *International Covenant on Economic, Social and Cultural Rights*[111] establishes an obligation for Canada to recognize everyone's rights to the "highest attainable standard of physical and mental health" as well as to assist them in that goal.[112]

PART 4: ISSUES WITH THE EXCESSIVE DEMAND PROVISION

A number of witnesses indicated to the Committee the serious consequences of a medical inadmissibility finding, especially when immigrating as a family.[113] The Committee also heard that challenges persist within Canada's immigration law, particularly in regards to people with disabilities.[114] Part 4 provides an overview of the individuals captured by the excessive demand provision as well as the specific impact of this provision on their ability to enter or reside in Canada.

A. Individuals Captured by the Excessive Demand Provision

In response to a question from the Committee about what triggers a finding of medical inadmissibility based on excessive demand, IRCC commented that "there is no specific medical diagnosis that renders a case as medically inadmissible. Medical assessments for each individual applicant are done on a case-by-case basis."[115] This individual assessment obligation stems from the 2005 Supreme Court of Canada decision in *Hilewitz v. Canada,* where the court "held that immigration and medical officers have an obligation to assess a family's 'ability and intent' statement"[116] in the case of a finding of excessive demand.[117] This statement or mitigation plan provides proof to the decision-maker that alternatives to the public resources will be used.

111 The *International Covenant on Economic, Social and Cultural Rights* came into force in Canada in 1976.

112 Macdonald Scott, Carranza LLP, *Written submission*, p.1.

113 Canadian Bar Association, *Written submission,* November 2017, p. 1, Legal Network and HALCO, *Written submission*, p. 7; CIMM, *Evidence*, 21 November 2017, 0950 (Felipe Montoya), CIMM, *Evidence*, 20 November 2017, 1955 (Mercedes Benitez, as an individual).

114 Centre for Israel and Jewish Affairs, *Written submission*, p. 1; CLKD and PooranLaw, *Written submission*, p. 1; CIMM, *Evidence*, 20 November 2017, 1835 (Lorne Waldman); CIMM, *Evidence*, 20 November 2017, 1840 (John Rae); CIMM, *Evidence*, 21 November 2017, 0950 (Felipe Montoya), CIMM, *Evidence*, 20 November 2017, 1955 (Mercedes Benitez).

115 IRCC, Response, *Question 23: Excessive Demand cases refused by medical diagnoses, immigration category and amount over the cost threshold.*

116 Claire Kane Boychuk, *Written submission*, p. 8.

117 *Hilewitz v. Canada (Minister of Citizenship and Immigration); De Jong v. Canada (Minister of Citizenship and Immigration)*, [2005] 2 S.C.R. 706, 2005 SCC 57.

IRCC officials informed the Committee that between 2013 and 2016, 3,960 medical examinations triggered a medical inadmissibility finding – the majority (78%) of those examinations were for permanent residence applications.[118] Of the 3,960 cases deemed inadmissible, 557 were for asymptomatic HIV positivity, 500 for chronic renal failure and 447 for intellectual disabilities.[119] It is important to note that cases deemed inadmissible at the medical evaluation stage are not yet considered refused. After receiving a procedural fairness letter, the applicant can, for example, submit a mitigation plan or the visa officer making the final decision can accept the applicant on humanitarian grounds. As such, from 2013 to 2016, a total of 1,444 permanent residence applications were refused based on the excessive demand provision.[120] More specifically, 224 were for chronic renal failure, 163 for intellectual disabilities and 133 for asymptomatic HIV positivity.[121] Figure 2 provides this information for the top 10 primary medical diagnoses recorded by IRCC between 2013 and 2016.

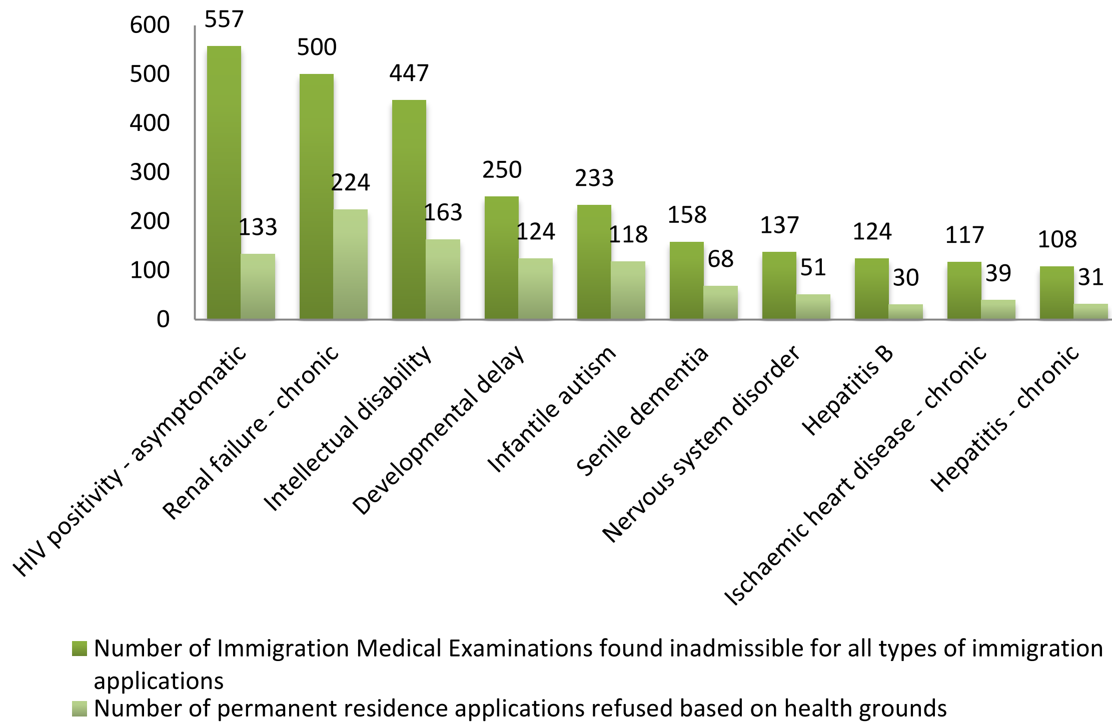
118 IRCC, Response, *Question 1: Medically Inadmissible Applicants.*

119 The total of cases for each year were 1,237 in 2013; 1,060 in 2014; 668 in 2015; and 995 in 2016. IRCC, Response, *Question 2: Diagnosis of Medically Inadmissible Cases.*

120 The total of cases for each year were 593 in 2013; 455 in 2014; 206 in 2015; and 190 in 2016. IRCC, Response, *Question 23: Excessive Demand cases refused by medical diagnoses, immigration category and amount over the cost threshold.*

121 IRCC, Response, *Question 23: Excessive Demand cases refused by medical diagnoses, immigration category and amount over the cost threshold.*

Figure 2 – Top 10 primary medical diagnoses: cases deemed inadmissible during Immigration Medical Examinations for all types of immigration applications versus refused cases for permanent residence applications (based on medical assessments conducted in 2013 to 2016)



Source: Chart created by the authors using Immigration, Refugees and Citizenship Canada's response to requests for information made by the Standing Committee on Citizenship and Immigration on October 24, 2017 (Question 1: Medically Inadmissible Applicants, Question 2: Diagnosis of Medically Inadmissible Cases and Question 23: Excessive Demand cases refused by medical diagnoses, immigration category and amount over the cost threshold)

According to witnesses, it is the prospective economic class immigrants that are most affected by the excessive demand provision.[122] Noting that the final number of permanent residence applications refused based on the excessive demand provision totaled 1,444 from 2013 to 2016 (for an average of 361 per year), witnesses argued that this represents a statistically insignificant fraction of the future users of health and social service and that these individuals will have an insignificant impact on wait times or

122 Legal Network and HALCO, *Written submission*, p. 6.

morbidity rates.[123] However, Professor Sweetman warned that a small number of users can make a great deal of difference to total costs.[124] He provided as an example the fact that 1.5% of Ontario's population represents 5% of those with the highest health costs because they incur about 61% of the total hospital and home care costs.[125]

Witnesses argued that people with disabilities and medical conditions are captured by the excessive demand provision because a disability lens is not applied to Canada's immigration policy. Ms. Kane Boychuk noted that IRPA and the federal government's policies and guidelines regarding medical inadmissibility are informed by a medical model of understanding disability.[126] According to her, under a medical model, "persons with disabilities are seen as objects of charity, medical treatment and social protection"[127] or, as other witnesses articulated, as a burden to society.[128] She, along with other witnesses, advocated for a "social model of disability" where persons with disabilities are socially included and empowered, which leads to a sense of belonging as an individual and valuing their contributions to society.[129] Additionally, two witnesses highlighted that attitudes of exclusion and segregation and their associated policies towards persons with disabilities are maintained by the medical model applied in the legislation and "are the antithesis of Canadian values."[130] For these witnesses, Canada should no longer maintain an excessive demand provision under IRPA.

Some witnesses provided how other countries have been successful in repealing the excessive demand provision. Specifically, Mr. Tomlinson informed the Committee that

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123 CIMM, *Evidence*, 20 November 2017, 1840 (John Rae); CIMM, *Evidence*, 20 November 2017, 1905 (Lorne Waldman); CIMM, *Evidence*, 20 November 2017, 1920 (Brent Diverty); Claire Kane Boychuk, *Written submission*, p. 29; Disability Positive, *Written Submission*, p. 2.

124 CIMM, *Evidence*, 21 November 2017, 0905 (Arthur Sweetman).

125 Ibid.

126 Claire Kane Boychuk, *Written submission*, pp. 20–21; The Canadian Association for Community Living in their written submission added that "the focus in the medical model is to 'fix' the persons with a disability so that they will function more 'normally' in society."

127 Claire Kane Boychuk, *Written submission*, pp. 20–21.

128 Claire Kane Boychuk, *Written submission*, p. 17; CIMM, *Evidence*, 21 November 2017, 0850 (Roy Hanes); Macdonald Scott, Carranza LLP, *Written submission*, p. 2; Felipe Montoya, *Written submission*, p. 2; Canadian Association for Community Living, *Written submission*, p. 2; MWAC and CAC, *Written Submission*, p. 2; OCASI, CSALC and SALCO, *Written Submission*, p.3.

129 Claire Kane Boychuk, *Written submission*, pp. 20–21; Joshua Goldberg, *Letter*, 13 November 2017, p. 2; Chun Chu, *Letter*, 17 November 2017, p. 2; CLKD and PooranLaw, *Written submission*, p. 1; Disability Positive, *Written Submission*, p. 2; Canadian Association for Community Living, *Written submission*, p. 2; MWAC and CAC, *Written Submission*, p. 2; OCASI, CSALC and SALCO, *Written Submission*, p.3

130 CLKD and PooranLaw, *Written submission*, p. 3.

the United Kingdom's all party parliamentary group on AIDS "concluded that the UK government cannot look to exclude individuals on the basis of poor health."[131] The Council of Canadians with Disabilities reassured the Committee that "there is no evidence to validate" the concern of an increase in applications if the excessive demand provision is repealed.[132]

B. Decision-making process

The Committee heard there are a number of challenges with the current decision-making process surrounding medical inadmissibility. The Council of Canadians with Disabilities qualified the current process as having an "ableist bias."[133] Other witnesses raised issues of clarity, consistency and accuracy.

1. Clarity

Mr. Mario Bellissimo, from the Canadian Bar Association, commented on the challenges faced by individuals when interacting with IRCC's excessive demand process. He noted that the language found "in fairness letters can be presumptive [and] unclear."[134] The information found on IRCC's website also does not offer much assistance for understanding the process.[135] He underlined that a lack of clarity is "contrary to the Courts' instruction [in *Hilewitz v. Canada,* which required] that the letters set out relevant concerns in clear language to allow all applicants (including those not represented by counsel) to understand the case against them, and how to meaningfully respond."[136] As such, the Canadian Bar Association recommended that the IRCC website clearly detail, in plain language, what is involved in excessive demand assessments and what information is required from individuals.[137]

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131 CIMM, *Evidence*, 20 November 2017, 1945 (Maurice Tomlinson, Senior Policy Analyst, Canadian HIV/AIDS Legal Network).

132 Council of Canadians with Disabilities, *Written submission,* p. 8.

133 Council of Canadians with Disabilities, *Written submission,* p. 7.

134 CIMM, *Evidence*, 21 November 2017, 0955 (Mario Bellissimo, Honourary Executive Member, Immigration Law Section, Canadian Bar Association).

135 Ibid.

136 Canadian Bar Association, *Written submission,* November 2017, p. 4.

137 For example, the Committee received a letter from Mr. Simeon Hanson for its study on medical inadmissibility, although his issue dealt with medical examinations of non-accompanying children. This shows the lack of clear information provided by the department on its website. He stated his frustration in not being able to speak to an immigration officer in order to clarify the situation.; Canadian Bar Association, *Written submission,* March 2017, p. 8.

The Canadian Bar Association also remarked that there are challenges in the decision-making process, especially in regards to instructions for medical and visa or immigration officers.[138] According to the Canadian Bar Association,

> IRCC's guidance to officers confuses their roles, and medical officers in certain cases are still not undertaking an assessment of all factors, including financial information. This is due, in part, to a failure to acknowledge the Supreme Court and Federal Court of Appeal instruction in the cases on excessive demand. Revisions to the guidance prepared by IRCC for these officers are required.[139]

In order to improve the decision-making process, witnesses recommended that more training should be offered to medical and visa officers, including training offered by disability rights advocates.[140]

2. Consistency and Accuracy

The Ontario Councils of Agencies Serving Immigrants, the Chinese and Southeast Asian Legal Clinic and the South Asian Legal Clinic of Ontario have observed that decision-makers do not take into account all the humanitarian factors found in an application that could justify, for example, a waiver of the excessive demand provision.[141] They also noted that waivers for medical inadmissibility are granted on a case by case basis without any consistency. As such, there could be similar circumstances that end with different results.[142]

Ms. Chantal Desloges, from Desloges Law Group, also drew the Committee's attention to the lack of consistency and accuracy in the decision-making process. She added that she often saw no explanation in the fairness letter that supported the decision of the officer.[143] She stressed that it was important for individuals to get a thorough and fair assessment.[144] As the Canadian Bar Association noted, an erroneous decision has serious consequences for the individual and their family, but also for Canada because it

138 Canadian Bar Association, *Written submission,* November 2017, p. 4.

139 Ibid.

140 Council of Canadians with Disabilities, *Written submission*, p. 10.

141 OCASI, CSALC and SALCO, *Written Submission*, p. 2.

142 OCASI, CSALC and SALCO, *Written Submission*, p. 2.

143 CIMM, *Evidence*, 21 November 2017, 1005 (Chantal Desloges, Lawyer, Desloges Law Group, as an individual).

144 Ibid.

"could lead to the admission of individuals whose medical conditions result in excessive demands on Canadian health and social services."[145]

In addition, Mr. Bellissimo raised the issue of "transparency and accuracy of pricing" the cost threshold, which does not fully reflect the variations in the cost of health and social services among provinces and territories.[146] For example, the Canadian Bar Association noted that those with medical conditions requiring prescription drugs cost the government different amounts depending upon the province in which province they reside.[147] The issue around pricing the cost threshold was also raised by Mr. Battista and Ms. Smith, who noted that it was important for IRCC to obtain updated information from provinces regarding the cost of treatment because it would reduce inefficient immigration processing.[148]

C. Impact of the Cost Threshold and Additional Costs

The Committee questioned IRCC about the number of applicants refused entry to, or residence in, Canada because the needs described in the mitigation plans were costed above the threshold set out by IRCC. The department responded that, in 2014, 391 cases were refused due to estimated costs over the annual cost threshold, which was of $31,635 over five years.[149] IRCC provided the Committee with a table that showed in increments of $500 the costs that were above the cost threshold, which ranged from $3,001 to $729,500 over the 2014 threshold of $31,635 for 391 cases.[150] The Committee has concerns that the data provided by the department was not full enough to base decisions upon.

Even if individuals captured by the excessive demand provision prepare mitigation plans, they would be refused if their plans are costed higher than IRCC's threshold.[151] Mr. Battista provided the Committee with the "example of an investor with significant assets [who] was refused because of the cost of his spouse's medication, which only exceeded the annual excessive demand threshold by $700."[152] The witness argued that

145 Canadian Bar Association, *Written submission,* November 2017, p. 1.

146 Ibid., p. 3.

147 Canadian Bar Association, *Written submission,* March 2017, p. 4.

148 Michael Battista and Adrienne Smith, *Written submission*, p. 2.

149 IRCC, Response, *Annex – Question 7: Inadmissible cases close to cost threshold.*

150 Ibid.

151 CIMM, *Evidence*, 20 November 2017, 1940 (Adrienne Smith, Barrister and Solicitor, Jordan Battista LLP).

152 Michael Battista and Adrienne Smith, *Written submission*, p. 5.

costs could be absorbed by the system, but there was no assessment of "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."[153] Two witnesses wrote to the Committee that "the focus should not be on whether the dollar value of the immigration policy is set at the correct level to trigger medical inadmissibility."[154] The focus should be on creating a more inclusive Canada that is accepting of the economic, social and cultural contributions of all persons of diverse abilities.[155] Currently, witnesses pointed out that there is no mechanism by which the potential abilities, contributions, skills and talents of individuals captured by the excessive demand provision, as well as their support network, are recognized.[156]

Witnesses also questioned the calculation of the cost threshold and the fact that the cost threshold is understood to be the average Canadian per capita cost for publically funded health care and social services.[157] Mr. Waldman claimed that the average calculation "was based upon fictitious information; there was no actual true calculation of the cost of the average person."[158] He stressed that the government's estimates are incorrect because the average cost should be based on the average cost of a person of the same age group as each age group incurs different costs.[159] CIHI, which provides part of the data for the cost threshold calculation, does disaggregate its data by age groupings;[160] however, that is not the data used to calculate the cost threshold. In addition, witnesses argued that IRCC relies on outdated and inaccurate cost assessments of disability supports and medical conditions.[161] Professor Hanes, of Carleton University, commented that the excessive demand provision is "kind of dated" as it was already in place with similar wording in the former Act and its regulations.[162]

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153 Ibid.

154 CLKD and PooranLaw, *Written submission*, p. 3.

155 CLKD and PooranLaw, *Written submission*, p. 3; Disability Positive, *Written Submission*, p. 2; Ameil J. Joseph, *Letter*, p. 3.

156 Canadian Association for Community Living, *Written submission*, p. 3; Michael Battista and Adrienne Smith, *Written submission*, p. 5.

157 CIMM, *Evidence*, 20 November 2017, 1835 (Lorne Waldman); Michael Battista and Adrienne Smith, *Written submission*, p. 5; Alex Tufford and A.J. Withers, *Written submission*, p. 2.

158 CIMM, *Evidence*, 20 November 2017, 1835 (Lorne Waldman).

159 Ibid., 1910.

160 CIMM, *Evidence*, 20 November 2017, 1920 (Brent Diverty).

161 Disability Positive, *Written Submission*, p. 2; OCASI, CSALC and SALCO *Written Submission*, p. 4.

162 CIMM, *Evidence*, 21 November 2017, 0945 (Roy Hanes).

Ms. Johnston argued that IRCC is also over-estimating the actual cost savings to the health and social services of the provinces as a result of the excessive demand provision.[163] It seems that "that the cost-savings estimate [of $135 million over five year] is coming from the procedural fairness letters."[164] However, those letters can be inaccurate; individuals can switch to a cheaper generic medication available in Canada after receiving the procedural fairness letter or can receive waivers of medical inadmissibility.[165] The department does not factor into any revisions to the cost estimates.[166] Witnesses also remarked that IRCC's cost savings estimates do not take into account the cost of actually administering the excessive demand program.[167]

1. Mitigation Plans

The Committee heard that mitigation plans are an additional burden of proof for individuals captured by the excessive demand provision.[168] They are also costly and not enforceable.[169] For Mr. Battista, that is part of a systemic injustice and unfairness, because not everyone can afford the legal fees to fight the determinations by preparing a mitigation plan.[170] He pointed out that his legal fees for a medical inadmissibility case are about $4,000 to $5,000.[171] His estimate does not include expert opinions "from doctors, specialists, psychologists, or autism specialists" that are often required to develop a mitigation plan.[172]

Mr. Battista argued that if the department wants to have the ability to enforce mitigation plans, it would have to "establish a mechanism for the provinces to report on individuals who create mitigation plans to track their health and social service spending in every

163 CIMM, *Evidence*, 20 November 2017, 2010 (Meagan Johnston).

164 Ibid.

165 Ibid.

166 Ibid.

167 CIMM, *Evidence*, 20 November 2017, 1835 (Lorne Waldman); CIMM, *Evidence*, 20 November 2017, 1935 (Michael Battista, Barrister and Solicitor, Jordan Battista LLP); CIMM, *Evidence*, 20 November 2017, 2010 (Meagan Johnston).

168 CIMM, *Evidence*, 21 November 2017, 0950 (Felipe Montoya); Peter Larlee, Larlee Rosenberg, Barristers and Solicitors, *Written brief*, pp. 1-3.

169 CIMM, *Evidence*, 20 November 2017, 2005 (Michael Battista).

170 Ibid.

171 Ibid.

172 Ibid.

province."[173] That would require additional resources and raise privacy concerns, which would be costly for both levels of government.[174] However, witnesses argued it would also create two classes of permanent residents because, currently, after becoming a permanent resident, individuals have access to health and social services as is the right of any permanent resident.[175]

Mr. Montoya remarked that individuals who have to prepare mitigation plans and demonstrate the availability of alternatives resources are being twice charged for what they have already contributed to through their taxes.[176] Other witnesses qualified the excessive demand provision as "a tax on all disabled people"[177] or "as a 'head tax' on the unhealthy."[178]

D. Excessive Demand Provision seen as Discriminatory

Witnesses qualified the excessive demand provision as discriminatory because it distinguishes individuals with different characteristics or needs from others and imposes additional administrative and financial burdens on them that are not imposed on others.[179] As such, individuals captured by the excessive demand provision have to overcome an additional hurdle by, for example, preparing a mitigation plan in order to be accepted to Canada, facing a burden of a proof that is not placed on healthy applicants.[180] Mr. Rae considered the excessive demand provision as inequitable because "temporarily able-bodied" individuals that put their health more at risk because of their lifestyle, such as heavy smokers, are not captured by the excessive demand provision.[181]

Witnesses also found the provision discriminatory because it is based on predicting the development of a health condition, which is associated with estimating "likely future

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173 Ibid., 2010.

174 Ibid.

175 Michael Battista and Adrienne Smith, *Written submission*, p. 2.

176 CIMM, *Evidence*, 21 November 2017, 0955 (Felipe Montoya).

177 Alex Tufford and A.J. Withers, *Written submission*, p. 2.

178 Michael Battista and Adrienne Smith, *Written submission*, p. 3.

179 CIMM, *Evidence*, 21 November 2017, 0950 (Felipe Montoya); Peter Larlee, Larlee Rosenberg, Barristers and Solicitors, *Written brief*, pp. 1-2; Alex Tufford and A.J. Withers, *Written submission*, p. 2.

180 Claire Kane Boychuk, *Written submission*, p. 8; Michael Battista and Adrienne Smith, *Written submission*, p. 3; Council of Canadians with Disabilities, *Written submission*, p. 6.

181 CIMM, *Evidence*, 20 November 2017, 1855 (John Rae).

costs over time."[182] It requires individuals to defend themselves by developing, for example, mitigation plans against something that has not yet occurred and may not occur.[183] As Mr. Battista and Ms. Smith pointed out, other inadmissibility provisions in IRPA that deal with misrepresentation or crime are based on past facts.[184] In addition, Professor Sweetman remarked that even the government cannot confirm how well it can predict, at the time of screening new immigrants, who will incur higher than average costs to the health system.[185]

According to Mr. Rae, the medical inadmissibility system is discriminatory because "when a particular disability is identified" the process does not take into account "the particular degree of that disability nor a person's background, attributes, and how they deal with the realities of their particular disability, nor does it speak to the contributions that person might make if they come to Canada."[186] As such, witnesses reasoned it is stereotyping all individuals captured by the excessive demand provision as a burden on society.[187] The Canadian Association for Community Living argued that the stereotypes and assumptions in the immigration system are based on the medical model of disability that sees the "inherent defects" of individuals with disabilities as a burden on society and the threat of increased costs for health and social services.[188] Mr. Montoya agreed and added that this is based in an underlying stigma against people with disabilities.[189] Ms. Toni Schweitzer, from Parkdale Community Legal Services, testified that "while the language of the [excessive demand] provision is in terms of cost, the way in which it is applied and interpreted is solely on the basis of a person's disability."[190]

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182 Council of Canadians with Disabilities, *Written submission*, p. 7; Michael Battista and Adrienne Smith, *Written submission*, p. 1.

183 Alex Tufford and A.J. Withers, *Written submission*, p. 2.

184 Michael Battista and Adrienne Smith, *Written submission*, p. 1.

185 CIMM, *Evidence*, 21 November 2017, 0905 (Arthur Sweetman).

186 CIMM, *Evidence*, 20 November 2017, 1910 (John Rae).

187 CIMM, *Evidence*, 21 November 2017, 0850 (Roy Hanes); Claire Kane Boychuk, *Written submission*, p. 17; Macdonald Scott, Carranza LLP, *Written submission*, p. 2; Felipe Montoya, *Written submission*, p. 2; Canadian Association for Community Living, *Written submission*, p. 2.

188 Canadian Association for Community Living, *Written submission*, p. 2.

189 Felipe Montoya, *Written submission*, p. 2.

190 CIMM, *Evidence*, 20 November 2017, 2000 (Toni Schweitzer, Staff Lawyer, Parkdale Community Legal Services); Felipe Montoya, *Written submission*, p. 2.

1. Affecting Children, Low-Income Individuals and Live-In Caregivers

IRCC explained that medical inadmissibility findings are tied to the cost of services and not to the identified health condition. As such, no specific medical diagnosis during the medical evaluation process renders a case automatically inadmissible because each individual's medical needs are considered individually on a case by case basis.[191] Ms. Smith, however, questioned IRCC's premise, in particular children with disabilities.[192] She provided, as an example, the case of a 14-year-old teenager who was found inadmissible because she was deaf.[193] She argued that children should not be seen as a burden on society because given the right set of circumstances they can bring positive change and impact to their communities and contribute to their society in the long-term.[194] Other witnesses "argued that applying medical ineligibility to children is a contradiction of the legislated requirements to consider the Best Interests of the Child."[195]

Witnesses also argued that the excessive demand provision creates additional obstacles for low-income individuals. The provision is "economically biased toward those who can afford the legal fees to fight the determinations."[196] Professors Withers and Tufford wrote that it "is prohibitively expensive for low-income people, regardless of the ultimate finding with respect to the permanent residency application."[197] Often individuals have to incur additional costs either by hiring a lawyer, which can help them navigate the complex immigration system, or by seeing additional specialists to prepare a mitigation plan.[198] Individuals that are low-income and disabled face "an uphill battle not only to win [their] application, but to obtain medical care."[199] Witnesses pointed out that a request for exemption from medical inadmissibility is possible under section 25 of IRPA, or under a temporary residence permit, but "these forms of relief are highly discretionary and do not address the fundamental unfairness resulting from the application of medical inadmissibility criteria."[200] Mr. Scott provided the example of a

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191 IRCC, Response, *Context and definitions to explain IRCC data and responses.*

192 CIMM, *Evidence*, 20 November 2017, 1940 (Adrienne Smith).

193 Ibid.

194 Ibid.

195 OCASI, CSALC and SALCO, *Written Submission,* p. 6.

196 CIMM, *Evidence*, 20 November 2017, 2005 (Michael Battista).

197 Alex Tufford and A.J. Withers, *Written submission,* p. 3.

198 Alex Tufford and A.J. Withers, *Written submission,* p. 3; MWAC and CAC, *Written Submission*, p. 2.

199 Macdonald Scott, Carranza LLP, *Written submission,* p. 2.

200 Michael Battista and Adrienne Smith, *Written submission*, p. 7; MWAC and CAC, *Written Submission*, p. 2.

client that made an application under section 25, but had his medical condition set against his application's humanitarian and compassionate factors.[201] The witness argued that his client experienced other obstacles because of his low-income status and his lack of resources to propose a plan to cover potential future costs.[202]

Other witnesses, such as Ms. Schweitzer and Mrs. Mercedes Benitez, spoke about the discrimination experienced by many live-in caregivers: they are deemed good to work in Canada but not good enough to remain and establish themselves with their families because one of their family members has been deemed medically inadmissible.[203] Mr. Scott wrote that it is unfair that migrant "workers give their labour, are separated from their families, and then subjected to discrimination when it comes time to apply to stay in Canada."[204] The Migrant Workers Alliance for Change agreed and underlined that the excessive demand provision "fails to account for the net benefit and contributions by migrant workers to Canada before they apply for permanent residence."[205]

E. Personal Hardships Due to the Excessive Demand Provision

Two individuals shared their experience of hardship with the Committee after being deemed inadmissible to Canada due to the medical condition of one of their family members. Mr. Montoya told the Committee that, because his son was deemed medically inadmissible, the permanent residence application for the whole family was delayed for more than three years.[206] During that time, there was great uncertainty and additional costs in time, energy and money.[207] He specifically spoke of the numerous medical evaluations his son, at the time 11 years old, had to go through.[208]

201 Macdonald Scott, Carranza LLP, *Written submission*, p. 2.

202 Macdonald Scott, Carranza LLP, *Written submission*, p. 2; OCASI, CSALC and SALCO, *Written Submission*, p. 4.

203 CIMM, *Evidence*, 20 November 2017, 1955 (Toni Schweitzer); CIMM, *Evidence*, 20 November 2017, 1955 (Mercedes Benitez).

204 Macdonald Scott, Carranza LLP, *Written submission*, p. 2.

205 MWAC and CAC, *Written Submission*, p. 2.

206 CIMM, *Evidence*, 21 November 2017, 0950 (Felipe Montoya).

207 Ibid.

208 Ibid.

For Mrs. Benitez, her permanent residence application process took more than seven years.[209] Five years after submitting her application, she was informed that her son was deemed medically inadmissible.[210] She stated:

> I was devastated. It hurts me to feel that Canada thought we were not good enough. The months of uncertainty since we received the letter have been some of the hardest months of my life. I had chest pains; at times I thought I was having a heart attack from the stress. There were so many sleepless nights worrying that any day I could be refused and sent back home after working so hard for so many years. I was afraid. Who would provide for my family? Sometimes it was too much to bear, and I thought of giving up, but my family relies on me for support. I am the sole breadwinner. I needed to be strong.[211]

She eventually got legal assistance to build her case and, two years after receiving the procedural fairness letter, was approved for permanent residence in Canada. However, the process of hiring lawyers and experts and undergoing "years of repeated medical testing and years of delay is exceedingly unfair and hurtful to the applicant and his [or her] family."[212] The Committee acknowledges that medical assessments impose hardships on applicants because they can often take too long.

Mr. Peter Larlee, of Larlee Rosenberg, stressed the delay and uncertainty of the process as the most difficult part for individuals because "IRCC is not accountable for the delays and resulting pain and frustration caused to families."[213] The Committee received testimony that other individuals are going through similar hardships and find it physically and mentally draining to fight the medical inadmissibility determinations made by the immigration or visa officer.[214]

Witnesses also emphasized that racialized communities often experience hardship when they cannot sponsor their parents or grandparents. As they explained, for many racialized communities, reuniting with their parents and grandparents in Canada is of equal priority to sponsoring their child or spouse.[215] It is emotionally very hard for individuals that will have to care for parents from afar.[216]

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209 CIMM, *Evidence*, 20 November 2017, 1955 (Mercedes Benitez).

210 Ibid.

211 Ibid.

212 Peter Larlee, Larlee Rosenberg, Barristers and Solicitors, *Written brief,* p. 2.

213 Ibid.*,* p. 3.

214 Chun Chu, *Letter*, 17 November 2017, p. 2.

215 OCASI, CSALC and SALCO, *Written Submission,* p. 5.

216 CIMM, *Evidence*, 20 November 2017, 1835 (Lorne Waldman); Ibid., 1945 (Maurice Tomlinson).

F. Deterring Potential Immigrants

Witnesses also highlighted the fact that Canada is competing for the best and brightest immigrants with other countries that do not have the same medical inadmissibility requirements.[217] Witnesses suggested that Canada's excessive demand provision hinders our ability to attract the most highly-skilled immigrants over the long term,[218] but the Committee did not receive any quantitative data. It was argued that economic immigrants might not want to establish themselves in Canada in the long term if they are separated from their family members, such as children, parents or grand-parents.[219] Witnesses noted that reuniting families is beneficial for communities because it increases support networks, promotes productivity and reduces stress.[220]

Ms. Johnston raised the specific case of international students who become infected with HIV during their studies in Canada. According to her, most of them will have their applications for permanent residence refused due to the possibility of excessive demand. This is "despite the fact that these students have skills that are in demand in Canada and, given the opportunity, would contribute to the economy, culture and society of Canada in many ways, including by paying taxes."[221]

PART 5: OPTIONS FOR REFORM

The Committee mostly heard testimony from those who would like to see section 38(1)(c) of IRPA repealed and less from those who would keep it, but would like to see improvements to IRCC's application of the excessive demand provision.

The Committee notes that only two witnesses, including the province of Saskatchewan, were adamant that the excessive demand provision should remain in place. However, the overwhelming majority of witnesses asked the Committee to take action and recommended its repeal.

The Committee acknowledges that Canadian society values diversity and inclusiveness, often coming together as communities to help others. The entire discussion on costs, which does not take into consideration the contributions of individuals deemed

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217 CIMM, *Evidence*, 20 November 2017, 1855 (Lorne Waldman); Ibid., 1945 (Maurice Tomlinson).

218 CIMM, *Evidence*, 20 November 2017, 1910 (Lorne Waldman); Centre for Israel and Jewish Affairs, *Written submission*, p. 2.

219 Legal Network and HALCO, *Written submission*, p. 7.

220 Ibid.

221 Ibid.

medically inadmissible, or the contributions of the entire family, does not reflect Canadian principles. Although some witnesses recommended improvements, others were categorical that the excessive demand provision was discriminatory and any fix would be too arduous.

The Committee realizes that IRCC effectively bars a truly small number of individuals with its excessive demand provision. However, the Committee notes that there has not been modeling completed for the cost increases on health and social services if the provision is repealed. Witnesses indicated that other countries, such as the United Kingdom, had repealed their excessive demand provision without spurring an increase in applications from individuals that would have been barred previously.[222] The Committee is cognizant of the competitive nature of global immigration and witnesses have indicated that highly skilled individuals may be deterred from applying to Canada because of the excessive demand provision. Discretionary measures, such as temporary resident permits or applications on humanitarian and compassionate grounds, are not an adequate remedy when basic human rights are infringed upon.

Taking stock of all these various issues with the excessive demand provision, the Committee makes the following recommendation:

Bringing the *Immigration and Refugee Protection Act* in Step with Canadian Values

Recommendation 1

That section 38(1)(c) of the *Immigration and Refugee Protection Act* and the exemptions to it be repealed; that the Governor in Council repeal all corresponding regulations; and that Immigration, Refugees and Citizenship Canada repeal all corresponding policies and guidelines.

However, the Committee acknowledges that there are ongoing consultations with the provinces and territories and that additional data would be helpful to inform the department's fundamental review of the excessive demand provision. As such, the Committee recommends:

222 CIMM, *Evidence*, 20 November 2017, 1945 (Maurice Tomlinson); Council of Canadians with Disabilities, *Written submission*, p. 8.

Consulting with Provinces and Territories

Recommendation 2

That the Minister of Immigration, Refugees and Citizenship continue to consult and negotiate with the provinces and territories on a repeal of section 38(1)(c) from the *Immigration and Refugee Protection Act.*

Collecting Data for Better Decision-Making

Recommendation 3

Until such time as section 38(1)(c) of the *Immigration and Refugee Protection Act* is repealed, that Immigration, Refugees and Citizenship Canada report to the House of Commons annually on the use of excessive demand by the department, including comprehensive data on: (i) the number of applications for which the estimation for which the estimation of excessive demand exceeds the threshold for any stage of the application; (ii) the medical cost estimates; (iii) the number of such applications delayed by duration delay; (iv) the number of such applications refused; (v) the number of such applications abandoned; (vi) the number of family members whose applications are also delayed, refused or abandoned as a result of the implication of an excessive demand process; (vii) the full costs of implementing excessive demand and appeals; and (viii) such other information as the department, provinces or territories determine to be relevant in negotiating the repeal of excessive demand.

The Committee recognizes that the Minister will need time to complete his fundamental review of the excessive demand provision. For that reason, the Committee recommends a number of immediate improvements to IRCC's application of the excessive demand provision. Recognizing that IRCC officials work within the legislative and regulatory framework that has been established for them and that decisions from the courts add interpretative guidelines, this creates a complex structure to the excessive demand provision. Witnesses stated, however, that there is difficulty in applying them in a consistent manner.:

The Committee also heard that the cost threshold used by IRCC is problematic on a number of levels. First, it would appear that the health services and social services listed in the Regulations may not reflect the current publicly funded services across Canada. Second, the costing for these services could benefit from experts such as economists, especially when at present IRCC adds an amount for social services that was calculated in 2004, indexed to inflation, to what the Canadian Institute for Health Information provides on costs for an average Canadian per year.

The Committee learned that some applicants, on the basis of humanitarian goals as well as family reunification, were exempted from the excessive demand provision at section 38(2) of IRPA. These are Convention refugees and protected persons, as well as spouses and children. However, parents and grandparents, as well as all economic applicants, even those applying from within Canada, are subject to the excessive demand provision.

IRCC officials assured the Committee that as part of their modernization agenda, they were addressing the issue of plain language in the procedural fairness letter. The content of the letter has been described as legalese and opaque when it comes to the specific findings that an individual would need to challenge. The Committee heard that information available on IRCC's website is also incomplete and not as helpful as it could be. As such, the Committee recommends the following interim measures:

Interim Measures

Recommendation 4

Pending repeal of section 38(1)(c) of the *Immigration and Refugee Protection Act,* in accordance with recommendation 1, that the following interim measures be implemented to the excessive demand regime:

Proper Training for Immigration/Visa Officers and Medical Officers

Recommendation 4(a)

That Immigration, Refugees and Citizenship Canada ensure that the final decision-makers on a permanent residence application are properly trained in assessing the reasonableness of the medical officers' recommendations; and that medical officers are properly trained to evaluate the individual's entire application.

Calculating the Cost Threshold for Excessive Demand

Recommendation4(b)

That Immigration, Refugees and Citizenship Canada fundamentally review how it calculates the cost threshold for excessive demand on health and social services by eliminating from current definitions those services that are not publicly funded.

Recommendation 4(c)

That Immigration, Refugees and Citizenship Canada ensure that the cost threshold for excessive demand on health and social services is calculated by economists based on provincial, territorial and federal data.

Expanding the Categories of Exemptions to the Excessive Demand Provision

Recommendation 4(d)

That Immigration, Refugees and Citizenship Canada expand the list of exempted persons from the excessive demand provision to include economic applicants that are already working in Canada and their family members.

Providing Clear and Comprehensive Information

Recommendation 4(e)

That Immigration, Refugees and Citizenship Canada provide applicants with timely decisions and procedural fairness letters that are written in plain language and are comprehensive in nature, including rationales, in order fully to inform applicants of the findings they must address to overcome a finding of excessive demand.

Recommendation 4(f)

That Immigration, Refugees and Citizenship Canada publish on its website, in plain language, all operation manuals and guidelines regarding health to help applicants understand the evidence they need to provide during their application process.

Parliamentary Review

Recommendation 5

That should, after a thorough consultation with the provinces and territories and analysis of all relevant data, Parliament repeal section 38(1)(c) of the *Immigration and Refugee Protection Act,* a full parliamentary review of the impact of these changes be undertaken within three years of its implementation and that such a review include its impact on the provinces and territories.

APPENDIX A
LIST OF WITNESSES

Organizations and Individuals	Date	Meeting
Department of Citizenship and Immigration	2017/10/24	78
Dawn Edlund, Associate Assistant Deputy Minister Operations		
Caitlin Imrie, Director General Migration Health Branch		
Michael MacKinnon, Senior Director, Migration Health Policy and Partnerships Migration Health Branch		
Arshad Saeed, Director, Centralized Medical Admissibility Unit Migration Health Branch		
As individuals	2017/11/20	84
Mercedes Benitez		
Lorne Waldman, Barrister and Solicitor Lorne Waldman and Associates		
Canadian HIV/AIDS Legal Network		
Maurice Tomlinson, Senior Policy Analyst		
Canadian Institute for Health Information		
Brent Diverty, Vice-President Programs		
Christopher Kuchciak, Manager Health Expenditures		
Council of Canadians with Disabilities		
James Hicks, National Coordinator		
John Rae, First Vice-Chair		
HIV & AIDS Legal Clinic Ontario		
Meagan Johnston, Staff Lawyer		

Organizations and Individuals	Date	Meeting
Jordan Battista LLP	2017/11/20	84
Michael Battista, Barrister and Solicitor		
Adrienne Smith, Barrister and Solicitor		
Parkdale Community Legal Services		
Toni Schweitzer, Staff Lawyer		
As individuals	2017/11/21	85
Sheila Bennett, Faculty of Education, Brock University		
Chantal Desloges, Lawyer Desloges Law Group		
As individuals	2017/11/21	85
Felipe Montoya		
Arthur Sweetman, Professor Department of Economics, McMaster University		
Canadian Bar Association		
Mario Bellissimo, Honourary Executive Member Immigration Law Section		
Council of Canadians with Disabilities		
Roy Hanes, Associate Professor School of Social Work, Carleton University		
Department of Citizenship and Immigration	2017/11/22	86
Hon. Ahmed Hussen, C.P., M.P., Minister of Immigration, Refugees and Citizenship		
Dawn Edlund, Associate Assistant Deputy Minister Operations		
Michael MacKinnon, Senior Director, Migration Health Policy and Partnerships Migration Health Branch		
Arshad Saeed, Director, Centralized Medical Admissibility Unit Migration Health Branch		

APPENDIX B
LIST OF BRIEFS

Organizations and Individuals

Hanson, Simeon

Joseph, Ameil J.

Larlee, Peter D.

Montoya, Felipe

Scott, Macdonald

Tabbara, Marwan, M.P., Kitchener South — Hespeler

Tufford, Alex

Withers, A.J.

Canadian Association for Community Living

Canadian Bar Association

Canadian HIV/AIDS Legal Network

Caregivers' Action Centre

Centre for Israel and Jewish Affairs

Chinese and Southeast Asian Legal Clinic

Community Living Kingston and District

Council of Canadians with Disabilities

Disability Positive

Government of British Columbia

Government of New Brunswick

Government of Newfoundland and Labrador

Government of Nunavut

Government of Saskatchewan

Organizations and Individuals

Government of Yukon

HIV & AIDS Legal Clinic Ontario

Jordan Battista LLP

Migrant Workers Alliance for Change

Ontario Council of Agencies Serving Immigrants

PooranLaw Professional Corporation

South Asian Legal Clinic of Ontario

REQUEST FOR GOVERNMENT RESPONSE

Pursuant to Standing Order 109, the Committee requests that the government table a comprehensive response to this Report.

A copy of the relevant *Minutes of Proceedings* (Meetings Nos. 78, 84, 85, 86, 87, 91 and 92) is tabled.

Respectfully submitted,

Robert Oliphant
Chair

Dissenting Report of Her Majesty's Official Opposition
The Conservative Party of Canada

Federal Government Policies and Guidelines Regarding Medical Inadmissibility of Immigrants

Larry Maguire, Member of Parliament for Brandon – Souris
Michelle Rempel, Member of Parliament for Calgary Nose Hill
Bob Saroya, Member of Parliament for Markham – Unionville

1.) INTRODUCTION

The Standing Committee on Citizenship and Immigration undertook a study on the medical admissibility and excessive demand regulations for potential newcomers. In particular, the Committee reviewed clause 38(1)(c) of the Immigration and Refugee Protection Act, which states that a foreign national is inadmissible on health grounds if their health condition might reasonably be expected to cause excessive demand on health or social services; or if their health condition would add to existing waiting lists and would increase the rate of mortality and morbidity in Canada as a result of an inability to provide timely services to Canadian citizens or permanent residents.

We agree with many components of the Committee's report. In particular, we agree that the evidence presented to the Committee showed serious problems that caused hardship with the use and application of the excessive demand provision, and that change needs to occur.

Two main policy options emerged from witness testimony to address these problems

- Repeal Section 38(1)(c) of the Immigration and Refugee Protection Act, or
- Make significant reforms to the process by which Section 38(1)(c) of the Immigration and Refugee Protection Act is applied.

In spite of attempts by the Committee to obtain quantifiable data regarding the potential costs and economic impact of these policy options, the Committee found that in many instances this data simply didn't exist or had significant gaps in its collection methodology. We wish for the reader of the Committee's report to note that the Committee's recommendations were made while lacking quantifiable data in several areas, including:

- Actual cost increases that may result from repealing 38(1)(c)
- The actual costs related to administering the system in its current form as opposed to the costs associated under a repeal scenario
- The actual costs related to administering the system should reforms be implemented
- The economic impact of immigrants who may not be eligible to enter Canada or who self-deselect from applying to enter Canada as a result of the existence of 38(1)(c)
- If a repeal of 38(1)(c) would result in an increase of applicants with high medical and social service needs

Additionally, at time of writing only four provinces and two territories provided briefs to the Committee during the study. Given that delivery of health and social services falls within their jurisdiction, we note this lack of input could impact both federal and provincial/territorial governmental ability to successfully implement the changes suggested within the Committee's report.

2.) CHANGE MUST OCCUR

We wish to emphasize that the overwhelming burden of evidence brought before the Committee suggests that there are serious problems with the use and application of Section 38(1)(c) of the Immigration and Refugee Protection Act. We encourage the government to take action to overcome these problems, in the context of the concerns raised below.

3.) TWO POLICY OPTIONS

Two main policy options emerged from witness testimony to address the problems identified with the current system.

The first was an outright repeal of Section 38(1)(c) of the Immigration and Refugee Protection Act[1].

The second option is to make significant reforms to the process by which Section 38(1)(c) of the Immigration and Refugee Protection Act is applied.

We note that these policy proposals may be mutually exclusive. If the government choses the former option, it would likely be wasteful to put resources into improving the current system, as the latter policy option is premised on the view that the current system can be improved and that repeal is not necessary. That said, implementing the repeal of Section 38(1)(c) will likely take time and resources that have not adequately been studied by the Committee, and applicants will continue to be adversely affected during the period between deciding to repeal the provision and full implementation of this new policy.

The Committee's report only entertained the option to repeal Section 38(1)(c). As the Committee's report does not consider ways to improve the current system, the following section will outline those possibilities. Potential reforms include, but are not limited to:

- Improving the accuracy of IRCC's costing as it relates to the concept of excessive demand
- Improving the timeliness of the department in processing all aspects of the finding of medical inadmissibility
- Simplifying the Procedural Fairness Letters to make rulings more clear and rationale more transparent for the applicant, and
- Clarifying the purpose of mitigation plans in order to for them to provide actual process utility

[1] CIMM, Evidence, 1st Session, 42nd Parliament, 20 November 2017, 1840, (John Rae, First Vice-Chair, Council of Canadians with Disabilities).

On the topic of improving the accuracy of IRCC's costing as it relates to the concept of excessive demand, the Canadian Bar Association (CBA) provided the Committee with two briefs and appeared in person to provide recommendations. They outlined the challenges associated with how IRCC calculates the costs to determine if someone is projected to cause an excessive demand on health and social services.[2]

The difficulties in estimating the costs for special education needs were brought to the Committee's attention. As education is a provincial jurisdiction, no two provinces that are identical in how they determine funding levels to assist students with special education needs. For example, Ontario's Inclusive Education Model funding is different than how Manitoba supports special education needs as every school division is unique in how support is provided for students with special needs. [3]

There is also a discrepancy between provinces with financial support for prescription drugs. In some provinces medically required services are covered in full while outpatient drug costs are not automatically covered. [4] There are also disparities in the amount of what each province reimburses residents for various prescription drugs. [5]

The CBA noted that the IRCC's Central Medical Accessibility Unit, which was recently introduced, might alleviate some of the challenges in determining the actual financial costs in determining if one will cause an excessive demand. However, they are urging IRCC to improve its Medical Officer's Handbook and to work with provincial and territorial governments to get the most up-to-date and accurate costing information available for the intended place of residence of the applicant. Denying applicants based on irrelevant information is not acceptable and all steps must be taken to ensure the accuracy of cost estimates.

Second, there were circumstances where IRCC took so long to review a medical assessment that it was deemed out of date. Due to IRCC's wait times for processing excessive demand applications, 886 applicants needed a new independent medical assessment.[6] If the government chooses system reform as the path forward, in our opinion this is unacceptable and IRCC needs to improve its service delivery if medical assessments are not being reviewed in a timely manner.

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[2] CIMM, Canadian Bar Association, *Submission on Excessive Demand on Health and Social Services Under Immigration and Refugee Protection Act,* Written Submission, p. 4.

[3] CIMM, Canadian Bar Association, *Submission on Excessive Demand on Health and Social Services Under Immigration and Refugee Protection Act,* Written Submission, p. 4.

[4] CIMM, Canadian Bar Association, *Submission on Excessive Demand on Health and Social Services Under Immigration and Refugee Protection Act,* Written Submission, p. 4.

[5] CIMM, Canadian Bar Association, *Submission on Excessive Demand on Health and Social Services Under Immigration and Refugee Protection Act,* Written Submission, p. 4.

[6] IRCC, Response, *Question 19: Average Processing Time.*

Third, many witnesses reported that IRCC has failed in some instances to provide specific cost estimates in Procedural Fairness Letters. The Federal Court of Appeal has ruled that a Medical Officer who is assessing medical inadmissibility has an obligation to provide the costs of the expected health and social services. Without providing this information, it would be next to impossible for the applicant to properly respond to IRCC's concerns.

It was brought to the Committee's attention that Procedural Fairness Letters can often be confusing and do not provide enough information for the applicant to in a meaningful way. [78] In many circumstances the language used in the letters is overly bureaucratic and is difficult to decipher.

Further, because IRCC mails Procedural Fairness Letters, the time it takes for the physical letter to arrive cuts into the already short 60 days that applicants are given to provide an answer. We were informed due to the time delays with mailing a letter to various parts of the globe and to gather the necessary information, it is difficult for an applicant to respond within the timeframe. Digitization would ameliorate some of these problems.

While the CBA is recommending that applicants retain legal counsel to respond to the Procedural Fairness Letter, it our desire that changes are made to simplify the process, make the language clearer and be explicit in the information that is sought. Seeking legal counsel should not be the *de facto* response for an applicant who has received a Procedural Fairness Letter.[9]

Finally, every applicant who has been given a Procedural Fairness Letter is given an opportunity to submit a mitigation plan to convince IRCC they will not cause an excessive demand on Canada's health or social services.

An IRCC officer is then tasked with reviewing the mitigation plan, verifying the authenticity of the plan as well the applicant's cost mitigation strategy. IRCC must be also satisfied that the applicant has the ability and intent to mitigate the cost of the required health (i.e., outpatient medication) and social services.[10]

While only one template mitigation plan was reviewed at Committee, it was discussed in broad strokes what one might include. We believe that should the government choose system reform as the path forward, it would be helpful to review how IRCC communicates what is expected in an applicant's mitigation plan.

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[7] CIMM, Evidence, 1st Session, 42nd Parliament, 21 November 2017, 1000, (Mario Bellissimo, Honorary Executive Member, Immigration Law Section, Canadian Bar Association)
[8] CIMM, *Evidence*, 20 November 2017, 2010 (Meagan Johnston).
[9] Peter Larlee, Larlee Rosenberg, Barristers and Solicitors, *Written brief,* p. 2.
[10] CIMM, Evidence, 1st Session, 42nd Parliament, 22 November 2017, 1310, (Dawn Edlund, Associate Assistant Deputy Minister, Operations, Department of Citizenship and Immigration)

Once IRCC is satisfied that the applicant or applicant's family member will not cause excessive demand on health and social services, their declaration of ability and intent is retained on file along with detailed case notes.

We were surprised to hear that once IRCC accepts a mitigation plan, mitigation plans do not need to be adhered to or enforced.[11][12] This calls the purpose of the mitigation plans into question; because once an applicant is a permanent resident they have no obligation to update IRCC on compliance with their mitigation plan.

If the government chooses to make these improvements, we note that it would be imprudent to seek repeal of Section 38(1)(c) prior to seeing if the effects of these changes improved the system for the applicant.

4.) LACK OF QUANTIFIABLE DATA TO SUPPORT WAY FORWARD

There were several areas in which the Committee had difficulty finding data to support assumptions being made in witness testimony in the argument of either policy option outlined in Section 3 above. This was in spite of many attempts by the Committee to bring in witnesses to provide this data. The following data gaps were particularly noteworthy.

Some witnesses claimed that our current system was having an impact on Canada's ability to attract and retain immigrants, but the Committee did not receive supporting data for this claim.[13] Despite this, the Committee maintained this argument in its report.

The Conservatives understand that IRCC gave the provinces a list of clear options that are being considered regarding ways to change the immigration system as it pertains to medical inadmissibility, yet the Committee has not been provided with a detailed list of these options. This may have caused some confusion in the Committee's correspondence with the provinces, as they may not have been sure who to communicate to.

The Committee also heard testimony repeatedly referencing international and domestic laws that witnesses felt Section 38(1)(c) contravened, but no evidence to this effect was presented. In fact, medical inadmissibility has been the subject of numerous court decisions, including a Charter challenge in *Deol v. Canada* where the policy was found to be Charter compliant because it is based on individual assessment.

Should the government elect to immediately repeal Section 38(1)(c), based on testimony provided to the Committee, it would be doing so without proper modeling on projected increased financial costs. While the Committee has an understanding of the current avoided

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[11] CIMM, Evidence, 1st Session, 42nd Parliament, 21 November 2017, 1020, (Chantal Desloges, lawyer, Desloges Law Group, As an Individual)

[12] CIMM, *Evidence*, 20 November 2017, 2005 (Michael Battista).

[13] CIMM, *Evidence*, 20 November 2017, 1910 (Lorne Waldman); Centre for Israel and Jewish Affairs, *Written submission,* p. 2.

costs, that calculation does not take into consideration how that might change with the repeal of the policy. To date, none of that data is available and must be flagged as an unknown financial risk.

Concerns were raised that if the excessive demand clause was to be eliminated, it will lead to higher costs than originally forecasted. As IRCC has not done any analysis nor has any information available on how many prospective applicants are deterred due to the current regulations, if the government moved to immediately eliminate the clause, it would be doing so without projecting what those increased costs would be.

The Provinces of Saskatchewan and New Brunswick also highlighted to the Committee the concern that individuals who are currently inadmissible could start applying to immigrate to Canada and the original projected avoided costs of $135 million per year would need to be revised upwards.[14]

5.) LACK OF PROVINCIAL / TERRITORIAL INPUT TO SUPPORT WAY FORWARD

The Committee's recommendations were made without significant input from provincial and territorial governments. At time of writing, only four provinces and two territories provided briefs to the Committee during the study.

Every provincial government who submitted a brief to the Committee had reservations about eliminating the clause or had qualms with repealing it without financial compensation, as the costs of eliminating the excessive demand clause will be exclusively borne by provincial and territorial governments.

Changing the excessive demand policy without a deeper understanding of the costs involved and without discussing how provinces will pay for the same will effectively download costs onto another level of government in an unplanned fashion. Should the government elect to repeal Section 38(1)(c), this issue would need to be addressed. The Committee's report does not adequately address this issue.

The Province of Newfoundland and Labrador said in their brief to the Committee:

"[they are] experiencing significant health-related expenditures, as a result of numerous social and demographic factors. Given Newfoundland and Labrador's current financial outlook, it is not possible for the province to support assuming additional expenses from the Federal Government, without considerations of solutions that take into account the financial impacts of changes to the policy."[15]

[14] Brief to the Standing Committee on Citizenship and Immigration from the Government of New Brunswick on December 5th, 2017 and Letter to the Standing Committee on Citizenship and Immigration from the Government Saskatchewan on November 20, 2017.

The comments that Newfoundland and Labrador made in their brief were also echoed by the Province of Saskatchewan as they stated in their letter to the Committee that the excessive demand policy, "helps protect provincial services from above-average costs and reduced the burden on provincial health, education and social services systems."[16]

While the Committee only received briefs from a minority of provincial governments, this may be the result of the Minister of IRCC having already presented them specific options on ways to change the excessive demand clause. It is important to note that none of those options the Minister of IRCC presented to the provinces and territories to date were shared with the Committee.

While the Minister informed the Committee he discussed the matter with the provinces and territories, he did not indicate that IRCC presented specific options on how the policy can be amended. For example, correspondence obtained by the Conservatives showed that IRCC presented an option to increase the cost threshold and continue to base the value on an objective data source for health and social services costs. Another proposal that was presented was for the excessive demand clause to be waived for economic immigrants / provincial nominees working or operating a business in Canada.

While we welcome the Minister consulting the provinces and territories, it is unfortunate he did not table with the Committee the options that he presented. Having a parallel discussion with the provinces and territories and not informing the Committee of the particulars only denies our final report from containing all the necessary information needed for such a multifaceted issue.

6.) CONCLUSION AND RECOMMENDATIONS

Given the rationale outlined herein, we recommend the following:

1. As there are serious problems with the use and application of Section 38(1)(c) of the Immigration and Refugee Protection Act, we encourage the government to take action to overcome these problems, in the context of the concerns raised within this dissenting report

2. That the dignity and human rights of those applying to enter Canada play a central role in the selection of a policy path forward

3. That the integrity of Canada's immigration system be maintained in the implementation of changes to the excessive demand policy and process

[16] Letter to the Standing Committee on Citizenship and Immigration from the Government Saskatchewan on November 20, 2017.

4. That the federal government select a path forward in full consultation and with the consent of provincial and territorial governments

5. In addition to the testimony provided to the Committee during the course of this study, that the data outlined above be obtained and utilized to justify and implement any policy change that the federal government selects in this regard, and that this data be made available to the public

6. That given the lack of data provided to the Committee during the course of this study, the federal government develop a more accurate system of evaluating the cost-benefit analysis of a policy change to the excessive demand provision

7. That the federal government ensure that additional costs related to the delivery of health care services resulting from any policy change to the excessive demand provision is considered in federal-provincial health transfer discussions

8. That any increased costs, as calculated in the context recommended within this dissenting report, be accounted for within a balanced federal budget

9. That the government develop and table a fully costed implementation plan for any changes made to address concerns with the excessive demand provision, which included data related to cost and utilization assumptions as outlined in this dissenting report

10. That any changes made by the government to address concerns with the excessive demand provision be studied by Parliament two years after implementation

Dissenting Opinion of the New Democratic Party of Canada

Introduction:

New Democrats are staunchly opposed to discrimination in all its forms. The NDP fully supported the Standing Committee on Citizenship and Immigration undertaking an in-depth study on the federal government's policies and guidelines regarding the medical inadmissibility of immigrants. Through the compelling and near unanimous views of of the witnesses, this study has cemented in the opinion of New Democrats that section 38(1)(c) is legislated discrimination against individuals with disabilities and that it needs to be recognized as such.

New Democrats, therefore, whole-heartedly support Recommendation 1 of the main report which clearly states:

> **"That section 38(1)(c) of the Immigration and Refugee Protection Act and the exemptions to it be repealed; that the Governor in Council repeal all corresponding regulations; and that Immigration, Refugees and Citizenship Canada repeal all corresponding policies and guidelines."**[i]

However, New Democrats feel obliged to express dissent to the main report because the report also recommends inconsistent half-measures which allow for the continuation of this discrimination. With no recommendation for a timeline to make the repeal, and no timeline announced for the Minister to finish his consultations, New Democrats cannot support these half-measure fixes to such a serious issue. These additional recommendations are contradictory to the fact that nearly all the witnesses shared the perspective there is no such thing as an acceptable threshold to allow for discrimination. It was clearly expressed by all but two witnesses that attempts to reduce the number of people subject to the discrimination is insufficient and the only option is to eliminate this legislated policy of discrimination.

Section 38(1)(c)

Section 38(1) of the Immigration and Refugee Protection Act (IRPA) states:

38(1) A foreign national is inadmissible on health grounds if their health condition

(a) Is likely to be a danger to public health;
(b) Is likely to be a danger to public safety; or
(c) Might reasonably be expected to cause excessive demand on health or social services[ii]

As the main report notes, Canada ratified the United Nations Convention on the *Rights of Persons with Disabilities* in 2010. Additionally, the *Canadian Charter of Rights and Freedoms* applies to everyone physically present in Canada, and Section 15 states that every individual has the right to equal benefit of the law without discrimination based on mental or physical disability.[iii]

Based on witness testimony, it is apparent that a vast majority of the witnesses believe that section 38(1)(c) of IRPA contradicts the Canadian Charter of Rights and Freedom not to mention Canada's commitment to the international community about the rights of persons with disabilities. Simply put, section 38(1)(c) is legislated discrimination against individuals with disabilities.

Even the Minister of Immigration, Refugees and Citizenship, in his appearance at the committee stated, "From a principled perspective, the current excessive demand provision policy simple does not align with our country's values on the inclusion of persons with disabilities in Canadian society."[iv]

A fundamental review of a policy that does not align with Canada's values is not an exercise in playing with dollar figures of a threshold, or adding more classes of newcomers who are exempt from this policy. This sentiment was echoed nearly unanimously amongst both witnesses and committee members during this study. This study produced a unique situation where sometimes the preambles to questions from the members of the committee were nearly as compelling and strongly worded as the responses from the witness.

The Opinion of Committee Members:

The Member for Scarborough-Centre echoed views of Professor Sheila Bennett who discussed the emotion and financial stress that families are put through when a member of the family is flagged under section 38(1)(c). This was because she knew from experience, as the Member's family had gone through that situation when sponsoring her husband's parents in 2002.[v]

The Member for St. John's-East declared his opposition to this policy stating to the Minister, "I must say that at this point in time I do not see how raising the threshold and excluding fewer people changes the fact that excluding anyone is prima facie discriminatory and violates Canadian values"[vi]

The Member for Surrey-Centre also spoke to his change of opinion about this policy, and evoked a strong and harsh image when he compared this policy to the mindset of the slave trade:

> "I would say that initially I thought it was a good policy, because that would perhaps be a big burden on Canadians, but then I looked back – and I don't want to equate it to this – and it's no different from the slave trade, in which only those selected as the strongest and the most able-bodied were brought from Africa. It's not that the whole policy is good at all, but I'm saying it is akin to discriminating when we're picking only people who are healthy, fully functioning, with no intellectual disabilities and no physical disabilities."[vii]

The Member for Surrey-Centre had previously summed up the views of the committee when he said, "As you can tell, almost all of us have an inclination that this policy is discriminatory. We already can see that even within immigration there's a two-tiered policy."[viii]

In addition to the opposition to the policy on grounds of discrimination, the committee also heard early in the study that section 38(1)(c) is used to deny the applications of under 1,000 people a year.[ix] Members of the committee expressed in their exchanges with witnesses, department officials, and the Minister, a difficulty in reconciling the point of such a discriminatory policy, given its little savings impact in the grand scheme of the immigration system and the healthcare system.

The Member for St. John's-East, in an exchange over the cost on the healthcare system asked, "It seems like a drop in the bucket? Why should we even care about the cost at all? Human rights can cost money. It's part of living in a free and democratic society. Why are quantifying this at all…?"[x]

It is clear to the New Democratic Party that the majority of committee members view this policy as discriminatory.

Furthermore, the committee's acceptance of recommendations in the main report around significant increases in data collection appears to directly contradict the views expressed by the Member for St. John's-East. Following his comments around the thus far quantified minimal additional costs associated with repeal of section 38(1)(c), he went on to say,

> "If it's a trivial amount, why should we even measure it? It may cost more to measure it. It may cause more unseemliness in the whole process than simply saying, 'Here, provincial government, is a transfer of $36 billion.' Notionally, $135 million of that is going to be associated with paying for the health care costs of about 5,000 immigrants over a five-year period, among almost 1.5 million immigrants, who are also going to be users of the health care system but paying taxes, but it all comes out in the wash."[xi]

The Opinion of the Witnesses:

Witnesses referred to the significant investigative journalism that Global News had undertaken which brought to light a range of significant concerns regarding Section 38(1)(c) and its application. Witnesses and department officials spoke about the issues raised by Global News. Of particular note, significant concerns were raised about the flaws in the calculation and determination of the medical and social cost threshold were raised by witnesses. As well, the inconsistency in which the policy was applied and the fact that the policy in and of itself is discriminatory were also observed by witnesses. Witnesses also highlighted the fact that there is no recognition of the benefit aspect of IRCC's cost/benefit analysis of the applications.

Nearly every witness who appeared before the committee was clear in the opinion that section 38(1)(c) needed to be repealed.

Immigration lawyer Adrienne Smith firmly stated her opposition to the policy saying, "We're questioning the implementation of this law. We're urging the committee to repeal it. You'll hear from other witnesses, and we've heard from the panel before us, that this is a system that discriminates against persons with disabilities."[xii]

Parkdale Community Legal Services representative Toni Schweitzer pointed to repeal as being the only way forward when asked if not repeal, could anything be done:

> "I don't have any suggestions actually. I think that the law discriminates, and the numbers that have been provided as a justification are arbitrary and inaccurate. It appears even that senior officials are not aware of some of the things that are being done by decision-makers. That's a situation that is unacceptable. I don't know what else I could say to that. I can say that the system as it stands is unacceptable and shouldn't continue."[xiii]

Canadian disability advocacy groups were loud and clear. John Rae of the Council of Canadians with Disabilities opened his testimony with "We recommend in the strongest possible terms that the excessive demand clause in the immigration act be repealed".[xiv]

Canadian HIV/AIDS advocacy groups were united in their opinions as well. Meagan Johnston of HIV&AIDS Legal Clinic Ontario urged the committee to "show leadership and recommend removing excessive demand inadmissibility by repealing paragraph 38(1)(c) of the IRPA."[xv] This was followed by Maurice Tomlinson of the Canadian HIV/AIDS Legal Network's view that,

> "Quite simply, we have to repeal this section. It is in complete violation of our international obligations, and any reasonable assessment would prove that. It is a violation. What is ironic is that we ratified the UN Convention on the Rights of Persons

> with Disabilities at the start of the Vancouver Paralympic Games, when we welcomed the world of disabled individuals to Canada. You could play here; you just couldn't stay here. That's the message that was sent."[xvi]

Individual cases of findings of medical inadmissibility under section 38(1)(c) of the *Immigration and Refugee Protection Act* (IRPA) have, over the past two years made national headlines and caused significant concern in the Canadian public. Two of the individuals that were gravely impacted, Professor Felipe Montoya, and Mercedes Benitez, appeared as witnesses before the Committee to share their story. Their individual stories have shone a spot light on the discriminatory nature of the medical inadmissibility provision and its unfair application.

Both Professor Montoya and Mercedes Benitez had gone through the experience of a loved one being deemed medically inadmissible under section 38(1)(c). Thankfully for these families, successful resolutions were found, allowing them to remain in Canada united with their families. However, that their situations were resolved was not enough for them.

Mercedes Benitez is a caregiver who came to Canada in 2008. After nearly a decade of separation from her family while she cared for Canadian families, she was informed her son was medically inadmissible due to an intellectual disability. While she was happy to have received the support, assistance, and ultimately intervention that addressed this injustice, she said that, "Even though my case is already resolved, I think the excessive demands should be repealed. I still feel the pain when they say I'm good to work, but not good enough to stay because of my son."[xvii]

Professor Felipe Montoya was a high profile case in the Canadian media when his son's intellectual disability was going to force the family to leave. This was despite having all been in Canada for years and making significant contributions to the community around them, and his son showing no evidence of placing an excessive demand on the health or social services in Canada. Professor Montoya addressed several reasons why this policy should be repealed:

> "It does not make sense on social grounds because social services considered for calculating excessive demand are a narrow selection of services, precisely those used by persons with disabilities, making the disabled community a burden to Canadian social services by definition. Second, paragraph 38(1)(c) implies that social services used by disabled persons are a burden, implying by extension that the disabled community of Canadian citizens and permanent residents is also a burden to Canadian society. Third, paragraph 38(1)(c) ignores the potential contributions of immigrant working families to Canadian society, in spite of, and sometimes even because of, the presence of a disability in the family, as has already occurred on countless occasions in Canada.
>
> It does not make sense on moral or ethical grounds because foreign immigrant workers are, in fact, Canadian taxpayers, and by signing a declaration of ability and intent, they

> are subject to being twice charged for what they have already contributed to through their taxes. Second, the attempt to resolve the inherently flawed paragraph 38(1)(c) of the IRPA by offering the option of signing a declaration of ability and intent simply adds another layer of discrimination, this time against people with lower incomes. Third, there already exists a moral precedent of offering exemptions to the clause of excessive demand to refugees, for example, so it is not inconceivable to extend an exemption to the category of temporary workers who have already been accepted into Canada and pay Canadian taxes. Fourth, reducing persons to what they cost the state rather than valuing them for what they can contribute can lead us down a dark path. The targets are the elderly and infirm. Fifth, it is beneath the dignity of the Canadian state, which is recognized the world over as a beacon of inclusion, to keep paragraph 38(1)(c) of the IRPA on the books when it is flawed on so many counts."[xviii]

It should be noted that during the course of this study, the Migrant Workers Alliance was circulating an open letter calling for the repeal of section 38(1)(c). As of November 22, 2017 that open letter had been signed by 1,001 individual persons, 396 individual endorsers with organizational affiliations, and 54 organizational endorsers.

Of those who did not directly recommend repeal, most noted the discriminatory elements of the policy and the difficulty in reconciling this policy with Canada's values and obligations regarding human rights. When asked if this policy constituted a violation of our basic human rights, Professor Arthur Sweetman stated, "Clearly, it does."[xix]

Mr. Mario Bellissimo, on behalf of the Canadian Bar Association acknowledged that this provision can "absolutely"[xx] be applied in a discriminatory fashion.

Ms. Chantal Desloges, arguably the most in favour of keeping section 38(1)(c), acknowledged serious issues with the administration of the provision in her opening remarks stating, "If these laws were properly applied by decision-makers, which they absolutely are currently not, our system would be functioning a lot better."[xxi]

Brent Diverty, representing the Canadian Institute for Health Information, while avoiding policy recommendations, noted the limited impact repeal could possibly have. He noted that, "based strictly on averages, it's hard to imagine how 900 people in 35 million could affect our average health care per capita of $6,600."[xxii]

The answer was made clear and obvious. Section 38(1)(c) has no place within Canadian immigration law.

In addition to the discriminatory nature of the policy, immigration lawyer Lorne Waldman spoke to high costs of administrating this policy not being worthwhile. He believes:

> “We should probably just eliminate medical inadmissibility because the number is so small, the costs associated with it are very high, it impedes our ability to compete for the immigrants we need, and it creates a lot of hardship.”[xxiii]

Recommendations:

This study has made it abundantly clear, that the only way forward is to repeal section 38(1)(c). Any attempt at a policy fix regarding this provision is changing the threshold for acceptable discrimination. It is the opinion of New Democrats that there is no such acceptable threshold. Therefore, the NDP recommends:

Recommendation 1:

“That section 38(1)(c) of the Immigration and Refugee Protection Act and the exemptions to it be repealed; that the Governor in Council repeal all corresponding regulations; and that Immigration, Refugees and Citizenship Canada repeal all corresponding policies and guidelines.”[xxiv]

While it was also made clear that there was little to no risk that repealing this provision would lead to a significant increase in formerly inadmissible individuals attempting to migrate to Canada, for those that do, there could be associated costs, as discussed in the main report. It is of the utmost importance that Canada’s health and social services are adequately funded. There are significant intersections of jurisdictional powers between the provinces, territories, and the federal government in the funding and provision of health and social services, and the immigration system. Given this, the NDP further recommends:

Recommendation 2:

That the federal government work with provinces and territories to determine any increased costs to social and/or health services as a result of repealing section 38(1)(c), and to increase CST and CHT funding appropriately.

Conclusion:

New Democrats agree with the Minister, those impacted by the policy, immigration lawyers, disability advocates, committee members, and the general public: section 38(1)(c) is out of line with Canadian values. However, New Democrats cannot support the report tabled for this study due to the fact that it included recommendations that while acknowledging discrimination is occurring, provide avenues to allow it to continue. As the main report states, consultations by the Minister of Immigration, Refugees and Citizenship regarding this policy have been ongoing since October 2016 as part of a “fundamental review of the excessive demand provision”[xxv].

The time has come for action to be taken. It is therefore the opinion of New Democrats that the only way forward is full repeal of this provision.

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[i] Building An Inclusive Canada: Bringing the Immigration and Refugee Protection Act in step with Modern Values
[ii] *Immigration and Refugee Protection Act,* http://laws-lois.justice.gc.ca/eng/acts/I-2.5/section-38.html
[iii] Building An Inclusive Canada: Bringing the Immigration and Refugee Protection Act in step with Modern Values
[iv] CIMM, Evidence, 1st session, 42nd Parliament, 22 November 2017 12:20
[v] CIMM, Evidence, 1st session, 42nd Parliament, 21 November 2017 09:35
[vi] CIMM, Evidence, 1st session, 42nd Parliament, 22 November 2017 12:55
[vii] Ibid.,
[viii] CIMM, Evidence, 1st session, 42nd Parliament, 21 November 2017 09:35
[ix] CIMM, Evidence, 1st session, 42nd Parliament, 24 October 2017 08:56
[x] CIMM, Evidence, 1st session, 42nd Parliament, 21 November 2017 09:10
[xi] CIMM, Evidence, 1st session, 42nd Parliament, 21 November 2017 09:13
[xii] CIMM, Evidence, 1st session, 42nd Parliament, 20 November 2017 19:40
[xiii] CIMM, Evidence, 1st session, 42nd Parliament, 20 November 2017 20:25
[xiv] CIMM, Evidence, 1st session, 42nd Parliament, 20 November 2017 18:40
[xv] CIMM, Evidence, 1st session, 42nd Parliament, 20 November 2017 19:51
[xvi] CIMM, Evidence, 1st session, 42nd Parliament, 20 November 2017 20:19
[xvii] CIMM, Evidence, 1st session, 42nd Parliament, 20 November 2017 20:22
[xviii] CIMM, Evidence, 1st session, 42nd Parliament, 21 November 2017 09:55
[xix] CIMM, Evidence, 1st session, 42nd Parliament, 21 November 2017 09:29
[xx] CIMM, Evidence, 1st session, 42nd Parliament, 21 November 2017 10:33
[xxi] CIMM, Evidence, 1st session, 42nd Parliament, 21 November 2017 10:05
[xxii] CIMM, Evidence, 1st session, 42nd Parliament, 20 November 2017 19:22
[xxiii] CIMM, Evidence, 1st session, 42nd Parliament, 20 November 201719:02
[xxiv] Building An Inclusive Canada: Bringing the Immigration and Refugee Protection Act in step with Modern Values
[xxv] Building An Inclusive Canada: Bringing the Immigration and Refugee Protection Act in step with Modern Values