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Medical Inadmissibility of Immigrants

**CANADIAN BAR ASSOCIATION
IMMIGRATION LAW SECTION**

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PREFACE

The Canadian Bar Association is a national association representing 36,000 jurists, including lawyers, notaries, law teachers and students across Canada. The Association's primary objectives include improvement in the law and in the administration of justice.

This submission was prepared by the CBA Immigration Law Section, with assistance from the Legislation and Law Reform Directorate at the CBA office. The submission has been reviewed by the Law Reform Subcommittee and approved as a public statement of the CBA Immigration Law Section.

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Medical Inadmissibility of Immigrants

I. INTRODUCTION

The Immigration Law Section of the Canadian Bar Association (CBA Section) appreciates the opportunity to participate in the Citizenship and Immigration Committee's study on federal government policies and guidelines on medical inadmissibility of immigrants.

The CBA is a national association of over 36,000 members, including lawyers, notaries, academics and law students, with a mandate to seek improvements in the law and the administration of justice. The CBA Section has approximately 1,000 members practicing all areas of immigration law. Our members deliver professional advice and representation in the Canadian immigration system to clients in Canada and abroad.

A medical inadmissibility finding has a serious consequence, barring entry to Canada for foreign nationals, ranging from family class applicants to temporary workers and economic migrants. It can hinder family reunification and have significant consequences for Canadian businesses. However, a decision made in error could also lead to the admission of individuals whose medical conditions result in excessive demands on Canadian health and social services.

In March 2017, the CBA Section commented on Immigration, Refugees and Citizenship Canada's (IRCC) review of the assessment process for cases involving excessive demand on health and social services, in section 38(1)(c) of the *Immigration and Refugee Protection Act* (IRPA).¹ This review was based on IRCC's November 2015 report, *Evaluation of the Health Screening and Notification Program* (the IRCC Report).²

In our March 2017 submission, we said that the Health Screening Notification (HSN) Program could be improved without significant overhaul of the program, or legislative and regulatory amendments at that time. It focused on three main issues in the IRCC Report: resolving

¹ Canadian Bar Association, *Excessive Demand on Health and Social Services under the Immigration and Refugee Protection Act* (March 13, 2017), available [online](http://ow.ly/re0l30goc8u) (<http://ow.ly/re0l30goc8u>). *Immigration and Refugee Protection Act*, SC 2001, c 27, available [online](http://ow.ly/8ApQ30gDcc5) (<http://ow.ly/8ApQ30gDcc5>).

² Immigration, Refugees and Citizenship Canada, *Evaluation of the Health Screening and Notification Program* (November, 2015), available [online](http://ow.ly/jkEE309RLK3) (<http://ow.ly/jkEE309RLK3>).

limitations on operationalizing excessive demand policy; reducing the number of overturned excessive demand cases; and enforcing mitigation plans undertaken by applicants in their signed declarations of ability and intent (if there was in fact evidence of non-compliance).

In this submission, the CBA Section comments on IRCC's current priorities and processes, individualized assessments, the cost threshold for excessive demand on health and social services, and enforcement mechanisms.

II. PRIORITIES AND PROCESSES

To deliver a successful immigration program, the need to protect public health and the integrity of the Canadian health care system must be balanced with the legitimate needs of migrants, in a manner consistent with Canadian *Charter* values and international human rights standards. This is particularly important given the vulnerability of non-citizens with disabilities. The focus cannot be on prohibiting applicants with a medical condition from entering Canada.

The cost of health care in Canada continues to rise with advances in technology and the aging population – accounting for increasing portions of federal and provincial budgets. At the same time, an increasing number of migrants are arriving in Canada, with associated increases in public health risks and health care costs. IRCC's existing policy on medical inadmissibility is based on the view that, where a health condition gives rise to substantial costs that will potentially be borne by the Canadian government, these costs must be considered in assessing applications. According to IRCC, a recent study of 2014 statistics revealed that IRPA's excessive demand provisions resulted in \$135 million of avoided costs for provinces and territories over five years for each year of decision (or approximately 0.1% of health spending in a given year).

This policy objective is achieved through a two-step process. First, through IRPA section 16(2)(b), which requires most foreign nationals and their dependents who apply for temporary or permanent migration to undergo a medical examination before entering Canada. Results for a permanent resident visa are not interchangeable with results for a temporary resident visa. Failure to undergo an examination can form the basis of a refusal on a separate ground of inadmissibility – such as non-compliance with IRPA or the *Immigration and Refugee Protection Regulations* (IRPR).³ It may also result in an application being considered

³ *Immigration and Refugee Protection Regulations*, SOR/2002-227, at s. 1(1), available [online](http://ow.ly/3QEH309RL0t) (<http://ow.ly/3QEH309RL0t>).

abandoned (IRPA section 41(a)). The second way this objective is achieved is by controlling the admission of prospective immigrants whose medical conditions would create an excessive demand, through IRPA section 38(1)(c).

Medical examinations must be carried out by a Panel Physician, who is designated by IRCC.⁴ IRCC delegated staff receive the results of an examination from the Panel Physician. A medical officer then assesses an applicant's medical examination results for information indicating whether they are likely to cause an excessive demand, and creates a Medical Profile.

This Medical Profile ultimately begins the medical admissibility determination. It is the code which denotes that an applicant underwent a medical examination and was or will be found either admissible or inadmissible. An M5 profile is assigned when it is believed that an applicant will cause an excessive demand, with a sub-code of T9 for excessive demand on social services, or H9 for excessive demand on health services.⁵

The medical officer prepares an opinion on the applicant's inadmissibility that includes a narrative – which forms the basis of the Procedural Fairness Letter (Fairness Letter) – as well as a list of required services and costs. The medical officer must also assess the applicant's response to the Fairness Letter, including both medical and non-medical factors. An Immigration Officer must then determine if the opinion is reasonable in making the final decision on admissibility. A number of operational challenges have been identified by IRCC in this bifurcated assessment.

Exemptions to findings of inadmissibility due to excessive demand in IRPA section 38(2) include family class members (spouses, common law partners and children) and protected persons. Those exceptions were not being reviewed at the time of our March 2017 submission.

We have come a long way since the Supreme Court of Canada decision in *Hilewitz v. Canada (M.C.I.)*⁶ twelve years ago, but medical and visa/immigration officers still face limitations in their ability to operationalize the current excessive demand regime for a number of reasons. First, costing thresholds for excessive demand are established federally, and do not fully reflect variations in the cost of health and social services between the provinces and territories. This

⁴ *Ibid* at s. 29 – Medical examinations include any or all of the following: a physical examination; a mental examination; a review of past medical history; laboratory tests; diagnostic tests; and a medical assessment of records respecting the applicant.

⁵ *Ibid* at ss. 1(1).

⁶ *Hilewitz v. Canada (M.C.I.); De Jong v. Canada (M.C.I.)*, 2005 SCC 57, available [online](http://canlii.ca/t/1lsvm) (<http://canlii.ca/t/1lsvm>).

contributes to errors in the assessments of responses to Fairness Letters, which do not accurately reflect the demand being alleged.

Second, a challenge stems from the lack of proper instruction for medical and visa/immigration officers. 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.⁷ Revisions to the guidance prepared by IRCC for these officers are required.

Third, applicants face similar obstacles in their ability to properly engage with officers when concerns are raised about excessive demand. The language in Fairness Letters is unclear, and the transparency and accuracy of pricing is uneven. This is also contrary to the Courts' instruction, requiring 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.

Our March 2017 submission made several recommendations to address these challenges, including the extension of IRCC's Centralized Medical Accessibility Unit's (CMAU) roles. In particular, to increase collaboration and information sharing with the provinces and territories, we recommended additional funding to expand CMAU's role to include the collection of provincial costing information for health and social services (including special education and prescription drug costs) throughout Canada, where possible. This information would better inform Fairness Letters and excessive demand assessments.

We also recommended that CMAU be staffed with additional medical officers equipped with timely, consistent, comprehensive and transparent information, and that the Medical Officer's Handbook be updated. CMAU could then take on more excessive demand assessments, with a view to eventually centralizing the process.

RECOMMENDATIONS

- 1. The CBA Section recommends focused and coordinated training between IRCC and CBSA explaining excessive demand case law and emphasizing the respective decision-making functions of officers under IRPA.**

⁷

Ibid (Hilewitz). *Sapru v. Canada (M.C.I.)*, 2011 FCA 35, available online (<http://canlii.ca/t/2flwr>). *Canada (M.C.I.) v Lawrence*, 2013 FCA 257, available online (<http://canlii.ca/t/g1srr>).

- 2. The CBA Section recommends rewriting Procedural Fairness Letters in plain language with clear instructions, including an explanation of which services are public, and which can be privately disbursed. The Letters should also recommend that applicants consider obtaining independent legal advice.**
- 3. The CBA Section recommends that IRCC websites provide more information for applicants on what is involved in excessive demand assessments, and what information is required in making them.**
- 4. The CBA Section recommends expanding the Centralized Medical Accessibility Unit's (CMAU) research and decision-making role to better inform Procedural Fairness Letters and excessive demand assessments.**

III. INDIVIDUALIZED ASSESSMENTS

The CBA Section stresses the importance of individualized assessments, and does not support the identification of specific conditions that would make an applicant inadmissible. All of IRPA, including sections related to excessive demand, must be considered in light of the standards set in Canadian case law (including *Hilewitz*), the *Canadian Charter of Rights and Freedoms* (section 15 in particular), and international human rights obligations.⁸

The categorical exclusion of applicants based on conditions remains a persistent and ongoing barrier for persons with disabilities in immigrating to Canada. The Canadian Association of the Deaf, for example, argues that medical inadmissibility discriminates against people who are deaf or have disabilities.⁹ Too many refusals are still based on an improper or inadequate consideration of an applicant's *individualized* needs, and this issue will continue to be at the forefront of litigation on medical inadmissibility refusals.

It is difficult to assess the significance of the number of applications refused – however the IRCC reported that 5090 applicants (0.2%) were required to undergo a medical assessment and received a finding of excessive demand between 2008 and 2012. The number of actual refusals is likely lower. Updated information has not been made public – and no estimate is

⁸ *Supra* note 6 (*Hilewitz*). *Canadian Charter of Rights and Freedoms, Part I, Constitution Act, 1982*, available [online](http://ow.ly/Ehl330gochH) (<http://ow.ly/Ehl330gochH>).

⁹ Canadian Association of the Deaf. *Immigration and Medical Inadmissibility* (July 3, 2015), available [online](http://ow.ly/KR4W309RMoB): (<http://ow.ly/KR4W309RMoB>).

available on the deterrent effect on potential migrants because of the existence of the medical inadmissibility provisions in place.

The IRCC Report summarized suggestions from officers to simplify excessive demand assessments. The suggestion of a list of conditions that would automatically render an applicant inadmissible would perpetuate these concerns and magnify the impact on thousands of migrants and their families impacted by these decisions.

Similarly, the suggestion to remove the ability to mitigate excessive demand would be inconsistent with Canadian law. Mitigation plans are often well received by IRCC, and play an important role in assisting applicants to overcome initial inadmissibility assessments. It is not legally possible to require a bond to cover the costs of treatment – nothing in the *Canada Health Act* (CHA) supports the personal coverage of costs.¹⁰ Any decision to amend the CHA to allow for bonds would need to consider the impact on Canadian citizens and permanent residents, from both a cost and timely provision of services perspective.

RECOMMENDATIONS

- 5. The CBA Section recommends continuing the use of individualized assessments, and does not support the identification of specific conditions that would make an applicant inadmissible.**
- 6. The CBA Section recommends continuing the use of mitigation plans, and does not support the use of bonds to cover the costs of treatment.**

IV. COST THRESHOLD FOR EXCESSIVE DEMAND

Demand is found to be excessive if it exceeds the average annual health care costs for Canadians during a specified period of time.¹¹ This average is set annually by IRCC's Health Management Branch, and is currently \$6,655 per year.¹² The cost threshold for medical inadmissibility is determined by multiplying the per capita cost by the number of years used in the medical assessment for the applicant. A five-year period is generally used, resulting in a \$33,275 threshold, unless the applicant's anticipated length of stay is shorter, or evidence

¹⁰ *Canada Health Act*, R.S.C., 1985, c. C-6, available [online](http://ow.ly/6QjM309RMwx) (<http://ow.ly/6QjM309RMwx>).

¹¹ *Supra* note 1 (IRPA) for definition of *excessive demand*.

¹² Justice Canada, *Divorce and Separation* (May 10, 2016), available [online](http://ow.ly/FIks309RLRT) (<http://ow.ly/FIks309RLRT>). For other examples see Canada Business Network, *Legal challenges? Maybe a business lawyer can help* (May 2011), available [online](http://ow.ly/oIZL309RLUL) (<http://ow.ly/oIZL309RLUL>).

shows that significant costs are likely to be incurred beyond that period, in which case a period of no more than ten consecutive years is used. This formula has not been revisited since 2004.

By way of comparison, Australia, the United Kingdom and the United States all have varying health related qualifications for entry, and Australia has adopted a financial threshold for demand on health services, which is currently AUD 40 000.¹³ Given the structure of the U.S. health care system, there is no threshold or time period as medical care is not universally covered.¹⁴

Various media reports and advocacy groups have raised concerns that the excessive demand regime is not rationally connected to its purported goal of controlling health care costs. This includes criticism over the statistical methods used to determine the cost threshold, and the factors considered in the excessive demand assessment (such as an individual's ability to contribute to the tax system).¹⁵ Media reports allege that up to \$40 billion in annual social service spending – or roughly \$1,105 a year per Canadian – is not fully accounted for. This would mean that the \$6,655 limit used to deny applicants should be at least \$7,404 if all social service spending were accounted for accurately.¹⁶

Our recommendation to increase the CMAU's research and information collection capacity (including the development and application of epidemiological knowledge) could help to address these concerns. A comprehensive study of health and social service costs, as well as impact on waiting lists relating to the rate of mortality and morbidity, is required to inform policy decisions on the threshold for medical inadmissibility, and any additional exceptions under section 38(2) of IRPA.

¹³ Australian Government, Department of Immigration and Border Protection, *Significant Costs and Services in Short Supply*, available [online](http://ow.ly/ah0v30gocmm) (<http://ow.ly/ah0v30gocmm>). UK Visas and Immigration, *Guidance Medical Issues (MED)*, (August 22, 2013), available [online](http://ow.ly/1QLV30gocon) (<http://ow.ly/1QLV30gocon>). UK Visas and Immigration, *Immigration Rules* (August 10, 2017), available [online](http://ow.ly/Ep0u30gocr7) (<http://ow.ly/Ep0u30gocr7>).

¹⁴ US Citizenship and Immigration Services, *Policy Manual*, available [online](http://ow.ly/QTt430gocu) (<http://ow.ly/QTt430gocu>).

¹⁵ Canadian HIV/AIDS Legal Network, HIV & AIDS Legal Clinic Ontario, COCQ-SIDA, Submission to Immigration, Refugees and Citizenship Canada on Medical Inadmissibility (November 29, 2016), available [online](http://ow.ly/P9V130gocxK) (<http://ow.ly/P9V130gocxK>).

¹⁶ Global News, *Family in 'shock' after permanent residency denied by Immigration Canada due to daughter's disability* (July 25, 2017) available [online](http://ow.ly/nmbH30goczy) (<http://ow.ly/nmbH30goczy>). Global News, *Canada rejects hundreds of immigrants based on incomplete data*, *Global News investigation finds* (July 4, 2017), available [online](http://ow.ly/X9qP30gocAZ) (<http://ow.ly/X9qP30gocAZ>). CBC, *Federal disabilities minister 'frustrated' after family denied residency over daughter's health needs* (July 28, 2017) available [online](http://ow.ly/fnaP30gocCY) (<http://ow.ly/fnaP30gocCY>).

RECOMMENDATIONS

- 7. The CBA Section recommends that the figures and formulas for the setting of the excessive demand threshold must be transparent, with the opportunity for stakeholder input and comment, including information sharing with provinces and territories.**
- 8. The CBA Section recommends that the threshold be better aligned with health and social service costs, the impact on waiting lists, and rates of mortality and morbidity.**
- 9. The CBA Section recommends requiring a consideration of all mitigating factors, including contributions to Canada by the applicant and their admissible family members.**
- 10. The CBA Section recommends that provincial and territorial stakeholders be more involved in the development of the excessive demand threshold, especially for provincial nominees.**
- 11. The CBA Section recommends that a comprehensive study of health and social service costs, as well as impact on waiting lists relating to the rate of mortality and morbidity is necessary to support policy decisions on the threshold for medical inadmissibility, and any additional exceptions under section 38(2) of IRPA.**

V. ENFORCEMENT MECHANISMS

To date, no evidence has been advanced to suggest that a serious issue with applicant non-compliance with mitigation plans exists. We recommended implementing a mandatory time-limited reporting pilot project to collect compliance evidence. If non-compliance is determined to be an issue, the potential use of various existing legal mechanisms to enforce the medical inadmissibility regime without legislative and regulatory amendment if there was in fact a serious issue of non-compliance.

RECOMMENDATION

- 12. The CBA Section recommends implementing a pilot project to collect information on applicant compliance with mitigation plans. If non-compliance is found to be an issue, a number of existing legal mechanisms**

could be used to enforce the regime without legislative and regulatory amendment.

VI. CONCLUSION

The CBA Section supports IRCC's efforts to streamline the excessive demand process, while maintaining inclusiveness and individualized assessments. This process could be significantly improved without the need for a significant overhaul of the program or legislative and regulatory amendment at this time. Any review of this process must balance the need to protect public health and the integrity of the Canadian health care system with the legitimate needs of migrants in a manner that is consistent with Canadian *Charter* values and international human rights standards.

VII. SUMMARY OF RECOMMENDATIONS

The CBA Section recommends:

- 1. Focused and coordinated training between IRCC and CBSA, explaining excessive demand case law and emphasizing the respective decision-making functions of officers under IRPA.**
- 2. Rewriting Procedural Fairness Letters in plain language with clear instructions, including an explanation of which services are public, and which can be privately disbursed. The Letters should also recommend that applicants consider obtaining independent legal advice.**
- 3. That IRCC websites provide more information for applicants on what is involved in excessive demand assessments, and what information is required in making them.**
- 4. Expanding the Centralized Medical Accessibility Unit's (CMAU) research and decision-making role to better inform Procedural Fairness Letters and excessive demand assessments.**
- 5. Continuing the use of individualized assessments, and does not support the identification of specific conditions that would make an applicant inadmissible.**
- 6. Continuing the use of mitigation plans, and does not support the use of bonds to cover the costs of treatment.**
- 7. That the figures and formulas for the setting of the excessive demand threshold must be transparent, with the opportunity for stakeholder input and comment, including information sharing with provinces and territories.**

8. That the threshold be better aligned with health and social service costs, the impact on waiting lists, and rates of mortality and morbidity.
9. Requiring a consideration of all mitigating factors, including contributions to Canada by the applicant and their admissible family members.
10. Involving provincial and territorial stakeholders more in the development of the excessive demand threshold, especially for provincial nominees.
11. That a comprehensive study of health and social service costs, as well as impact on waiting lists, rate of mortality and morbidity is necessary to support policy decisions on the threshold for medical inadmissibility, and any additional exceptions in subsection 38(2) of IRPA.
12. Implementing a pilot project to collect information on applicant compliance with mitigation plans. If non-compliance is found to be an issue, there are a number of existing legal mechanisms that could be used to enforce the regime without legislative and regulatory amendment.