Court File No. [redacted]

FEDERAL COURT

BETWEEN:

[redacted]

HIV LEGAL NETWORK

Applicants

- and –

THE MINISTER OF CITIZENSHIP AND IMMIGRATION

Respondent

AFFIDAVIT OF SANDRA KA HON CHU
(ON BEHALF OF THE HIV LEGAL NETWORK)

I, Sandra Ka Hon Chu, of the City of Toronto, Province of Ontario, SOLEMNLY AFFIRM as follows:

1. I am the co-Executive Director of the HIV Legal Network (the "Legal Network"), formerly called the Canadian HIV/AIDS Legal Network. I have worked at the Legal Network since 2007 and have been co-Executive Director since 2021. I am responsible for the Legal Network's effective overall operation and for implementing our mandate, and I also guide the Legal Network's research, advocacy, litigation, and public legal education activities.

2. I have personal knowledge of the matters deposed herein. Where facts are based on information obtained from others, I believe that information to be true.

BACKGROUND

A. Description of the HIV Legal Network

3. The HIV Legal Network is a non-governmental organization founded in 1992 and federally incorporated in 1993 as a not-for-profit organization with charitable registration.

4. The Board of Directors consists of people living with HIV, service providers, researchers, and legal professionals from across Canada and internationally. At all times, there must be

at least one board member from each of the five regions of Canada, and a minimum of two board members must be people openly living with HIV.

5. The HIV Legal Network promotes the human rights of people living with HIV and other populations disproportionately affected by HIV, punitive laws and policies, and criminalization, in Canada and internationally. The Legal Network works towards a world in which the human rights of all people, including people living with HIV and other populations disproportionately affected by HIV and criminalization, are respected, protected, and fulfilled; where all people understand and can exercise their human rights; and where laws and policies facilitate access to prevention, care, treatment, and support.

6. We work towards our mission and vision through research and analysis, litigation and other advocacy, public education, and community mobilization. The work focuses on a wide range of issues in Canada and internationally, including, but not limited to:

- HIV-related stigma and discrimination;
- Criminal law, and its application to people living with HIV;
- Privacy rights, and their application to people living with HIV;
- Drug policy, and access to health services for people who use drugs;
- Sex work laws, and the rights of people engaged in sex work;
- Prison policy, and access to health services for people in prison; and
- Immigration law and policy, and the rights of non-citizens living with HIV.

7. In short, the HIV Legal Network has an extensive history of work on a wide range of legal and policy issues related to the human rights of people living with HIV and of communities particularly affected by HIV, both domestically and internationally.

B. The HIV Legal Network's Work

8. The HIV Legal Network has been granted leave to intervene in many cases related to a range of issues, including, but not limited to, the criminalization of HIV non-disclosure, the constitutionality of criminal law provisions related to sex work, access to medical cannabis, access to supervised injection sites without the risk of criminal prosecution, and the excessive demand provision under the *Immigration and Refugee Protection Act* ("*IRPA*") (the impugned provision in the present matter). The cases are:

- *R v Cuerrier,* [1998] 2 SCR 371, [1998] SCJ No 64;

- *Canada (Attorney General) v PHS Community Services Society*, 2011 SCC 44;
- *R v DC*, 2012 SCC 48;
- *Canada (Attorney General) v Downtown Eastside Sex Workers United Against Violence Society,* 2012 SCC 45;
- *Canada (Attorney General) v Bedford*, 2013 SCC 72;
- *R v Hutchinson*, 2014 SCC 19;
- *R v Wilcox*, 2014 SCC 75;
- *R v Smith*, 2015 SCC 34;
- *Carter v Canada (Attorney General)*, 2015 SCC 5;
- *R v Lloyd*, 2016 SCC 13;
- *Sherman Estate v Donovan*, 2021 SCC 25;
- *R v Kirkpatrick*, 2022 SCC 33;
- *R v Sharma*, 2022 SCC 39;
- *R v Ndhlovu*, 2022 SCC 38;
- *R v JT,* 2008 BCCA 463;
- *R v Wright,* 2009 BCCA 514;
- *R v Mabior*, 2010 MBCA 93;
- *R v Mernagh*, 2013 ONCA 67;
- *R v Mekonnen*, 2013 ONCA 414 and *R v Felix*, 2013 ONCA 415;
- *Tanudjaja v Canada (Attorney General)*, 2014 ONCA 852;
- *R v Gowdy*, 2016 ONCA 989;
- *Christian Medical and Dental Society of Canada et al v. College of Physicians and Surgeons of Ontario*, 2019 ONCA 383
- *R v Boone*, 2019 ONCA 652;
- *R v G(N)*, 2020 ONCA 494;
- *R v Aziga,* 2023 ONCA 12;
- *R v Thompson*, 2018 NSCA 13;
- *AB v Canada (Citizenship and Immigration)*, 2017 FC 1170; and
- *Elementary Teachers' Federation of Ontario v Ontario (Minister of Education)*, 2019 ONSC 1308.

9. In addition to the above, the Legal Network was granted public interest standing in *Simons v Ontario (Minister of Public Safety)*, 2020 ONSC 1431. As a member of the Canadian Alliance for Sex Work Law Reform, the Legal Network was also granted public interest standing in *Canadian Alliance for Sex Work Law Reform v Attorney General*, 2023 ONSC 519.

10. The Legal Network's public legal education activities include handling hundreds of information requests each year from people living with HIV, service providers, and policy makers, in Canada and abroad. Questions related to immigration law, specifically restrictions on people living with HIV, are among the most frequently answered questions.

11. Between 1 January 2023 and 31 January 2024, the Legal Network received and responded to 109 information requests from people living with HIV regarding travel and migration to Canada. Of those requests, 51 involved concerns about immigration restrictions on people living with HIV, including one person who was told by an Immigration, Refugees, and Citizenship Canada ("IRCC") panel physician that they would not be allowed to enter Canada because of their HIV status, and another person who sought help to respond to a procedural fairness letter.

12. The Legal Network's public legal education activities also include conducting workshops and presentations for communities across the country on HIV-related issues. In 2022-2023, for instance, the Legal Network collaborated to present five workshops with Indigenous audiences on HIV criminalization and on drug policy, 11 presentations at the 2022 International AIDS Conference, and a dozen more workshops on other topics related to HIV and human rights.

13. The Legal Network also publishes materials, particularly for the benefit of people living with HIV, service organizations, and other front-line service providers. For example, in 2015, the HIV Legal Network published a Question and Answer ("Q&A") for newcomers on HIV disclosure to sexual partners, including information about criminal law and immigration law and, in 2023, published an update to its long-standing Q&A on immigration and travel to Canada for people living with HIV, focusing on the application of the excessive demand provision under *IRPA*.

14. The Legal Network's public legal education activity has also included training sessions for judges. In March 2010, the Legal Network and HIV & AIDS Clinic Ontario ("HALCO"), in collaboration with the National Judicial Institute, organized a half-day training session on HIV and criminalization for dozens of judges from across the country. Numerous presenters — including medical experts, social scientists, and people living with HIV — were recruited for the session, and material from the Legal Network was included in the training.

15. The Legal Network's community mobilization focuses on collaborating with other organizations to mobilize action. For instance, the Legal Network has continuously

collaborated with sex workers and sex workers' rights organizations to foster conversations about the human rights and *Charter* violations perpetuated by Canada's criminal laws on sex work. In February 2023, the Legal Network partnered with Butterfly (Asian and Migrant Sex Workers Support Network) to host an in-person convening in Toronto of migrant sex workers from across Canada.

16. Similarly, the Legal Network is a founding member, and current secretariat, of the Canadian Coalition to Reform HIV Criminalization, which has led community consultations with people living with HIV, service providers, allies, researchers, and legal experts. The consultations have led to the creation of a Community Consensus Statement, *Change the Code: Reforming Canada's Criminal Code to Limit HIV Criminalization*, endorsed by more than one hundred civil society organizations.

17. The Legal Network's research and analysis is informed by consultations with people directly affected by the laws and policies being studied. For instance, in 2021, the Legal Network, in collaboration with Butterfly and academics from McMaster University and Osgoode Hall Law School produced *Caught in the Carceral Web: Anti-Trafficking Laws and Policies and The Impact on Migrant Sex Workers,* evaluating the impact of criminal laws, immigration laws, human trafficking laws, and municipal bylaws targeting sex work and human trafficking, and centered the perspectives of migrant sex workers.

18. Given the Legal Network's expertise, it has regularly been consulted by government and by other organizations on legal and human rights issues affecting people living with HIV.

19. At the domestic level, the Legal Network has appeared numerous times before Parliamentary committees examining a range of legislative proposals affecting HIV prevention, care, treatment, and support, and has made submissions to provincial and federal policymakers and legislators regarding issues such as immigration policy, discrimination, HIV testing, criminal law, prison health, public health, and more. For instance, in June 2023, the Legal Network, in collaboration with Butterfly, provided submissions on *Bill S-224, An Act to amend the Criminal Code (trafficking in persons)*.

20. At the international level, the Legal Network served as the Secretariat to the Reference Group on HIV and Human Rights of the Joint United Nations Programme on HIV/AIDS

(UNAIDS) from 2012-2021 and has been commissioned on numerous occasions by UNAIDS, the United Nations Development Program (UNDP) and the UN Office on Drugs and Crime to research and prepare a variety of materials related to HIV and human rights, from legislative analyses for more than two dozen countries to educational materials for lawyers, judges, and community organizations. The Legal Network has also collaborated with UNAIDS and the Office of the UN High Commissioner for Human Rights in the elaboration of the *International Guidelines on HIV/AIDS and Human Rights*.

21. Since 2014, the Legal Network has also provided technical assistance on human rights, gender, and HIV to the Global Fund to Fight AIDS, Tuberculosis, and Malaria, the world's largest multilateral funding mechanism for funding countries' responses to these three diseases. Our work with the Global Fund has spanned countries in Eastern Europe, West Africa, and Southern Africa.

THE HIV LEGAL NETWORK'S INTEREST IN THE PRESENT MATTER

22. The Legal Network represents the voices of many people living with and affected by HIV in Canada, including non-citizens affected by Canada's immigration law and policy. The Legal Network has an interest in, and commitment to, ensuring the rights of people living with, or disproportionately affected by, HIV are protected.

23. Specifically, the Legal Network has strong expertise and experience regarding the stigma and discrimination faced by migrants living with HIV, and the excessive demand provision, given the provisions' disproportionate effect on migrants living with HIV.

24. For instance, in 2000, the Legal Network published *An ethical analysis of the mandatory exclusion of refugees and immigrants who test HIV-positive*, which considered whether Canada's immigration policies were ethically justified. On the "excessive demand" regime (under the *Immigration Act*, the predecessor to the *IRPA*), the authors concluded:

> A cost–benefit analysis of immigrants to Canada in 1988 calculated the net benefits of testing in the decade after immigration to be between $1.7 and $13.7 million. That estimate must be put in context, however. The overall demand for health-care services in Canada is driven by much bigger and more powerful forces, including: the aging of the population; the ever-expanding array of expensive pharmaceutical and technological interventions; the failure of health promotion efforts to have

> significant impacts on behaviour such as smoking; and the expectations of public and health-care professionals. Genuine attempts to address the perceived health-care crisis should be directed at those forces, and not deflected by worries about the "excessive demand" that immigrants might impose on health-care services.

25. In 2001, the Legal Network testified before, and made written submissions to, the House of Commons committee leading up to the adoption of the *Immigration and Refugee Protection Act* in 2001, with a particular focus on how legislative and regulatory proposals would affect people living with HIV. It then produced a comprehensive report, entitled *HIV/AIDS and Immigration*, detailing the medical inadmissibility regime and the impact it would have on prospective immigrants living with HIV. In it, the author considered, "Are restrictions on immigration of people with HIV to protect the public purse justified?" I attached to this Affidavit as **Exhibit "A"** relevant excerpts.

26. In 2008-2009, the Legal Network participated in an advisory group, providing input to a study led by Professor Peter Coyte of the University of Toronto, focused on defining a statistical threshold for "excessive demand" under the *Immigration and Refugee Protection Act*, and applying that threshold to people living with HIV seeking admission to Canada. The results of the study were published as P.C. Coyte et al, "The economic burden of immigrants with HIV: When to say no?," *Journal for Global Business Advancement* 2010; 3(1): 60-78. I attached to this Affidavit as **Exhibit "B"** the article.

27. In 2016, the Legal Network, in collaboration with HALCO and the Coalition des organismes communautaires Québécois de lutte contre le sida ("COCQ-SIDA"), provided a detailed brief during the IRCC's review of the excessive demand policy. A summary of the brief was also shared with the House of Commons Standing Committee on Citizenship and Immigration in May 2017, during the Committee's review of its study of the 2011 *LGBTQ Refugee Pilot Project*.

28. In the brief, the organizations detailed the intense and ongoing stigma and discrimination faced by people living with HIV, and the way the excessive demand regime perpetuates that stigma:

> … HIV continues to attract intense stigma and discrimination, in large part because it is associated with stigmatized behaviours and populations, such as LGBTQI people, people who use drugs and sex workers. Persistent beliefs that HIV is highly

> contagious also sustain unreasonable fears regarding the risk of transmission. In fact, the risk of transmission is much lower than many people believe. Recent research reveals that actual transmission risks for people with undetectable viral loads may be zero or close to zero.
>
> In a June 2011 survey, 15% of Canadian respondents stated that they "felt afraid" of people living with HIV; nearly 20% said that they would be somewhat or very uncomfortable working in an office with someone living with HIV; over 20% expressed discomfort shopping at a small neighbourhood grocery store owned by someone with HIV; and approximately 25% felt uncomfortable wearing a sweater worn by a person living with HIV.
>
> … Discrimination is inherent to the excessive demand regime itself. No amount of individualized assessments can diminish the reality that the excessive demand regime reduces an applicant living with HIV (or another disability) to a single characteristic: the cost of their medications. The reductive analysis of the excessive demand regime contributes to anti-HIV stigma. In the *Hilewitz* decision, the Supreme Court of Canada recognized that even "exclusionary euphemistic designations" can conceal prejudices about disability. The excessive demand regime conceals outdated prejudices that people living with HIV, like other people with disabilities, are a burden on Canadian society.

29. In 2017, the Legal Network, with HALCO, made written and oral submissions to the House of Commons Standing Committee on Citizenship and Immigration concerning the medical inadmissibility regime. Again, in the submissions, the organizations detailed the ways the excessive demand regime perpetuates stigma against people living with HIV. I attached to this Affidavit as **Exhibit "C"** the written submission.

30. In oral submissions to the Committee, then Legal Network Senior Policy Analyst, Maurice Tomlinson, explained:

> As a Caribbean immigrant to Canada, I'm aware of our shared history of discriminatory colonial-era laws. Canada has excluded immigrants with disabilities, since before Confederation, when it denied immigration to persons considered physically and mentally defective.
>
> While the Immigration and Refugee Protection Act no longer employs such reprehensible language, the excessive demand regime is rooted in discrimination and conceals outdated prejudices that people with disabilities are a burden on Canadian society. Ironically, the U.K., which was the source of these discriminatory laws, got rid of them, while we cling to a regime that fails to serve its stated purpose.
>
> … Several countries do not have any laws or policies that deny immigration based on HIV status. For example, the U.K. does not impose mandatory HIV testing for

> those entering the country as immigrants. Driven by increasing public pressure to reduce the number of migrants to the U.K., on the grounds that they were overburdening the social welfare infrastructure, nevertheless, the U.K.'s All-Party Parliamentary Group on HIV and AIDS concluded that the U.K. government cannot look to exclude individuals on the basis of poor health in the U.K., while simultaneously working to provide access to health in developing countries.
>
> … On a personal note, my brother and I now live in Canada, while my ill parents are left alone in Jamaica. Neither would qualify as Canadian permanent residents because of excessive demand. When one parent eventually dies, we will have the hard choice of what to do about the other. Our parents have been a great source of support to us. Now, Canada's discriminatory immigration regime excludes them and many others like them from the care they need simply because they are deemed undesirable.

31. In 2021, following public policy changes to the impugned provision, the Legal Network, with HALCO, once again submitted a brief to the IRCC regarding the excessive demand regime. In the submissions, the organizations reiterated that, despite the public policy changes, the excessive demand provision continued to contribute to the stigma and discrimination faced by people with disabilities, including people living with HIV. I attached to this Affidavit as **Exhibit "D"** the brief.

32. In June 2023, the Legal Network, together with HALCO and COCQ-SIDA, submitted a brief to the IRCC regarding the HIV Automatic Partner Notification policy. The organizations called for the revocation of the policy, as unjustified and discriminatory against people living with HIV:

> While medical treatment has transformed HIV into a chronic manageable medical condition, people living with HIV still face extremely high levels of social stigma. This stigma arises from various factors, including fear of contagion, moral judgements, misconceptions of HIV, homophobia and racism. Despite the science surrounding HIV today, it is stigmatized by many, particularly by those outside of communities that have been disproportionately impacted by HIV. This is primarily a result of HIV's association with the AIDS epidemic and with historically stigmatized communities.
>
> In addition to social stigma, people living with HIV face other challenges that stem from their HIV positive status. For example, people living with HIV are at a greater risk of domestic and other violence, and often face discrimination, particularly in employment and housing, due to their HIV positive status. Though public awareness campaigns and sexual education have sought to alleviate stigma and discrimination against people living with HIV, HIV remains one of the most stigmatized medical conditions today.

33. In 2023, the Legal Network, with HALCO and COCQ-SIDA, provided the new Minister of Immigration, Refugees, and Citizenship with a brief outlining the most pressing changes needed to Canada's immigration system necessary to protect and respect the rights of people living with HIV, including the revocation of the excessive demand regime.

34. Michael Battista first contacted the Legal Network about the inadmissibility decision at issue on 29 September 2023. The Legal Network promptly agreed to join the application. Michael Battista later informed me that, on 25 October 2023, he contacted the Canadian Council for Refugees, Canadian Bar Association, Refugee Lawyers Association, and Canadian Immigration Lawyers Association to involve additional individuals directly affected by the excessive demand provision in this application. He received a response from one individual who had received a procedural fairness letter and who was willing to join the litigation. However, she chose not to join the litigation until she had received a final decision on her immigration application.

35. Given its extensive record of research, legal and policy analysis, community engagement, education, and advocacy, both in Canada and internationally, the Legal Network has developed considerable expertise in the analysis of legal issues facing people living with HIV, particularly concerning issues of HIV and immigration. Moreover, particularly given the barriers faced by non-citizens living with disabilities and chronic health conditions in bringing forward constitutional challenges, the Legal Network will provide a valuable perspective to the deliberations before the Court in this matter.

DECLARED remotely by)
SANDRA KA HON CHU)
at the City of Toronto, in the)
Province of Ontario, before me)
on this 1st day of February,)
2024 in accordance with O. Reg.)
431/20, Administering Oath)
or Declaration Remotely.)

Anne-Rachelle Boulanger
Anne-Rachelle Boulanger (Feb 1, 2024 16:34 EST)

Sandra Ka Hon Chu

Anne-Rachelle Boulanger

Sandra Ka Hon Chu

A COMMISSIONER, ETC.

DEPONENT

EXHIBIT "A"

This is Exhibit "A" as mentioned in the Affidavit of Sandra Ka Hon Chu, solemnly affirmed before me by videoconference from Toronto, this 1st day of February 2024.

Anne-Rachelle Boulanger
Anne-Rachelle Boulanger (Feb 1, 2024 16:34 EST)

A Commissioner, etc.

HIV/AIDS and Immigration

Final Report

prepared by

Alana Klein

Background

Throughout history, the emergence of epidemics has resulted in national policies that exclude outsiders in the hopes of limiting the spread of disease. These restrictions have been motivated by various factors, including fear, anger, a wish to differentiate between "us" and "them," a view of migrants as vectors of disease and, at times, "a measure of reason."[1]

The HIV/AIDS epidemic has resulted in particularly controversial migration policies. The disease's magnitude, lingering misconceptions about it,[2] the lack of a cure, and its association with marginalized populations in an era of unprecedented movement of persons across borders, are factors that make HIV/AIDS-related restrictions on migration an especially contentious issue. For example, in the US, HIV-positive people are barred from entering the country even for short periods of time and all applicants for permanent residence are required to submit to an HIV test.[3] US policy has attracted so much criticism that many international and national organizations in protest boycotted the 1990 VI International Conference on AIDS held in San Francisco.[4] Since 1987, the World Health Organization has implemented a policy of not sponsoring international conferences on AIDS in countries with restrictions on short-term entry.[5] This policy has been endorsed by the highest UN interagency coordinating body (the Administration Committee on Coordination), which has recommended that all organizations of the UN system adopt it.

In Canada, short-term visitors with HIV have generally not been denied entry into the country since 1991, and thus far there has been no legal requirement for or policy of mandatory testing for either short-term visitors or all longer-term immigrants. However, there have still been significant restrictions on the immigration of HIV-positive persons to Canada. For example, persons known by immigration authorities to be HIV-positive are generally considered "medically inadmissible" and denied

Throughout history, the emergence of epidemics has resulted in national policies that exclude outsiders in the hopes of limiting the spread of disease.

[1] Mann JM. Foreword I. In: Haour Knipe M, Rector R (eds). *Crossing Borders: Migration, Ethnicity, and AIDS.* London: Taylor & Francis, 1996, at viii-ix.

[2] See Jürgens R. *HIV Testing and Confidentiality: Final Report.* Montréal: Canadian HIV/AIDS Legal Network & Canadian AIDS Society, 2001 (2nd edition), at 21.

[3] See Johnson DS. The United States' denial of the immigration of people with AIDS. *Temple International and Comparative Law Journal* 1992; 6: 145-167 at 150-152.

[4] Somerville MA, Wilson S. Crossing boundaries: travel, immigration, human rights and AIDS. *McGill Law Journal* 1998; 43: 781 at 802.

[5] World Health Organization. "WHO policy of non-sponsorship of international conferences on AIDS in countries with HIV/AIDS-specific short-term travel restrictions," February 1993, with reference to World Health Assembly Resolution WHA41.24 (1988) ("Avoidance of discrimination in relation to HIV-infected people and people with AIDS").

permanent resident status on the ground that they would place excessive demands on Canadian health or social services. Some of those deemed "medically inadmissible" may be permitted to remain in Canada under a Minister's Permit, but permits are granted for a limited time and can be revoked; permit holders are also usually not eligible for most health or social services.

At the time of writing, a major review of Canada's immigration law and policy is underway. A new *Immigration and Refugee Protection Act* [6] is being proposed to replace the current *Immigration Act*.[7] It is planned that under the new Act, some family-class immigrants and refugees would be exempt from some health-related restrictions on immigration. At the same time, as part of the review, Citizenship and Immigration Canada asked Health Canada to provide advice on "which medical screening procedures are required to protect public health."[8]

On 10 August 2000, Health Canada recommended to Citizenship and Immigration Canada that testing all prospective immigrants for HIV, and excluding those testing positive, is the "lowest health risk course of action [and therefore] the preferred option."[9] On 20 September 2000, Canadian newspapers reported to the public that Health Canada had advised Citizenship and Immigration Canada that this constituted the "best public health option."[10] Subsequently, the Minister of Citizenship and Immigration, Elinor Caplan, publicly stated that her department is indeed considering implementing mandatory HIV testing for all prospective immigrants to Canada, and excluding all those testing positive (with the exception of refugees and family-class sponsored immigrants) from immigrating to Canada on both public health and excessive-cost grounds.[11]

In the following months, many organizations and individuals across Canada raised their concerns about this proposal with the Minister of Citizenship and Immigration and the Minister of Health. In March 2001, the Minister of Citizenship and Immigration stated that her department was still proceeding with developing a plan for routine medical testing, to include HIV, for all prospective immigrants and refugees.[12] In its 2000 Annual Report, released in late March 2001, the Canadian Human Rights Commission reacted to this announcement by saying that it "is troubled to hear that Citizenship and Immigration Canada is considering mandatory screening of immigrants." The Commission went on to say that it "is not convinced that mandatory HIV testing is necessary to ensure the health and safety of Canadians. Nor does it believe that the acceptance of HIV+ immigrants would necessarily impose an undue burden on the health care system."[13]

In April 2001, while this Report was undergoing layout, the Minister of Health provided further advice to the Minister of Citizenship and Immigration on whether mandatory HIV testing and exclusion of HIV-positive immigrants are required for public health reasons. According to the advice, which replaced the advice given in August 2000 and was based on further analysis of the issues and extensive consultation, mandatory testing for HIV is necessary, but prospective immigrants with HIV, after receiving counseling, need not be excluded from immigrating to Canada on public health grounds.

[6] Bill C-11, 37th Parliament, 1st Session, 2001 (available at www.parl.gc.ca or www.cic.gc.ca). Bill C-11 is a slightly amended version of legislation previously introduced as Bill C-31, 36th Parliament, 2nd Session, 2000.

[7] RSC 1985, c I-2.

[8] Citizenship and Immigration Canada. *Building on a Strong Foundation for the 21st Century.* Ottawa: Public Works and Government Services Canada, 1998, at 55.

[9] Letter from David Dodge, Deputy Minister, Health Canada, to Janice Cochrane, Deputy Minister, Citizenship and Immigration Canada, 10 August 2000 [on file].

[10] Papp L. Immigrants may face HIV test. *Toronto Star* 20 September 2000: A1, A21.

[11] Clark C. Immigrants facing blood tests: AIDS groups denounce proposed plan to test for HIV and hepatitis B viruses. *Globe and Mail* 21 September 2000: A4; Bueckert D. Minister eyes HIV, hep-B tests for immigrants. *Gazette* [Montréal] 21 September 2000: A11.

[12] Letter from the Honourable E Caplan, Minister of Citizenship and Immigration to G Dafoe, Chief Executive Officer, Canadian Public Health Association, dated 9 March 2001 [on file].

[13] Canadian Human Rights Commission. *2000 Annual Report.* Ottawa: The Commission, 2001, at 13 (available at www.chrc-ccdp.ca).

Issues

An immigration policy must consider the following questions with regard to HIV/AIDS:

- Should visitors with HIV ever be restricted from coming into Canada?
- Should there be mandatory HIV testing of all prospective immigrants?
- Should persons with HIV seeking to immigrate to Canada be prevented from becoming permanent residents?
- Should there be mandatory testing of refugees?
- Should refugees with HIV ever be barred from entering Canada?
- Should there be any restrictions imposed on immigrants and/or refugees with HIV who are admitted once they arrive in the country?

History

Restrictions on the migration of people with HIV have usually been justified as measures to prevent the spread of disease to and within receiving countries or, alternatively, as measures to protect publicly funded health or social services. This chapter provides a brief overview of the origins of health-related restrictions on immigration in order to give context to the current debate regarding immigration and HIV/AIDS.

The chapter notes that models of mandatory testing and exclusion rooted in 19th century infectious disease/public health legislation are being replaced by a new notion of protection of public health. This new approach maintains that when dealing with diseases that cannot be transmitted by casual contact, non-coercive measures such as education and voluntary testing are superior to the coercive measures favoured in the past.

In addition, the chapter discusses the exclusion of immigrants who, as a result of their health condition, are expected to make excessive demands on health or social services. While the current explanation for exclusion in these circumstances is economic, "the history and underlying inconsistencies of immigration policy suggest that financial arguments mask a more fundamental stereotype that immigrants with disabilities will not be worthwhile members of … society."[14]

Restrictions on Immigration to Protect Public Health

In the 19th century, countries dealt with the threat of diseases and epidemics through coercive and restrictive measures such as screening, confinement through quarantine, and exclusion of people with disease.[15] Indeed, the US first passed a law in 1891 restricting the admission of people "suffering from dangerous contagious diseases."[16] As early as 1869, pre-Confederation colonial governments in Canada introduced exclusionary policies directed at preventing the spread of disease.[17]

[14] Mosoff J. Excessive demand on the Canadian conscience: disability, family, and immigration. *Manitoba Law Journal* 1999; 26: 149-177 at 149.

[15] Somerville & Wilson, supra, note 4 at 792.

[16] See Kidder R. Administrative discretion gone awry: the reintroduction of the public charge exclusion for HIV-positive refugees and asylees. *Yale Law Journal* 1996; 106: 389-422 at 394-396.

[17] Goundry S. Final brief on the proposed amendments in Bill C-86 to sections 19(1)(a) and (b) of the Immigration Act. Canadian Disability Rights Council, Winnipeg, Manitoba, 19 September 1992 [unpublished].

In recent years, however, there has been increasing recognition that coercive measures like those favoured in the 19th century are not an effective tool for promoting public health and preventing the spread of HIV in the absence of a cure. When transmission can be avoided by modifications in the behaviour of the local population, public health efforts should focus on promoting safe behaviour in their attempts to prevent spread. Margaret Duckett refers to this as a "new" public health approach, "one that relies less on exclusion and screening and moves more to inclusion and co-operation with the relevant sub-population."[18] The new model is based on measures such as harm reduction, education, voluntary testing and counseling, and protection of privacy. In keeping with this philosophy, the International Guidelines on HIV/AIDS and Human Rights have stated that: "There is no public health rationale for restricting liberty of movement or choice of residence on the grounds of HIV status."[19]

Despite the philosophic trend supported by many academics, public health officials, and non-governmental organizations,[20] many countries have reacted to the HIV/AIDS epidemic with legislation that is more reflective of the old approach.[21] This is particularly true in the area of travel and immigration, where over 50 countries, including the United States, have enacted HIV-related entry restrictions.[22]

Canada, however, has generally followed the new public health model in all areas related to HIV, including immigration. For example, calls for mandatory testing of so-called "high-risk groups" such as injection drug users and gay men, as well as other populations such as prisoners and pregnant women, have been rejected.[23] In addition, the Canadian government's position on HIV/AIDS in the context of its immigration policy has been that "HIV/AIDS is not considered a dangerous, infectious disease, but rather a chronic disease like cancer or heart disease."[24] Canada's approach to dealing with the spread of HIV/AIDS has generally not been to treat it as a public health issue for which coercive measures are appropriate.

The principle of non-discrimination requires that when states exclude persons with medical conditions or disabilities, they must do so based on actual costs that the person is reasonably expected to place on publicly funded services, and not on assumptions and generalizations.

Restrictions on Immigration to Protect the Public Purse

The "public charge" rationale for the exclusion of certain individuals dates back even earlier, into the 19th century. In 1875, the United States Congress enacted legislation to prevent the emigration of people likely to become dependent on the public coffers for support.[25] In Canada, the 1869 *Immigration Act* required masters of sailing vessels to post a three-hundred-dollar bond in order to secure the landing of any person who was "Lunatic, Idiotic, Deaf and Dumb, Blind or Infirm" and therefore likely to become a public charge.[26] This public-charge rationale for exclusion of persons with certain conditions or disabilities predates the introduction of broader, state-sponsored health care.

From 1906 to 1976, labels and diagnoses became absolutely determinative of inadmissibility to Canada.[27] For example, certain diagnoses such as epilepsy made a person inadmissible, regardless of cost of treatment, severity, whether the condition could be controlled, or whether the state would be required to pay for treatment. "The result was that no amount of family support, no compensating strength, attribute, or proof of independent living could overcome the label and permit admission to Canada."[28] The exclusion of persons with disabilities was based on an assumption that such persons would not be able to support themselves.[29] Again, this assumption predates the advent of socialized health care.

[18] Duckett M. Migrants' Right to Health, May 2000 [unpublished draft], at footnote 75.

[19] Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS. *HIV/AIDS and Human Rights. International Guidelines.* United Nations, New York and Geneva, 1998, at 39 (HR/PUB/98/1).

[20] Bayer R. Editorial Review – Ethical and social policy issues raised by HIV screening: The epidemic evolves and so do the challenges. *AIDS* 1989; 3:119-124.

[21] Duckett M, Orkin AJ. AIDS-related migration and travel policies and restrictions: a global survey. *AIDS* 1989, 3 (Suppl 1): S231-S252; Gilmore N et al. International travel and AIDS. *AIDS* 1989; 3(Suppl 1): S225-S230.

[22] Health Canada, Laboratory Centre for Disease Control, Travel Medicine Program. *Countries with HIV-Related Entry Restrictions.* Ottawa, June 1997.

[23] See Jürgens, supra, note 2 at 121-131.

[24] Employment and Immigration Canada & Health and Welfare Canada, *Medical Inadmissibility Review Discussion Paper.* Ottawa: Employment and Immigration Canada, 1991, at 44.

[25] See Kidder, supra, note 16.

[26] *Immigration Act, 1869*, SC 1869 c 10, s 11(2).

[27] *Immigration Act*, RSC 1906 c 93.

[28] Mosoff, supra, note 14 at 157.

[29] Ibid at 159.

Persons with disabilities are frequently being denied entry into Canada on the basis of discriminatory assumptions and practices.

But the principle of non-discrimination requires, at a minimum, that when states exclude persons with medical conditions or disabilities, they must do so based on actual costs that the person is reasonably expected to place on publicly funded services, and not on assumptions and generalizations about persons with particular medical conditions.[30] This has been the position taken by the World Health Organization[31] and by the United Nations.[32] It has also been affirmed in Canadian law.[33] Many countries fail to respect that principle by automatically refusing permanent residence to persons with particular medical conditions (including HIV/AIDS), as Canada did from 1906 to 1976.[34] Other countries, including Canada, have moved away from such blanket restrictions in their legislation to require case-by-case assessments. Even so, those assessments are regularly based on dubious or incorrect assumptions about demands that persons with certain medical conditions are likely to place on publicly funded services.

In 1976, Canada enacted its current *Immigration Act*, which removed references to specific diagnoses and focused instead on the actual cost that each person is likely to incur. This was expected to remove the reliance on stereotypical assumptions that made persons with disabilities automatically excludable. However, Mosoff remarks that

> [a]lthough the language has been updated in recent times and the justifications for exclusion made more apparently rational, the same themes persist. The history shows that disability-based exclusions preceded the development of publicly funded health care and other important social programs in Canada [reference omitted]. Therefore, our current justification to exclude people with disabilities because they might draw too heavily on publicly funded health or social services is really a new twist on an old policy that is based on even older stereotypes.[35]

Indeed, persons with disabilities appear in reported jurisprudence with disproportionate frequency.[36] In many such cases, courts have overturned findings of medical inadmissibility because medical officers have presumed that persons with disabilities would place excessive demands on health or social services based simply on diagnoses and without sufficient evidence about actual demands that the disabled person is expected to make.[37] These cases demonstrate that even in the application of the current *Immigration Act*, which is intended to preclude the reliance on stereotypical assumptions that form the basis of systemic discrimination, persons with disabilities are frequently being denied entry into Canada on the basis of discriminatory assumptions and practices. Furthermore, as discussed in more detail below, while Canada's legislation does not directly discriminate against people with HIV disease or other disabilities, the exclusion of would-be immigrants on the basis of "excessive cost" does indirectly discriminate.

[30] Goodwin-Gill GS. AIDS, HIV, Migrants and Refugees: International Legal and Human Rights Dimensions. In: Haour Knipe & Rector, supra, note 1, 50-69 at 53-54.

[31] WHO. Global Program on AIDS: Statement on Screening of International Travellers for Infection with Human Immunodeficiency Virus, at 1.

[32] *HIV/AIDS and Human Rights: International Guidelines*, supra, note 19.

[33] *Deol* v *Minister of Employment and Immigration* (1992), 18 Imm LR (2d) 1 (FCA); *Litt* v *Canada (Minister of Citizenship and Immigration)* (1995), 26 Imm LR (2d) 153 (FCTD); *Poste* v *Canada (Minister of Citizenship & Immigration)* (1997), 42 Imm LR (2d) 84, 5 Admin LR (3d) 69 (FCTD); *Fei* v *Canada (Minister of Citizenship and Immigration)* (1997), 39 Imm LR (2d) 266 (FCTD); *Lau* v *Canada (Minister of Citizenship and Immigration)* (1998), 43 Imm LR (2d) 8 (FCTD).

[34] Health Canada. *Countries with HIV-Related Entry Restrictions*, supra, note 22.

[35] Mossop, supra, note 14 at 160.

[36] See Goundry, supra, note 17.

[37] See, for example, *Poste*, supra, note 33; *Fei*, supra, note 33; and *Lau*, supra, note 33.

Current Policy

This chapter examines Canada's current policies on HIV testing and admission of non-Canadian persons seeking entry into Canada. Some other countries' policies regarding HIV/AIDS, immigrants and refugees are then briefly canvassed.

Canada

Non-Canadians who are in Canada, or who seek to come into Canada, can be divided into three broad categories: visitors, immigrants, and refugees.

A visitor is a person who is in Canada or who is seeking to come into Canada for a temporary purpose.[38] The category includes students and temporary workers as well as tourists.

Immigrants are persons who seek "landing" in Canada, defined as "lawful permission to establish permanent residence in Canada."[39] A person who has been granted landing but has not become a Canadian citizen is often referred to as a "landed immigrant," although the current official term for this status is "permanent resident."

Refugees, as defined by international law, are persons who: (1) are outside their country of nationality or former habitual residence; (2) have a well-founded fear of persecution due to their race, religion, nationality, membership in a particular social group, or political opinion, and (3) are unable or, owing to that fear, unwilling to return their country of origin.[40] Refugees can be divided into two categories, each governed by different policies: those seeking protection either from within Canada or at a port of entry, and those applying from abroad for resettlement in Canada.[41]

Canada's current *Immigration Act* does not mention HIV/AIDS or any other disease or illness specifically. However, s. 19(1)(a) of the Act sets out the classes of persons who are inadmissible because of their medical condition. It states:

[38] *Immigration Act*, supra, note 7 at s 2(1).

[39] Ibid.

[40] Ibid.

[41] Galloway D. *Immigration Law*. Concord, Ontario: Irwin Law, 1997, at 117. See the 1951 UN Convention Relating to the Status of Refugees, (1954) 189 UNTS 137, [1969] CTS 29.

> 19. (1) No person shall be granted admission who is a member of any of the following classes:
> (a) persons who are suffering from any disease, disorder, disability or other health impairment as a result of the nature, severity, or probable duration of which, in the opinion of a medical officer concurred in by at least one other medical officer,
> (i) they are or are likely to be a danger to public health or to public safety, or
> (ii) their admission would cause or might reasonably be expected to cause excessive demands on health or social services.

This provision applies to all classes of persons seeking entry into Canada other than those specifically exempted from its application by some other provision of the *Immigration Act*. The remainder of this section will address HIV testing and the application of this provision to the various classes of non-Canadians seeking to enter into and/or remain in Canada.

Visitors

Testing

The *Immigration Act* does not require all visitors to undergo a medical examination. However, it does provide that every visitor of a "prescribed class" is required to undergo a medical examination.[42] Visitors who are required to undergo medical examinations are listed in the *Immigration Regulations* as:

- visitors in particular occupations where the protection of public health is essential;
- persons who wish to remain in Canada for longer than six months; and
- visitors who have recently resided in a country where the incidence of communicable disease is higher than in Canada.[43] This latter category may include many residents of sub-Saharan Africa, parts of Asia, and Latin America.

In addition, if an immigration officer or a visa officer [44] suspects that a given visitor might be a threat to public health or safety, or might cause excessive demands on health or social services, the officer may require the visitor to undergo a medical examination.[45]

The HIV status of a visitor may become known to immigration authorities in one of three ways.

- First, visitors from many countries are required to fill in a visa application form that includes an item asking applicants to disclose whether they have been "treated for any serious physical or mental disorders or any communicable or chronic diseases."[46] Applicants who do not disclose risk denial of entry or removal later if this is discovered.
- Second, if the visitor is required to undergo a medical examination, as part of the examination the medical officer will ask the visitor if they have ever tested positive for HIV or any other immune deficiency.
- Third, the form used by medical officers during their examination states that an HIV test should be ordered where "clinically indicated."[47] According to instructions circulated among examining physicians in Canada and internationally, "apparently healthy applicants for short

[42] *Immigration Act*, supra, note 7 at s 11(1).

[43] *Immigration Regulations*, SOR/78-172, s 21.

[44] Immigration officers are the officials in charge of processing in Canada and at its borders; visa officers are responsible for processing in countries outside Canada.

[45] *Immigration Act*, supra, note 7 at s 11(2).

[46] Citizenship and Immigration Canada, Visitor's Visa Application Form IMM-5257.

[47] Citizenship and Immigration Canada. Medical Report Form, Section B – Functional Inquiry into Applicant's Declaration.

[48] Citizenship and Immigration Canada. Changes to the Role of Designated Medical Practitioners for Canadian Immigration Medical Examinations. 30 March 1998 [on file].

term temporary visa to Canada should be asked to undergo HIV testing only if signs of the acquired immunodeficiency syndrome are present."[48]

Exclusion

Prior to 1991, the government considered that people with HIV/AIDS represented a threat to public health. It was government policy that they should not be allowed to visit Canada. An exception was made for the V International Conference on AIDS in Montréal in 1989; people with HIV/AIDS were allowed to enter the country to attend the conference.

In April 1991, the Ministers of Health and Welfare and of Employment and Immigration jointly announced a new policy for short-term visitors. The policy stated that persons with HIV/AIDS did not constitute a threat to public health during short-term travel to Canada, and henceforth would be treated like any other visitor to Canada. Those who

> posed a risk of becoming a significant burden on the health care system while in Canada would still be generally inadmissible, or at least subject to medical assessment, but the new policy effectively means that asymptomatic HIV-positive people entering Canada for a short term visit (less than six months) should not be denied entry or encounter trouble at the border because of their HIV status.[49]

Asymptomatic HIV-positive people entering Canada for a short-term visit (less than six months) should not be denied entry or encounter trouble at the border because of their HIV status.

However, even after the new policy was announced, there were still a few instances of people with HIV being denied entry to Canada:

> The new policy got off to a rocky start when an American man, Craig Rowe, alleged that he was denied entry for a three-day visit to Montreal on 29 December 1991. He is suing the government, alleging that an immigration officer told him that he posed a risk of becoming a burden on the health care system because he was HIV positive. This was despite Mr Rowe's being in good health, having private medical insurance, and possessing a return ticket indicating that his intended visit was very brief.[50]

Immigration officials later acknowledged that more training of border personnel was necessary to ensure uniform application of the short-term visitor policy.

On 3 August 1994, then Minister of Immigration Sergio Marchi wrote to the Canadian AIDS Society clarifying the government's policy. According to Minister Marchi:

- a diagnosis of HIV/AIDS is not in itself a barrier to visiting Canada;
- persons with HIV/AIDS do not generally represent a danger to the public under s 19 of the *Immigration Act*;
- the issue is therefore whether visitors with HIV/AIDS would place excessive demand on the Canadian health-care system;
- it is not normally expected that asymptomatic visitors with HIV would place any demand on the Canadian health-care system;
- therefore, for the vast majority of short-term visits by persons with HIV/AIDS, the excessive demand criterion would not likely be invoked;
- the excessive demand criterion will only be invoked if there is a reason to believe a person would need medical treatment while in Canada, although even in this case, a person may still be able to enter the country if they have made arrangements for treatment and payment;

[49] Bartlett WC. *AIDS: Legal Issues.* Ottawa: Library of Parliament Research Branch, Current Issue Review 93-7E, 14 April 1994 (revised 19 April 1995) at 6-7.

[50] Ibid.

- the carrying of HIV/AIDS medication is not a ground for refusing admission; and
- the government will provide immigration officers with thorough information on the travel policy and implement a training program on HIV/AIDS for immigration officers.

This policy is still in place. On 20 September 2000, Minister of Citizenship and Immigration Elinor Caplan reaffirmed that it is not feasible to impose the HIV test on the millions of visitors and returning citizens/residents who enter Canada every year, saying: "We know that it is impossible to shrink wrap our borders."[51]

"We know that it is impossible to shrink wrap our borders."

– Elinor Caplan, Minister of Citizenship and Immigration Canada, 2000

Applicants for Permanent Residence

Testing

The *Immigration Act* requires every would-be immigrant to undergo a medical examination,[52] which must be conducted by a physician whose name appears on a list of designated medical practitioners.[53] Generally, prospective immigrants must apply for permanent residence from outside the country. Exceptions include refugees, participants in the "live-in caregiver" program, persons who have been in Canada under a Minister's Permit for five years, and those who are given special permission to apply for permanent residence from within Canada because of compassionate and humanitarian reasons. Medical examinations, therefore, usually take place in the country of origin.

There is currently no mandatory HIV test administered as part of the medical examination (this may change in the near future, see infra). As in the case of visitors, immigration officials can learn that a given applicant for permanent residence has HIV or AIDS in one of three ways. First, the application form requires applicants to disclose any serious illness,[54] and applicants who do not disclose risk refusal of entry or removal or prosecution after entry. Second, applicants are asked during the medical examination whether they have ever tested positive for HIV.[55] Third, examining physicians may order HIV tests when, in their opinion, it is "clinically indicated."[56] Once a test is ordered, according to the *Medical Officers' Handbook*, "the protocol with regard to pre-and post-test counseling and consent for HIV antibody testing should be based upon that required under the jurisdiction where the test is to be performed."[57]

Instructions have been circulated to examining physicians internationally indicating how they should exercise their discretion in ordering HIV tests. They state that "a test for HIV is not required as routine. Country of origin, race, gender, and sexual orientation, by itself, is NOT a sufficient reason to warrant a screening test for HIV."[58] Physicians are reminded that HIV testing is required only when clinically indicated, and the age of the applicant should be taken into account and "common sense and a realistic estimation of risk should prevail" when testing is being considered. The instructions then provide the following "partial list of indications for HIV screening":

(1) The applicant has a history of receiving unscreened blood transfusions or blood products or the equipment utilized was reusable with inadequate sterilization.
(2) The applicant has unexplained significant weight loss.
(3) The applicant has used intravenous drugs at some point in the past – especially if the needles were shared.
(4) The applicant's history/physical examination is consistent with an

[51] Thompson A. No entry for immigrants with HIV. *Toronto Star* 21 September 2000: A6.

[52] *Immigration Act*, supra, note 7 at s 11.

[53] *Immigration Manual* IR-3 at 19.

[54] See, for example, Citizenship and Immigration Canada, Immigrant Application Form – Independent IMM-0008.

[55] Medical Report Form IMM-5419, Part B.

[56] Ibid at Part D.

[57] Health and Welfare Canada, Medical Services Branch. *Medical Officers' Handbook: Immigration Medical Service*. Ottawa: Health and Welfare Canada, 1986, at 4.2.11(5)(e).

[58] See supra, note 48 [emphasis in original].

AIDS-defining condition.

(5) The applicant has X-ray evidence of a prior TB infection and is at risk of having acquired the human immunodeficiency virus (eg, unprotected sexual intercourse with prostitutes in areas where such HIV transmission is common).
(6) The applicant's biologic mother was HIV-positive at the time of the applicant's birth.
(7) The applicant has taken part in unsafe sexual practices where the HIV status of the sexual partner was known to be positive (or where it was reasonable to assume that the partner was HIV-positive).
(8) The applicant has reason to believe that they may be HIV-positive.
(9) Any child for adoption where there is a significant likelihood that the HIV status of the biologic mother was positive at the time of the child's birth.

Despite these instructions, it has been reported that some physicians have ordered HIV tests even where none of these indicators are present.[59] Although Citizenship and Immigration Canada has denied that this occurs, and has reiterated that all physicians are required to follow the guidelines described above,[60] reports of HIV testing in the absence of appropriate indicators persist.

Exclusion

Prospective immigrants, like visitors, may be excluded from Canada on medical grounds if the examining physician determines that as a result of their medical condition they are or are likely to be a danger to public health or safety, or that their admission would likely cause excessive demands on health or social services.[61]

No automatic exclusion of people with HIV on public health grounds

Current policy holds that persons with HIV do not themselves represent a danger to public health and safety. Employment and Immigration Canada has observed that the *Immigration Act* does not require a medical officer to determine

> *whether the exclusion of an individual applicant will in any way prevent the spread of a particular disease in Canada…. What the* [Immigration Act] *does demand is the medical officer's opinion on whether an individual applicant's medical condition is such that the applicant is likely to be a danger to public health. The distinction is important; the* Immigration Act *is not intended to stand for a Public Health Act….* A person who is infected with the HIV virus is capable of infecting others and so such a person is *potentially* a threat to public health. *The real question is whether that person is 'likely' to do so*.[62]

Exclusion based on "excessive demands" on health or social services

However, persons with HIV are generally prevented from becoming permanent residents because it is considered that they will place "excessive demand" on the public purse.[63] How does an examining physician determine whether someone will place an excessive demand on health or social services?

There is no clear definition of excessive demand in the *Immigration Act* or the Regulations, which courts have called "troubling."[64] Section 22 of the *Immigration Regulations*[65] provides a list of factors for medical officers to

Current policy holds that persons with HIV do not themselves represent a danger to public health and safety.

There is no clear definition of excessive demand in the *Immigration Act* or the Regulations, and Canadian courts have offered little guidance on how determinations of excessive demand should be made.

[59] Communication with Ruth Carey, HIV & AIDS Legal Clinic Ontario, 3 October 2000.

[60] Communication with Dr GA Giovinazzo, Director, Immigration Health Services, 26 July 2000.

[61] *Immigration Act*, supra, note 7 at s 19(1)(a).

[62] Employment and Immigration Canada. 1991. *Medical Inadmissibility Review: Discussion Paper*. Ottawa, at 45-46 [emphasis in original].

[63] Supra, note 7 at s 19(1)(a).

[64] *Nyvlt* v *Canada* (1995), 26 Imm LR (2d) 95 at 98; *Choi* v *Canada (Minister of Citizenship and Immigration)*, [1995] FCJ No 1068 (TD) (QL); *Chun* v *Canada (Minister of Citizenship and Immigration)*, [1998] FCJ No 1551 (TD) (QL).

[65] Supra, note 43.

The general rule is that demands are to be considered "excessive" if they are "more than what is normal or necessary."

Medical officers must not automatically exclude all persons with particular medical conditions, but are to make individual assessments of the demand that each person is likely to make.

consider in determining whether a person is likely to be a danger to public health or to cause excessive demands on health or social services. However, in the case of *Ismaili* v *Canada (Minister of Citizenship and Immigration)*,[66] the Federal Court found that, as a result of 1992 amendments to the *Immigration Act*, s 22 of the *Regulations* was technically beyond the jurisdiction of the federal government insofar as it applied to determinations of excessive demand. The section was found to be applicable only to determining when a person is likely to be a threat to public health. Therefore, the court ruled that the "excessive demands" provision of the *Immigration Act* "must be interpreted without reference to the provisions of section 22 of the Regulations."[67] Despite this ruling, on at least one subsequent occasion, the court itself, seemingly unaware of the *Ismaili* decision, has considered the factors in section 22 of the Regulations in reviewing an immigration officer's decision that an applicant was medically inadmissible on the basis of excessive demands.[68]

Canadian courts have offered little guidance on how determinations of excessive demand should be made. The general rule is that demands are to be considered "excessive" if they are "more than what is normal or necessary."[69] This has been interpreted by Citizenship and Immigration Canada to mean that demand is excessive any time it is greater than that of the average Canadian.[70] The courts have also affirmed that the determination of "excessive" is to be made on an individual, case-by-case basis. Medical officers must not automatically exclude all persons with particular medical conditions, but are to make individual assessments of the demand that each person is likely to make.[71]

In response to the *Ismaili* decision, an operations memorandum was circulated among medical officers (most of whom are located outside Canada, given the general requirement that an application for landing be made from outside the country) outlining how they should exercise their discretion when considering whether a particular applicant is likely to make excessive demands on government services. It stated that "[m]edical officers must now interpret A19(1)(a)(ii) in view of all the reasonable information available to them. They must not restrict themselves to the factors in the former Regulation 22. They should also consider other relevant factors."[72]

The factors pointed out in the memorandum include:

- medical reports;
- availability of health or social services and, if available, whether they are in short supply;
- whether medical care or hospitalization (short- or long-term) is required;
- whether (short- or long-term) home care is required;
- whether the person's condition is likely to respond to treatment or is chronic, requiring on-going monitoring or treatment on an indeterminate basis;
- any report by school boards, social workers or other social service providers on the likely costs associated with a person and/or class of person's admission; and
- whether special education, occupational therapy, physiotherapy, or other rehabilitative devices are required on a short- or long-term basis.

After considering these factors, the medical officer states the reasonable or likely medical or social services that a given immigrant will require. There is no definite time period for which projected costs are to be assessed.

[66] (1995), 29 Imm LR (2d) 1 (FCTD), [1995] FCJ No 1127 (TD) (QL).

[67] Ibid at para 23 (QL).

[68] *Boateng* v *Canada (Minister of Citizenship and Immigration)*, [1998] FCJ No 1389 (TD) (QL).

[69] *Jim* v *Canada (Solicitor General)* (1993), 22 Imm LR (2d) 261 (FCTD); *Choi*, supra, note 64; *Yogeswaran* v *Canada (Minister of Citizenship and Immigration)* (1997), 129 FTR 151 (TD); *Mo* v *Canada (Minister of Citizenship and Immigration)*, [2001] FCJ No 216 (TD) (QL).

[70] *Jim* v *Canada*, ibid.

[71] *Ismaili* v *Canada (Citizenship and Immigration)*, supra, note 66; see also *Ajanee* v *Canada*, infra, note 77; *Poste* v *Canada (Minister of Citizenship and Immigration)*, supra, note 33; *Fei*, supra, note 33; *Lau*, supra, note 33; *Cooner* v *Canada (Minister of Citizenship and Immigration)*, [1999] IADD No 412 (QL); *Canada (Minister of Employment and Immigration)* v *Jiwanpuri* (1990), 10 Imm LR (2d) 241 (FCA).

[72] Citizenship and Immigration Canada, Operations Memorandum IP 96-08/OP 96-05 (1996).

Generally, although there is no express rule or instruction to this effect, examining physicians will compare the expected demand of the applicant over the first five years following admission. If the average annual demand that the applicant is expected to make is higher than that of the average Canadian, the medical officer may determine that the individual has a medical condition that justifies refusal under s 19(1)(a)(ii) of the *Immigration Act*.[73]

Procedure: The Medical Officers' Handbook

According to the directives in the *Medical Officers' Handbook*, examining physicians are to assign a case code to each applicant indicating their medical status, and then forward the code and its basis to immigration officers. These classifications are based on five criteria that are graded on a seven-point scale, which include risk to public safety or health (H); expected demand on health or social services (D); response to medical treatment (T); need for surveillance (S); and potential employability or productivity (E). Based on the grades the applicants receive in each of these five categories, they are assigned one of the following case codes:

> M1: there is no health impairment sufficient to warrant exclusion;
> M2: the applicant has a medical condition and could pose a risk to public health but exclusion is not warranted;
> M3: the applicant has a condition that will place some demand on health or social services, but the demand is not excessive and does not warrant exclusion;
> M4: the applicant has a condition that represents a danger to public health and safety and is presently inadmissible, but the condition may respond to treatment and the person might be admissible in the future;
> M5: the applicant has a condition which might reasonably be expected to cause excessive demands on government services, but the condition might respond to future treatment and the person may be admissible in the future;
> M6: the applicant has a condition that renders them likely to be a threat to public health and safety and precludes admission at present and in the foreseeable future;
> M7: the applicant has a condition that will place excessive demand on government services which is not expected to decrease in the future and precludes admission at present and in the foreseeable future.

Generally, examining physicians will assess the expected demand of the applicant over the first five years following admission.

The instructions and information regarding HIV/AIDS in the *Medical Officers' Handbook* include a sample case code assignment for prospective immigrants with HIV/AIDS. It reads:

> "HIV positive $H_4D_4T_4S_1E_4M_7$
> AIDS $H_4D_4T_4S_1E_4M_7$"[74]

In practice, people with HIV are generally assigned case code M7.[75] Somerville and Wilson have expressed concern that this classification system actually precludes the individual, case-by-case assessments that the *Immigration Act* prescribes:

> This classification is supposed to be a summary of the various factors looked at by the medical officer in determining the

[73] Dr GA Giovinazzo, Director, Immigration Health Services, indicated that, in practice, medical officers often decide that the person is likely to make excessive demands only when their demands *significantly* exceed those of the average Canadian: supra, note 59.

[74] *Medical Officers' Handbook*, supra, note 56 at 4.2.11(6)(b)(1).

[75] Communication with Dr GA Giovinazzo, supra, note 59.

> individual's ability to be a contributing member of society. But these codes could be used to exclude people with certain diseases. Rather than looking at the individual's ability to contribute to Canada and whether his or her health status is likely to interfere with this contribution if the applicant is found to be HIV positive he or she may be automatically labelled an M7 and excluded on that basis. In other words, the concern is that the codes are being used to state a particular medical condition and to exclude an applicant on that basis, rather than on a proper evaluation of the individual's condition and all relevant circumstances. The medical officer looks up a particular condition in the Medical Officer's Handbook and sets forth the applicable codes in the prospective immigrant's medical profile…. [T]his procedure appears to limit, almost prohibit, the proper exercise of discretion by the medical officer and sets up a regime of rubber stamping certain conditions as being an excessive demand and therefore excluding the applicant automatically.[76]

The concern is that the use of case codes precludes the proper, case-by-case assessment of the individual's condition and all relevant circumstances.

In *Ajanee*,[77] the Federal Court considered whether the use of the *Medical Officer's Handbook* encourages examining physicians to automatically exclude persons with particular diagnoses and thus "fetters the discretion" of the medical officer. In that judgment, MacKay J quoted Cullen J's description of the proper function of guidelines such as the ones in the *Medical Officers' Handbook*:

> Care must be taken so that any guidelines formulated to structure the use of discretion do not crystallize into binding and conclusive rules. If the discretion of the administrator becomes too tightly circumscribed by guidelines, the flexibility and the judgment that are an integral part of discretion may be lost.[78]

There are at least five cases in which a person living with HIV has succeeded in obtaining permanent resident status in Canada after being found medically inadmissible.

MacKay J held that use of the Handbook does not amount to an improper fettering of physicians' discretion. However, he qualified his opinion, stating that:

> Medical Officers may utilize and apply the rules set out in the Medical Officer's Handbook, but they must be flexible and look beyond the guidelines to decide whether an applicant is medically inadmissible on the basis of his or her individual circumstances. The medical officers must look upon the Medical Officer's Handbook as simply one of the elements of evidence to be considered in assessing individual cases. The weight assigned to the guidelines in the Handbook may vary in light of the circumstances of each case.[79]

The reasoning in *Ajanee* was endorsed wholeheartedly in a decision released shortly thereafter. In *Ludwig*, Nadon J reiterated that:

> Medical officers must be careful not to apply the Handbook too rigidly; they must be flexible enough to look beyond the guidelines in the Handbook and decide the admissibility of each applicant on the basis of that person's individual circumstances. If medical officers determine that they are bound by the Handbook and cannot diverge from its guidelines, that would be a fetter on their discretion…. It is also arguable that it would not be unrea-

[76] Somerville & Wilson, supra, note 4.

[77] *Ajanee* v *Canada (Minister of Citizenship and Immigration)* (1996), 33 Imm LR (2d) 165 (FCTD).

[78] *Dawkins* v *Minister of Employment and Immigration* (1991), 45 FTR 198 at 204 (FCTD).

[79] *Ajanee*, supra, note 77 at para 28.

> sonable for medical officers to place a great deal of weight on the Handbook. Unlike guidelines, which reflect government policy, the Handbook reflects common medical knowledge and practice. As such, it is similar to medical journals and textbooks…. Medical officers must therefore examine the applicant's particular circumstances in light of these guidelines.[80]

If, after an individual assessment of a given applicant's medical condition, the medical officer determines that an applicant can be expected to place excessive demands on health or social services, the opinion is forwarded to the visa or immigration officer. Although the visa or immigration officer does not have the authority to overturn medical diagnoses, the officer is required to look at the reasonableness of the opinion.[81] For example, visa or immigration officers must be sure that all appropriate evidence was considered,[82] and that there is a clear link between the applicant's medical condition and the likelihood of excessive demands.[83] Visa and immigration officers are required to refer back to the medical officers for review of any medical report form that has obvious errors[84] or is "vague, insufficient, ambiguous, or uncertain, or [if] their opinion was not reasonable at the time it was rendered."[85] If there are no such errors, the applicant will be considered medically inadmissible and will be denied landed immigrant status.

The applicant is then entitled to a letter in which the reason for the inadmissibility is provided.[86]

Appeals

If a sponsored "family class" applicant[87] who is HIV-positive is found medically inadmissible on "excessive costs" grounds, their *sponsor* has an automatic right to appeal the decision to the Immigration Appeals Division of the Immigration and Refugee Board. The appeal can be based on mistake of fact or law, or on the ground that "there exist humanitarian and compassionate considerations that warrant the granting of special relief."[88] Courts have ruled that, on such an appeal regarding whether there are sufficient humanitarian and compassionate considerations to warrant granting landing to the medically inadmissible person, the issue of their possible demand on health or social service systems is not to be considered as a countervailing consideration.[89] Although not stated in the cases, certainly to do otherwise would arguably violate the equality rights protected by the Charter: it would be blatant discrimination to require the person with a more serious illness or disability to bring forward a more compelling case of humanitarian and compassionate reasons to justify granting landing than a person who is also medically inadmissible but who has a less costly condition.[90]

However, for an independent applicant, there is no automatic right of appeal of a decision of medical inadmissibility. The applicant may only apply to the Federal Court for judicial review of the decision.[91] The application for judicial review can only be based on mistakes of law or fact. Compassionate and humanitarian considerations cannot form the sole basis for the court to review the original decision.

There is one reported case in which an independent applicant sought judicial review of a visa officer's decision that he was medically inadmissible. On the facts of that case, the court rejected his argument that the medical information on which the decision was based was not up to date.[92]

There are at least five cases in which a person living with HIV has succeeded in obtaining permanent resident status in Canada after being

[80] *Ludwig* v *Canada (Minister of Citizenship and Immigration)*, [1996] FCJ No 474 (TD) (QL) at paras 19-20.

[81] For example, see: *Deol*, supra, note 32; *Ahir* v *Minister of Employment and Immigration* (1983), 49 NR 185; *Mohamed* v *Minister of Employment and Immigration* (1986), 68 NR 20; *Badwal* v *Minister of Employment and Immigration* (1989), 9 Imm LR (2d) 85 (FCA).

[82] *Gingiovenanu* v *Canada (Minister of Employment and Immigration)*, [1995] FCJ No 1436 (FCTD) (QL).

[83] Operations Memorandum, supra, note 72.

[84] Ibid.

[85] *Uppal* v *Minister of Employment and Immigration*, [1987] 3 FC 565; 2 Imm. LR (2d) 143 (CA); *Jiwanpuri*, supra, note 70; *Mohamed (Nargisbanu Mohammad Ali)* v *MEI* [1986] 3 FC 90 (CA).

[86] See *Immigration Manual*, OP 14 at s 4 and OP 19 at s 4.

[87] "Family-class applicant" is a person who has been sponsored by a close family member who is a Canadian citizen or permanent resident. Family members that can be sponsored are defined in the *Immigration Regulations* at s 2(1). A sponsor undertakes to provide for the applicant for up to 10 years. Sponsored applicants are generally granted permanent resident status without being assessed under the "points system" used to assess independent immigrants. However, sponsored applicants are still required to meet the medical criteria in the *Immigration Act*.

[88] *Immigration Act*, supra, note 7 at s 77(3).

[89] *Kirpal* v *Canada (Minister of Citizenship and Immigration)*, [1997] 1 FC 352, [1996] FCJ No 1380 (TD) (QL); *Sandhu* v *Canada (Minister of Citizenship and Immigration)*, [2000] FCJ No 1398 (QL).

[90] Note, however, that this discriminatory reasoning is precisely that adopted by the Immigration Appeal Division in *Jugpall* v *Canada (Minister of Citizenship and Immigration)*, [1999] IADD No 600 (QL), and in *Sandhu* v *Canada (Minister of Citizenship and Immigration)*, [1999] IADD No 970 (QL). In the *Sandhu* case, this was overturned by the Federal Court Trial Division, which ruled that the IAD had failed to follow the binding precedent in *Kirpal*: see *Sandhu*, supra, note 89.

[91] *Immigration Act*, supra, note 7 at s 82(1).

[92] *Singh* v *Canada (Minister of Citizenship and Immigration)*, [2000] FCJ No 1297 (TD) (QL).

found medically inadmissible; there has also been at least three reported unsuccessful cases. In each of the successful appeals, the decision was based on compassionate and humanitarian considerations rather than a finding that the HIV-positive applicant would not in fact place excessive demands on health or social services.

There are at least five cases in which a person living with HIV has succeeded in obtaining permanent resident status in Canada after being found medically inadmissible.

Successful appeals

In *Paslawski* v *Canada*,[93] a Canadian citizen appealed the refusal to approve the sponsored application of his wife, who is HIV-positive. He did not contest the finding that she would have placed excessive demands on government services. However, he argued successfully that due to their marital relationship, there existed compassionate or humanitarian considerations to warrant the granting of special relief. Although Singh J ultimately based his decision on the "love of a husband and wife and their natural desire to be together,"[94] he devoted a considerable part of his judgment to the positive assessment of the applicant's health and the medical finding that she "is likely to continue to do well for at least the next 10 years and probably well beyond that."[95] While it did not disadvantage the applicant in this particular case, it should be noted that, in light of the *Kirpal* decision noted above, the consideration of whether she was likely to require medical care in the coming years was incorrect. The focus should have been solely on the humanitarian and compassionate considerations.

The case of *Keels* v *Canada (Secretary of State)*[96] involved a married man and woman both living with HIV. The husband applied for permanent residence, but his application was denied by the visa officer; he was found medically inadmissible on the basis of "excessive costs." His Canadian wife appealed. Although the issue of whether the refusal was valid was brought up before the hearing, the parties finally agreed not to argue this issue. As a result, the appeal was based only on compassionate and humanitarian grounds. The tribunal took a less generous approach than in *Paslawski* to family reunification, ruling that

> the desire for family reunification is not, in and of itself, a basis for allowing an appeal on humanitarian or compassionate grounds, because family reunification is the common feature of all family class sponsorship applications. The issue really is whether there are exceptional circumstances in this case which in some way justify the granting of special relief, quite apart from the natural and normal desire for family members to be reunited.[97]

Ultimately, however, the tribunal did rule that there were sufficient humanitarian and compassionate reasons to allow the appeal. It found that because the husband and wife were both HIV-positive, had a child together, and did not have an extensive support network, the family members were particularly dependent on each other.

In *Colterjohn* v *Canada (Minister of Citizenship and Immigration)*,[98] a husband contested the refusal of his HIV-positive wife's application for permanent residence. Unlike the *Paslawski* and *Keels* cases, not only did the husband ask for special relief on humanitarian and compassionate grounds; he also challenged the finding that his wife would in fact cause excessive demands on health or social services as a result of her HIV infection. The tribunal chose to dismiss his argument against the finding of excessive demand on the ground that there was insufficient evidence to support it. As

93 *Paslawski* v *Canada (Minister of Citizenship and Immigration)*, [1999] IADD No 151 (QL).

94 Ibid at para 13, citing Mahoney J in *Canada (Minister of Employment and Immigration)* v *Burgon* (1991), 13 Imm LR (2d) 102 (FCA).

95 Ibid at para 9.

96 [1994] IADD No 270 (QL).

97 Ibid.

98 [1998] IADD No 1335 (QL).

in *Paslawski* and *Keels*, the appeal was allowed on compassionate and humanitarian grounds, based on the couple's marital situation and their inability to settle elsewhere.

In *Gretchen* v *Canada (Minister of Citizenship and Immigration)*,[99] the Canadian adoptive parents of an orphan from Romania with HIV and multiple other disabilities sponsored the application for immigration of their child (whose younger sister they had already adopted and brought to Canada). The application was refused on the ground of medical inadmissibility. The federal Minister of Immigration did not indicate opposition to the child's entry into Canada, and would have granted a Minister's Permit had the provincial government in question not refused agreement. The parents successfully appealed on humanitarian and compassionate grounds; the adjudicator of the Immigration Appeal Division found that the conditions of this case "do excite in the Board the desire to relieve the misfortune" of the child and her adoptive parents.

In *Alziphat* v *Canada (Minister of Citizenship and Immigration)*,[100] a father sponsored the application of his HIV-positive son from Haiti. After a finding of medical inadmissibility, the father successfully appealed the refusal on humanitarian and compassionate grounds. The adjudicator found a strong connection between the son and the father and his wife, that the biological mother was not capable of properly looking after the son but the father's wife who had a strong connection with the child was better equipped, and that the son missed his younger brother (already living in Canada with the father).

The outcome of appeals of "medical inadmissibility" refusals based on compassionate and humanitarian considerations is unpredictable.

Unsuccessful appeals

In three reported cases, sponsors have been unsuccessful in sponsoring their HIV-positive spouses for immigration to Canada as permanent residents.

In *Jijimbere* v *Canada (Minister of Employment and Immigration)*,[101] a husband appealed the refusal to allow his HIV-positive wife to immigrate. He did not challenge the finding of medical inadmissibility, but based his claim on humanitarian and compassionate considerations. An ethnic Hutu originally from Burundi, his wife was under the protection of the UN High Commissioner for Refugees in Rwanda. He had no other family in Canada, and was himself HIV-positive. However, the Immigration Appeal Division stated that he had chosen to have unprotected sex with his wife knowing the risks of infection and that his economic situation was such that he could not support another person likely to become sick, in addition to his own health expenses. Noting that he was alone in Canada, the adjudicator concluded he could not count on the support of family. The adjudicator somehow reached the view that there were not sufficiently compelling reasons to justify the special measure of allowing his medically inadmissible wife to immigrate to Canada on humanitarian grounds.

In *Marchand* v *Canada (Minister of Employment and Immigration)*,[102] a wife appealed the refusal of her application to sponsor her HIV-positive husband from Haiti on medical inadmissibility grounds. She claimed that the diagnosis was incorrect, but did not provide convincing proof to the contrary. The adjudicator seemingly felt it necessary to describe her as "very imprudent" for having married a person without a good idea as to his health status and as being "extremely reckless" for having had unprotected sex with him after knowing of his HIV-positive diagnosis, although the adjudicator also felt that, in fact, she knew the diagnosis of HIV infection was correct and was taking the risk of unprotected sex as she claimed she was not. The adjudicator

[99] [1994] IADD No 685 (QL).

[100] [1995] DSAI No 1229 (QL) [DSAI is the French version of the IADD database on QL].

[101] [1994] DSAI No 582 (QL).

[102] [1994] DSAI No 592 (QL).

also stated, seemingly without considering any evidence on these points, that [TRANSLATION] "it is widely known that people with AIDS need expensive care and that such care is limited. There is a lack of medications to treat them, and a lack of shelters in which to house them.… For the moment, [the husband's virus] is in a period of incubation. He does not yet have AIDS. Sooner or later, the disease will declare itself and at that time that he will become an excessive burden on our limited resources. I am unable to evaluate when [he] will develop the disease."

Courts have ruled that it is wrong to simply assume, based on a person's medical condition alone, that the person will place "excessive demands" on health or social services.

Finally, an appeal was dismissed in the case of *Baginski* v *Canada (Minister of Citizenship and Immigration)*,[103] where a father contested the exclusion from Canada of his HIV-positive son, who was declared inadmissible on both medical and criminal grounds. Again, the validity of the refusal was not contested, but rather the father sought relief on compassionate and humanitarian grounds. The panel, after describing the applicant's criminal past and noting that he was very likely to require expensive medical treatment, found that "this case is not an appropriate one for the exercise of the Appeal Division's discretionary relief. In [our] view, the circumstances of this case, when assessed in their entirety, are not of the kind warranting extraordinary relief."[104]

Conclusions regarding appeals

The tribunals have yet to pronounce on whether it is reasonable to find that a person living with HIV will, merely by virtue of their HIV infection, place excessive demands on health or social services.

A number of points can be extracted from these cases:

First, the outcome of the appeals based on compassionate and humanitarian considerations is necessarily unpredictable. Tribunals view the relief as "extraordinary" and not necessarily justified simply because of marital or familial bonds.

Second, the potential costs that the applicant may place on health or social services may be considered in determining whether relief on compassionate and humanitarian grounds is justified, even though the current weight of legal authority indicates that this is legally incorrect and constitutes reviewable and reversible error on the part of the panel or adjudicator hearing an appeal on humanitarian and compassionate grounds. It appears that someone with a more promising medical prognosis is more likely to be granted landing on compassionate and humanitarian grounds despite a finding of medical inadmissibility.

Third, there has not yet been a case where a tribunal seriously questioned the validity of the finding that a person with HIV will necessarily place excessive demands on health or social services. Yet Canadian courts have held that it is wrong to simply assume, based on an applicant's medical condition alone, that the applicant will place "excessive demands" on these services. Instead, a proper assessment of likely costs is required: "merely suffering from a disease or disorder does not render a person inadmissible: it is the effect of the disease that it is critical to the determination."[105]

Finally, there do not appear to have been any cases in which HIV-positive immigrants outside the "family class" have succeeded in getting refusals based on "medical inadmissibility" overturned. This is not surprising: as noted above, unsponsored applicants cannot argue their case on "humanitarian and compassionate" grounds, and are limited to simply arguing that the initial decision of medically inadmissibility is factually or legally wrong. But, thus far, tribunals have based their decisions granting permanent residence to medically inadmissible HIV-positive individuals on "humanitarian and compassionate" grounds, rather than overturn the original decision that the person will necessarily place excessive demands on

[103] [1997] IADD No 1899 (QL).

[104] Ibid at para 4.

[105] *Mo*, supra, note 69 at paras 37, 42; see also: *Deol*, supra, note 33 and *Litt*, supra, note 33.

health or social services. The tribunals have yet to pronounce on whether it is reasonable to find that a person living with HIV will, merely by virtue of their HIV infection, place excessive demands on health or social services.

Refugees

"Convention refugees" are persons who are outside their country of nationality or habitual residence, and are unwilling or unable to return to their home country owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership in a particular social group, or political opinion. In Canada, the basic rule is that refugees who appear at the border or who are in Canada have a right to stay in the country no matter what their health status. As a result, once it is determined that an individual in Canada or at its borders is in fact a refugee, that individual cannot be excluded from the country for testing positive for HIV.

Canada is bound by the 1951 United Nations Convention Relating to the Status of Refugees.[106] According to Article 33 of the Convention, states that have acceded to the Convention may not expel or return a refugee to a country where the refugee's life or freedom is threatened. This is referred to as the principle of *non-refoulement*. A country in which a refugee is seeking asylum can expel a refugee only in one of two circumstances:

Convention refugees within Canada have a right to remain, regardless of their medical condition.

a) if the refugee constitutes a "danger to the security of the country [of asylum]" or
b) if the refugee has been convicted of a "particularly serious crime" and therefore "constitutes a danger to the community of that country."

The Article does not provide for any exception to the principle of *non-refoulement* on public health or economic grounds. (Essential medical care for refugee claimants in Canada whose claims have not yet been adjudicated – and who are therefore not permanent residents entitled to coverage under the public health insurance plan of the province in which they are located – is covered by the Interim Federal Health Program (IFHP) administered by Citizenship and Immigration Canada.)

Because Article 33 of the Convention precludes a state from expelling or returning a refugee, a strict reading requires states to admit only those refugees who are at or within its borders. Refugees in other countries are not caught by Article 33, and therefore the Convention has generally been interpreted as not imposing any positive obligation on states to accept refugees who are situated in other countries.

Canada has reflected the distinction between refugees in Canada and those outside Canada in its legislation by creating separate legal regimes for the two kinds of refugee claimants. As outlined below, under these regimes, persons in Canada found to be Convention refugees are not subject to the medically inadmissibility criterion in the *Immigration Act*, whereas refugees outside may be excluded as medically inadmissible.

Refugees in Canada

Persons claiming to be Convention refugees from within Canada or at its borders may seek to have their claim determined by the Convention Refugee Determination Division of the Immigration and Refugee Board (CRDD).[107] The *Immigration Act* sets out which claims are eligible to be referred to the CRDD.[108]

Where such persons' claims are successful, they are granted various rights as Convention refugees. First, section 4(2.1) of the *Immigration Act* provides that Convention refugees in Canada have a right to remain in Canada except

[106] Supra, note 41.

[107] *Immigration Act*, supra, note 7 at s 44(1).

[108] Ibid, s 46.01. For example, persons who have made prior refugee claims that have either been denied or abandoned, and persons who have been recognized as Convention refugees by a country other than Canada to which they can be returned, are not eligible to have their claims determined by the CRDD.

in certain cases where they have committed serious criminal offences. Convention refugees also have a right to seek an employment authorization.[109] Finally, the *Immigration Act* states that persons recognized as Convention refugees by the CRDD "shall" be granted landing.[110] While there are some exceptions to the landing requirement listed in that provision, medical condition is not one of them. As a result, persons in Canada determined to be Convention refugees have a right to stay in Canada, to work in Canada, and to become permanent residents of Canada regardless of their medical condition.

Although refugee claimants are required to undergo a medical examination "within such reasonable period of time as is specified by a senior immigration officer,"[111] a Convention refugee's medical condition will have no (legal) bearing on their right to remain in Canada. As a result, refugees may be required to undergo HIV testing under the same conditions as all other immigrants, but any positive test result will not be a bar under the law to admission into Canada.

Persons at risk who are not Convention refugees

Refugee claimants in Canada who are found not to meet the definition of Convention refugee by the CRDD may apply to become a member of the Post-Determination Refugee Claimants in Canada (PDRCC) class.[112] They will be eligible to apply for permanent residence if their removal from Canada would subject them to an "objectively identifiable risk" that would apply in every part of the country to which they would be returned and would not be faced generally by other individuals in or from that country. The risk has to be the person's life, or a risk of "extreme sanctions" or "inhumane treatment."[113] Citizenship and Immigration Canada has stated that the objective of establishing this PDRCC class was to "provide a 'safety net' … [for] persons who might fail to meet the Convention definition, but who nonetheless should not be removed because they would be facing a personal risk of serious harm."[114]

Like Convention refugees, persons in the PDRCC class are exempted from the medical inadmissibility provisions of the *Immigration Act*. [115] However, there is a very significant limitation on the protection afforded by the PDRCC rules: the risk to the immigrant's life that might entitle a person to remain in Canada can be any risk "other than a risk to the immigrant's life that is caused by the inability of that country to provide adequate health or medical care."[116] Therefore, people with medical conditions who are at risk of death, extreme sanctions, or inhumane treatment may be able to remain in Canada even if a claim for refugee status fails, but only if the risk arises from something other than the fact that they cannot receive adequate health care in their country of origin. People who will die or face other serious harms by being returned to a setting of inadequate health care are denied the benefit of the PDRCC class.

This exclusion would seem to be at odds with the objective of placing security ahead of economic considerations, which is already reflected in the fact that persons in the PDRCC class need not be medically admissible to remain in Canada. It has been challenged as violating constitutional rights to life and security of the person (Charter section 7), as well as amounting to discrimination on the basis of disability in violation of equality rights (Charter section 15), but as the case was settled, the issue was not decided by the courts.[117] (The same provision is maintained in the proposed new legislation and may be subject to challenge.[118])

[109] *Immigration Regulations*, supra, note 43 at s 19(4)(j).

[110] *Immigration Act*, supra, note 7 at s 46.04(1) and (3).

[111] Ibid at s 11 (1.1).

[112] *Immigration Regulations*, supra, note 43 at s 11.4. A person is not eligible if they have been found to have no credible basis for a refugee claim, or if they have been found inadmissible based on criminality or security considerations.

[113] Ibid at s 2(1).

[114] Citizenship and Immigration Canada. Operations Memorandum IS 93-19(a), issued 17 June 1993.

[115] *Immigration Act*, supra, note 7 at s 11.4(1).

[116] *Immigration Regulations*, supra, note 43 at s 2(1).

[117] Communication from G Sadoway to R Jürgens, dated 6 November 2000, and accompanying factum in *"X"* v *Minister of Citizenship and Immigration* (FCTD), dated 13 December 1999 [on file].

[118] Bill C-11, supra, note 6 at s 97(1)(iv).

Refugees outside Canada

Persons who meet the definition of a Convention refugee but who are outside Canada and seek permanent residence in Canada are not subject to the special refugee determination process outlined in the *Immigration Act*. They are also not granted the same set of rights and privileges as those in Canada found to be Convention refugees. They can, however, be considered "Convention refugees seeking resettlement," which is a subcategory of the general class of immigrants.

Under current law, refugees outside Canada are required to undergo a medical examination and may be denied entry into Canada on the basis of medical inadmissibility.

The *Immigration Act* provides that categories of immigrants prescribed by regulation may be granted landing for reasons of public policy or for compassionate and humanitarian reasons.[119] In order to give effect to that policy, certain categories of immigrants have been created; immigrants in those classes are subject to special landing requirements. In addition to Post-Determination Refugee Claimants in Canada[120] (the PDRCC class just discussed above), included under this rubric are Convention refugees seeking resettlement[121] and the Humanitarian Designated Classes.[122]

Immigrants who are included in these various humanitarian categories do not have the same right to remain in Canada as Convention refugees in Canada, but generally have to meet less stringent requirements than independent immigrants. Convention refugees seeking resettlement need not qualify under the "points system" by which independent immigrants' applications are assessed, but must nonetheless demonstrate that they will be able "to become successfully established in Canada."[123] This determination is based on the age of the applicant, level of education, work experience and skills, number and age of accompanying dependents, and personal suitability of the applicant and accompanying dependents.[124] In addition, applicants must be sponsored or have sufficient financial resources to support themselves. They may be sponsored either by a private group or by the government, which provides settlement costs for a specified number of refugees each year.[125]

Convention refugees seeking resettlement are, like all other immigrants, required to undergo a medical examination. In addition, as they are treated as a class of immigrants and not subject to the same regime as refugees, members of the various humanitarian classes are subject to the medical inadmissibility provisions in the *Immigration Act*, whereas refugee claimants already in Canada are not. Therefore, those who are found to be HIV-positive are generally denied entry into Canada in the same manner as other immigrants.[126]

HIV/AIDS as the Basis of a Refugee Claim

Not only must persons with HIV/AIDS in Canada who are found to be Convention refugees be granted the right to remain in Canada *despite* being diagnosed HIV-positive, but, in some cases, persons might be granted refugee protection precisely *because* they are HIV-positive. In order for such a claim to be successful, claimants would have to demonstrate that they have a well-founded fear of persecution owing to their "membership in a particular social group." Claimants would also have to show that they were unwilling or unable to avail themselves of the protection of their country of habitual residence.

There have been several cases in which HIV/AIDS-based persecution has been a basis for a successful refugee claim in Canada. In *Re GPE*,[127] the Immigration and Refugee Board accepted that the claimant, if returned to Mexico, would face inadequate state protection from harassment as a gay man and would also be persecuted as person who is HIV-positive. In *Re OPK*,[128]

[119] *Immigration Act*, supra, note 7 at s 6(3) and 6(5).

[120] Ibid at s 11.4.

[121] *Immigration Regulations*, supra, note 43 at s 7.

[122] The Humanitarian Designated Classes consist of two categories: (a) persons outside their country of origin who do not meet the definition of Convention refugee but who have been and continue to be personally and seriously affected by massive human rights violations, armed conflict, or civil war in their country of origin (known as the Country of Asylum class); and (b) persons from particular countries identified in the Regulations who are still residing in their country of origin and who have been unfairly imprisoned or affected by civil war or armed conflict in their country of origin, or would fit the definition of Convention refugee if they were outside their country of origin (known as the Source Country class).

[123] *Immigration Act*, supra, note 7 at s 6(1).

[124] *Immigration Regulations*, supra, note 42 at s 7(1)(c).

[125] Galloway, supra, note 40 at 176.

[126] Communication with Dr GA Giovinazzo, supra, note 59.

[127] [1997] CRDD No 215 (QL).

[128] [1996] CRDD No 88 (QL).

There have been several cases in which HIV/AIDS-based persecution has been a basis for a successful refugee claim in Canada.

the Board accepted that a gay man with HIV from Singapore had good grounds for fearing persecution based on his sexual orientation and "AIDS condition." In *Re YHI*, [129]the Board accepted that being an immediate family member of a person with HIV/AIDS could constitute membership in a "particular social group" that could face persecution (although on the facts it rejected the unrepresented Romanian claimant's claim of a well-founded fear of persecution because it felt that he had an "internal flight alternative" to move within Romania to avoid persecution). There have been a number of other, unreported cases in which refugees have successfully claimed asylum in Canada as a result of persecution based on their HIV status.[130]

The most extensive and significant discussion of HIV/AIDS as a basis for refugee claims is in the case of *Re TNL*,[131] where a Polish former drug user with HIV was found to be a Convention refugee as a result of persecution faced by people with HIV/AIDS in Poland.

The Immigration and Refugee Board held that the harm feared by the claimant was serious enough to constitute persecution (as opposed to mere discrimination, which would not be sufficient to support a refugee claim). In addition to factors such as denial of medical care to people with HIV, the majority noted that people with HIV (together with drug users, with whom they are closely associated in Polish society) faced such violent threats as firebombing of their homes to drive them out of their communities.

The Board affirmed that the denial of so-called "core human rights" such as the right to physical integrity guaranteed in Article 3 of the Universal Declaration of Human Rights[132] constitutes persecution. The Board also went on to state that in some circumstances, the denial of so-called "lower-level rights" (such as the right to personal privacy,[133] the right to housing,[134] the right to international movement and choice of residence,[135] the right to work,[136] the right to medical care,[137] and the right to social security[138]) may also amount to persecution. The Board stated that

> [w]hile the standard of persecution for some rights is less absolute than for others, where a minority of the population, such as persons who are HIV-positive, is excluded from the enjoyment of lower level rights then we are no longer dealing with mere discrimination but with persecution.[139]

It was also held that the Polish government was not taking sufficient initiatives to protect people with HIV and AIDS in Poland from the persecution they suffer.

However, to meet the definition of a Convention refugee, it is not sufficient merely to have a well-founded fear of persecution and for the country of origin to fail to protect the refugee claimant. In addition, the persecution feared must be based on one of the five grounds listed in the Convention refugee definition: race, religion, nationality, political opinion, or membership in a particular social group. The Immigration and Refugee Board stated that "membership in a particular social group" refers to groups defined by an "innate or unchangeable characteristic," such as gender, linguistic background, or sexual orientation. A condition such as being HIV-positive is indeed unchangeable. On that basis, the Board found that the claimant had established a well-founded fear of persecution owing to his membership in a particular social group – persons with a medical disability.

It should be noted that, in this case, the Immigration and Refugee Board allowed the claim based on the fact that the claimant was a member of a

[129] [1996] CRDD No 65 (QL).

[130] Written communications from R Hughes, Barrister & Solicitor (13 March 2001); E Kkahi, Barrister & Solicitor (13 March 2001), and T Quandt, BCPWA (14 March 2001). Successful claimants have been from countries such as: Egypt, Mexico, Chile, Singapore, Uganda, Philippines, Antigua, St Vincent, Jamaica, and Peru.

[131] [1997] CRDD No 251, No T95-07647 (QL). See also Wilson S. HIV-positive refugee admitted into Canada. *Canadian HIV/AIDS Policy & Law Newsletter* 1995; 1(3): 5.

[132] UN General Assembly Resolution 217 A (III), UN Doc A/810.

[133] Article 17, International Covenant on Civil and Political Rights, (1976) 999 UNTS 171, [1976] CTS 47 (ICCPR).

[134] Article 11(1), International Covenant on Economic, Social and Cultural Rights, (1976), 993 UNTS 3, [1976] CTS 46 (ICESCR).

[135] ICCPR, Article 12(1).

[136] ICESCR, Article 6.

[137] Ibid, Article 12.

[138] Ibid, Article 9.

[139] *Re TNL*, supra, note 131 at para 11.

minority of the population that was *singled out for exclusion* from "lower-level rights." That is, persons with HIV in Poland were systematically being denied rights that other citizens were being allowed. Refugee claimants who come from countries that may not have the resources to provide adequate medical care, housing, and social security for all its citizens, including those who have HIV/AIDS, will likely have more difficulty making a successful refugee claim on that basis.

Minister's Permits

Some persons who are found medically inadmissible under s 19(1)(a) of the *Immigration Act* may apply for a Minister's Permit that would allow them to enter into and/or remain in Canada despite medical inadmissibility.

In most provinces and territories, immigrants who are found medically inadmissible and issued Minister's Permits are not eligible for publicly insured health services.

What Is a Minister's Permit?

A Minister's Permit is a document that allows inadmissible or removable persons to legally enter into and/or remain in Canada for a temporary period. It is issued under the discretionary authority of the Minister of Citizenship and Immigration; no applicant is entitled to receive a permit. From a policy perspective, Minister's Permits are intended for people who are legally inadmissible, but for whom there are compelling reasons to allow them to enter into and/or remain in the country.[140] According to Citizenship and Immigration Canada,

> Minister's Permits may be issued for a variety of reasons, whether the inadmissibility is on technical, medical or criminal grounds. Permits can be issued to facilitate family reunification, protect refugees or bring highly skilled workers to Canada. In all cases, it will have been determined that admitting, rather than barring the person is the appropriate response.[141]

Who Can Be Granted a Minister's Permit?

Refugee claimants whose applications are being processed, applicants for permanent residence, and visitors who are found to be inadmissible may apply for a Minister's Permit. However, there are two exceptions: a family-class immigrant whose sponsor has lost an appeal of a finding of inadmissibility may not apply for a Minister's Permit, nor may persons against whom a removal order has been made.[142]

The *Immigration Manual* provides guidelines to immigration and visa officers on when and how to issue Minister's Permits. It stipulates that permits should only be granted for humanitarian or compassionate reasons, or if it is in the national interest that the person in question be allowed to remain in Canada. Minister's Permits, it is emphasized, should only be issued in special circumstances.[143]

A visa officer or immigration officer who considers recommending the issuance of a Minister's Permit is instructed to begin by ensuring that the risk posed by the applicant to Canadian society is minimal. These risks include any threat to the health, safety, and good order of Canadian society that the person might pose. In the case of persons who are medically inadmissible on "excessive cost" grounds, immigration and visa officers are instructed to consider all factors related to the demands that the individual is likely to place on health or social services. Regarding those who are suffering from communicable or contagious diseases, the Manual states that it must be "guaranteed" that the individual "will not pose a threat to ANYONE encountered en route or in Canada."[144]

[140] *Immigration Manual*, c IP-12/OP-19 at 1.3.

[141] Citizenship and Immigration Canada, News Release 99-23, 29 April 1999 (hereinafter 1999 News Release).

[142] *Immigration Act*, supra, note 7 at s 37(2)(c).

[143] *Immigration Manual*, supra, note 140 at 1.3.

[144] Ibid at 5.2 [emphasis in original].

If the visa officer considers the risks posed to be minimal, the officer may assess the needs of the individual to remain in Canada and balance them against whatever risk is posed. The *Immigration Manual* states that "an inadmissible person wanting to enter or remain in Canada would have to demonstrate a higher level of need than an admissible person…. [T]he need may be compelling enough in the case of a spouse of a Canadian citizen where there is a *bona fide* relationship, whereas the need may be less compelling for distant relatives."[145]

Following an assessment that the needs of an applicant to be in Canada outweigh the risks, an immigration or visa officer may choose to recommend the issuance of a Minister's Permit. When the original reason for inadmissibility was related to the applicant's health condition, the recommendation is then forwarded to the provincial health authorities, if the province to which the person is destined has indicated a desire for such involvement. The province will make a recommendation as to whether a permit should be issued based on public safety, health-care access, and health-care eligibility concerns. While the province's opinion is not binding, Minister's Permits are generally only issued with the support of provincial health authorities.[146]

The Manual emphasizes that "*[a] Minister's permit is a document issued only in special circumstances. It can carry privileges greater than visitor status, therefore great care should be exercised in its issuance*."[147] Indeed, the exceptional nature of the Minister's Permit is evidenced by the fact that the Minister is required to make a report to Parliament indicating the number of permits issued per year and to which inadmissible class the permit holder belongs.[148] While Minister's Permits were once considered a relatively common device for the exercise of ministerial discretion to overcome statutory barriers,[149] the number of permits issued has dropped considerably in recent years from more than 16,000 in 1992[150] to only 2600 in 1998.[151]

What Rights Do Permit Holders Have?

Persons who are admitted to Canada on Minister's Permits are not considered visitors or immigrants, but are simply known as "permit holders."[152] They may remain in Canada for the length of time stated on the face of the permit. Permits may be valid for up to three years, and are renewable.[153] In addition, the federal cabinet may authorize the landing of a person who has resided in Canada for at least five years as a permit holder.[154]

Minister's Permits, however, can be canceled at any time,[155] and they are intended to be temporary in nature.[156] Once a Minister's Permit expires or is canceled, the permit holder can be deported.

Minister's Permits are granted in a wide variety of circumstances. When permits are issued, a "type of case" code is entered on the face of the permit. The "type of case" code indicates whether the applicant originally sought entry as a visitor or for permanent residence. It also indicates whether the applicant is inadmissible for the time being because their file is incomplete or is awaiting an expected approval (known as "early admission" or "under application" cases), or whether the applicant has been refused permanent residence for criminal or security reasons or for medical inadmissibility.

Codes are indicated on the face of the permit, and are used by the province or territory to which the immigrant is destined to determine eligibility for health insurance and social assistance.[157] In most provinces and

[145] Ibid at 4.2.

[146] Communication with R Wallace, Director, Health Insurance Registration, Saskatchewan Health, 27 June 2000.

[147] Supra, note 140 at 1.3 [emphasis in original].

[148] *Immigration Act*, supra, note 7 at s 37(7).

[149] Wydrzynski CJ. *Canadian Immigration Law and Procedure.* Aurora, Ontario: Canada Law Book Limited, 1983, at 347.

[150] Citizenship and Immigration Canada, News Release 97/21, 16 April 1997.

[151] 1999 News Release, supra, note 141.

[152] Supra, note 140 at 1.4.

[153] *Immigration Act*, supra, note 7 at s 37(3) and (4).

[154] Ibid at s 37(5). In the case of permit holders in Québec, the Governor in Council may authorize landing only with the consent of the province: s 38(2).

[155] Ibid at s 37(4).

[156] 1999 News Release, supra, note 141.

[157] *Immigration Manual*, supra, note 140 at 3.7.

territories, immigrants who are found medically inadmissible and issued Minister's Permits are not eligible for publicly insured health services. [See Appendix A for a list of case codes and summary of eligibility for government health insurance in each province and territory.]

International

Many countries have restrictions on the admission of travelers, immigrants, and even refugees with HIV/AIDS. This section will describe various national governments' policies regarding restrictions on the travel and migration of persons living with HIV/AIDS.

United States

United States policy regarding travelers and immigrants with HIV/AIDS has been described as "one of the most unenlightened in the world."[158]

The US Immigration and Naturalization Service currently conducts the largest mandatory HIV-testing program in the world. Every applicant for permanent residence over the age of 15 is required to undergo HIV testing, and largely without informed consent or pre- and post-test counseling.

Furthermore, since 1987, US immigration law has provided for the exclusion on public health grounds of visitors and applicants for permanent residence who are living with HIV. Certain limited classes of people seeking to enter or remain in the US may be eligible for waivers of medical inadmissibility.

Visitors may obtain waivers allowing them to remain in the US for up to thirty days if they are in the US for one of the following reasons:

(a) to participate in academic or health-related activities;
(b) to conduct temporary business;
(c) to seek medical treatment; or
(d) to visit close family members.

Applicants for permanent residence with a spouse, parent or child who is a permanent resident of the US, as well as refugees applying from outside the US, may also be eligible for waivers of medical inadmissibility. However, these applicants must prove the following:

(a) that there are sufficient humanitarian grounds to support the granting of a waiver;
(b) that they will present minimal danger to the public health of the United States; and
(c) that they will impose no cost on any government agency without the prior consent of that agency.[159]

Asylum seekers (refugees) applying from inside the US may not be excluded from the US for medical reasons, in keeping with the principle of *non-refoulement*.

Opposition to the US policy culminated in a boycott of the VI International Conference on AIDS held in San Francisco in June 1990; the threat of another international boycott of the VIII International Conference on AIDS scheduled in Boston in 1992 led its sponsors to move the conference to Amsterdam. While there were attempts by the administration in 1993 to remove the public health exclusion of persons with HIV, Congress quickly responded by passing a bill maintaining the exclusion. HIV thus remains a statutory basis for exclusion until the unlikely event of a repeal by Congress.[160]

United States policy regarding travelers and immigrants with HIV/AIDS has been described as "one of the most unenlightened in the world."

[158] Rubenstein WB, Eisenberg R, Gostin LO. *The Rights of People Who Are HIV Positive: The Authoritative ACLU Guide to the Rights of People Living with HIV Disease and AIDS*. Carbondale and Edwardsville, Illinois: Southern Illinois University Press, 1996, at 315.

[159] See ibid at 315-331 for an overview of United States immigration law as it affects persons living with HIV/AIDS. See also Webber DW (ed). *AIDS and the Law* (3rd ed). New York: Wiley Law Publications, 1997, 471-513 for a more detailed account.

[160] See Webber, ibid at 490.

Australia

Other countries, such as Australia and New Zealand, have immigration policies that more closely resemble the Canadian one. The Australian system allows people with HIV permanent residence in certain circumstances.[161]

Australia does not exclude persons with HIV for public health reasons.

Australia currently includes an HIV test as a part of its medical examination procedure. Therefore, HIV testing is compulsory for applicants for permanent residence or longer-term temporary residence (more than 12 months) who are aged 15 years or older, for refugees applying both from within and from outside the country, and for a minority of short-term entry applicants.[162]

However, a positive test result does not necessarily lead to automatic exclusion. In December 1989, the Australian government issued the following statement as part of its *National HIV/AIDS Strategy* with regard to HIV testing of migrants:

> HIV testing will be required for applicants for permanent residence. This is not intended to have a significant impact on the spread of HIV infection, but HIV infection status, as with other medical conditions, is a factor to be considered when assessing applications on the ground that there are considerable potential costs to the Australian community. A positive result will not automatically exclude applicants from permanent residency; scope will be retained to approve applications where justified by compassionate or other circumstances.[163]

In keeping with this policy, Australia does not exclude persons with HIV for public health reasons. Visitors are therefore not generally excluded. However, applicants for permanent residence living with HIV/AIDS and other persons who are expected to remain in Australia and use its services may be denied permanent residence due to costs that they are expected to impose on Australian social and medical services as a result of their condition.

In order to determine whether an applicant's potential cost to Australian government-sponsored services is enough to warrant exclusion, an applicant's potential cost is compared to a threshold of approximately A$16,000 over five years. However, if applicants are unlikely to incur immediate costs, but can be expected to incur costs in the foreseeable future totaling over approximately A$240,000, then they may also fail the medical test. As a result, even HIV-positive applicants who are in present good health are likely to fail the medical test.[164]

Those who fail the medical test can apply to an Australian migration officer for a waiver. Waivers are available only for spouses, de facto spouses, gay or lesbian partners, or children of Australian citizens or permanent residents, as well as for persons making refugee and humanitarian applications. If an applicant in any of these classes does not meet the usual health requirements, the Department of Immigration and Ethnic Affairs (DIEA) has an obligation to consider the question of whether to waive the health requirements. In making this decision, the DEIA must weigh the estimated costs (a "negative factor") against the positive factors identified in the application, including any compelling or compassionate or humanitarian grounds. Wealth is not normally considered a "positive factor," nor can one opt out of future medical care. If the positive factors are stronger, the decision-maker may waive the health requirements and grant the visa.[165] Note, however, that even if a person is a refugee, they must still apply for a waiver of the health

[161] See Jürgens R. Australia: allowing people with HIV permanent residence. *Canadian HIV/AIDS Policy & Law Newsletter* 1996; 2(3): 16-17, with reference to Alexander M. HIV and permanent residence. [Australian] *HIV/AIDS Legal Link* 1995; 6(2): 8-10. Parts of the following text are taken from Alexander's article. See also New Zealand AIDS Foundation. Refugees, HIV and Immigration: Comparison of New Zealand's HIV/AIDS Immigration Proposal with Australia, January 2000 (on file), from which parts of the following text are also taken (hereinafter NZAF Comparison).

[162] Applicants for short-term entry may be required to undergo medical examinations if it is thought their health is of special significance to their work or lifestyle (for example if they work in a classroom, in healthcare, food processing, hospitality) or where there are other indications they might not meet health requirements.

[163] Jürgens, supra, note 2 at 203.

[164] NZAF Comparison, supra, note 161.

[165] Ibid. See also Jürgens, supra, note 2 at 203.

requirement, which theoretically could be refused, meaning the refugee could be removed from the country.[166]

According to the Australian Federation of AIDS Organisations (AFAO), the policy appears to be working satisfactorily. The Federation is not aware of any applicant since early 1994 who has been refused permanent residence solely on the basis of having HIV. Applications have been approved in the following circumstances: husbands and wives of Australian citizens and permanent residents; gay partners of Australian citizens and permanent residents; children of Australian citizens and permanent residents; and refugees.[167]

It is important to note that that those testing HIV positive are still assessed as to their likely cost, rather than immediately failed. In this sense, applicants with HIV are considered in the same way as applicants with other disabilities, such as heart disease. However, there are still many people with HIV who are otherwise qualified to migrate who cannot possibly qualify for residence under the present law because they are expected to impose excessive costs and are not eligible for waivers.

New Zealand

In New Zealand, mandatory HIV testing of immigrants has recently been introduced by the Ministry of Immigration despite opposition from immigrant and HIV/AIDS rights groups,[168] and in the face of opposition from the Ministries of Health, Foreign Affairs and Trade, Social Policy, Internal Affairs, and Labour, and the Crown Law Office.[169] As of 1 July 2000, all applicants who intend to stay in New Zealand for two years or more, including refugees, are required to submit to mandatory HIV testing. Refugees at or within New Zealand's borders are not excluded based on their medical condition. However, all other applicants with HIV who seek residence for more than two years may be excluded if they are expected to make demands on health services in excess of approximately NZ$20,000 over five years. As in Australia, the assessment is conducted on a case-by-case basis. In addition, persons with HIV who seek to enter New Zealand could theoretically be excluded on public health grounds; unlike Australia, New Zealand has not declared that persons with HIV are not a "public health risk." Some ministerial waivers of medical inadmissibility are contemplated in New Zealand's immigration scheme, but unlike in Australia, these are used only exceptionally.[170]

European Union

Article 14 of the European Community Treaty provides for the removal of all internal frontiers among member states and ensures the free movement of persons within the European Union. Article 2-1 of the Convention implementing the Schengen agreement (which was signed by every EU member state with the exception of the UK, Ireland, and Denmark) ensures that internal borders may be crossed at any point without controls. As a result, internal borders may be crossed by EU-country citizens as well as citizens of other countries without restrictions of any kind, including health-related restrictions.[171] Non EU–country nationals, however, have an onus upon them to make a declaration as to their nationality and their entry into the country when they travel among Schengen signatory states.[172]

According to a European Community directive, member states may refuse residence or refuse entry to Union citizens arriving from non-EU countries on grounds of public health.[173] The directive, which was issued in

[166] Department of Immigration and Multicultural Affairs. DIMA Fact Sheet 2: Health Checks to Enter Australia. 13 September 1999. (Available at www.immi.gov.au/facts/22health.htm, accessed 13 January 2001).

[167] Ibid.

[168] New Zealand Aids Foundation. Mandatory Testing and Exclusion of HIV Positive Immigrants and Refugees (April 1999): on file.

[169] Office of the Minister of Immigration. Paper: HIV Testing Quota Refugees (CAB (99) 653), 5 October 1999; Office of the Minister of Immigration. Paper: HIV/AIDS: Testing Residence Applicants and Quota Refugees (CAB (99) 690), 15 October 1999.

[170] NZAF Comparison, supra, note 161.

[171] Carlier JY. *The free movement of persons living with HIV/AIDS* at para 30 (available at http://europa.eu.int/comm/development/aids/html/freemov_en.htm).

[172] Art 22; see ibid at para 22.

[173] Directive 64/221.

1964, contains a list of medical conditions that may support a public health exclusion. Obviously, the list does not include HIV. Any countries that have enacted public health exclusions pursuant to this directive have reproduced or partially reproduced the list contained in the directive, and no country has added HIV. As a result, citizens of one EU country are not denied entry into other EU countries for being HIV-positive, nor are they generally refused permanent residence solely on that ground.[174]

Thus, there are currently no HIV-related restrictions on short-term travel or choice of residence within the EU for citizens of European Union states.

Refugees are generally not required to submit to mandatory HIV testing in European Union states.[175] In addition, all EU countries (with the exception of Bavaria, a German *Land*) respect the principle of *non-refoulement* and do not return refugees on health grounds.

With regard to nationals of non-EU states, each EU country determines its own policy independently. The policies of Germany, France, and the UK are examined below.

France

France does not require mandatory HIV testing of travelers, immigrants, or refugees.[176] As a result, there is no restriction on short-term travel to France for persons with HIV. Travelers who plan to stay more than three months are, however, required to undergo a medical examination, and HIV testing may be required as part of the examination if the applicant shows clinical signs of HIV infection.

France does not require mandatory HIV testing of travelers, immigrants, or refugees.

French law stipulates that foreigners do not fulfil the health requirements for obtaining residence if they are suffering from plague, cholera, yellow fever, active pulmonary tuberculosis, drug addiction, or mental disorder. However, a December 1987 government circular concerning the health inspection of foreigners wishing to stay in France stipulates that the existence of positive serology for HIV, in the absence of clinical signs, does *not* constitute a ground for refusing a right of residence. This has generally been interpreted as meaning that the mere presence of HIV cannot, in itself, justify a refusal to grant residence, though some have expressed concern that the requirement could be read as stating that residence *may* be refused when clinical signs *are* present.[177] Nonetheless, in order to be granted residence, an applicant with HIV would still be required to meet the usual conditions for the granting of residence imposed on all applicants.

Other than tourists, all foreigners residing in France (including those without official residence permits) have the same right to health care as French nationals.[178]

Germany

The German *Aliens Act*[179] does not require medical examinations for entering the country. Although a circular from the Minister of the Interior of the Federal Republic of Germany previously authorized border police to refuse entry to the territory of persons suspected of suffering from AIDS, that circular is no longer in application.

Normally, the granting of German residence does not depend on a prior medical examination, and consequently there is no routine HIV testing of persons seeking long-term residence. However, German law does authorize refusal of a residence permit if the applicant is suffering from a contagious disease, and will request a medical certificate if this appears to be the case. HIV is considered a contagious disease under the federal law on epidemics.

[174] Carlier, supra, note 171 at para 35 et seq and 63.

[175] Ibid at para 71.

[176] Ibid at para 131.

[177] Ibid at para 138.

[178] Ibid at para 141.

[179] *Aliens Act* (Auslandergesetz) of 9 July 1990 (BGBl, at 1354) (1994 version: BGBl, I, at 3186), cited in Carlier, supra, note 171 at para 103 et seq.

In practice, therefore, persons with HIV can be refused permanent residence on public health grounds if they show symptoms of HIV infection, are consequently required to submit to a medical examination, which may include an HIV test, and are found to be HIV-positive.[180]

The *Land* of Bavaria, however, provides an exception to this general policy of not routinely requiring HIV testing, and has enacted several measures aimed at preventing foreigners with HIV/AIDS from residing in Bavaria. It is the *Länder* that establish the conditions for the medical certificate to be provided. Bavaria requires mandatory screening of all foreigners wishing to stay in Bavaria for more than three months, with the exception of EU citizens and nationals of a handful of other countries.[181] There may be exceptions to the screening requirement for people with special links to Germany, such as marriage to a German national. Those who are HIV-positive may still be granted a residence permit provided they give assurance that they will not spread the disease. Once a permit is obtained despite seropositivity, it can be rescinded at any time at the discretion of immigration authorities, who will take into account the foreigner's ties with Germany, family ties, and length of residence. The European Commission has condemned Bavaria's policy as contravening the principle of free movement of persons.[182]

United Kingdom

Non-EU citizens seeking entry to the UK may be examined by a medical inspector, but there is no mandatory HIV testing as part of the medical examination. When immigration officials are aware that the person seeking temporary entry is suffering from AIDS, the person will not be automatically excluded on public health grounds or on the ground of costs that they might be expected to impose. However, if it appears for some specific reason that public health may be at risk, advice would be sought from the Department of Health, and the applicant could be excluded. Furthermore, an applicant for short-term entry who is known to be HIV-positive must prove that they have sufficient means to pay for medical treatment while in the UK.[183]

Persons with HIV/AIDS are permitted to enter the country to seek treatment, provided they can show that the treatment will be of finite duration; that they have the intention of leaving the UK after the treatment is complete, that they can pay for the treatment, and that, in the case of communicable diseases, there is no danger to public health.[184]

Non-EU citizens seeking to reside in the UK for the long term (more than six months) must report to a medical inspector. If the inspector finds that a foreigner is suffering from an illness that might affect their ability to support themselves and their family (as HIV/AIDS may be), this will be taken into account in deciding whether to grant a right of residence. There is, however, no financially based automatic exclusion, nor is there any public health–based exclusion for persons with HIV/AIDS.[185]

It should be noted that EU citizens cannot be refused residency in the UK based on insufficient resources, as they are not, in principle, subject to the system of prior authorization for entry or residence in the territory.[186] While they can be excluded for public health reasons, as discussed above, HIV/AIDS is not considered a disease that warrants a public health exclusion.[187]

[180] Ibid at 104.

[181] Andorra, Iceland, Liechtenstein, Malta, Monaco, San Marino, Switzerland, and Norway. See Carlier supra, note 171 at para 111.

[182] Ibid at para 107.

[183] Ibid at para 208.

[184] Ibid at para 212.

[185] Ibid.

[186] *Immigration Act* 1988 (1988, c 14), s 7 (Persons Exercising Community Rights and Nationals of Member States).

[187] See Carlier, supra, note 171 at para 221.

New Directions

A Review of Immigration Law and Policy

Citizenship and Immigration Canada has been planning a major restructuring of its immigration and refugee policy, laws, and regulations. Since it was first passed in 1976, the *Immigration Act* has been amended over 30 times, but it has never been subject to a comprehensive review. In 1996, the Legislative Review Advisory Group was appointed to evaluate Canada's immigration system. The Group submitted a report to the Minister of Citizenship and Immigration that included 172 recommendations for reform.[188] The then Minister of Citizenship and Immigration, Lucienne Robillard, responded in 1998 by publishing a document outlining the broad directions of the proposed reform.[189] Elinor Caplan, Minister of Citizenship and Immigration, followed up in April 2000 by tabling Bill C-31, the *Immigration and Refugee Protection Act*. Parliament was dissolved for general elections held in November 2000, which returned the same party to government. With some minor changes as a result of public input, the legislation was re-introduced into the new Parliament in February 2001 as Bill C-11. If passed, this will replace the current *Immigration Act*. At the same time as the framework legislation is being proposed, the accompanying regulations and administrative procedures are being developed, and the immigration program's medical screening procedures are being reviewed.

Changes to the Immigration Act (and Regulations)

The proposed legislation and regulations would have a significant impact on Canada's immigration policy, and the Minister has invited comment on these new developments. There are a number of changes contemplated in both the proposed new Act and the accompanying regulations (which have

[188] Immigration Legislative Review. *Not Just Numbers: A Canadian Framework for Future Immigration.* Ottawa: Minister of Public Works and Government Services Canada, 1998.

[189] See supra, note 8.

yet to be fully developed) that would affect people with HIV/AIDS. Some of these are positive changes, but some are cause for serious concern. Five major areas of change are discussed here.

(1) First, slight changes in the wording of the provision on medical inadmissibility could (but should not) weaken the requirement for individual, case-by-case assessment of likely demands.
(2) Second, exemptions from the medical inadmissibility provision have improved, but some concerns remain.
(3) Third, the possibilities for directly granting permanent residence on humanitarian and compassionate grounds have expanded, which could be of benefit to people living with HIV/AIDS.
(4) Fourth, as mentioned above, HIV testing may soon become a mandatory component of the medical examination given to all immigrants.[190] In April 2001, the Minister of Health, in a letter to the Minister of Citizenship and Immigration, reaffirmed that mandatory testing is necessary, but emphasized that there are no public health reasons to exclude those testing HIV-positive from immigrating to Canada.[191] The background to this proposal is presented here, and the next section of the report analyzes it in detail.
(5) Finally, in the regulations accompanying Bill C-11, Citizenship and Immigration Canada plans to define "excessive demand" on health or social services in relation to a five-year window "unless reasonable evidence indicates that significantly longer-term costs are likely to occur," in which cases "the assessment window may be extended, though rarely beyond ten years." In addition, it is planned to compare costs "to the average annual cost of health and social services for Canadians (currently $2800 annum), multiplied by the number of years for the assessment window."[192] For many reason, such a definition is of serious concern for people living with HIV/AIDS (and for all other people living with chronic, life-threatening diseases).

Each of these areas is discussed below.

Changes to the Wording of the Medical Inadmissibility Provisions

The provision governing inadmissibility has been reworked for the proposed legislation and generally appears to maintain the existing grounds for medical inadmissibility. However, it has become more vague, and could be read as derogating from the principle that each applicant must be assessed on a case-by-case basis.

As already noted above, the medical inadmissibility provision in the current *Immigration Act* states:

> 19. (1) No person shall be granted admission who is a member of any of the following classes:
>
> (a) persons who are suffering from any disease, disorder, disability or other health impairment as a result of the nature, severity, or probable duration of which, in the opinion of a medical officer concurred in by at least one other medical officer,
>
> (i) they are or are likely to be a danger to public health or to public safety, or
> (ii) their admission would cause or might reasonably be expected to cause excessive demands on health or social services.

[190] Clark, supra, note 11.

[191] Previously, Health Canada had identified exclusion of all persons who test positive as the preferred public health approach (see Health Canada Report, 26 November 1999, Annex 3, Montebello Process; on file). After further analysis of the issues and extensive consultations, this position was however changed.

[192] Citizenship and Immigration Canada. Bill C-11. *Immigration and Refugee Protection Act*. Explanation of Proposed Regulations. Prepared for members of the House of Commons Standing Committee on Citizenship and Immigration. Ottawa, CIC, March 2001, section on "definition of excessive demand" (available via www.cic.gc.ca).

The proposed replacement of that provision in Bill C-11 reads as follows:

> 38. A foreign national, other than a permanent resident, 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.

"A finding of medical inadmissibility cannot be premised solely on the medical condition under review; rather, the individual applicant's personal circumstances must be carefully reviewed."
– *Lau* v *Canada*, 1998

Case law under the existing provision has affirmed that an individualized assessment is required in evaluating medical inadmissibility under the current *Immigration Act*.[193] For example, in *Lau* v *Canada (Minister of Citizenship and Immigration)*, the court ruled that "[t]he jurisprudence has clearly established that a finding of medical inadmissibility cannot be premised solely on the medical condition under review; rather, the individual applicant's personal circumstances must be carefully reviewed."[194]

The language of section 38 of Bill C-11 refers to a foreign national's "health condition" without any further clarification or definition. The wording of this provision could be interpreted to allow for the automatic exclusion of persons with particular medical conditions, regardless of other personal circumstances. As discussed above, the concern has already been raised (and taken seriously by the courts) that the case codes currently used by examining physicians should not lead to applicants being deemed inadmissible solely on the basis of the illness or disability they have, precluding an individual, case-by-case assessment.[195] The wording of the new legislation could encourage such improper fettering of the medical officer's discretion.

However, this should not (and likely would not) happen. Citizenship and Immigration Canada has stated that this provision "maintains the existing inadmissibility grounds for medical reasons."[196] And the basic principle of fairness that underlies the existing requirement for individual assessments under the current Act would be just as applicable under the new legislation. However, it would be best to err on the side of caution, given that lack of clarity can have a significant impact on the person being assessed: Citizenship and Immigration Canada must ensure clear written policy instructing all examining medical and immigration/visa officers that under any provisions regarding medical (in)admissibility in new legislation, the requirement for individual, case-by-case assessments of medical (in)admissibility remains.

Exemptions from "Excessive Demand" Criterion: Improved but Not Perfect

Expanded Exemptions for Certain Family Members and Refugees Welcome

Under the proposed new Act and regulations, it is planned that the following persons would be exempt from inadmissibility to Canada based on "excessive demand" on health or social services:

- the family class spouse, common-law partner or child of a Canadian citizen or permanent resident; and
- Convention refugees in Canada, overseas Convention refugees, and persons in need of protection (and their dependants).

In a few key respects, this expands the category of people who are exempt

[193] See, eg, *Poste*, supra, note 33; see also *Lau*, supra, note 33; and other cases cited above.

[194] Supra, note 33.

[195] Eg, see *Ajanee*, supra, note 77; *Ludwig*, supra, note 80.

[196] Citizenship and Immigration Canada. *Immigration and Refugee Protection Act* (Bill C-31): Clause by Clause Analysis. June 2000, at 30. New Bill C-11 available at www.cic.gc.ca; see supra, note 6.

from the excessive demand barrier to entry into Canada. In a statement accompanying the planned changes, Citizenship and Immigration Canada offers several rationales for this change.

First, under the current system,

> A significant number of excessive demand–based refusals of sponsored family class spouses and dependants are overturned on appeal to the IAD on humanitarian and compassionate grounds and immigrant visas are subsequently issued. In other cases, Minister's permits are issued to allow the spouse or child to enter and remain in Canada. Thus, many family class sponsored spouses and dependants, deemed medically inadmissible on excessive demand grounds, are already entering Canada as permanent residents or with the possibility of eventually obtaining permanent residence.[197]

Those exempted from medical inadmissibility based on excessive demand would still be subject to inadmissibility if their health condition represents a threat to public health or to public safety.

Creating a general exemption for refugees and for certain family-class immigrants would therefore result in greater efficiency and uniform treatment among family-class immigrants. It would also provide support for Canada's commitment to family reunification.[198]

Second, the Minister is seeking equality in the application of medical assessment criteria for Convention refugees whether they are in Canada or overseas. She has stated:

> The exemption is in keeping with Canada's humanitarian stance towards refugees and is key to giving meaning to the policy of making the need for protection the overriding objective in resettlement from abroad…. It would be inconsistent to accept that a person is in need of protection and then render them inadmissible because they would cause excessive demands on health services.[199]

Those exempted from medical inadmissibility based on excessive demand would still be subject to inadmissibility if their health condition represents a threat to public health or to public safety. As mentioned above, since 1991 persons with HIV have not been considered to be a threat to public health. If that view continues (as it should), refugees, family class–sponsored spouses and dependent children, overseas Convention refugees, as well as persons in need of protection and their dependants, would not be excluded from Canada based on HIV seropositivity or a diagnosis of AIDS under the proposed regulations.

However, had Citizenship and Immigration Canada, based on the initial advice provided by Health Canada in August 2000, decided to exclude persons with HIV on public health grounds, everyone known to be HIV-positive would have been excluded. This would have been contrary to what Minister Caplan stated on 20 September 2000, when she said that refugees who come to Canada because they fear persecution in their homelands, or immigrants who already have close family members in Canada, would not be banned from entering Canada even if HIV-positive.[200] At the time of writing, Citizenship and Immigration Canada had not taken a final decision, but it seemed unlikely that persons with HIV would be considered to be a threat to public health. If the Minister of Health's final advice of April 2001 is followed, HIV-positive people belonging to the groups exempted from medical inadmissibility based on excessive demand will not be excluded from Canada based on their HIV status.

[197] Citizenship and Immigration Canada. Immigration and Refugee Protection Act – Issue Paper 4. March 2001: 1. Available at www.cic.gc.ca.

[198] *Immigration Act*, supra, note 7 at s 3(c).

[199] Supra, note 196.

[200] Thompson, supra, note 51.

Same-Sex Partners

In a welcome move, the government has recognized that the "family class" of immigrants must include not only married spouses, but also common-law partners, and that same-sex couples must be included in the category of common-law partners. Common-law partners are expressly referred to in Bill C-11 (s 12). According to Citizenship and Immigration Canada, the proposed regulations require persons to have cohabited in a conjugal relationship for one year in order to be considered common-law partners.[201]

The government has also stated that the regulations will "be sensitive to the needs of same-sex couples who cannot live together in the country of origin." Specifically, it has said that the regulations will provide that "an individual who has been in a conjugal relationship with a person for at least one year, but has been unable to cohabit with the person due to exceptional reasons such as persecution or any form of penal control, may be considered a common-law partner of the person."[202]

However, placing such provisions in regulations, as opposed to the Act itself, means they can be easily changed by the government of the day, without having to go through the process of amendments introduced and debated in Parliament. A core concept such as who has access under the "family class" should be defined in the Act itself, rather than in the regulations. The term "common law partner" in Bill C-11 should therefore be replaced by the phrase "common law partner (same-sex or opposite-sex)."

Furthermore, as the Ottawa-based organization EGALE has pointed out in its brief of 27 March 2001 to the House of Commons Standing Committee on Citizenship and Immigration, there is concern with the proposed definition of "common law partner" as "a person who is cohabiting in a conjugal relationship with another person, having so cohabited for a period of at least one year:"[203]

> [I]t is inappropriate in the immigration context to treat cohabitation as a prerequisite for a qualifying relationship.
>
> In practice, couples in *bona fide* relationships may not cohabit for a wide variety of reasons, including discrimination, cultural, social and financial factors. The most common scenario will be same-sex partners who are unable to live together due to visa restrictions or their immigration status. Couples will be in a cruel Catch-22 position if they are separated by immigration difficulties and thereby precluded from fulfilling the one prerequisite they need to overcome their immigration difficulties. Many of these couples are currently admitted to Canada on humanitarian and compassionate grounds and, ironically, would be worse off under a regime where they are disqualified from the family class.
>
> Even those couples able to live in the same country may not cohabit for straightforward and legitimate reasons, such as the need for one partner to study in a different city, to work elsewhere or to attend language training in a different part of the country. It would be wholly unjust if couples maintain a *bona fide* relationship and take every opportunity to spend weekends and other time together, but are precluded from meeting the requirements of the family class by unreasonably high prerequisites.

[201] Citizenship and Immigration Canada. Bill C-11. Explanation of Proposed Regulations, supra, note 192.

[202] Ibid, section on "common-law partners" under "family class sponsorships."

[203] EGALE. Brief to the House of Commons Standing Committee on Citizenship and Immigration. Bill C-11: the *Immigration and Refugee Protection Act*. Ottawa: EGALE, 27 March 2001 (available at www.egale.ca/documents/c-11committeebrief.htm). See also the Canadian HIV/AIDS Legal Network's original submissions (dated 26 September 2000) on the proposed regulations under the new Act (then Bill C-31), including discrimination against "de facto" partners, which can be found at www.aidslaw.ca/Maincontent/issues/Immigration/BillC-31comments.htm.

As mentioned above, the proposed regulations make some provision for an individual who has "been in a conjugal relationship with a person for at least one year," but has been unable to cohabit "due to exceptional reasons such as persecution or any form of penal control." This recognizes that some lesbians, gay men, bisexual and transgendered people live in countries where they are unable to cohabit for fear of persecution, but appears to set a very high threshold and does not cover a variety of other situations in which people in genuine relationships do not cohabit.

According to EGALE,

> the goal should be to identify *bona fide* relationships, and it should be sufficient to define a common-law partner as someone who has "maintained a conjugal relationship with another person for a period of one year." The submission of written materials documenting the legitimacy of the relationship has worked well for the past 7 years without any real practical difficulties based on fraud. In practice, couples maintaining a *bona fide* long-distance relationship frequently have ample evidence in the form of photographs, letters, testimonials, phone bills, proof of visits etc to support the bona fides of the relationship.
>
> The proposed regulations will create a hierarchy of relationships, irrespective of the *bona fides* of the relationship. Married opposite-sex spouses and those who are engaged to be married automatically qualify under the family class without needing to satisfy any cohabitation requirement. By contrast, same-sex couples, with no current capacity to marry or become engaged, will be denied access to the family class irrespective of the *bona fides* or duration of their relationship, unless they can meet a cohabitation requirement or meet the high threshold for inability to cohabit.
>
> As a result, cohabitation is not a prerequisite for all opposite-sex couples, and may be unattainable by many same-sex couples due to practical, financial, social or other reasons. There seems to be little constitutional or policy justification for distinguishing between different classes of relationship, each of which is equally genuine. In EGALE's view, the proposed hierarchy of relationships would invite a challenge under the *Charter of Rights.*[204]

Finally, EGALE points out that it is not clear what constitutes one-year cohabitation:

> Given that many couples are separated by immigration restrictions, is it sufficient for the partners to visit each other in their respective home countries for extended periods within a one-year time-frame? Must they actually be domiciled together in one country? How much time apart can they spend before they are deemed to be no longer cohabiting?

As EGALE states:

> These are questions a married or engaged heterosexual couple will not need to address. The same criteria should apply to all couples, whether married or unmarried, heterosexual or same-sex. Heterosexual fiancé(e)s are not required to cohabit or maintain a relationship for a specific duration. Equality requires that any

[204] Ibid.

provisions available to opposite-sex couples be available to same-sex couples.

EGALE therefore urged the Standing Committee on Citizenship and Immigration to recommend that, in developing regulations:

- the one-year cohabitation requirement be removed, and a common-law partner be defined to include a person who has maintained a *bona fide* conjugal relationship with another person for a period of one year;
- if the cohabitation requirement is retained, the threshold of the exemption for couples unable to live together be at least broad enough to cover couples separated by reason of immigration; and
- care be taken to ensure that every provision applicable to opposite-sex "spouses" and fiancé(e)s is equally available to "common-law partners."[205]

The current practice of allowing persons to remain on Minister's Permits, but then denying them access to the public health system, calls into question the very principles of humanitarianism and compassion that are the reasons for granting the permit in the first place.

If implemented, EGALE's recommendations would, among other things, clarify that HIV-positive prospective immigrants who have maintained a *bona fide* conjugal relationship with a Canadian sponsor for a period of one year would be exempted under the proposed new medical inadmissibility provision in Bill C-11 (s 38) from the "excessive demand" barrier to immigrating to Canada.

Granting Permanent Residence Based on Compassionate and Humanitarian Considerations

Section 25 of the proposed *Immigration and Refugee Protection Act* allows the Minister to grant permanent resident status (or an exemption from any part of the Act) to a "foreign national"[206] who is inadmissible or does not meet the requirements of the Act "if the Minister is of the opinion that it is justified by humanitarian and compassionate considerations relating to them, taking into account the best interests of a child directly affected, or by public policy considerations."

This marks a positive change from the current Act, which allows the Minister to grant landing on compassionate and humanitarian considerations only to members of classes prescribed under the regulations.[207] This new section could be used to grant landing directly to otherwise inadmissible persons with HIV who are not eligible to appeal to the Immigration Appeal Division on humanitarian and compassionate considerations.

It could also be used to grant an otherwise inadmissible person permanent resident status immediately, without requiring them to apply for and receive a succession of Minister's Permits over a five-year period, with the accompanying disenfranchisement from most health or social services.[208] This would be consistent with granting landing on humanitarian and compassionate grounds. It would represent an improvement over the current half-hearted practice that allows a person to remain in Canada on a Minister's Permit but in limbo for years, with no or limited access to public health care or social services and no certainty about their future status in the country. This current practice of allowing persons to remain on Minister's Permits, but then denying them access to the public health system, calls into question the very principles of humanitarianism and compassion that are, according to Citizenship and Immigration Canada, the reasons for granting the permit in the first place.[209]

It should be remembered that in the case of "humanitarian and compas-

[205] Ibid.

[206] "Foreign national" is defined as any person who is not a Canadian citizen, including a stateless person (who technically does not have a nationality): Bill C-11, s 2.

[207] *Immigration Act*, supra, note 7 at s 6(5).

[208] It should be noted that the proposed Act would also allow an immigration officer to issue a "temporary resident" permit, which may be canceled at any time, to an otherwise inadmissible person if the officer "is of the opinion that it is justified in the circumstances": Bill C-11, s 24(1). This would, in essence, be equivalent to the current practice under the present Act of issuing a Minister's Permit – it would not confer the entitlements of permanent residence, such as access to public health care.

[209] *Immigration Manual*, supra, note 140 at 1.3.

sionate" appeals to the Immigration Appeal Division by a person who is medically inadmissible, it has been ruled incorrect[210] (and is arguably unconstitutional) for the adjudicator to take into account the possible health-care demands of the person in deciding whether there are sufficiently compelling humanitarian and compassionate reasons to allow the person to immigrate. The same considerations should apply to the Minister in exercising such discretion under the new provision proposed in Bill C-11; the question is whether there are humanitarian and compassionate considerations, not the possible cost to the health-care system that the person may represent.

Plans to Change the Medical Screening Procedures

The exemption of certain classes of immigrants from medical inadmissibility based on excessive demand would enable certain immigrants with HIV/AIDS to enter Canada, and is welcome. But policies threaten to become more restrictive in other ways.

In particular, as mentioned above, HIV testing may soon become a mandatory component of the medical examination given to all immigrants. Minister Caplan first announced on 20 September 2000 her intention to institute mandatory testing of all prospective immigrants.[211] At the time, she stated that it was being considered to exclude those who test positive for HIV (with the exception of refugees and the spouses and children of people already admitted to Canada) on both public health and "excessive cost" grounds. This would have marked a significant change in Canada's policy with respect to HIV/AIDS, which since 1991 has not treated persons with HIV as a threat to public health simply because they are HIV-positive. At the time of going to print, it seemed, however, more likely that HIV testing would become mandatory, but that those testing positive, after receiving counseling, would not be excluded on public health grounds.

Health Canada undertook focus groups in order to assess possible public reactions to mandatory HIV testing and exclusion of those who test positive.

Background

Since the early preparation stages of the reforms, Citizenship and Immigration Canada has been planning to change the immigration program's medical screening procedures.[212] Specifically, it has been seeking advice from Health Canada on "which medical screening procedures are required to protect public health,"[213] as Health Canada currently has responsibility for all aspects of national health policy, including the determination of what diseases constitute threats to public health. At the same time, in early 2000, the Auditor General released a report that criticized Citizenship and Immigration Canada's current medical screening procedures and expressed concern that there is currently no universal testing for HIV and hepatitis.[214]

The Montebello Process

In September 1995, representatives from Health Canada and Citizenship and Immigration Canada met at Château Montebello to discuss the development of new medical screening and risk-assessment procedures. A technical working group under the supervision of Health Canada was established following that meeting. The working group developed a risk-assessment approach that, according to its designers, "uses decision tree methodology as the underlying scientific process to examine the rationale for medical screening"[215] of infectious diseases. This new approach was dubbed the "Montebello Process."

Specifically, the Montebello Process analyzes the public health risks posed by certain diseases by estimating the degree to which a given disease will spread through the population from a given source. In determining spread, the analysis takes into account various disease-specific factors, such as mode of transmission (eg, can the disease be transmitted through casual contact?

[210] *Kirpal*, supra, note 89; *Ludwig*, supra, note 80.

[211] Clark, supra, note 11.

[212] Supra, note 8 at 55.

[213] Ibid at 55.

[214] 2000 Report of the Auditor General of Canada, Chapter 3: Citizenship and Immigration Canada: The Economic Component of the Canadian Immigration Program; available at www.oag-bvg.gc.ca/domino/reports.nsf/html/00menu_e.html.

[215] Health Canada Report, November 26, 1999, supra, note 191.

sexually transmitted? transmitted from mother to child?); period of communicability; infectivity; and susceptibility of the population (eg, has the local population been vaccinated against the disease?).[216]

Some factors must be estimated or assumed in the application of the Montebello analysis. For example, in order to determine the likely spread of HIV from one migrant in the Canadian population, the analyst might estimate the number of times the average person might be likely to engage in unprotected sex, or the likelihood that the average prophylactic on the market will be ineffective.[217] An underlying *assumption* used in the Montebello model was that an immigrant to Canada who is HIV-positive will spread the virus to, on average, one other person already resident in Canada.[218]

There are serious concerns about the manner in which the focus group sessions were conducted and the accuracy of the information that participants were given.

The Montebello Process was used to compare the public health outcomes of what Health Canada claimed to be "only possible options."[219]

(1) No screening to identify the infected individual.
(2) Identification of the infected individual and exclusion from entry of the infected individual.
(3) Identification of the infected individual but inclusion for entry with the implementation of certain public health interventions.

The current practice of asking applicants if they have ever tested positive for HIV, of testing only when there are clinical indications to do so and of excluding only in cases of "excessive costs," was not considered or assessed using the Montebello Process.

According to the Montebello Process, mandatory HIV screening of all prospective immigrants and exclusion on that basis was considered the best way to protect public health, "as there can be no spread from persons who are excluded."[220] Health Canada's report indicated that requiring screening but allowing entry provided each person identified as HIV-positive undergo counseling on reducing risk behaviour would be the second most desirable policy.

Focus Groups to Evaluate Public Opinion on Proposals for Mandatory Testing and Exclusion

Health Canada undertook focus groups in order to assess possible public reactions to mandatory HIV testing and exclusion of those who test positive. The focus groups were not satisfied with the current screening process as it was presented to them and supported mandatory HIV testing and exclusion of all immigrants who test positive.[221]

However, judging from the available reports and summaries of the focus group sessions, there are some serious concerns about the manner in which the focus group sessions were conducted and the accuracy of the information that participants were given.

First, participants were not accurately informed about current practice with regard to HIV testing. There was no mention that the medical questionnaire currently used contains a question about whether the person has tested positive for HIV, and that it is at the discretion of the examining physician whether to require an HIV test or not. Instead, participants were told that "in some countries, doctors can ask for HIV/AIDS testing to be done. However, this is not consistent, and Canada has no policy on what to do if someone tests positive."[222] In fact, since 1991 Canada has not considered prospective immigrants with HIV to be a public health risk, but has routinely excluded them on "excessive cost" grounds.

Second, participants may not have accurately understood the options

[216] Communication with Quarantine and Migration Health, Centre for Emergency Preparedness and Health Security, Population and Public Health Branch, Health Canada, 27 July 2000.

[217] Ibid.

[218] Letter from Quarantine and Migration Health, Centre for Emergency Preparedness and Health Security, Population and Public Health Branch, Health Canada, dated 16 November 2000, on file.

[219] Supra, note 191.

[220] Ibid.

[221] Angus Reid Group. Health Canada – Migrant Screening: Final Report, November 1999 [on file].

[222] Ibid at 14.

open to Citizenship and Immigration Canada. Health Canada only advises on whether HIV screening should become mandatory for public health reasons. Independent of this advice regarding public health, it is still open to Citizenship and Immigration Canada to choose to exclude some immigrants based on excessive cost. According to the report of the consultants hired to run the focus groups, this issue of costs was reportedly the primary concern of focus group participants.[223] Yet without a clear understanding of Canada's current practice of generally excluding would-be immigrants with HIV on "excessive cost" grounds, the focus group participants may have concluded that if they did not endorse mandatory screening and exclusion of all immigrants testing positive, all immigrants with HIV would be permitted to immigrate.

Had the participants been better informed about current policy and about the distinction between exclusion based on public health grounds and "excessive cost" grounds, they may have responded differently to the survey. Consequently, the conclusions reached by the focus groups should be disregarded.

In addition to concerns about *how* the focus groups were conducted, there are concerns about *why* they were conducted. Health Canada's mandate was to assess the public health risks created by various policies regarding different communicable diseases, and to advise Citizenship and Immigration Canada of the wisest course of action in that regard. Public opinion regarding choice of policy should not have entered into Health Canada's analysis of the consequences of the various policy options open to Citizenship and Immigration Canada. Not only is it irrelevant to the "scientific" Montebello process, it also suggests that the rights and interests of immigrants and people living with HIV/AIDS can or should legitimately be determined or influenced by public opinion (ill-informed opinion in this case), which is ethically suspect.

Additional Analysis and Consultation

As mentioned above, on 10 August 2000, Health Canada recommended to Citizenship and Immigration Canada that testing all prospective immigrants for HIV, and excluding those testing HIV-positive, is the "lowest health risk course of action [and therefore] the preferred option." This advice was based on the analysis undertaken in the Montebello process (and on the focus group results). Subsequently, the Minister of Citizenship and Immigration publicly stated that her department was indeed considering implementing mandatory HIV testing for all prospective immigrants to Canada, and excluding those testing positive – with the exception of refugees and sponsored "family class" immigrants – from immigrating to Canada on both public health and "excessive cost" grounds. In the months following these announcements, many organizations and individuals from across Canada expressed their concerns about this proposal with the Minister of Citizenship and Immigration and the Minister of Health. In particular, they:

- noted that Health Canada, when providing advice to Citizenship and Immigration on the issue of medical screening, should have considered the matter in a broad public health context, rather than providing narrow advice on what allegedly constitutes "the lowest health risk course of action";
- pointed out that the Montebello Process only provides information on probabilities of infection, based on many assumptions, but does not provide answers for decision makers;

[223] Ibid.

- emphasized that using the Montebello Process alone was therefore not enough for Health Canada to be able to provide the advice that Citizenship and Immigration Canada requested, namely advice on "which medical screening procedures are required to protect public health"; and
- concluded that further analysis of the broader public health and human rights implications of the various options considered by Health Canada was required, including weighing the estimated level of risk against the harms that may derive from adopting a policy of screening and exclusion on prevention efforts in Canada; human rights; compassionate and humanitarian considerations; etc.

Most importantly, organizations and individuals pointed out that persons with HIV are not a threat to public health since HIV is not transmitted through casual contact, and that the exclusion of immigrants with HIV is therefore not necessary for the protection of Canadians. In addition, organizations and individuals expressed concern that, by claiming that immigrants with HIV are a threat to public health by virtue *only* of their HIV status and regardless of their behaviour, people with HIV generally would be stigmatized as dangers to public health and safety. Finally, concern was expressed that the exclusion of prospective immigrants with HIV on the ground that they represent a danger to public health would stigmatize not only all Canadians living with HIV, but also all immigrants, regardless of whether they are or are not HIV-positive.

In light of these concerns, the Minister of Health agreed to undertake further analysis of the issues related to mandatory testing and exclusion, as well as more extensive consultations. As mentioned above, while this report was undergoing layout, the Minister did provide further advice to the Minister of Citizenship and Immigration, stating that mandatory HIV testing was necessary, but that prospective immigrants with HIV, after receiving counseling, did not need to be excluded from immigrating to Canada on public health grounds. While no final decisions had been taken as of April 2001, it is likely that HIV testing will soon become a mandatory component of the medical exam that each prospective immigrant has to undergo.

Definition of "Excessive Demand"

Finally, as mentioned above,[224] there is no clear definition of what constitutes "excessive demand" on health or social services in the current *Immigration Act* or the *Regulations*. Courts have called this "troubling."[225] This general assessment of testing and exclusion policies informs the final chapter, which makes recommendations for Canadian policy. However, the proposal to define "excessive demand" in relation to up to a ten-year window (when there is reasonable evidence indicating that longer-term costs are likely to occur, such as would likely be the case with HIV/AIDS),[226] and without taking financial and social contributions that an applicant is expected to make over the same period into account, causes serious concern. In practice, this could result in all persons living with HIV or AIDS being considered medically inadmissible, unless they fall into the narrow categories of persons who are exempt from inadmissibility to Canada based on "excessive demand" on health or social services, or are granted permanent residence based on compassionate and humanitarian considerations. This issue is analyzed in detail in the next chapter.

[224] Chapter on "Current Policy," at notes 63 ff.

[225] See supra, note 64.

[226] Citizenship and Immigration Canada. Bill C-11. Explanation of Proposed Regulations, supra, note 192.

Assessment: Non-Discrimination and HIV-Related Entry Restrictions

> Canada has a strong commitment to human rights, but for most of us this is a commitment in theory rather than one that is regularly tested in practice. HIV transmission and AIDS present a test in practice of our real commitment to human rights; and how we meet that challenge in relation to immigration will provide a particular and important example in this respect.[227]

Can Canada choose to admit or exclude anyone, based on any criteria whatsoever? This chapter begins by discussing whether and how the Canadian government is restricted in the way it treats non-citizens seeking to enter or remain in the country. While it is not certain in law, there is at least a strong case to be made that the protections set out in the *Canadian Charter of Rights and Freedoms* should apply in many circumstances that would arise in the application of Canadian immigration law. Furthermore, the *Immigration Act* itself proscribes discrimination inconsistent with the Charter in the design and implementation of Canada's immigration policy, and this is consistent with guidance from international human rights principles. This chapter will discuss how the requirement of non-discrimination delimits Canada's treatment of persons with HIV/AIDS.

The *Immigration Act* itself proscribes discrimination inconsistent with the Charter in the design and implementation of Canada's immigration policy.

[227] Somerville MA. The case against HIV antibody testing of refugees and immigrants. *Canadian Medical Association Journal* 1989; 141: 889 at 893.

Could Canada choose to exclude someone based on their race, age, or political views?

This chapter will then demonstrate that mandatory HIV testing and automatic exclusion, whether based on public health grounds or excessive costs to public services, are not justified. Blanket exclusions based on either ground are discriminatory and will do little if anything to achieve any goals related to public health or economics. Rather, "from the perspective of an uninformed and apprehensive public, for whom elected representatives want to be seen as 'doing something,' screening [and exclusion] seems an easy enough and necessary way by which to raise a barrier to the spread of disease and to protect the public purse."[228]

This general assessment of testing and exclusion policies informs the final chapter, which critically reviews Canada's current and proposed policies toward visitors, immigrants, and refugees, and makes recommendations for Canadian policy in each of these areas.

The Principle of Non-Discrimination in Canadian Immigration Law

The Canadian Disability Rights Council has argued that:

Mandatory HIV testing and automatic exclusion are not justified.

> Persons who apply [to come to Canada] and are processed under [the *Immigration*] *Act* and its Regulations are entitled to the constitutional guarantees [against discrimination] provided by s. 15 [of the *Canadian Charter of Rights and Freedoms*.] Section 3(f) of the *Act* is further evidence that legislators intend that immigration applicants will have their applications processed in accordance with s. 15 of the *Charter*. Simply stated, this means that there can be no discrimination against immigration applicants with disabilities (and refugees) at any point in the application process."[229]

The Application of the Canadian Charter of Rights and Freedoms

It can be said that for those who are not permanent residents, entry into Canada is a privilege, not a right. If Canada is under no legal obligation to admit non-Canadians (other than refugees at or within its borders), can it decide, in its immigration program, to treat any applicant in any manner it wants? For example, could Canada choose to exclude someone based on their race, age, or political views? Could it choose to restrict the liberty of applicants?

Immigration law is a complicated area in which to apply principles of equality and non-discrimination. As Galloway points out:

> Immigration law has as its primary subject the stranger: the outsider who is under no obligation of allegiance to the state, who is not represented in its political processes, and whose needs and interests are, in most situations, accorded less concern than those of people who already participate in the social and political life of the community.[230]

It is clear that Canada does not owe the same legal duties to outsiders that it owes to its own citizens. Nonetheless, it has been held that the *Canadian Charter of Rights and Freedoms*[231] is, at least under certain circumstances, applicable to non-citizens who are subject to the *Immigration Act* and its regulations.

The Supreme Court has ruled that the acts of the Canadian state in conducting extradition proceedings are subject to the Charter, particularly the

[228] Goodwin-Gill, supra, note 30 at 64.

[229] Goundry, supra, note 17 at 6.

[230] Galloway D. Strangers and members: equality in an immigration setting. *Canadian Journal of Law and Jurisprudence* 1994; 7:149-172 at 149.

[231] Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act, 1982* (UK), 1982, c. 11 [hereinafter the *Charter*].

principles of fundamental justice.[232] However, it has also ruled in *Chiarelli* [233] that the scope of these principles must be informed by considering the principles and policies underlying immigration law, and the most fundamental principle of immigration law is that non-citizens do not have an unqualified right to enter or remain in the country. In that case, which involved the deportation of a permanent resident convicted of a serious offence, the Court found that a deportation scheme that applies to permanent residents, but not citizens, does not infringe the equality provisions (s 15) of the Charter, and that the Charter (s 6) specifically provides for differential treatment of citizens and permanent residents in this regard.

There is also some uncertainty as to whether the Charter might protect people outside Canada in the application of Canadian immigration law. In *Singh* v *Minister of Employment and Immigration*,[234] Justice Wilson of the Supreme Court of Canada stated that the word "everyone" in section 7 of the Charter "includes every human being who is physically present in Canada and by virtue of such presence amenable to Canadian law."[235] The meaning of that pronouncement has been the subject of considerable debate – specifically, was Wilson J stating that physical presence in Canada was a *necessary* prerequisite for Charter application in general, or merely *sufficient* for the Charter to apply in the *Singh* case itself?[236] Subsequent cases would appear to show that it is the latter – that is, in the *Singh* case, it was sufficient for the Charter to apply that Singh was physically present in Canada, but it was not necessary, as the Charter may in fact apply outside Canada in some cases.

The extent to which the Charter may be extraterritorially applied to the benefit of non-citizens remains uncertain.

The extent to which the Charter may be extraterritorially applied to the benefit of non-citizens remains uncertain. There is no doubt that the Charter may apply outside Canada's borders in some circumstances. This has been expressly stated by the Supreme Court of Canada.[237] A number of cases indicate the Charter applies to the conduct of officials applying Canadian law abroad, and this should arguably include in the context of the Canadian immigration system.

In the *Cook* case (involving Canadian police interrogating, in the US, a US citizen suspected of a crime in Canada), the Supreme Court held that the Charter is not absolutely restricted in its application to just Canadian territory, but can apply outside Canada to Canadian authorities engaged in the enforcement of Canadian law where this will not conflict with the foreign state's jurisdiction.[238] The Court held that it was reasonable both to expect Canadian officers to comply with Charter standards, and to permit the accused who was being made to adhere to Canadian law and procedure, to claim Canadian constitutional rights relating to the interrogation by Canadian officers. However, the Supreme Court cautioned that "the holding in this case marks an exception to the general rule in public international law discussed above that a state cannot enforce its laws beyond its territory. The exception arises on the basis of very particular facts before us. Specifically, the impugned actions were undertaken by Canadian governmental authorities in connection with the investigation of a murder committed in Canada for a process to be undertaken in Canada. The appellant, the rights claimant herein, was being compulsorily brought before the Canadian justice system. This situation is far different from the myriad of circumstances in which persons outside Canada are trying to claim the benefits of the Charter simpliciter."[239]

In the *Harrer* case, the Supreme Court held that the Charter cannot generally apply to evidence gathering abroad by *foreign* officers. But the Court stated that what was "determinative" in that case was that the US authorities "were not acting on behalf of any of the governments of Canada, the

[232] *Canada* v *Schmidt*, [1987] 1 SCR 500; 33 CCC (3d) 193.

[233] *Chiarelli* v *Canada (Minister of Employment and Immigration)*, [1992] 1 SCR 711.

[234] [1985] 1 SCR 177; 12 Admin LR 137 [hereinafter cited to SCR].

[235] Ibid at 202.

[236] Galloway D. The extraterritorial application of the *Charter* to visa applicants. *Ottawa Law Review* 1991; 23: 335.

[237] *R* v *Harrer*, [1995] 3 SCR 562 at paras 10-11; *R* v *Cook*, [1998] 2 SCR 597 at para 33.

[238] *Cook*, ibid.

[239] Ibid at para 53.

provinces or the territories, the state actors to which, by virtue of s. 32(1) the application of the Charter is confined.… It follows that the Charter simply has no direct application to the interrogations in the United States because the governments mentioned in s. 32(1) were not implicated in these activities."[240]

The Charter is not merely a list of protections which 'the people' have negotiated for themselves while striving to maximize their self-interest.

In the subsequent *Terry* case, the Supreme Court clarified that the Charter does not apply to foreign officers merely informally assisting Canadian authorities, such as US police arresting a fugitive facing charges in Canada at the request of Canadian police. However, McLachlin J for the majority acknowledged that a state "may … formally consent to permit Canada and other states to enforce their laws within its territory for limited purposes. In such cases, the Charter may find limited application abroad."[241] As noted in *Terry* and two later cases,[242] one reason for this conclusion is the principle of international comity, which suggests that it would be unrealistic to expect foreign authorities to know and comply with the laws of Canada.

While these decisions do not directly address the issue of whether Charter protections apply in the administration of Canadian immigration law abroad, they certainly suggest that they should. This would certainly accord with the principle of comity: to use the language of the Supreme Court in the *Schreiber* case (cited in *Cook*), officials acting on behalf of the Canadian government abroad in the application of Canadian immigration law "can be expected to have knowledge of Canadian law, including the Constitution, and it is not unreasonable to require that they follow it."[243] Such officials could, for example, include visa officers and medical officers acting on behalf of Citizenship and Immigration Canada applying Canadian law.

Galloway offers other persuasive arguments in favour of applying the Charter to strangers seeking admission to Canada, and thus according them rights that could be asserted in a Canadian court. He rejects the view that the Charter is "merely a list of protections which 'the people' have negotiated for themselves while striving to maximize their self-interest." Instead, he claims, "it is more felicitous to conceive of a Constitution as a document which expresses a community's devotion to humanist principles."[244]

Galloway cites Wilson J's statement in *McKinney* v *University of Guelph* that "the purpose of the equality guarantee is the promotion of human dignity."[245] He notes that

> she does not qualify this statement with references to membership or to other criteria which would exclude strangers or otherwise limit the class of beneficiaries. Equality is presented as a universal value and the right to equality is a right which people have solely by virtue of being equal.[246]

He argues that immigration policies that contravene the principles of human dignity protected by the Charter, such as those that discriminate based on race, cannot be acceptable for a number of reasons. First, others of the same group, or indeed all members of minority races in Canada, would suffer indirect injury from a racist immigration criterion. Perhaps more important, "liberal communities are founded on the principle that it is not only wrong for us to treat ourselves in that manner, it is also wrong to treat others thus."[247] After all, if Canadians subject to Canadian laws are protected by the rights guaranteed in the Charter (which is the supreme law of the country), why should others subject to Canadian laws not also have the same

[240] *Harrer*, supra, note 237 at para 12.

[241] *R* v *Terry*, [1996] 2 SCR 207 at para 15, cited in *Cook*, supra, note 237 at para 38.

[242] *Schreiber* v *Canada (Attorney General)*, [1998] 1 S.C.R. 841, at para 15; *Cook*, ibid at para 45.

[243] Ibid at para 16; *Cook* at para 46.

[244] Supra, note 230 at para 23.

[245] [1990] 3 SCR 229 at 391.

[246] Supra, note 230 at para 56.

[247] Galloway, supra, note 236 at 362.

protections? Furthermore, the principles expressed in the provisions of the Charter are fundamentally the same as those expressed in international human rights law, which Canada has agreed to respect and promote.

Galloway points out that even if the government had a constitutional right not to admit any aliens, it does not follow that once it decides to do so, it can admit aliens according to any criteria or impose any conditions it chooses. As Goodwin-Gill points out,

> a restriction or limitation that is otherwise permissible must not itself be imposed in a discriminatory manner, and even though a state may not be obliged to provide a benefit or entitlement, where it does so, it ought not to introduce discriminatory measures in its implementation.[248]

Thus, Galloway concludes that the rights enshrined in the *Canadian Charter of Rights and Freedoms* that are accorded to "all persons" should equally be accorded to those who participate in the immigration program.

The application of the Charter to persons seeking entry into Canada would afford them, in addition to protection from discrimination, protection from infringements on their life, liberty and security of the person, and from other rights enshrined in the Charter as the most fundamental to Canadian society. In addition to substantive guarantees, it would provide procedural guarantees and, finally, a cause of action in Canadian courts if those guarantees were not met. Galloway concludes:

> Having taken the responsibility for the treatment of aliens, the government is committed to ensuring that the treatment is proper, much as the Good Samaritan who offers treatment to an injured party is held legally liable for his or her negligence, but is under no obligation to intervene in the first place.[249]

If Canadians subject to Canadian laws are protected by the rights guaranteed in the Charter, why should others subject to Canadian laws not also have the same protections?

Parliament has clearly articulated its commitment to the principle of non-discrimination in the *Immigration Act* itself.

The Principle of Non-Discrimination in the Immigration Act

In addition to the protection to immigrants that may be afforded by the Charter if it applies directly, Parliament has clearly articulated its commitment to the principle of non-discrimination in the *Immigration Act* itself. Section 3 of the Act sets out the objectives and basic principles on which the immigration program is based. It states in section 3(f):

> 3. It is hereby declared that Canadian immigration policy and the rules and regulations made under this Act shall be designed and administered in such a manner as to promote the domestic and international interests of Canada recognizing the need…
>
> (f) to ensure that any person who seeks admission to Canada on either a permanent or temporary basis is subject to standards of admission that do not discriminate in a manner inconsistent with the *Canadian Charter of Rights and Freedoms*.

The proposed new Act (Bill C-11) contains a similar (but improved) statement of this principle in section 3(3):

> 3(3). This Act is to be construed and applied in a manner that…
>
> (d) ensures that any person seeking admission to Canada is subject to standards, policies and procedures consistent with the *Canadian Charter of Rights and Freedoms*, including its principles of equality and freedom from discrimination.

[248] Goodwin-Gill, supra, note 30 at 54. This very principle was affirmed by the Supreme Court of Canada in its decisions in *Vriend* v *Alberta*, [1998] 1 SCR 493 and *Eldridge* v *British Columbia (Attorney General)*, [1997] 3 SCR 624.

[249] Galloway, supra, note 236 at 363.

Whether or not the Charter itself applies to strangers extraterritorially in their dealings with the Canadian government, it is clear that Parliament intended that the immigration process be conducted according to non-discriminatory principles. The conception of prohibited discrimination in the immigration process is to be understood the same way as it has been under the Charter. The remainder of this section will therefore briefly describe the protection from discrimination afforded under the *Canadian Charter of Rights and Freedoms*.

The Meaning of Discrimination in the Canadian Charter of Rights and Freedoms

Section 15 (1) of the Charter states that:

> Every individual is equal before the law and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age, or mental or physical disability.

Not every distinction, however, will be considered unlawful discrimination. Goodwin-Gill defines unlawful discrimination as "some exclusion or restriction, privilege or preference, which has the effect of nullifying a particular right."[250] He further points out that:

> The principle of non-discrimination places on those who would make distinctions in the recognition or protection of rights, the burden of showing that any particular status is a relevant basis for differentiation; that the distinction is implemented in pursuit of a reasonable aim or objective; that it is necessary, no alternative action plan being available; and that the discriminatory measures taken or contemplated are proportional to the end to be achieved.[251]

This definition closely parallels the way in which Canadian courts have determined whether a particular government action constitutes discrimination under the *Canadian Charter of Rights and Freedoms*. The Supreme Court of Canada's approach to identifying discrimination is expressed in *Law* v *Canada (Minister of Employment and Immigration)*:[252]

(1) Is there substantively differential treatment between the person and others on the basis of one or more personal characteristics, either because the law draws a formal distinction between the person and others, or because the law fails to take into account the person's already disadvantaged position within Canadian society? (*differential treatment*)

(2) Is that differential treatment based on one or more of the grounds that are either listed in the Charter as prohibited grounds of discrimination (race, national or ethnic origin, colour, religion, sex, age, disability) or are analogous to the listed grounds (eg, sexual orientation, marital status)? (*distinction on prohibited ground*)

(3) Does the differential treatment discriminate in a substantive sense, contrary to the purpose of the Charter's equality guarantee, the overriding concern of which is protecting and promoting human dignity by remedying such ills as prejudice, stereotyping and historical disadvantage? (*discrimination)*

[250] Supra, note 30 at 59.

[251] Ibid, at 54.

[252] [1999] 1 SCR 497.

Once an action has been found to constitute discrimination, the question is whether that discrimination is unlawful. It is unlawful when it is not "demonstrably justified in a free and democratic society."[253] In *R* v *Oakes*,[254] the Supreme Court of Canada stated that in order for a restriction or denial of benefit to be justified:

HIV/AIDS has been called the "scapegoat disease of our era."

- First, the objective which the denial of benefit is designed to serve must be sufficiently pressing and substantial to warrant the overriding of a constitutionally protected right or freedom. (*important objective*)
- Second, the means chosen must be "carefully designed to achieve the objective in question. They must not be arbitrary, unfair, or based on irrational considerations. In short, they must be rationally connected to the objective."[255] (*rational connection*)
- Third, if the means are rationally connected to the objective in question, they should impair as little as possible the right or freedom in question. (*minimal impairment*)
- Finally, "there must be a proportionality between the *effects* of the measures which are responsible for limiting the [freedom] and the objective which has been identified as of 'sufficient importance'"[256] (*proportionality*)

In *Law*, Iacobucci J indicated that

> probably the most compelling factor favouring a conclusion that differential treatment imposed by legislation is truly discriminatory will be, where it exists, pre-existing disadvantage, vulnerability to stereotyping, or prejudice experienced by the individual or group.[257]

HIV/AIDS has been called the "scapegoat disease of our era."[258] Because HIV and AIDS are associated with marginalized and stigmatized populations such as drug users, gay men, and prostitutes, people with HIV and AIDS have been subject to many kinds of discriminatory treatment.[259] Whenever people with HIV are singled out for differential treatment, we must carefully examine whether those distinctions are justified.

This has been recognized in the interpretation of international human rights law, specifically in the context of HIV/AIDS. The UN's International Guidelines on HIV/AIDS and Human Rights indicate that the settled interpretation of international human rights law reflects an approach essentially the same as the *Oakes* analysis under the Canadian Charter:

> In order for restrictions on human rights to be legitimate, the State must establish that the restriction is [among other things] based on a legitimate interest, as defined in the provisions guaranteeing the rights, [and] proportional to that interest and constituting the least intrusive and least restrictive measure available and actually achieving that interest in a democratic society.[260]

The remainder of this paper, in examining whether HIV testing and exclusion are warranted, will examine how the principle of non-discrimination applies to immigration and refugee policy in relation to HIV/AIDS. This analysis, along with other considerations that have been identified throughout the paper, then informs the recommendations for Canadian policy presented at the end.

[253] Charter, supra, note 231, s 1.

[254] [1986] SCR 103; 19 CRR 308.

[255] Ibid at para 70.

[256] Ibid.

[257] *Law*, supra, note 252 at para 63.

[258] Somerville, supra, note 227 at 893.

[259] Johnson, supra, note 3 at 148. For a discussion, see de Bruyn T. *HIV/AIDS and Discrimination: A Discussion Paper*. Montréal: Canadian HIV/AIDS Legal Network & Canadian AIDS Society, 1998.

[260] *International Guidelines*, supra, note 19 at para 82.

- Overall, the harmful effects of stigma and personal hardship that would be visited upon all would-be immigrants who are HIV-positive by a policy of automatically excluding all of them on public health grounds would be grossly disproportionate to any benefit, marginal if any, to be gained in protecting the public health.

Current Canadian immigration policy holds that demands are "excessive" when they exceed the cost of health care for the average Canadian.

Are Restrictions on Immigration of People with HIV to Protect the Public Purse Justified?

The issue of whether states should deny permanent residence to people with HIV on the ground that they are likely to place an excessive burden on health or social services is complex. It is a reasonable criterion for immigration that the individual be expected to contribute to the society where they seek permanent residence. Indeed, people with HIV can be expected to place demands on health or social services, as do other immigrants and current citizens and residents. But are these demands "excessive"? And is it justified to presume that *all* people with HIV will place "excessive demands" on health or social services?

The UN's International Guidelines on HIV/AIDS and Human Rights state:

> Where States prohibit people living with HIV/AIDS from longer-term residency due to concerns about economic costs, States should not single out HIV/AIDS, as opposed to comparable conditions, for such treatment and should establish that the costs would indeed be incurred in the case of the individual alien seeking residency. In considering entry applications, humanitarian concerns, such as family reunification and the need for asylum, should outweigh economic considerations.[285]

Not All Persons with HIV Will Place "Excessive" Demands on Health or Social Services

It is difficult to determine what kinds of demands constitute "excessive" demands. Somerville points out that "all of us, including immigrants, will at one time or another place some demand on the health care system. Whether the cost of that demand is excessive, assuming the cost of the demand is a relevant criterion, is a value judgment."[286] Indeed, as described above, neither the current *Immigration Act* or regulations, nor the courts, have offered any clear standard for making this assessment. Despite this, on at least three occasions, the Immigration Appeal Division of the Immigration and Refugee Board has rejected a challenge that this provision is void because it is unconstitutionally vague.[287]

Current Canadian immigration policy holds that demands are "excessive" when they exceed the cost of health care for the average Canadian.[288] This is problematic in that it presumes that any Canadian who draws more heavily than the average on the health-care system is imposing an "excessive" burden.

Citizenship and Immigration Canada plans to provide a clear definition of "excessive demand" in the regulations that will accompany Bill C-11. As mentioned above, it plans to define excessive demand "in relation to a 5-year window unless reasonable evidence indicates that significant longer-term costs are likely to occur," in which cases "the assessment window may be extended, though rarely beyond ten years."[289] "Costs would be compared to the average annual cost of health and social services for Canadians (currently $2800 per annum), multiplied by the number of years for the assessment period."[290] At the time of writing, no further details were known, and it was thus

[285] Supra, note 19 at 50, para 106.

[286] Somerville, supra, note 227 at 891.

[287] *Natt* v *Canada (Minister of Citizenship and Immigration)*, [1997] IADD No 1143 (QL); *Grewal* v *Canada (Minister of Citizenship and Immigration)*, [1997] IADD No 1181 (QL); *Renthey* v *Canada (Minister of Citizenship and Immigration)*, [1997] IADD No 1559.

[288] See *Jim*, supra, note 69.

[289] Citizenship and Immigration Canada. Bill C-11. Explanation of Proposed Regulations, supra, note 192.

[290] Ibid.

not clear how "excessive" will be defined.

However, what is known is cause of great concern for persons living with HIV or AIDS and, more generally, for all persons with disabilities or chronic, life-threatening diseases. Because of the difficulty in predicting costs far into the future, an applicant's projected demands on health or social services should not be assessed over a period of up to ten years. Furthermore, what is being proposed differs from the definitions of "excessive demand" suggested by international organizations such as the United Nations and the World Health Organization. The World Health Organization, for example, has stated that when a state considers excluding a person on "excessive cost" grounds, it should do so only if "the cost of the financial support exceeds the benefits that are expected from the traveller."[291] If the goal of any exclusion on "excessive demand" grounds is indeed to protect the public health-care system, then contributions by each immigrant to the domestic economy and hence to the health-care system must be also taken into account. Current and proposed future Canadian policy only considers the "demands" side of the equation, ignoring the "contributions" side.

Current Canadian policy only considers the "demands" a potential immigrant might make on health or social services systems, and ignores their likely financial and other contributions to Canada.

Yet, as Hoffmaster and Schrecker point out, the criteria for acceptance as an immigrant

> are designed to ensure that the individuals admitted will make financial contributions to Canadian society through taxes and premiums, in addition to making claims on tax-supported services. Determinations of "excessive demand" therefore require a comparison of potential benefits and costs. Moreover … that comparative judgment must be made on an individual, not a class, basis. The relevant issue is whether *this particular* immigrant would contribute more than he or she would cost. [292]

Many immigrants with HIV will make a greater net financial contribution to the economy of the state to which they are destined than the costs they will impose on its health-care system. "Because of new treatments, people with HIV lead longer and potentially very productive lives during which they can contribute a lot to … society."[293] While it is true that these treatments can be expensive, there will be many cases in which the economic contribution will be greater than the cost of those treatments, particularly since the cost of treatment will vary from person to person.

Furthermore, people with HIV can make important non-economic contributions to society that should be considered when determining whether the costs they will impose on society are "excessive." There is no question that it is difficult to measure non-economic contributions, as these cannot be quantified. However, this does not mean it is impossible for such factors to be considered. Canadian courts and tribunals are called upon daily to interpret qualitative requirements or factors set out in statutes, and to weigh non-quantifiable evidence in the balance in attempting to do justice. In the context of immigration and refugee cases, they currently already engage in such a task when assessing humanitarian and compassionate considerations for landing an otherwise inadmissible person, or when assessing the risk of persecution to which a refugee claimant may be subjected if removed from Canada. A list of factors to be considered in determining whether the costs required for care of a particular individual would be "excessive" should be developed. This list should include, among other factors: (1) expected contributions to domestic work supporting a household, caring for dependents

[291] Carlier, supra, note 171, summarizing the position of the WHO.

[292] Hoffmaster B, Schrecker T. *An Ethical Analysis of the Mandatory Exclusion of Refugees and Immigrants Who Test HIV-Positive.* Halifax: The Names Project, 2000, at 19 (available at www.aidslaw.ca/Maincontent/issues/immigration.htm).

[293] Jürgens, supra, note 2 at 206.

(children, elders, family member with disability or special needs); (2) expected contributions to community services; (3) meeting a particular need for skilled/trained workers in a particular area (a factor already considered for independent applicants); (4) expected contribution to Canada's educational, scientific, or cultural life; and (5) compassionate and humanitarian factors, such as the need for reunification with loved ones and the suffering that could result from being returned to the applicant's country of origin.

Somerville and Wilson have noted that applying the "excessive demand" criterion for exclusion, without taking other considerations into account, would

> indicate an unacceptable attitude toward migrants as persons – in that it views them only in terms of the economic benefit they offer. In addition, it places only a monetary value on their worth – in that it states that they do not merit the cost they would present to society.[294]

In addition, as Hoffmaster and Schrecker have said, "[r]egarding prospective immigrants solely in economic terms and therefore as potentially substitutable (e.g., an applicant with a medical condition that could be expensive to manage can be replaced by a more cost-effective one who does not have such a condition) denies them inherent moral dignity and status as persons."[295]

Finally, Hoffmaster and Schrecker remark that, although

> the financial pressures being exerted on Canada's health care systems make every avenue for controlling costs appealing, it is not clear how or whether those pressures would be eased by barring prospective immigrants who are HIV-positive …
>
> The overall demand for health services in Canada is driven by much bigger and more powerful forces, including the aging of the population; the ever-expanding array of expensive pharmaceutical and technological interventions; the failure of health promotion efforts to have significant impacts on behaviour such as smoking; and the expectations of the public and health care professionals. Genuine attempts to address the perceived health care crisis should be directed at those forces, and not deflected by worries about the "excessive demands" that immigrants might impose on health care services.[296]

"The financial pressures being exerted on Canada's health care systems make every avenue for controlling costs appealing, [but] it is not clear how or whether those pressures would be eased by barring prospective immigrants who are HIV-positive."

– Hoffmaster & Schrecker, 2000

Routinely Excluding People with HIV on the Grounds That They Will Place Excessive Demands on Health or Social Services Would Be Unjust

Stigma

The assumption that all immigrants with HIV will excessively burden the public purse reinforces views of immigrants as abusers of the social welfare system,[297] and of persons with HIV as people who are unable to contribute to society.

Parity with Other Diseases

If a country chooses to institute mandatory testing and exclusion policies on grounds of economic cost to public health or social services, it must do so in a non-discriminatory manner. In March 2001, the Minister of Citizenship and Immigration stated that she would not accept testing for HIV/AIDS if it was

[294] Somerville & Wilson, supra, note 4, at 831.

[295] Supra, note 292, at 23.

[296] Ibid, at 20.

conducted in a discriminatory manner, and that she opposed the *mandatory* exclusion of those that test positive.[298] One way in which testing for HIV would be done in a discriminatory fashion is to single it out for screening as opposed to other medical conditions that risk imposing a similar or even greater burden on the public purse.

For example, one study that may provide a useful example despite the fact that it is now somewhat dated, found that the estimated cost of caring for coronary heart diseases in the five-year period immediately following diagnosis is in fact greater than the cost of medical care incurred by an individual who tests positive for HIV.[299] While this study predated the advent of protease inhibitors as part of the standard of care in Canada for people living with HIV/AIDS, there have no doubt also been corresponding changes to the standard treatment for heart disease, including new, expensive drugs. The point to be noted is that costs for treatment are variable over time, not just with treatment of HIV/AIDS but of other medical conditions as well. This is due not only to medical advances, but also to marketplace considerations that affect various components of the cost of treatment (eg, prices of drugs). This highlights the difficulty of making a fair assessment or comparison that justifies singling out one disease condition from others in excluding would-be immigrants on "excessive demand" grounds.

With respect to the criterion of "excessive demand" on health or social services, how different is HIV-positive status from other medical conditions?

Generally, Hoffmaster and Schrecker ask:

> With respect to the criterion of "excessive demand" on health or social services, how different is HIV-positive status from other medical conditions?[300]

They point out that the list of potentially costly medical conditions and risk factors for future illness, such as tobacco consumption and alcohol abuse, could easily be extended. They conclude that consistency and fairness demand that they be treated the same.[301]

Slippery slope to further exclusion

This leads is to the question of how far we want to go in excluding those who can be expected to use health or social services. Should we hold persons over 50 years of age medically inadmissible because they are more likely to need health or social services? Should we use genetic screening tools to predict who might develop expensive genetic conditions?

As Hoffmeister and Schrecker point out:

> If mandatory testing of immigrant were introduced, and if parity with other diseases were accepted, the slide down an ethically problematic slippery slope could be impossible to stop. The internationally funded and conducted Human Genome Project, which will map the entire human genome, is well ahead of schedule. One outcome of all the genetic information being produced will be the equally rapid development of an extensive set of genetic screening tools. The ability of medical science to identify individuals who are more likely than the population as a whole to develop serious or lethal diseases will be enormously enhanced. It is already possible to identify carriers of a limited number of hereditary conditions, to determine the probability of transmission to offspring, and (in a much smaller number of cases) to screen for individual susceptibility. Testing for Huntington's disease is an example of the last category. The

[297] Somerville & Wilson, supra, note 4 at 798.

[298] See supra, note 12.

[299] Zowall H et al. Economic impact of HIV infection and coronary heart disease in immigrants to Canada. *Canadian Medical Association Journal* 1992; 147: 1163-1172.

[300] Supra, note 292, at 22.

[301] Ibid.

recent commercialization of a test for the BRCA 1 mutation, which confers high hereditary susceptibility to breast cancer, is almost certainly a harbinger of a much larger range of genetic tests.

Would the "excessive demand" criterion justify expanding the medical screening of immigrants to include such tests? How might that criterion be interpreted as more and more tests become readily available? What apprehensions about the medical costs of treating the offspring of prospective immigrants who are carriers of a particular condition might lead to blanket exclusions? Are we comfortable with a future in which, for example, prospective immigrants at high hereditary risk for breast cancer would be excluded based on the "excessive demand" criterion? After all, prospective immigrants are not our compatriots, and it is easy to imagine the subtle and covert introduction of "biological fitness" as a *de facto* test for admission to Canada.[302]

Blanket exclusion would be discriminatory

In addition, as has been noted, Canada's courts have already ruled in the 1992 *Deol* case (widely cited in subsequent cases, including the 1995 *Litt* case) that it is legally wrong to automatically assume, based on a person's medical condition, that they will place an excessive demand on health or social services, and that a fuller, individual assessment is required.[303] Indeed, in the recent *Mo* case, the court reiterated the point that "merely suffering from a disease or disorder does not render a person inadmissible: it is the effect of the disease that is critical to the determination."[304]

Thus, any judgment about "excessive demand" has to be individualized. Imposing a blanket exclusion of all persons with HIV on the *assumption* that they would *all* place excessive demands on health or social services would constitute an unjustified generalization, and discriminate against those who would not place excessive demands on health or social services. Such a blanket denial of the benefit of residence to all people who are HIV-positive would likely not pass Charter scrutiny under the *Oakes* test outlined above.

- The objective of protecting the Canadian health care and social services systems from "excessive" demands is an important objective.
- However, a policy of excluding all people living with HIV/AIDS would not meet the *rational connection* requirement because it would not be "carefully designed to meet the objective." As explained above, not all HIV-positive people place an "excessive" demand on the health or social services systems. In order to meet this constitutional requirement, a policy would need to take into account the costs that each applicant would be expected to impose on health or social services, given all their personal circumstances.
- A policy of exclusion of all HIV-positive applicants would also fail the requirement of *minimal impairment* of Charter equality rights in pursuing the objective of preventing excessive demand. Those HIV-positive applicants who would be excluded would have been discriminated against because of their HIV-positive status by being denied landing – and all the associated benefits – even if they would not have placed an "excessive" demand on Canada's health or social services systems. This would certainly be more than a minimal impairment of equality rights.

[302] Ibid at 22-23.

[303] *Deol*, supra, note 33; *Litt*, supra, note 33.

[304] *Mo*, supra, note 69 at para 37. It should be noted that there is (at least) one reported case in which an adjudicator of the Immigration Appeal Division, with very little analysis, dismissed the argument that it is unconstitutional disability discrimination to automatically determine that a disability will create an excessive demand. The adjudicator was "not satisfied that the Charter is applicable to the instant case, as at issue is the medical status and potential admissibility of a non-Canadian living outside Canada": *Sidhu* v *Canada (Minister of Citizenship and Immigration)*, [1997] IADD No 1064 (QL) at para 17. Given the many other cases that confirmed the requirement of looking at the probable link between a health condition and the demand for services, the discussion above about the complexity of whether or not the Charter could govern the application of Canadian immigration law, and the lack of any substantive analysis in this case, it is properly seen as an aberration and likely bad law.

- Finally, the harmful effects of a policy of exclusion of all HIV-positive applicants, such as the stigma and significant personal hardship described above, would be out of proportion to any savings to the health or social services systems resulting from excluding that subset who would place an "excessive" demand on those systems.

Is Mandatory HIV Testing of Immigrants and Refugees Justified?

Arguments Advanced in Favour of Mandatory Testing

Mandatory testing can only be justified if it serves a worthy goal. Those who advocate mandatory testing justify it on three major grounds.

First, they argue that it would protect public health by identifying those who are HIV-positive in order that they may be excluded from Canada and prevented from contributing to the spread of HIV in Canada. However, as has been demonstrated above,[305] exclusion of immigrants with HIV on public health grounds is unjustified. This means that mandatory testing to serve the purpose of exclusion on public health grounds is equally unjustified.

Mandatory testing of all prospective immigrants can be characterized as arbitrary, unfair, and based upon irrational considerations.

Second, some argue that, even if those who test HIV-positive are not excluded from immigrating to Canada on public health grounds, testing all prospective immigrants for HIV, and providing counseling, would protect the public health. They argue that immigrants who know that they are HIV-positive and have received counseling would be less likely to engage in risky behaviours. However, for the same reasons that mandatory testing for the purpose of excluding all HIV-positive prospective immigrants is unjustified, mandatory testing for the purpose of providing counseling and other risk-reducing interventions to those testing positive is also unjustified. The ostensible objective of mandatory testing of all immigrants is to reduce the threat of HIV transmission from immigrants to Canadians. This is an important objective. However, it is arguable the measure of testing all immigrants for HIV is not rationally connected to the objective. Persons with HIV are not a threat to public health simply because they are HIV-positive. Mandatory testing of all prospective immigrants and providing counseling and other risk-reducing interventions may prevent the transmission of the disease from a given individual to another, so there could conceivably be some marginal benefit in a relatively small number of instances. However, by fostering a false sense of security and by undermining people's responsibility for protecting themselves, by singling out immigrants for mandatory testing in a manner that obscures other potential sources of exposure to HIV, the measure may indeed achieve the very opposite of its objective of preventing infection among Canadians. In that sense, as a measure to protect the Canadian public, mandatory testing of all prospective immigrants can be characterized as "arbitrary, unfair, and based upon irrational considerations." In addition, even if mandatory testing of all immigrants were an effective way to prevent spread of HIV within the population, it is *not the way that least impairs* the right to be free from discrimination. Encouraging all individuals to undergo voluntary testing and to avoid risky behaviour is a less impairing and far more effective way to protect members of the public from contracting HIV. This means that mandatory HIV testing for this purpose is also unjustified.

Finally, those in favour of mandatory HIV testing argue that it would allow for the identification and exclusion of those who might pose an excessive burden on the health-care system. As shown above,[306] excluding all

[305] Supra, at notes 261 ff.

[306] See supra, at pages 57-59

immigrants with HIV from immigrating to Canada on "excessive demand" grounds cannot be justified. It would fail to take into consideration the individual circumstances of each immigrant, when both our immigration tradition and fairness require that each prospective immigrant be assessed individually. Many immigrants living with HIV would make contributions to Canadian society that would far outweigh the cost they would impose on the health-care system. Mandatory HIV testing for the purpose of excluding all those testing HIV positive on excessive cost grounds could therefore also not be justified. However, if the goal simply is to identify HIV-positive immigrants, so that an individual assessment of costs (and contributions) can be undertaken, a mandatory HIV testing program could reach this goal. However, there are several drawbacks of a program of mandatory HIV testing of prospective immigrants.

If we mandate HIV testing of immigrants, will we soon mandate genetic screening tests?

Drawbacks to Mandatory Testing

Discrimination

There is concern that a policy of mandatory HIV testing would unfairly single out HIV for testing when there are other conditions that can be as expensive or more expensive than HIV that are not tested for.

Stigma

If immigrants were required to submit to mandatory HIV testing, they would be the only population in Canada that would be statutorily required to do so. This would stigmatize all prospective immigrants and those already living in Canada, who would be perceived as a group with high rates of HIV. "It would appeal to the deepest prejudices of people opposed to anyone they perceive as unlike themselves, of whom immigrants are often considered to be a prime example."[307] It would also stigmatize persons with HIV, reinforcing the view that persons with HIV must be targeted and identified, are dangerous, are to be blamed for the transmission of the virus, and are a burden to society.

Slippery slope to HIV testing of other populations

Most Canadians are protected from involuntary testing under the *Canadian Charter of Rights and Freedoms*.[308] However, by endorsing the mandatory testing of all prospective immigrants, the government might encourage calls for mandatory testing of other populations, such as people in health-care professions, prisoners, or sex workers.

Slippery slope to implementing other tests

More and more tests, particularly genetic screening tools, are becoming available that "enable us, if we wish to use them, to predict with greater or lesser accuracy when and from which disease a person will likely die."[309] If we mandate HIV testing of immigrants, are such genetic screening tests also justified?

Cost

The costs of large-scale testing could approach or even outweigh the savings generated from excluding HIV-positive immigrants on excessive-cost grounds. In the United States, for example, US$1 million was spent between 1990 and 1996 to detect three confirmed HIV-positive cases among all the Russian immigrants who were screened.[310]

Humanitarian concerns

Mandatory HIV testing gives rise to a number of humanitarian concerns with respect to prospective immigrants.

[307] Somerville, supra, note 227 at 893.

[308] Stolz L, Shap L. *HIV Testing and Pregnancy: Medical and Legal Parameters of the Policy Debate.* Ottawa: Health Canada, 1999.

[309] Somerville, supra, note 227 at 892.

[310] *AIDS Weekly* 8 September 1997.

If Canada is going to require that applicants take an HIV test, it should ensure that the testing it requires be done according to Canadian standards.

First, because testing is carried out in the country of origin, it is subject to that country's rules on consent, and pre- and post-test counseling.[311] According to the International Guidelines on HIV/AIDS and Human Rights, "public health legislation should ensure that HIV testing of individuals should only be performed with the specific informed consent of the individual."[312] The doctrine of informed consent to medical procedures has been repeatedly affirmed by the Supreme Court of Canada.[313] While there are slightly varying definitions of informed consent articulated in various pieces of legislation,[314] they are generally reflective of the basic principles enunciated by an Expert Working Group of the Canadian Medical Association in *Counselling Guidelines for HIV Testing*, which help define the legal standard of care that health professionals should exercise in doing HIV testing:

- Informed consent cannot be implied or presumed;
- Obtaining informed consent "involves education, disclosing advantages and disadvantages of testing for HIV, listening, answering questions and seeking permission to proceed through each step of counselling and testing"; and
- To obtain informed consent for HIV, a patient must be deemed competent, must understand the purposes, risks, harms and benefits of being tested, as well as those of not being tested, and his/her consent must be voluntary.[315]

Standards of consent vary from country to country, and by requiring mandatory HIV testing from all prospective immigrants, Canada may be requiring testing that is in fact not consensual by Canadian or international standards. In addition, many countries from which prospective immigrants apply provide no or inadequate post-test counseling, which "may be even more important than pre-test counselling."[316] Post-test counseling is necessary to explain the possibility of false-negative results due to the "window period" between HIV exposure and the time when tests can detect HIV antibodies, as well as to explain care and treatment options and risk-reduction strategies.

If Canada is going to require that applicants take an HIV test, it should ensure that the testing it requires be done according to Canadian standards, whether or not the tested immigrant is eventually permitted to emigrate to Canada. "In certain circumstances, to test individuals without also offering the possibility of treatment or counselling will likely constitute cruel or inhuman or degrading treatment, especially if such testing is not necessary, is not related to a legitimate objective, or is out of proportion to the aim sought to be realized."[317]

Second, people who live in countries with harsh, coercive, or punitive policies on HIV/AIDS and who want to come to Canada would have to make a difficult decision. They "would be forced to choose between losing any opportunity to do this and taking a risk of what could happen to them in their country of origin if they were rejected as immigrants on the basis of HIV antibody positivity." [318] They could pay a high price in their countries of origin for their dream of a better life in Canada.[319]

Third, some might be excluded based on false-positive results in countries where they may not be offered confirmatory tests. Somerville has observed:

> After having been tested [only once], some people may live their lives believing that they have a life-threatening illness

[311] See *Medical Officers' Handbook*, supra, note 57.

[312] *International Guidelines*, supra, note 19 at 12.

[313] *Reibl* v *Hughes*, [1980] 2 SCR 880; *Hopp* v *Lepp*, [1980] 2 SCR 192.

[314] Eg, *Health Care Consent Act, 1996*, SO 1996, c 2; *Health Care (Consent) and Care Facility (Admission) Act*, SBC 1993, c 48; *Hospitals Act*, RSNS 1989, c 208; *Health Act*, SYT 1989-90, c 36; Art 11 CCQ; *Health Care Directives Act*, SM 1992, c 33; *Dependant Adults Act*, SS 1989-90, c D-25.1.

[315] Canadian Medical Association. *Counselling Guidelines for HIV Testing*. Ottawa: The Association, 1995 at 5-6.

[316] Jürgens, supra, note 2 at 81.

[317] Goodwin-Gill, supra, note 30 at 64.

[318] Somerville, supra, note 227, at 893.

[319] Hoffmaster & Schrecker, supra, note 292, at 21.

> when this is not the case. We would not want to add to the numbers of such people; therefore, if Canada were to require HIV antibody testing of prospective immigrants it would have an ethical obligation to make available confirmatory testing facilities.[320]

Somerville makes a case for the ethical values that a policy of not testing immigrants would promote.

An ethical case for not testing

Finally, Somerville makes a case for the ethical values that a policy of not testing immigrants would promote:

> Canada could provide an important, indeed critical, example to the rest of the world if it is prepared to state that the potential costs, in economic terms, to care for people admitted as immigrants who later develop HIV-related illness are more than compensated for by the values – humaneness, humanitarian concern and respect for human rights – that we wish to uphold in *choosing* not to test asymptomatic prospective immigrants for HIV antibodies … [T]he benefits accruing to Canada from this approach and the example that Canada would set to the rest of the world in adopting this position … far outweigh any cost to Canada in terms of the economic burden that asymtomatic HIV-antibody-positive immigrants would impose on our health care system.[321]

As Hoffmaster and Schrecker put it,

> [m]aking that case to committed realists is, of course, difficult because moral values are not hard enough for their tough-minded, self-interested approach. Somerville's exhortation does, however, exactly what morality is supposed to do. It gets people to think in terms that go beyond self-interest. Realists may reject Somerville's call, but then their rejection should be seen for what it is – a dismissal of the very claim of morality.[322]

[320] Somerville, supra, note 227 at 893.

[321] Ibid at 894.

[322] Supra, note 292 at 24.

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EXHIBIT "B"

This is Exhibit "B" as mentioned in the Affidavit of Sandra Ka Hon Chu, solemnly affirmed before me by videoconference from Toronto, this 1st day of February 2024.

Anne-Rachelle Boulanger
Anne-Rachelle Boulanger (Feb 1, 2024 16:34 EST)

A Commissioner, etc.

The economic burden of immigrants with HIV: When to say no?*

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1.0 Introduction

In 2005, the *Canada Communicable Disease Report* estimated that 58,000 people in Canada were living with HIV.[a] During that year it was estimated that between 2,300 and 4,600 new cases of HIV emerged, with the incidence rate relatively uniform since 2002.[b] The number of people worldwide living with HIV is approximately 33 million and increasing.[c] As the worldwide HIV population expands, there is expected to be an increase in the number of HIV-positive immigrants applying for entry to Canada,[d] and accordingly, it is important to critically review federal immigration policies that affect such applicants.

The Canadian *Immigration and Refugee Protection Act* (IRPA), states in Section 38(1) that:

> 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.

While IRPA does not specifically mention HIV or related illnesses, Canada generally excludes people infected with HIV if they can be expected to place an "excessive demand" on publicly funded health or social services. It is important to note that entry

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[a] D. Boulos, P. Yan, D. Schanzer, R. S. Remis, and C.P. Archibald. Canada Communicable Disease Report 2006. Public Health Agency of Canada. Ottawa: Government of Canada, 2006. 165-176.
[b] "Estimates of the Number of People Living with HIV in Canada, 2005." Public Health Agency of Canada. 2005. Government of Canada. 14 Apr. 2008 <www.phac-aspc.gc.ca/media/nr-rp/2006/20060731-hiv-vih-eng.php>.
[c] World Health Organization. "Worldwide HIV Statistics." Avert. 2007. AVERT.Org. 14 Apr. 2008 <http://www.avert.org/worldstats.htm>.
[d] "Number of HIV Positive Immigrants to Canada Triples in One Year, Immigration Department Says," The Henry Kaiser Family Foundation. 14 May 2004, citing M Friscolanti, "Number of HIV-positive immigrants to Canada triples in one year, Immigration Department says," *National Post*, 13 May 2004 at A1. Accessible at www.kaisernetwork.org/daily_reports/print_report.cfm?DR_ID=23718&dr_cat=1

restrictions to Canada based on HIV status do not apply to short-term visitors staying for less than six months.[e] This is indicative of the underlying assumption that HIV is not highly contagious and therefore is not reason in itself for a person to be denied entry to Canada. The extent to which an immigrant is likely to place an excessive burden on the health care system is indicated as the primary concern and is evaluated based on whether an applicant's projected annual health care costs would exceed the annual health care costs of an average Canadian,[f] which in 2007 was $4,867.40.[g] It is not specified what constitutes an 'average' Canadian, given the large within-group variation that exists among the general population, but it is likely that an HIV-positive person receiving antiretroviral treatment will incur expenses that exceed that threshold. While the law has resulted in denial of admission due to "excessive burden" to only 3.4%[h] of all HIV-positive applicants between 2006 and 2007, the overwhelming majority (94.7%) of the remainder were exempt from this condition as they were admitted as spouses or legal dependents under family-class sponsorship or as officially recognized refugees. Consequently, 64.3% of those HIV-positive applicants who were at potential risk of denial of admission due to the potential "excessive burden" attributable to their HIV status were indeed denied admission between 2006 and 2007.[i]

[e] Recent Changes to Visitor Visa Process Affecting Entry Into Canada for People Living with HIV. XVI International AIDS Conference. Toronto: Canadian HIV Legal Network, 2005. 1-3.
[f] "Number of HIV Positive Immigrants to Canada Triples in One Year, Immigration Department Says," The Henry Kaiser Family Foundation. 14 May 2004, citing M Friscolanti, "Number of HIV-positive immigrants to Canada triples in one year, Immigration Department says," *National Post*, 13 May 2004 at A1. Accessible at http://www.kaisernetwork.org/daily_reports/print_report.cfm?DR_ID=23718&dr_cat=1.
[g] Canadian Institute for Health Information: National Health Expenditure Trends, 1975-2007. Canadian Institute for Health Information: Ottawa, 2007.
[h] Access to Information Request, Citizenship and Immigration Canada, May 12, 2008.
[i] Ibid.

The purpose of this paper is threefold: first, to review the application of Canadian immigration law and jurisprudence as it pertains to persons with HIV and to place this review within a broader international context of restrictions on international mobility; second, to derive a statistical definition of excessive demand and to apply that threshold to persons with HIV who are seeking admission to Canada; and third, to estimate the economic contributions of new immigrants associated with tax revenues on labour market earnings in order to obtain a more complete assessment of both the costs and benefits associated with immigration. In order to achieve this end, we review the application of Canadian immigration law in Section 2.0 as it pertains to persons with HIV. In Section 3.0, we review and assess the current threshold used to determine excessive demand on Canadian health or social services. Section 4.0 yields a synthesis of the clinical, epidemiological and economics literatures concerning the expected burden placed on health or social services by persons with HIV. In Section 5.0, we derive estimates of the 5-year, 10-year, and lifetime economic burden associated with a new immigrant with HIV after stratifying for their underlying state of health, age and sex at the time of admission. Section 6.0 affords a comparison between the thresholds derived to measure excessive demand with the expected economic burden that immigrants with HIV may place on Canadian health or social services in order to yield evidence-informed criteria for the determination of medical inadmissibility. Section 7.0 discusses the economic contributions of immigrants in terms of the tax revenues that flow from earned income. We end with a brief summary of our findings.

2.0 Canadian and International Experience with Medical Inadmissibility

While international standards do not prohibit the practice of screening prospective immigrants for communicable diseases prior to entry, the scope of restrictions on people with HIV is strictly constrained. According to the International Guidelines on HIV and Human Rights:

> The right to liberty of movement encompasses the rights of everyone lawfully within a territory of a State to liberty of movement within that State and the freedom to choose his/her residence, as well as the rights of nationals to enter and leave their own country….
>
> Where States prohibit people living with HIV from longer-term residency due to concerns about economic costs, States should not single out HIV, as opposed to comparable conditions, for such treatment and should establish that such costs would indeed be incurred in the case of the individual alien seeking residency.[j]

In the United Kingdom, Australia and the United States, it is common to deny admission to prospective immigrants with HIV. In the United Kingdom, denial of admission to HIV-positive immigration applicants has occurred on the basis that required treatments may be too expensive for the applicant to afford.[k] While a publicly funded National Health Service (NHS) allows citizens of the United Kingdom to seek health care treatment at minimal individual cost, the UK's immigration practice has been to stringently enforce its policy of medical inadmissibility to deter persons with HIV from engaging in 'treatment tourism'.[l]

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[j] International Guidelines on HIV and Human Rights, 2006 Consolidated Version, Office of the United Nations High Commissioner for Human Rights and UNAIDS, paras, 126 and 128.

[k] "Countries and Their Entry Restrictions." AIDSmap Living with HIV. 2008. AIDSmap. 14 Apr. 2008 <http://www.aidsmap.com/en/docs/C92D5639-E779-44EC-B8F8-0CECCC23275A.asp>.

[l] Pembrey, Graham. "AIDS in the UK." Averting HIV. 9 May 2008. AVERT.org. 15 Apr. 2008 <http://www.avert.org/aidsuk.htm>.

In Australia, travelers wishing to stay temporarily in the country for short visits may do so but are required to sign a declaration of good health, or otherwise state the health problems with which they are currently living.[m] Based on the information provided, a person may be deemed inadmissible for even a temporary visit, although such cases are typically reserved for severe circumstances. In order to immigrate to Australia, each applicant must undergo HIV testing and if it is suspected that the cost of health care treatment will be excessive, or will subsequently deny Australian citizens access to limited health care resources, an applicant may be denied admission.[n]

In the United States, no person with HIV, in principle, may be admitted to the country as an immigrant.[o] Under exceptional circumstances a person may be admitted temporarily (30 days or less) to visit family, seek medical treatment or to conduct business.[p] While admission to the United States does not require one to undergo a medical examination, it is important to note that if a foreign national knowingly declares that he or she is HIV-negative and is found to have HIV in the United States after arrival, that person will be deported to his or her country of origin.[q]

Such strict international migration policies are not the global standard, however, as in both Denmark and Sweden there are few entry restrictions for HIV-positive persons.[r] Indeed, highly regulated international immigration policies may generate positive

[m] "Countries and Their Entry Restrictions." AIDSmap Living with HIV. 2008. AIDSmap. 14 Apr. 2008 <http://www.aidsmap.com/en/docs/C92D5639-E779-44EC-B8F8-0CECCC23275A.asp>.
[n] Ibid.
[o] Ibid.
[p] Ibid.
[q] "Countries and Their Entry Restrictions." AIDSmap Living with HIV. 2008. AIDSmap. 14 Apr. 2008 <http://www.aidsmap.com/en/docs/C92D5639-E779-44EC-B8F8-0CECCC23275A.asp>.
[r] Ibid.

externalities by serving to increase worldwide HIV surveillance. Nevertheless, many resource-rich countries are denying medical treatment to persons with HIV who are often from countries in which access to antiretroviral (ARV) treatment is not readily available.[s] Further, the incidences of deportation which have been noted in both the United States and the United Kingdom,[t] on the grounds that HIV-positive persons tend to place excessive demands on health care services, has been questioned on the basis of health as a human right, while the act of deportation itself has been deplored as 'immoral'[u] and 'unjustifiable'.[v]

The financial burden of HIV on the general population is evaluated at the level of the individual and is typically based on a metric involving the calculation of hospitalization costs, ARV and drug treatment expenses as well as the use of other health care services.[w] In a 2001 study conducted by Chen et al., concerning the per capita costs of HIV based on medication and hospitalization expenditures in the United States, it was found that disbursements for highly active ARV therapy were relatively constant at $10,500 USD across all CD4 cell count strata.[x] However, patients with CD4 cell counts less than 50 cells/mm^3 incurred costs that were 2.6 times greater than the total annual expenditures of

[s] Sadoway, Geraldine. Personal interview. 29 Feb. 2008.
[t] Gibson, Katie. "UK: House of Lords Upholds Deportation Order." HIV Policy & Law Review 10 (2005). Aug. 2005 <http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=224>.
[u] Pembrey, Graham. "AIDS in the UK." Averting HIV. 9 May 2008. AVERT.org. 15 Apr. 2008 <http://www.avert.org/aidsuk.htm>.
[v] Ibid.
[w] Bozette, Samuel A., Geoffrey Joyce, Daniel F. McCaffrey, Arleen A. Leibowitz, and et al. "Expenditures for the Care of HIV-Infected Patients in the Era of Highly Active Antiretroviral Therapy." New England Journal of Medicine 344 (2001): 817-824.
[x] Chen, Ray Y., Neil A. Accortt, Andrew O. Westfall, Michael J. Mugavero, James L. Raper, Gretchen A. Cloud, Beth K. Stone, Jerome Carter, Stephanie Call, Maria Pisu, Jeroan Allison, and Michael S. Saag. "Distribution of Health Expenditures for HIV-Infected Patients." Clinical Infectious Diseases (2006): 1003-1010.

patients with CD4 cell counts less than 350 cells/mm^3.[y] The study concluded that an increase in disease severity was positively correlated with increased health care costs.[z] The implications of this finding suggest that health care demands of persons with HIV increase over time and must be accounted for during the evaluation of applicants seeking to immigrate to countries such as Canada. At present, Citizenship and Immigration Canada (CIC) uses an Operational Processing Instruction manual to assess the eligibility of HIV-positive applicants that may enter Canada. The manual indicates that certain applicants may be Excessive Demand Exempt (EDE), according to section 38(2) of the IRPA, in cases where one

> (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 […]

Such applicants, as defined above, are assessed for entry based on whether or not they present a threat to public health or safety. Problematically, it is not clear from the IRPA guidelines what may constitute a public health or safety threat. Moreover, non-EDE applicants must undergo testing to determine their CD4 cell count. If the test indicates that an applicant has a CD4 cell count below 350 cells/mm^3, ARVs are required based on Canadian guidelines.[aa] In such cases, an applicant is said to represent excessive demand[bb]

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[y] Ibid.

[z] Ibid.

[aa] Operational Processing Instruction 2002-2004. Citizenship and Immigration Canada. Ottawa: Government of Canada, 2002. 1-7.

irrespective of the source of finance for such mediations.[cc] The interpretation of excessive demand also includes those who may in the future require ARVs to mitigate the progression of the disease, substantially decreasing the possibility that any HIV-positive person would be found admissible without a separate claim to entry under family-class sponsorship or as a refugee.[dd]

While the cost of ARVs may be a long-term financial burden on the Canadian public health care system, the results of sustained ARV treatment have led to a decrease in the frequency and duration of hospitalizations by HIV-positive persons.[ee] In addition, the methods used by CIC to determine whether an applicant represents an excessive burden fail to account for the productivity that any given person could generate within Canada after immigrating.[ff] As CIC has affirmed, immigration plays “an increasingly important role in supporting Canada’s economic prosperity and competitiveness” and immigration is “a key source of labour force growth in the future.”[gg] Indeed, immigrants arriving in Canada between 1991 and 2001 represented 70 percent of the decade’s total net labour force growth, and notably accounted for 24 percent of the labour force growth of the health and social services sector during that period.[hh] Moreover, immigration makes an

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[bb] Ibid

[cc] Approximately one-third of all Canadian ARV expenditures are privately financed, personal communication, Bayer Inc Canada.

[dd] "Number of HIV Positive Immigrants to Canada Triples in One Year, Immigration Department Says." The Henry Kaiser Family Foundation. 14 May 2004. 14 Apr. 2008 <http://www.kaisernetwork.org/daily_reports/rep_index.cfm? DR_ID=23718>.

[ee] Mocroft, A, A Monforte, O Kirk, M A. Johnson, N Friis-Moller, D Banhegyi, A Blaxhult, F Mulcahy, J M. Gatell, and J D. Lundgren. "Changes in Hospital Admissions Across Europe: 1995-2003." HIV Medicine 5 (2004): 437-447.

[ff] Sadoway, Geraldine. Personal interview. 29 Feb. 2008.

[gg] Annual Report to Parliament on Immigration, 2007, Citizenship and Immigration Canada, 2007, available at http://www.cic.gc.ca/ENGLISH/resources/publications/annual-report2007/section1.asp

[hh] Immigration As A Source of Skills, Canadian Labour and Business Centre, 2003. In 2007, the national unemployment rate for immigrants was only 6.6%. See “The Canadian Immigrant Labour Market

enormous contribution to the pool of people in Canada with post-secondary qualifications. In 2006, among new immigrants 15 years of age and over, almost 42 percent of economic immigrants to Canada held a university degree and a further 15.5 percent held some other form of post-secondary credentials such as a non-university diploma or trade certificate.[ii] Therefore, the relative contribution of HIV-positive individuals to Canadian society needs to be evaluated in addition to the health care costs he or she may accrue in managing the progression of HIV in order to yield a comprehensive assessment of net cost (or net benefit) associated with each immigration applicant.

On October 21st, 2005, in a landmark decision made by the Supreme Court of Canada in the cases of *Hilewitz v. Minister of Citizenship and Immigration* and *de Jong v. Minister of Citizenship and Immigration*, it was decided that persons with disabilities could contribute valuably to Canadian society.[jj] Supreme Court Justice Abella wrote the majority decision in which CIC was directed to evaluate immigration applications on an individualized basis, so as to incorporate into admissibility decision-making schemes the ability of each applicant to invest personal resources of time, money, and social support to sustain the livelihood of themselves or family members with disabilities.[kk] The Supreme Court decision validated the concern that an objective metric for evaluating the eligibility of a prospective immigrant fails to account for important individualized circumstances, and it acknowledged the legitimate claim that an applicant's individual

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in 2007," *The Immigrant Labour Force Analysis Series*, May 13, 2008 available at http://www.statcan.ca/english/freepub/71-606-XIE/71-606-XIE2008003.htm.

[ii] Facts and Figures 2006, Immigration Overview: Permanent and Temporary Residents, 2007, available at http://www.cic.gc.ca/english/resources/statistics/facts2006/permanent/25.asp.

[jj] Hilewitz V. Minister of Citizenship and Immigration. Supreme Court of Canada. 21 Oct.2005.

[kk] Ibid.

resources may offset the costs that would otherwise mean he or she would place an excessive burden on public costs in Canada. The *Hilewitz* decision concerned excessive demand in relation to social services; to date, no official court ruling has been made to extend the reasoning behind the *Hilewitz* decision to the context of health care services in Canada.

The decision to deny an HIV-positive applicant admission into Canada can bear grave implications. In countries with high HIV prevalence, people living with HIV are often subject to stigma, social isolation, exclusion and denial of treatment.[ll] In such situations, people may seek to immigrate or seek asylum in countries such as Canada. There are countless circumstances, however, in which appeals made by applicants to remain in Canada on humanitarian and compassionate grounds have failed - to the severe detriment of the appellants.[mm] There are several areas of concern that need to be addressed when examining the process by which permanent resident status is gained in Canada for people with HIV.

For an HIV-positive person to obtain permanent resident status in Canada as a refugee, it must be proven that the individual would face persecution, torture, cruel or unusual treatment or punishment or a risk to life if the individual returns to his or her country of origin.[nn] The risk to life cannot arise due to the inability of the claimant's country to provide adequate health or medical care.[oo] This can often be difficult to prove, as stigma,

[ll] Allen, Tim, and Alan Thomas. Poverty and Development Into the 21st Century. New York: Oxford UP, 2000.
[mm] Sadoway, Geraldine. Personal interview. 29 Feb. 2008.
[nn] Ibid., , IRPA, ss. 96, 97
[oo] IRPA, ss. 97(1)(b)(iv)

social exclusion, isolation, persecution and limited access to ARVs are not easily established.

An application for permanent residence in Canada on humanitarian and compassionate grounds is legally rooted in Section 25(1) of IRPA, which states that:

> The Minister shall, upon request of a foreign national who is inadmissible or who does not meet the requirements of this Act, and may, on the Minister's own initiative, examine the circumstances concerning the foreign national and may grant the foreign national permanent resident status or an exemption from any applicable criteria or obligation of this Act if the Minister is of the opinion that it is justified by humanitarian and compassionate considerations relating to them, taking into account the best interests of a child directly affected, or by public policy considerations.

This section of the Act allows people to apply to remain in Canada as a permanent resident based upon evidence that they would face unusual, undeserved or disproportionate hardship if they return to their country of origin.[pp] Therefore, this section can be used by people with HIV to obtain Canadian permanent residence if they face harsh treatment or denial of health care in their countries of origin.

Unlike refugees and some sponsored family class members, successful applicants for permanent residence on humanitarian and compassionate grounds under s. 25 of IRPA are not exempt from medical inadmissibility criteria. Therefore, a person with HIV initially accepted under this section due to the harsh circumstances in his or her country of origin can be rejected if her HIV status is expected to cause an "excessive demand" in Canada.

[pp] Citizenship and Immigration Canada Processing Manuel IP5

Applicants for permanent residence on humanitarian and compassionate grounds can apply for an exemption from medical inadmissibility criteria under Operational Bulletin 021 (June 22, 2006). However, the processing of such exemption requests is problematic. There presently stands only one delegate appointed by the Minister of Citizenship and Immigration, who has for thirty years acted as the sole immigration officer at the CIC responsible for overseeing petitions by immigration applicants to be exempt from the medical inadmissibility clause. The reasoning behind some of this officer's decisions have been challenged as vague and unclear, resulting in several Federal Court judicial review applications.[qq]

In the event that an applicant is determined medically inadmissible, an application can be made to enter or reside in Canada via a temporary resident permit (TRP).[rr] In such cases, the temporary residency permit with code number 90 is administered to the refugee or asylum seeker.[ss] This permit allows individuals to reside in Canada, but does not allow them access to provincial health care, for a period of up to three years.

Sections 15(1) and 15(2) of the Canadian *Charter of Rights and Freedoms* (Charter) state that:

> **15.** (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.
>
> (2) Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or

[qq] Battista, Michael. Personal Interview. 10 Mar. 2008.
[rr] IRPA, s. 24
[ss] Sadoway, Geraldine. Personal interview. 29 Feb. 2008.

> groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability[tt]

It has been argued in Canadian courts that Section 15(1) of the Charter is meant to prevent discrimination in the provision of health care, and to therefore promote equal access to health care services.[uu] While the response to such legal challenges has been that *cost* discrimination is distinct from discrimination against a *person*, the impact of such decisions on prospective immigrants always result in their removal from Canada, denial of entry to Canada, and denial of access to essential medical treatment.[vv]

In sum, the literature suggests that fair treatment of people with HIV requires evidence-based policies at home and abroad. Immigration policies for persons with HIV will become increasingly important as legal, political and humanitarian concepts of access to health care services evolve. Presently, Canadian federal immigration policies reflect somewhat arbitrary and rigid standards for determining excessive demand for persons with HIV. These assessments are conducted without individualized assessments of those who are not exempt from IRPA's medical inadmissibility clause. Whether or not such standards serve to protect the Canadian health care system and the citizens of Canada has yet to be affirmed, given: the positive contributions HIV-positive persons may make to Canada; and the possibility that applicants' private financial and social resources may reduce their relative demand on health care services.

[tt] "Equality Rights." Canadian Charter of Rights and Freedoms. 1982. Government of Canada. 14 Apr. 2008 <http://laws.justice.gc.ca/en/Charter/index.html#egalite>.
[uu] Sadoway, Geraldine. Personal interview. 29 Feb. 2008.
[vv] Ibid.

3.0 Threshold for Excessive Demand on Canadian Health or Social Services

In this Section, we review and assess the current threshold used to determine excessive demand on Canadian health or social services in the light of Canadian health expenditure characteristics.

Although the provision of health care is a provincial concern in Canada, the federal government has influenced the development of policy. Since January 1, 1971, all ten provinces and the territories have had public health insurance plans covering all necessary medical and hospital services. Since the federal government covers a substantial portion of all health expenditures, it has been able to establish certain criteria that the provinces and territories must meet if they were to qualify for their full share of federal transfers. Reasonable access by all residents to the full range of insured services without financial impediments to utilization captures the essence of the federal funding criteria.[ww]

In 2007, average per capita Canadian health care expenditures were $4,867.40.[xx] These expenditures included various categories of health service expenditures whether financed publicly or privately. While the public share accounts (in 2007) for 70.6% of total expenditures, most services are delivered privately. For example, physicians are generally self-employed, but reimbursed by provincial health insurance plans on a fee-for-service basis; while hospitals, which are owned and operated on a not-for-profit basis by

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[ww] Vayda E, Deber RB.: The Canadian Health Care System: An Overview. Social Science and Medicine 1984; 3: 191-197. and Evans RG, Lomas J, Barer ML et al.: Controlling Health Expenditures: The Canadian Reality. New England Journal of Medicine 1989; 320:9, 571-577.

[xx] Canadian Institute for Health Information: National Health Expenditure Trends, 1975-2007. Canadian Institute for Health Information: Ottawa, 2007.

various organizations, receive prospective global budgets from provincial governments to finance ambulatory and inpatient services.

To assess whether a potential immigrant represents an “excessive” demand on Canadian health or social services, a threshold is required as stipulated in the legislation. Current practice by CIC has been to set the annual cost threshold at the same value as that for average per capita Canadian health care expenditures. However, that threshold is arbitrary <u>and</u> may be shown to be neither a reasonable nor statistically appropriate interpretation of the term “excessive” demand used in IRPA.

We propose that “excessive” demand on Canadian health or social services be defined as a cost profile for a prospective immigrant that is *statistically* <u>*greater*</u> than that for Canadians. To establish this “excessive” demand threshold, we construct a statistical test to determine how large costs need to be before a prospective immigrant ”might reasonably be expected to cause “excessive” demand on health or social services” in accordance with Section 38(1) of the Canadian *Immigration and Refugee Protection Act* (IRPA) of 2001.

To operationalize this statistical test, the distribution of Canadian health care costs, the cost profile of a prospective immigrant, and the level of statistical significance all need to be established.

Based on the distribution of Canadian health care costs, we may test whether the expected health care cost experience of an immigration applicant is the same as or is greater than that for Canadians. Specifically, we construct a statistical test to determine how large costs might need to be before a prospective immigrant's cost profile is deemed to be "excessive", ie statistically different from that for a representative Canadian.

While average per capita health expenditures in Canada in 2007 were $4,867.40, there is a paucity of data on the distribution of such costs across all Canadians. It may be convenient to hypothesize that health care costs follow a normal (or bell-shaped) distribution; however, experience suggests that health care costs are non-negative and positively skewed, i.e. skewed towards the high end. A distribution that is consistent with such costs (i.e. non-negative and positively skewed) is a Gamma distribution. This distribution has been used previously in modeling health care costs,[yy,zz,aaa,bbb] and it is relatively simple to describe because it is defined in terms of a scale and a shape factor. These factors may be estimated as the ratio of the variance of costs to average costs (σ^2/μ) and the ratio of squared average cost to the variance of costs (μ^2/σ^2), respectively. The scale parameter determines the practical range of costs, while the shape parameter determines the distributional profile of costs. In other words, the Gamma distribution is based on two parameters: average costs; and the relative variance in costs (i.e. the

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[yy] Diehr P, Yanez D, Ash A, Hornbrook M, Lin DY: Methods for analyzing health care utilization and costs. Annu Rev Public Health 1999; 20:125–44.
[zz] Fryback DG, Chinnis JO Jr, Ulvila JW. Bayesian cost-effectiveness analysis. An example using the GUSTO trial. Int J Technol Assess Health Care. 2001; 17(1):83-97.
[aaa] Nixon RM, Thompson SG. Parametric modeling of cost data in medical studies. Stat Med. 2004; 23(8):1311-31.
[bbb] Briggs A, Gray A. The distribution of health care costs and their statistical analysis for economic evaluation. J Health Services Res Pol 1998; 3(4):233–245.

coefficient of variation which is defined as the ratio of the standard deviation of costs to its mean, σ/μ. A low relative variance yields cost observations concentrated around average costs, while observations are more dispersed when the relative variance is high.

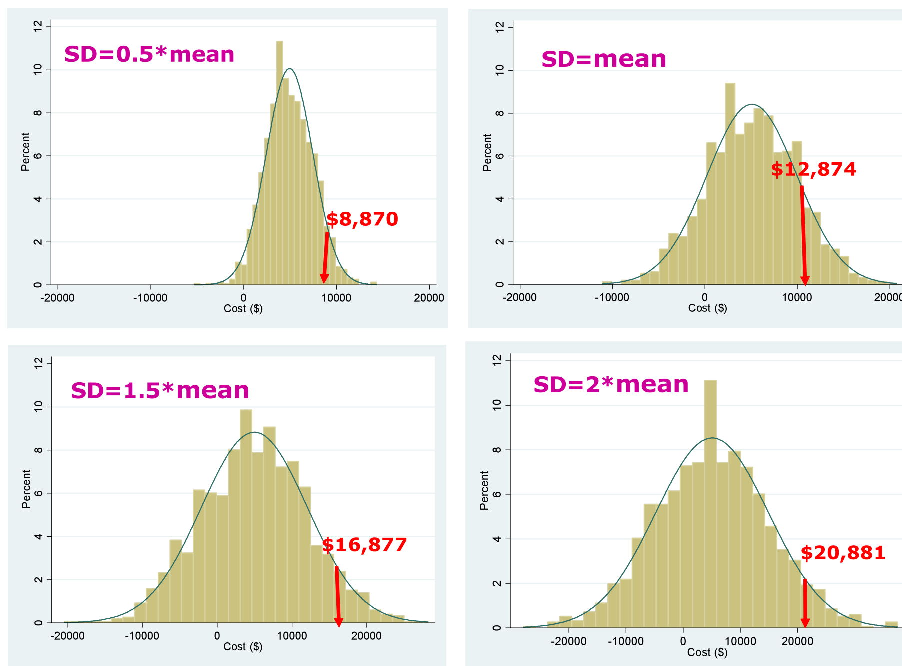
Once the cost distribution for Canadians and for a prospective immigrant have been established, the level of statistical significance used to test the null hypothesis that a prospective immigrant exhibits a cost profile that is the *same* as that for Canadians against the alternative that such costs are *greater* than those for Canadians needs to be established. While it is conventional in the health services research literature to use a 5 percent significance level (ie Fisher, 1925)[ccc], this level of significance is discretionary and depends on the confidence warranted in the test. Use of a 5 percent significance level implies that the statistical test correctly rejects the null hypothesis that a prospective immigrant has the same cost distribution as a Canadian 95 percent of the time. A less stringent requirement to be correct (ie only 90 percent) yields a significance level of 10 percent, while a more stringent requirement to be correct (ie 98 percent) yields a significance level of 2 percent. A less stringent requirements increases the chance that the null hypothesis is rejected when a prospective immigrant has the same cost distribution as a Canadian. Based on the distribution of costs for Canadians and for a prospective immigrant, the significance level invoked yields a unique “excessive” demand threshold as described in Figures 1(i) and 1(ii).

[ccc] http://books.google.ca/books?id=Mo7NUGTqb1QC&pg=PA465&lpg=PA465&dq=fischer+5+percent+significance+level&source=bl&ots=Xop73TC9yW&sig=TV3fKZulfCympDJYybaRsDe9veQ&hl=en&ei=8z31SeTAM9WUkAX1l9zzCg&sa=X&oi=book_result&ct=result&resnum=6

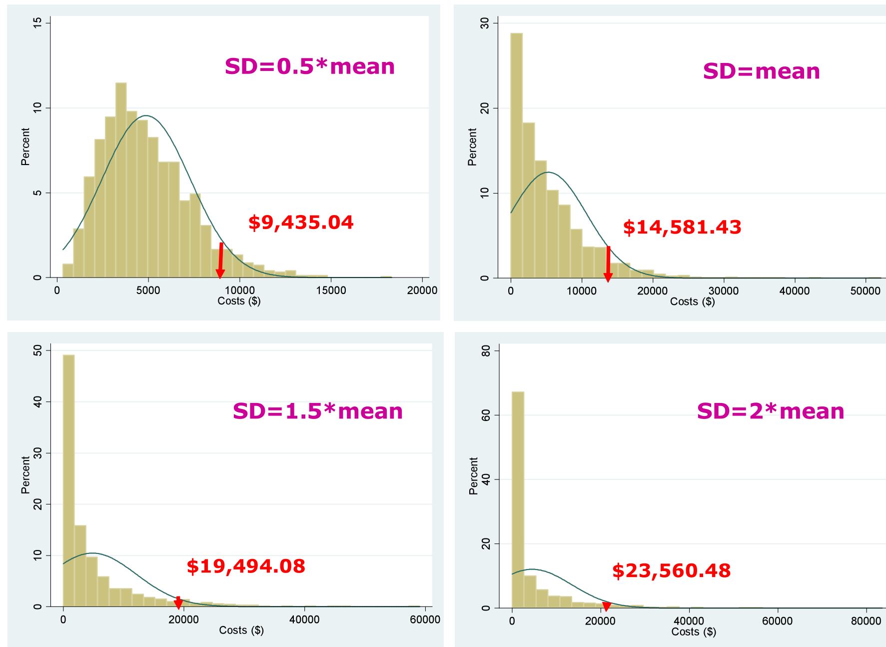
Figures 1(i) and 1(ii) represent two sets of simulated distributions of Canadian health care expenditures when we know average per capita health care expenditures, but where assumptions are made about both their relative variance and proposed distribution. Figure 1(i) represents four possible normal (or bell-shaped) distributions for Canadian health care costs, while Figure 1(ii) offers equivalent Gamma distributions for the same set of values for the relative variance of costs. The solid curves represent continuous probability density functions, while the bar charts represent the proportion of observations that fall within various intervals. As the relative variance increases, from 0.5 to 2.0, the simulated distributions of health care costs become more dispersed. Consequently, the red arrows that represent the threshold of health care costs experienced by 5 percent or fewer Canadians grow as the relative variance of costs increase, and is consistent with a significance level of 5 percent.

Figures 1: Annual Cost Thresholds for Excessive Demand for a (i) Normal Distribution; and (ii) for a Gamma Distribution

(i) Normal Distribution:



(ii) Gamma Distribution:



In general, annual cost thresholds for excessive demand are reported in Table 1 that dependent on the assumed cost distribution (normal or gamma), the relative variance of such costs (0, 0.5, 1, 1.5, or 2), and the significance level used to test the null hypothesis that an immigration applicant exhibits a cost profile that is the *same* as that for a Canadian or is *higher*. Three findings may be summarized. First, the Gamma distribution consistently yields a larger cost threshold than that obtained when using a normal distribution. This occurs because the Gamma distribution yields only positive values for health expenditures and incorporates a positive skew to such costs. In contrast, non-positive costs are possible under a normal distribution, with the distribution of costs symmetric around the mean of such costs. Second, for both the normal and the gamma distribution, and for each invoked level of statistical significance, the annual cost threshold for excessive demand consistently increases with the relative variance in costs. Only when the relative variance in costs is zero, ie all Canadians incur the same annual

costs for health care, would that threshold be the same as that currently used by CIC. In all other instances, the cost threshold is higher. Finally, the annual cost threshold for "excessive" demand increases with a decline in the invoked level of statistical significance, i.e. if the statistical test is designed to be correct in rejecting the null hypothesis that a prospective immigrant has the same cost profile as a Canadian, the threshold needs to be higher.

Table 1: Annual Cost Thresholds for "Excessive" Demand Contingent of the Distribution of Costs, the Relative Variance in Costs, and Significance Levels.

		Cost Threshold in 2007 C$					
		Normal Distribution			Gamma Distribution		
		2 percent	5 percent	10 percent	2 percent	5 percent	10 percent
Relative Variance (or Coefficient of Variation, CV = σ /μ)	0	4,867.40	4,867.40	4,867.40	4,867.40	4,867.40	4,867.40
	0.5	9,866.22	8,870.84	7,987.40	11,054.01	9,435.04	8,129.51
	1	14,865.04	12,874.27	11,107.41	19,041.38	14,581.43	11,207.60
	1.5	19,863.86	16,877.71	14,227.41	27,879.94	19,494.08	13,483.14
	2	24,862.68	20,881.15	17,347.41	36,739.56	23,560.48	14,609.86

Table 1 yields wide variations in the cost threshold that may be used to determine "excessive" demand. Thresholds vary from a low of $4,867.40 (the current threshold used by CIC) when the relative variance of costs is zero to a threshold of $36,739.56,

which is almost eight-fold greater. While there are circumstances in which each threshold is appropriate, there is compelling evidence to support a Gamma distribution in contrast to a Normal distribution. Moreover, for those who have studied the distribution of health care costs they have tended to invoke a Gamma distribution and have used unity as the relative variance of costs.[ddd,eee,fff,ggg] Moreover, use of a conventional level of statistical significance of 5 percent, yields a health care cost threshold for "excessive" demand as $14,581.43, as reported in Table 1. If a potential immigrant were to exhibit a cost profile yielding higher costs, then the hypothesis that that potential immigrant had a cost profile that is the same as that for a representative Canadian would be rejected. Consequently, this is how we interpret, in a statistical sense, the meaning of "excessive" demand within Section 38(1) of IRPA, ie statistically different from that for a representative Canadian.

4.0 Potential economic burden on health or social services by persons with HIV

This Section offers a synthesis of the clinical, epidemiological and economics literatures concerning the economic burden placed on health or social services by persons with HIV. In reviewing data for inclusion in our assessment of the relationship between disease

[ddd] Diehr P, Yanez D, Ash A, Hornbrook M, Lin DY: Methods for analyzing health care utilization and costs. Annu Rev Public Health 1999; 20:125–44.
[eee] Fryback DG, Chinnis JO Jr, Ulvila JW. Bayesian cost-effectiveness analysis. An example using the GUSTO trial. Int J Technol Assess Health Care. 2001; 17(1):83-97.
[fff] Nixon RM, Thompson SG. Parametric modeling of cost data in medical studies. Stat Med. 2004; 23(8):1311-31.
[ggg] Briggs A, Gray A. The distribution of health care costs and their statistical analysis for economic evaluation. J Health Services Res Pol 1998; 3(4):233–245.

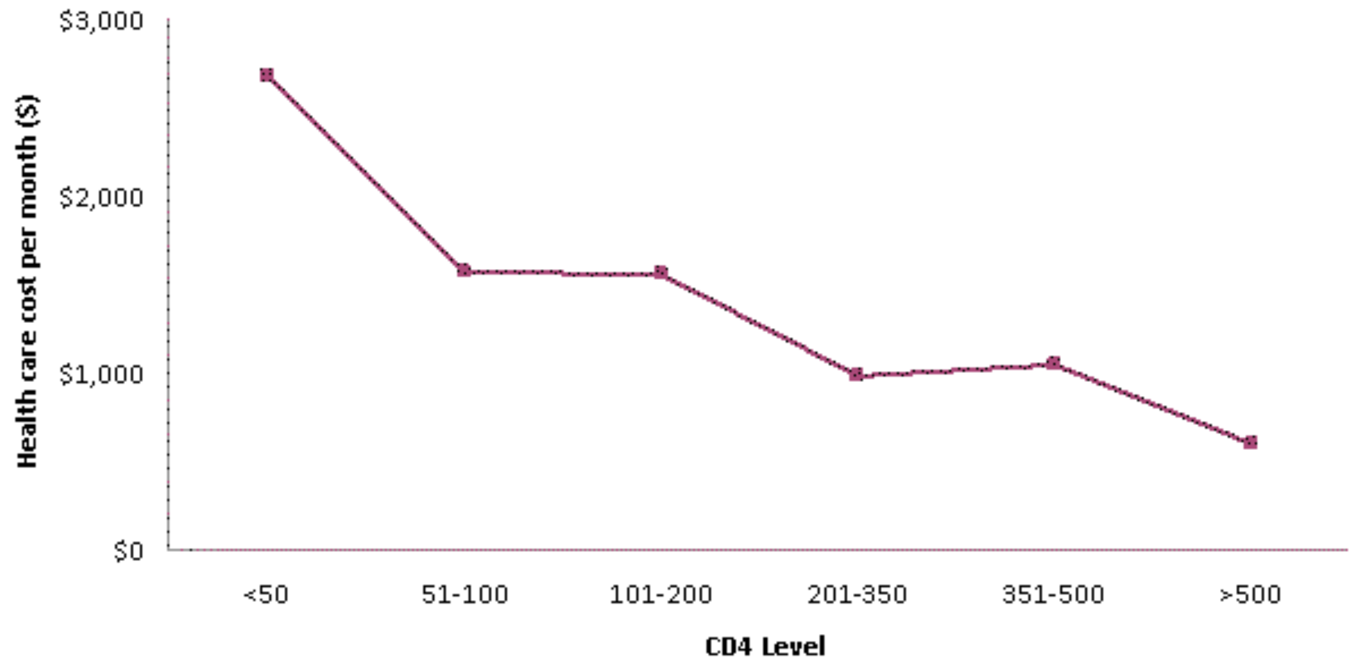
progression and health care costs, studies reviewed in a publication by Levy et al[hhh] were used. Only nine studies met three inclusion criteria: (i) peer-reviewed publication in English; (ii) original, patient-level data yielding mean monthly or annual direct estimates of medical costs of treating people with HIV, where anti-retroviral medication was included as routine clinical practice even when CD4 cell counts were over 500 cells/mm^3; and (iii) medical cost estimates stratified by CD4 cell counts. A recent Canadian study, which was not included in the review by Levy et al, yields slightly lower cost estimates than those reported below.[iii] Data from the studies reported by Levy et al were extracted from either the original article or directly from the author(s). Monthly health care costs in 2007 US dollars were presented after stratification by CD4 cell count categories as shown in Figure 2. A wide range of cost components were captured, including inpatient, outpatient, laboratory, and medication costs.

There is a general tendency for health care costs to increase with disease progression, but our confidence in some of the point estimates are limited by the underlying sample size. Specifically, while there are only 71 and 385 patients captured for the CD4 cell count categories 51-100 cells/mm^3 and 201-350 cells/mm^3, respectively, all other cost estimates were based on samples of more than 23,000 patients.

[hhh] Levy AR, Annemans L, Tramarin A, Montaner JS: The impact of disease progression on direct medical costs of treating persons with HIV: a review of the international literature. Pharmaco-economics, forthcoming, 2009

[iii] Krentz HB, Gill MJ: Cost of medical care for HIV-infected patients within a regional population from 1997 to 2006. HIV Medicine 9 (2008): 721-730.

Figure 2: Disease Progression & Average Monthly Health Care Costs in 2007 US$

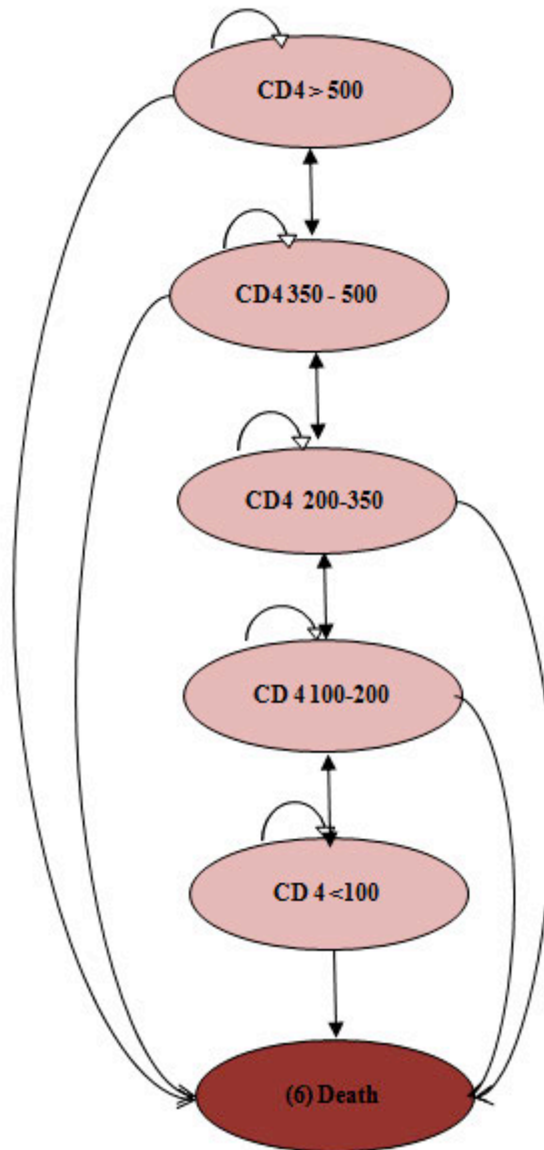


5.0 The economic burden of persons with HIV over various time horizons

Estimates of the economic burden of new immigrants with HIV are derived over three different time horizons (5-years, 10-years, and the remaining lifetime) after stratifying for underlying health states, age and sex at the time of admission to Canada.

In order to derive estimates of the economic burden a Markov model was developed, as shown in Figure 3 that describes the transition of a cohort of immigrates with HIV through various health states, here defined as CD4 cell count categories.

Figure 3: Health-State Transition for the Markov Model



In Figure 3, a cohort of immigrants is classified into initial health states according to the CD4 count measured at the time of application for admission to Canada. Transitions between health states are assessed on an annual basis. Potential health state transitions are: death; progression to a lower CD4 cell count health state; disease improvement to a higher CD4 cell count health state; or the status quo in which individuals remain in their

current health state. The model tracks the proportion of individuals in each health state after each cycle. Transitions are based on conditional probabilities that depend on average age, the sex distribution, and the current CD4 cell count category. Table 2 reports transition probabilities for each CD4 cell count category.

Table 2: Transitional Probabilities Used in the Markov Model for Immigration Applicants with HIV

Input Parameters		Source
Transition probabilities from "CD4 > 500" state		
Annual risk of having "CD4 350-500"	**7.59%**	**#1**
Relative risk of death[#]	**5.00**	**#2**
Transition probabilities from "CD4 350-500" state		
Annual risk of having "CD4 200-350"	**6.92%**	**#1**
Annual risk of recovering to "CD4 > 500"	**2.71%**	**#1**
Relative risk of death[#]	**7.00**	**#2**
Transition probabilities from "CD4 200-350" state		
Annual risk of having "CD4 100-200"	**3.13%**	**#1**
Annual risk of recovering to "CD4 350-500"	**2.71%**	**#1**
Relative risk of death[#]	**9.00**	**#2**
Transition probabilities from "CD4 100-200" state		
Annual risk of having "CD4 < 100"	**1.79%**	**#1**
Annual risk of recovering to "CD4 200-350"	**1.22%**	**#1**
Relative risk of death[#]	**13.00**	**#2**
Transition probabilities from "CD4 < 100" state		
Annual risk of recovering to "CD4 100-200"	**1.22%**	**#1**
Relative risk of death[#]	**20.00**	**#2**

[#] Baseline age-sex adjusted general population mortality

1. Sypsa V, Touloumi G, Karafoulidou A, Hatzakis A. Comparison of smoothing techniques for CD4 data in a Markov model with states defined by CD4: an example on the estimation of the HIV incubation time distribution. Statist. Med. 2001; 20:3667–3676.
2. Sighem, A, Sven D, Azra C, Luuk G, Roy A, Frank de W. Mortality in patients with successful initial response to highly active antiretroviral therapy is still higher than in non-HIV-infected individuals. Journal of AIDS 2005; 40(2):212-8.

Economic burden estimates for immigrant applicants with HIV depend crucially on the projected trajectory of disease, the anticipated incidence of mortality, health care cost estimates stratified by CD4 cell count categories, the rate at which future care costs are discounted to present values, and the time horizon over which cost are assessed. In order to derive economic burden estimates for each immigration applicant with HIV, costing weights (as discussed in Section 4.0) and reported in 2007 Canadian dollars in Table 3, are applied to each health state as represented by CD4 cell count categories.

Table 3: Input Cost Parameters for the Markov Model in 2007 Canadian Dollars

Input Cost Parameters	Values	Source
Annual Health Costs by CD4 Cell Count Categories (in 2007 Canadian Dollars)		
CD4 > 500	**$ 7,919.84**	**#3**
350 < CD4 < 500	**$13,807.59**	**#3**
200 < CD4 < 350	**$12,985.83**	**#3**
100 < CD4 < 200	**$20,438.48**	**#3**
CD4 < 100	**$35,372.88**	**#3**

3. Levy AR, Annemans L, Tramarin A, Montaner JS: The impact of disease progression on direct medical costs of treating persons with HIV: a review of the international literature. Pharmaco-economics, forthcoming, 2009

Because standard practice in the economic evaluation requires adjustment for the timing of costs, the analysis follows current practice and invokes a discount rate of 3 percent to convert the annual stream of expected health care costs to present valve terms.[iii] Moreover, in order to assess the economic burden of immigrants with HIV, three separate

[iii] Drummond ME, O'Brien BJ, Stoddart GL, Torrance GW: Methods for the Economic Evaluation of Health Care Programmes Second Edition, Oxford University Press: Oxford), 1997.

time horizons are considered, 5-years, 10-years, and lifetime for both men and women using mortality rates derived from Canadian life tables.[kkk]

Application of the Markov model yields estimates of the economic burden of new immigrants with HIV that depend on the time horizon used to assess the impact on health care costs (5-years, 10-years, and the remaining lifetime) as well as baseline CD4 cell count, age and sex of individuals at the time of admission to Canada. These estimates are reported in Tables 4(i)-4(iii).

There are four notable findings regarding the economic burden of new immigrants. First, the economic burden of immigration applicants increases with disease progression, i.e. the burden is larger if immigration applicants have smaller CD4 cell counts, indicating more serious symptoms. This occurs because such immigrants present a higher cost profile than other immigrants. Second, the burden increases when the time horizon over which health care costs are assessed increases. This occurs because more years are included in the assessment of the burden on health or social services. Third, the burden is greater for women than for men, and particularly so if the time horizon for assessment is longer. This occurs because women face a lower mortality rate, and consequently a longer life expectancy. Forth, the burden falls with the age of the immigration applicant, because older immigrants face a higher mortality rate than younger immigrants.

[kkk] Statistics Canada: Canadian Life Tables, Ottawa: 2007. http://www.statcan.ca/english/freepub/84-537-XIE/tables.htm, Last accessed February 8, 2007.

Table 4: Present Value of Health Care Expenditures in 2007 Canadian Dollars for

(i) Immigration Applicants aged 30 years with HIV.

	Males			Females		
Baseline CD4	5-Year	10-Year	Lifetime	5-Year	10-Year	Lifetime
>500	$36,151	$71,384	$183,612	$36,339	$72,263	$205,176
351-500	$55,945	$100,969	$222,100	$56,320	$102,503	$247,959
201-350	$55,562	$104,361	$233,254	$56,055	$106,477	$264,464
101-200	$85,181	$155,631	$311,042	$86,263	$160,089	$356,852
<100	$142,023	$248,953	$437,669	$144,725	$259,282	$508,296

(ii) Immigration Applicants aged 40 years with HIV.

	Males			Females		
Baseline CD4	5-Year	10-Year	Lifetime	5-Year	10-Year	Lifetime
>500	$35,871	$69,725	$144,155	$36,117	$71,024	$165,621
351-500	$55,393	$98,151	$175,847	$55,881	$100,374	$201,258
201-350	$54,836	$100,494	$179,028	$55,476	$103,536	$208,807
101-200	$83,599	$147,659	$234,983	$84,995	$153,932	$277,205
<100	$138,115	$231,178	$326,926	$141,565	$245,214	$390,022

(iii) Immigration Applicants aged 50 years with HIV

	Males			Females		
Baseline CD4	5-Year	10-Year	Lifetime	5-Year	10-Year	Lifetime
>500	$35,005	$65,028	$102,997	$35,541	$67,872	$124,277
351-500	$53,687	$90,283	$126,832	$54,742	$95,027	$152,061
201-350	$52,608	$89,965	$122,940	$53,983	$96,265	$151,367
101-200	$78,807	$126,838	$156,726	$81,754	$139,139	$195,700
<100	$126,522	$187,344	$211,688	$133,610	$212,772	$268,164

6.0 Inadmissibility depends on an applicant's characteristics and time horizon

Thresholds used to define excessive demand are determined in this Section and applied to estimates of the economic burden of persons with HIV in order to identify which immigration applicants may be deemed to be inadmissible on medical grounds.

In Section 3.0, we demonstrated that the current annual cost threshold used by CIC to determine whether an applicant is likely to pose "excessive" demand ($4,867.40) is too low, and that there might be justification under some circumstances for a threshold that is almost eight-fold greater at $36,739.56. Under there extreme positions either all individuals with HIV would be denied admission or all would be accepted. In Section 3.0, we proposed a middle position that we felt was a statistically more appropriate annual cost threshold at $14,581.43 (or three-fold greater than the current CIV threshold). Application of this annual cost threshold to assessment periods extending for multiple years warrant even higher cost thresholds to be compared to the cost profile of each immigration applicant. Table 5 reports the present value of cost thresholds (in 2007 Canadian dollars) for representative Canadians based on their age, sex, and the time horizon for assessment. Consequently, in order to assess whether immigrant applicants present a cost profile that is higher than that for a matched representative Canadian warrants a comparison between the figure in each cell in Table 5 and an appropriate figure from Tables 4(i)-4(iii).

Table 5: Thresholds for the Present Value of Health Care Costs by Age, Sex and Time Horizon discounted in advance at 3% in 2007 Canadian Dollars ($14,581.43)

	Males			Females		
Age	5-Year	10-Year	Lifetime	5-Year	10-Year	Lifetime
30 years	$68,892	$130,702	$441,832	$68,958	$130,982	$468,558
40 years	$68,793	$130,175	$383,757	$68,880	$130,593	$414,254
50 years	$68,483	$128,595	$316,614	$68,676	$129,568	$351,073

Comparison between the figures in Tables 4(i)-4(iii) and Table 5 yields the shaded regions in Tables 4(i)-4(iii). These shaded regions identify individuals who **do not**

represent an excessive burden on Canadian health or social services. Classification as medically inadmissible depends on the unique characteristics of each potential immigrant including their age, sex and baseline CD4 cell count as well as on the time horizon over which an applicant is assessed to impact health or social services.

The baseline CD4 cell count category, at which immigration applicants with HIV are deemed to represent an excessive burden on Canadian health or social care, falls as the time horizon for assessment increases. Specifically, a five-year or ten-year time horizon generally warrants individuals with CD4 cell counts <200 cells/mm^3 to be deemed inadmissible, while a lifetime horizon provides for admission to all except for women aged 30 years with CD4 cell counts <100 cells/mm^3. These finding occurs because persons with HIV are at a greater risk of death than the general population which lowers the present value of their potential economic burden. Similarly, as women have greater life expectancies than men, their potential economic burden on Canadian health or social care is accordingly greater. This only makes a difference in Table 4 in two instances: when a ten-year horizon is employed for immigration applicants at 50 years of age; and when a lifetime horizon is employed for immigration applicants at 30 years of age. Moreover, as the age of the applicant increases, their life expectancy falls. This decline lowers their potential economic burden on health or social services, and accordingly, lowers the CD4 cell count threshold at which potential immigrants may be classified as being medically inadmissible. This effect is only noticeable in two instances: first, when a ten-year horizon is used whereby the threshold for being medically inadmissible drops for men aged 40 to 50 from CD4 cell counts <200 cells/mm^3 to <100 cells/mm^3; and

second, when a lifetime horizon is used whereby the threshold for being deemed medically inadmissible drops for women aged 30 to 40 from CD4 cell counts <100 cells/mm^3 to include all women irrespective of their CD4 cell count when aged 40 years. These are interesting sex related differences and suggest that women face a greater likelihood of being deemed medically inadmissible than men.

7.0 Economic Contributions of Immigrants

Estimates of the contributions of new immigrants to the public treasury through taxes paid on labour market earnings are constructed in this Section in two steps. First, earnings projection equations are estimated using data from the master files of the 2001 and 2006 Canadian censuses.[lll] Second, the federal and provincial tax revenues due on these earnings are estimated using the Canadian Tax and Credit Simulator (CTaCS).[mmm] Separate calculations are made for immigrants who (alternatively) arrive in Canada at ages 30, 40 and 50.

Earnings Projections

The samples from the censuses consist of wage and salary workers in Ontario, exclude non-permanent residents, and were drawn separately for males and females. The age restrictions imposed vary by the assumed age when the immigrant arrived in Canada. For example, the sample used to project the earnings of immigrants who arrived in Canada at age 30 consists of immigrants who arrived in Canada between ages 25 and 35 who are

[lll] The master files of these censuses were access through the Toronto Region Statistics Canada Research Data Centre.
[mmm] CTaCS was created by Kevin Milligan of the Department of Economics, University of British Columbia.

aged 25 through 59, and native born individuals aged 25 through 59. The native born subsample is restricted to start at age 25 because by definition that is the youngest age possible for any member of the immigrant subsample; however, there is no corresponding definitional limit to the upper age in the immigrant subsample. Someone who arrived in Canada at age 25 in 1968 would be 63 when observed in the 2006 census. An upper age limit of 59 was chosen to avoid early retirement issues for those sample members who have CPP/QPP benefits available at age 60. Similarly, the samples used to project earnings of immigrants who arrived in Canada at age 40 (or age 50) comprises immigrants who arrived in Canada between ages 35 and 45 (or between 45 and 55) who are aged 35 (or 45) through 59, and native born individuals aged 35 (or 45) through 59.

The methods used to estimate the earnings projection equations are well known in the literature (Baker and Benjamin 1994, Bloom and Gunderson 1991, Borjas 1985, Grant 1999). They require the use of at least two cross sectional data sets on immigrant (and native born) outcomes, and the assumption that any year (secular) effects are common to the immigrant and native sub-samples. We satisfy these requirements by using data from both the 2001 and 2006 censuses and assume that any labour market shocks in 2006 are common to immigrants and the native born. The measure of earnings in each census is for the previous calendar or “reference” year (2000 and 2005, respectively)

The earnings projections allow immigrants’ earnings to vary by both their period of arrival in Canada and by the number of years they have lived in Canada. The following specification of the earning equation is used:

(1) $\ln w = f(AGE) + g(YSM) + h(yoa) + j(pob) + \gamma t + X\beta + \varepsilon$

where:

- ln *w* is the log of an individual's wages and salary measured in 2005 Cdn dollars;
- *f (AGE)* is cubic in the individual's current age;
- *g(YSM)* is cubic in years since arrival in Canada (0 for the native born);
- *h(yoa)* are a series of dummy variables for the following Canadian arrival periods: 1975 or before, 1976-1980, 1981-1985, 1986-1990, 1991-1995, 1996-2000, 2001-2005 (all 0 for the native born);
- *j(pob)* are a series of dummy variables for the birthplace: US, UK, West Indies, Other Americas, Europe, Central Asia, East Asia, South Asia, South East Asia, Oceania, Other (all 0 for the native born);
- *t* is a dummy variable for observations from the 2006 census; and
- *X* are control variables that include dummy variables for: living in an urban area; married or in a common law relationship; activity limitation at work, school or in other activities; presence of at least one child aged 5 or less in the household; education levels; knowledge of Canada's official languages; and use of one of the official languages at home.

Equation (1) is estimated separately using individuals who work full year full time (FYFT: 48 weeks or more in the reference year) and for "other workers".[nnn]

Once estimates of equation (1) are obtained, they are used to project inflation-adjusted earnings growth for an immigrant who arrived in Canada in the period 2001-2005, at the assumed age of arrival. The explanatory variables are set for these projections following

[nnn] This sample will include part time workers and part year full time workers.

specific client profiles. A life profile of earnings is then created starting in 2005 allowing both age and years in Canada to change over time. A separate earnings projection equation is used for immigrants who arrive in Canada at ages 30, 40 and 50, respectively.

Estimating Tax Revenues

The tax obligations resulting from the estimated life profiles of earnings are estimated using CTaCS. CTaCS simulates the Canadian federal and provincial personal income tax and transfer system in any year between 1962 and 2005. For current purposes the tax parameters for 2005 were used matching the reference year for the 2006 census. Although CTaCS incorporates the full set of deductions and tax credits, the tax simulations are specified quite modestly—age, gender and residence in Ontario—to maximize the generality of the results.

The simulation results yield the sum of federal and provincial taxes owed assuming the 2005 tax system is in place. To translate the tax burden in each year to a common basis, the present value of the sum of the taxes to be paid at different points over the life course is reported, assuming a discount rate of 3 percent. The simulations presented use the provincial tax parameters for Ontario.

Results

The results of these calculations are presented in Table 6 for three hypothetical clients. For each, we present the sum of the present value of federal and provincial tax payments, under different scenarios that vary by the age at which the individual arrives in Canada

and the year in which their labour market employment ends. The ages of arrival are 30, 40 or 50 respectively, and the assumed working lives are 5 or 10 years, or a "lifetime" which is to age 59. For example, the first client in Table 6 is a female from southeast Asia, who is a high school graduate and lives in an urban area. Assuming she arrives in Canada at age 30 and works just 5 years the present discounted sum of the tax payments she will make is estimated to be $14,101.40 measured in 2005 dollars.

Table 6: Present Value of Federal and Provincial (Ontario) Tax Revenues for a Full-Time Full-Year Working Immigrant by Age, Sex and Time Horizon discounted in advance at 3% in 2005 $CAD

	Working Life		
Age at Immigration	**5 Years**	**10 Years**	**Lifetime**
Client 1: Female, High School Graduate, Single, from Southeast Asia, living in an urban area			
30 years	$14,101.40	$31,906.20	$99,664.93
40 years	$14,418.09	$31,136.55	$64,659.76
50 years	$15,328.54	$29,471.16	$29,471.16
Client 2: Male, M.A. degree, Single, from the U.S.A., living in an urban area.			
30 years	$55,430.21	$115,862.49	$341,782.96
40 years	$66,869.10	$138,341.10	$264,021.80
50 years	$71,997.23	$140,803.65	$140,803.65
Client 3: Female, B.A. degree, Single, from Africa, living in an urban area.			
30 years	$35,492.40	$77,923.98	$234,343.62
40 years	$38,228.15	$80,801.26	$162,627.03
50 years	$46,717.60	$89,159.59	$89,159.59

Notes: Lifetime is to age 59.

There are some common patterns across the results by client. First, because earnings (and therefore tax obligations) generally rise with age, five years of employment after immigration at age 40 will generate more tax revenue than five years of employment after

immigration at age 30. However, since the age profile of earnings typically flattens at later ages this is not always true for a comparison of the results for immigration at age 40 versus age 50. Second, because the samples used to project earnings had an upper age limit of age 59, the lifetime tax obligations when immigration is at age 50 are the same as the 10 year estimate.

The differences in the results across clients reflect both corresponding differences in their earnings capacities and the progressivity of the Canadian tax system. For example, the highest tax revenues are recorded for Client 2. This is because this individual is male, highly educated and from the United States (US). Immigrants from the US and the United Kingdom generally command higher earnings in the Canadian labour market than immigrants from other locations.

A comparison of clients 1 and 3 highlights the impact of education and country of origin holding gender constant. Client 3 has much larger revenues both because of the earnings premium to a university degree, and because among females working full year full time immigrants from Africa command higher earnings than those from south east Asia.

8.0 Conclusions and Limitations

There are a paucity of studies assessing thresholds used by immigration officials in the determination of medical inadmissibility. Despite the need for evidence informed immigration policy, and the substantive findings contained in this report, there are a number of limitations that warrant discussion. First, the definition of “excessive” demand

is inherently subjective. While we offer a statistical definition of "excessive", we demonstrate that the precise threshold is discretionary; it depends on the confidence warranted in the test that a prospective immigrant has a cost profile that is the same as that for Canadians. A more stringent confidence requirement (i.e. that we are correct in rejecting this hypothesis) than the customarily 5 percent significance level, warrants a higher threshold. Second, while we have shown how the statistical threshold used to determine "excessive" demand depends on the underlying distribution of health care costs, unless precise estimates of that distribution are acquired the resulting threshold will always be an approximation. Third, present value estimates of the economic burden of illness are limited by the available literature and the sophistication in the modeling of the underlying health conditions. This is also true in the context of HIV and is crucially dependent not just on the unit cost of specific CD4 cell count health states, but also in the transition from one health state to another. We should never forget that the estimates reported herein are just point estimates, and furthermore, are dependent on current medical practices in the settings that yielded the original data. Fourth, in order to engineer an assessment of which HIV-positive individuals would be deemed to be medically inadmissible, consideration of the trajectory of costs for both HIV-positive individuals and those for Canadians were converted to present value terms for particular assessment horizons. Variation in underlying assumptions concerning discounting practices, disease progression and relative rates of mortality influence the findings and should be considered in a comprehensive assessment of current policy. Finally, in order to have a balanced assessment of the costs and contributions of a prospective immigrant, the economic contribution of a new immigrant in terms of tax revenues generated from

earned income is estimated; however, such estimates reflect only a specific type of monetary contributions and even then only a subset of such contributions.

Notwithstanding the limitations, four substantive findings are offered in this paper. First, the current cost threshold used by CIC in assessing whether an applicant is likely to pose "excessive" demand on Canadian health or social services is too low. A statistically more appropriate threshold is three-fold greater at $14,581.43. Second, there is a close relationship between disease progression (measured by CD4 cell counts) and health care costs, with annual costs increasing from under C$8,000 for CD4 >500 cells/mm^3 to over C$35,000 for CD4 <100 cells/mm^3. Third, application of these cost estimates to a revised cost threshold for inadmissibility indicates that classification depends on individual characteristics, including age, sex and baseline CD4 cell count as well as on the time horizon over which each applicant's projected demand for health or social services is assessed. "Excessive" demand is more likely to occur for applicants with low CD4 cell counts and a shorter time horizon for assessment (i.e., 5-years versus their lifetime). Women and younger applicants are slightly more likely to be deemed inadmissible than men and older immigration applicants. Finally, estimates of the economic contributions of new immigrants to the public treasury through taxes paid on labour market earnings are substantial, and often exceed estimates of their health care costs. These economic contributions are dependent on the age, sex, and region of origin of prospective immigrants as well as on other conventional determinants. Exclusive focus on the health care costs of prospective immigrants without consideration of the economic contributions (albeit measured in tax revenue terms) yields an incomplete evaluation of immigrants

Our findings suggest that the adjudication guidelines and policies used by CIC warrant urgent review so that they are informed by the existing clinical, epidemiological and economics evidence, and that they conform to an appropriate statistical interpretation of "excessive" demand. In the absence of this review, current policy results in immigration denial on medical inadmissibility grounds and the consequent loss to Canadian society of some gifted individuals.

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EXHIBIT “C”

This is Exhibit “C” as mentioned in the Affidavit of Sandra Ka Hon Chu, solemnly affirmed before me by videoconference from Toronto, this 1st day of February 2024.

Anne-Rachelle Boulanger
Anne-Rachelle Boulanger (Feb 1, 2024 16:34 EST)

A Commissioner, etc.

Submission to the House of Commons' Standing Committee on Citizenship and Immigration in relation to its study of Federal Government Policies and Guidelines Regarding Medical Inadmissibility of Immigrants

November 2017

Introduction

The HIV & AIDS Legal Clinic Ontario ("HALCO") and the Canadian HIV/AIDS Legal Network ("Legal Network") welcome this opportunity to provide our submission to the House of Commons' Standing Committee on Citizenship and Immigration with respect to its current review of medical inadmissibility. HALCO is a community legal clinic that provides services to people living with HIV in Ontario, and regularly represents individuals living with HIV in relation to various areas of law, including those who are alleged to be medically inadmissible to Canada due to excessive demand. The Legal Network is a national organization in Canada that works exclusively on legal and policy issues related to the human rights of people living with HIV and AIDS, including in the areas of immigration law and policy and HIV-related stigma and discrimination.

In this submission, we will outline how the excessive demand regime violates the *Canadian Charter of Rights and Freedoms* ("Charter"), contributes to stigma and discrimination against people living with HIV, is inconsistent with international law and the practice of other countries, is a cumbersome and inefficient process to administer, and undermines the objectives of the *Immigration and Refugee Protection Act* ("IRPA"). Given the numerous human rights issues and operational flaws associated with the excessive demand regime, we recommend its total repeal.

Background

The *Immigration and Refugee Protection Act* ("IRPA") stipulates that foreign nationals are inadmissible to Canada on health grounds if their health condition might reasonably be expected to cause an "excessive demand" on health or social services, or if they have an inadmissible family member (i.e., an inadmissible spouse or dependent child). The IRPA's associated Regulations set out a comprehensive definition of excessive demand, as follows:

a) a demand on health services or social services for which the anticipated costs would likely exceed average Canadian per capita health services and social services costs over a period of five consecutive years immediately following the most recent medical examination required under paragraph 16(2)(b) of the Act, unless there is evidence that significant costs are likely to be incurred beyond that period, in which case the period is no more than 10 consecutive years; or

b) a demand on health services or social services that 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 [emphasis added].

The Regulations define "health services" as any health service where the majority of funds is contributed by governments, including the services of family physicians, medical specialists and hospital care. Every year, Immigration, Refugees and Citizenship Canada ("IRCC") sets the excessive demand threshold — currently at $6,655 — by multiplying the per capita cost of Canadian health and social services by the number of years used in the medical assessment for the individual applicant.[1] Notably, the IRPA provides some exceptions to excessive demand inadmissibility, exempting accepted refugees and protected persons, their spouses, common-law partners and dependent children as well as spouses, common-law partners and dependent children sponsored through family class sponsorships.

Over the years, courts have been tasked with providing further guidance on how immigration officers must apply the medical inadmissibility provisions. In *Hilewitz v. Canada (MCI),* the Supreme Court of Canada determined that immigration officers must conduct an individualized assessment that takes into account the specific circumstances of the applicant, instead of a generic assessment based on a health condition.[2] These specific circumstances include an individual's likely demands on public services (rather than mere eligibility for them) and the reasonable probability that these excessive demands will arise (as opposed to a remote possibility). In the case of health services, individualized assessments are relatively limited. In *Deol v. Canada (MCI)*, the Federal Court of Appeal held that an applicant's willingness and ability to pay for health services is not relevant to the excessive demand analysis, as promises to pay for health services are unenforceable.[3] However, the subsequent Federal Court decision in *Companioni v. Canada (MCI),* in which HALCO intervened, stipulated that the excessive demand assessment includes consideration of whether an applicant has a viable private insurance plan.[4]

Due to the high cost of antiretroviral medications, people living with HIV are generally medically inadmissible. In HALCO's experience, clients who are medically inadmissible

[1] "Excessive demand on health and social services." Excerpt from the Immigration, Refugees, and Citizenship Canada website, http://www.cic.gc.ca/english/resources/tools/medic/admiss/excessive.asp ["Excessive demand"]
[2] *Hilewitz v. Canada (MCI),* 2005 SCC 57 (Supreme Court of Canada).
[3] *Deol v. Canada (MCI)*, 2002 FCA 271 (Federal Court of Appeal). Social services are treated differently. In *Hilewitz,* the Supreme Court noted that social services in Ontario contemplated the possibility of financial contributions from families able to make them. It is therefore important to consider whether the applicants were willing and able to pay for services, as well as the family support or assistance which might affect use of services.
[4] *Companioni v. Canada (MCI)*, 2009 FC 1315 (Federal Court). In Ontario, applicants are required to exhaust their private insurance before drawing on the province's public drug-funding program. Therefore, an individual with private insurance may not be medically inadmissible due to excessive demand, and their permanent residence application could be accepted.

typically have antiretroviral medication regimens that cost $12,000 – $15,000 per year, significantly exceeding the excessive demand threshold of $6,655 per year. As a result, HIV-positive applicants are generally inadmissible to Canada unless they fall within one of the exceptions to the excessive demand rule (i.e., they are the spouse, common-law partner or dependent child of a permanent resident or they are an accepted refugee or protected person, or the spouse, common-law partner or dependent child of an accepted refugee or protected person); can obtain an humanitarian and compassionate ("H&C") exemption from the excessive demand rule; or their individualized assessment shows that the cost of their health care will be below the excessive demand threshold (e.g., if they are on less costly generic antiretroviral medications or have private insurance that covers a sufficient portion of their medications).

The Case for Repealing Excessive Demand

Excessive demand is discriminatory and violates the Charter

The Charter guarantees equality before and under the law and the right to the equal protection and equal benefit of the law without discrimination, including on the basis of disability.[5] Section 3 of the IRPA mandates that decisions taken under the Act must be consistent with the Charter, including its principles of equality and freedom from discrimination. The excessive demand regime violates the Charter by discriminating against people with disabilities, including people who are living with HIV.

While the excessive demand regime may appear neutral on the surface because it does not single out HIV or any other particular medical condition and focuses instead on the *cost* of an applicant's medical condition, cost is not a neutral factor. Federal and provincial governments incur many costs associated with immigration, such as the cost of language classes, settlement services and the education of newcomer children, but these costs are not considered in the immigration application process. In contrast, IRCC rejects residence applications from people living with HIV solely due to the cost of their life-saving medications.[6] People living with HIV are therefore unfairly disadvantaged by a law that appears neutral — a form of indirect discrimination that contravenes the Charter.[7]

The excessive demand regime also erases the potential contributions that an applicant may make to Canadian society. In *Hilewitz*, the Supreme Court recognized that "most immigrants, regardless of the state of their resources when they come to Canada, eventually contribute to this country in a variety of ways."[8] United Nations ("UN") agencies, including the Joint UN Programme on HIV/AIDS ("UNAIDS") and the International Organization for Migration, have

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[5] *Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982,* being Schedule B to the *Canada Act (1982)* UK, 1982, c. 11.

[6] For example, a skilled worker who has four young children, all of whom attend public schools at a reported cost of roughly $10,700 to $13,000 per year, would cost a provincial government over $40,000 a year in education expenses alone, but they would not be considered to pose an excessive demand on public resources. However, a single person living with HIV with annual medication costs of $15,000 could be refused due to excessive demand. See "A numerical exploration of education in Canada," *CBC News,* August 5, 2010 (www.cbc.ca/news/a-numerical-exploration-of-education-in-canada-1.922061).

[7] *Andrews v. Law Society of British Columbia,* [1989] 1 SCR 143, 1989 CanLII 2 (SCC).

[8] *Hilewitz, supra* note 2 at para. 39.

highlighted the positive impact of antiretroviral medication on the longevity and productivity of people living with HIV. With the falling costs of these drugs, "it is increasingly difficult to argue that people living with HIV incur greater costs to the destination country compared to the benefits they could contribute over a long-term stay."[9] People living with HIV participate in the labour force, pay taxes and contribute to their communities in many ways. As UNAIDS' International Task Team on HIV-Related Travel Restrictions acknowledged, "HIV-related travel restrictions on entry, stay and residence … do not rationally identify those who may cause an undue burden on public funds."[10]

We do not, however, advocate a "net fiscal benefit" approach. Such an approach would maintain all of the complications of the current excessive demand assessment, but would be even more onerous for both applicants and decision-makers. Applicants would still be required to confirm the amount of their health care costs in addition to providing evidence of the "fiscal benefit" they would provide to Canadian society. Officers would be required to not only complete the medical assessments but also somehow confirm the accuracy of a submission with respect to the applicant's net fiscal benefit. Immigration, Refugees and Citizenship Canada ("IRCC") itself acknowledges the difficulty of conducting a net fiscal benefit assessment.[11] More importantly, a net fiscal benefit analysis would dehumanize applicants by reducing their potential contribution to society solely to quantifiable factors.

No amount of individualized assessment can diminish the reality that the excessive demand regime reduces an applicant living with HIV (or another disability) to the cost of their medications. The reductive analysis of the regime contributes to anti-HIV stigma. In *Hilewitz*, the Supreme Court recognized that even "exclusionary euphemistic designations" can conceal prejudices about disability.[12] By focusing solely on alleged use of health services as grounds for exclusion and ignoring the important contributions that people with HIV make to Canadian society, the excessive demand regime conceals outdated prejudices that people living with HIV — like other people with disabilities — are a burden on Canadian society.

Excessive demand violates Canada's international law obligations

International law prohibits States from discriminating against a person in the enjoyment and exercise of their human rights on the basis of their health status,[13] and the UN has repeatedly

[9] UNAIDS, *The Gap Report 2014*, 2014, p. 103. Available at http://www.unaids.org/en/resources/documents/2014/20140716_UNAIDS_gap_report. See also UNAIDS and IOM, *Statement on HIV/AIDS Related Travel Restrictions*, June 2014, p. 9.

[10] UNAIDS, *Report of the International Task Team on HIV-related Travels Restrictions: Findings and Recommendations*, December 2008, p. 5.

[11] Testimony of Mr. Michael MacKinnon, Senior Director, Migration Health Policy and Partnerships, Migration Health Branch, Department of Citizenship and Immigration, at the Standing Committee on Citizenship and Immigration, Evidence Number 78 (Unedited Copy), 0905-0910.

[12] *Hilewitz, supra* note 2 at para. 48.

[13] The UN Commission on Human Rights has confirmed that "other status" in non-discrimination provisions in international human rights texts should be interpreted to cover health status, including HIV. UN Commission on Human Rights, *The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS)*, Resolutions 1995/44, ESCOR Supp. (No. 4) at 140, UN Doc. E/CN.4/1995/44 (1995); and 1996/43, ESCOR Supp. (No. 3) at 147, U.N. Doc. E/CN.4/1996/43 (1996).

called upon countries to eliminate HIV-related restrictions on entry, stay and residence.[14] The Office of the UN High Commissioner for Human Rights and UNAIDS also hold that HIV-related discrimination in the immigration context violates the right to equality before the law.[15]

The excessive demand regime also violates Canada's obligations under the *Convention on the Rights of Persons with Disabilities*. By ratifying this Convention in 2010, Canada signalled a commitment to uphold the rights of persons with disabilities, including the right to non-discrimination, full and effective participation and inclusion in society, and equality of opportunity.[16] The Convention also requires State Parties to take all appropriate measures to abolish discriminatory laws and practices.[17] Article 18 of the Convention specifically calls on State Parties to "recognize the rights of persons with disabilities to liberty of movement, to freedom to choose their residence and to a nationality" and ensure that persons with disabilities have the right to acquire and change a nationality. By effectively preventing people living with HIV from becoming legal residents and fuelling stigma, the excessive demand regime not only violates the right of people living with HIV to equality before the law, but also their rights to education,[18] employment[19] and the highest attainable standard of physical and mental health.[20]

Excessive demand is not in line with other countries' practices

Numerous countries including Austria, Belarus, Belgium, Finland, France, Ireland, Italy, Lithuania, Luxembourg, Norway, Spain, Sweden, Switzerland, the U.K. and the U.S. do not have any laws, policies or known practices that deny migration based solely on HIV status.[21] The U.K., for example, does not impose mandatory HIV testing for those entering the country as visitors or immigrants, nor does it require a declaration of HIV status.[22] Driven by increasing public pressure to reduce the number of asylum seekers and migrants coming into the country on the grounds that they were overburdening the education, health and social welfare infrastructure, the U.K.'s All-Party Parliamentary Group on AIDS in its study of HIV and migration nevertheless concluded that "the UK Government cannot look to exclude individuals on the basis of poor health in the UK, while simultaneously working to provide access to health in developing

[14] See, for example, UN General Assembly, *Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS*, A/RES/65/277, July 8, 2011, para. 79 and UNAIDS, *The Gap Report*, 2014, p. 169.
[15] Office of the United Nations High Commissioner for Human Rights and the UNAIDS, *International Guidelines on HIV/AIDS and Human Rights 2006 Consolidated Version*, s. 131.
[16] Article 3 of the *Convention on the Rights of Persons with Disabilities*. 24 January 2007, A/RES/61/106,
[17] *Ibid*, Article 4a.
[18] Article 13 of *International Convention on Economic, Social and Cultural Rights*, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3 and Article 24 of the *Convention on the Rights of Persons with Disabilities.*
[19] Article 6 of *International Convention on Economic, Social and Cultural Rights* and Article 27 of the *Convention on the Rights of Persons with Disabilities.*
[20] Article 12 of *International Convention on Economic, Social and Cultural Rights* and Article 25 of the *Convention on the Rights of Persons with Disabilities*.
[21] See UNAIDS, *Eliminating Travel Restrictions*, undated, available via www.unaids.org/en/targetsandcommitments/eliminatingtravelrestrictions and *The Global Database on HIV-specific Travel and Residence Restrictions*, available via http://hivtravel.org/Default.aspx?pageId=152.
[22] NAM aidsmap, *Immigration and asylum law*, January 2014. Available at http://www.aidsmap.com/Immigration-and-asylum-law/page/1255093/#item1255521.

countries."[23] Similarly, in 2010, bolstered by human rights arguments against its HIV-specific travel ban, the U.S. lifted all restrictions affecting people with HIV wishing to enter or migrate, and prospective migrants are not required to undergo HIV testing as part of the required medical examination for U.S. immigration.[24]

Excessive demand undermines the objectives of the IRPA

By barring otherwise qualified applicants, the excessive demand regime undermines many of the objectives of the IRPA. These objectives include permitting Canada to pursue the maximum social, cultural and economic benefits of immigration, enriching and strengthening the social and cultural fabric of Canadian society, supporting the development of a strong and prosperous economy, reuniting families in Canada, promoting successful integration of permanent residents, and attaining immigration goals through consistent standards and prompt processing. To immigrate to Canada, individuals must meet the requirements of one of these programs, be it through the economic class, family sponsorship or an H&C application.

a. Economic class applicants

Canada seeks to attract global talent through the economic class, in order to bolster the Canadian economy and realize the economic benefits of immigration. However, prospective economic class immigrants are affected most adversely by excessive demand medical inadmissibility. Many applicants refused on the basis of excessive demand are economic class immigrants — the very immigrants that the Canadian government claims it most wants to attract. If the excessive demand criterion was repealed, economic class applicants would still need to meet the remaining criteria to become permanent residents, including demonstrating that they have skills which are in demand in Canada.

For example, HALCO frequently advises international students who become infected with HIV during their studies in Canada. These students are often pursuing graduate studies, gaining valuable work experience in Canada through co-op and summer placements, and seeking to put their skills and talents to use in Canada. Most of these students will have their applications for permanent residence refused due to excessive demand, 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. In another example, Provincial Nominees living with HIV could be denied residence due to health care costs to be incurred by the province that nominated their application. The province has no opportunity to advocate that Nominees be accepted despite their health care costs.

In yet another example, HALCO has been contacted on numerous occasions by live-in caregivers whose children overseas tested positive for HIV during the immigration medical exam. These women had been apart from their children for many years while they fulfilled the requirements of the live-in caregiver program and then waited for their permanent residence applications to be

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[23] All-Party Parliamentary Group on AIDS, *Migration and HIV: Improving Lives in Britain. An Inquiry into the Impact of the UK Nationality and Immigration System on People Living with HIV*, July 2003, p. 6. Available at www.appghivaids.org.uk/sites/default/files/pdf/2003/migrationandhiv.pdf.
[24] N. Ordover, "Defying Realpolitik: Human Rights and the HIV Entry Bar," *The Global Database on HIV-specific Travel and Residence Restrictions*, 4 June 2012. Available at http://hivtravel.org/Default.aspx?pageId=149&elementId=10375.

processed.[25] As a result of vicarious inadmissibility, both the children and the caregiver applicant would be inadmissible to Canada due to excessive demand, nullifying the caregiver's years of sacrifice and hard work in Canada.

b. Family class applicants

Some family class applicants, such as parents, grandparents, orphaned nieces and nephews, or family members of "lonely Canadians," remain subject to the excessive demand inadmissibility.[26] This undermines the IRPA's goals of reuniting families and promoting the integration of newcomers. Reuniting families reduces stress, promotes mental health and productivity, and increases support networks. Parents and grandparents in particular are stigmatized as "drains" on Canadian society. However, they make important contributions to society by, to give an oft-cited example, providing practical support such as free childcare which allows people with children to return to work rather than rely on social assistance — a particularly important contribution since Canada does not have a national child care strategy, and high fees and long wait lists persist for daycare.

c. Humanitarian and compassionate applicants

H&C applicants are only approved if they can demonstrate that they would experience undue, undeserved or disproportionate hardship in their country of citizenship. HIV-positive applicants for H&C frequently raise HIV-related hardship in their country of origin, such as discrimination, stigma and lack of adequate health care. In HALCO's experience, H&C applicants living with HIV are usually granted waivers from the requirement to be medically admissible, on the basis that it would be inhumane to determine that an individual would suffer undue hardship in their country of origin but then refuse their application because they require health services. This is particularly the case when the application is based on health-related hardship, as is common in H&C applications for people living with HIV.

The frequency with which H&C applicants receive waivers demonstrates that the excessive demand assessment for this category is usually a symbolic exercise. Requiring these applicants to obtain the waiver does not reduce health care costs, yet it adds at least one year to the processing time of their immigration application. This undermines the IRPA's objective of promoting the integration of newcomers. Applicants who are unable to demonstrate that they would face serious hardship will not be approved, regardless of their health status.

Excessive demand causes operational problems

a. Excessive demand inadmissibility does not effectively control health care costs

There is limited evidence that the excessive demand regime meaningfully controls health care costs. As noted above, excessive demand inadmissibility does not apply to spouses, dependent children or refugees but primarily to economic class applicants, other family class sponsorships, and H&C applications. According to the figures reported to the Standing Committee, there are

[25] On November 9, 2017, the processing time for live-in caregiver applications on the IRCC website was 56 months.
[26] The "lonely Canadian" sponsorship refers to sponsorships under section 117(1)(h) of the *Immigration and Refugee Protection Regulations*. Under this section, Canadian citizens or permanent residents with (i) no close family members in Canada, and (ii) no family members eligible to be sponsored as members of the family class are allowed to sponsor a relative who would not otherwise be eligible to be sponsored.

only 900-1,000 refusals each year due to excessive demand. IRCC estimates that this results in $135 million in cost savings over each 5-year period, with an average cost savings of $27 million per year.[27] IRCC's calculations, however, appear to be solely based on the initial assessments conducted by a departmental officer.[28] This cost savings estimate does not factor in applicants who may have switched to less expensive medications (e.g., generic medications), who may have access to private insurance, or who may ultimately receive a waiver from IRCC for their inadmissibility. Any actual cost savings would be much less than the cost estimate IRCC has provided.

More importantly, health care costs are not predictable. An applicant may be medically admissible but suffer a catastrophic accident the day after becoming a permanent resident, In the case of people living with HIV, the main concern is the cost of prescription medication. While this may seem like a predictable cost, an applicant's medication costs could easily decrease over time. Antiretroviral medications frequently become available in generic forms, drastically reducing an individual's health care costs. One of HALCO's clients, for example, switched to generic forms of antiretroviral drugs, lowering her annual medication costs from over $9,000 to approximately $3,000, thus placing her well within the excessive demand threshold. Persons living with HIV could also obtain a job that offers private health insurance after they become permanent residents, which would disqualify a significant portion of their medical costs from public health care coverage.

b. The excessive demand cost threshold is too low

The excessive demand cost threshold is too low because it measures "above average" demand but not the "excessive" demand stipulated in the Act. As noted above, the excessive demand threshold is set annually by multiplying the per capita cost of Canadian health and social services by the number of years used in the medical assessment for the individual applicant. The excessive demand test captures an anticipated health care cost of even one dollar more than the average per capita health cost.

Health care economists have criticized this threshold because it is "neither a reasonable nor statistically appropriate interpretation of the term 'excessive' demand used in IRPA."[29] IRCC's method of determining the excessive demand threshold is based on statistical models where there is no variation in health care costs and all Canadians incur the same annual costs for health care.[30] In reality, health care costs are skewed to the high end of a statistical model; that is, many users do not use much in the way of health care services, while a smaller number of users have very high health care costs. A statistical model that accurately represents the reality of health care usage consistently yields a significantly higher cost threshold than the model currently

[27] Testimony of Mr. Michael MacKinnon, Senior Director, Migration Health Policy and Partnerships, Migration Health Branch, Department of Citizenship and Immigration, at the Standing Committee on Citizenship and Immigration, Evidence Number 78 (Unedited Copy), 0905-0915
[28] *Ibid.*
[29] P. Coyte and M. Battista, "The economic burden of immigrants with HIV/AIDS: When to say no?" *J for Global Business Advancement* 3,1 (2010).
[30] This model is called a "normal" or bell-shaped distribution: the majority of people use the average amount of health care services, while a relatively equal amount of outliers use a lot more or a lot fewer health services.

employed by IRCC.[31] For a demand to be truly "excessive," it should be *statistically greater* than average Canadian use of health care.[32]

However, increasing the excessive demand threshold would be an inadequate "band aid" solution that would not resolve problems with the excessive demand regime. Any excessive demand threshold is necessarily arbitrary due to the various statistical models that could be used to produce this figure. The cost threshold model itself permits refusal if an individual's health care costs exceeds the threshold by even one dollar, and an increased cost threshold would not prevent applicants from being required to undergo the lengthy medical inadmissibility procedural fairness process. Raising the excessive demand threshold would also fail to address the underlying human rights concerns inherent in the excessive demand regime.

c. Cumbersome and inefficient process causes delays

The excessive demand assessment imposes a costly and inefficient process on both the federal government and applicants. Due to the requirement to perform an individualized assessment articulated by the Supreme Court in *Hilewitz*, there is now a procedural fairness process in place for every case where there may be excessive demand inadmissibility. Accordingly, visa or immigration officers are required to obtain a medical officer's opinion and prepare a procedural fairness letter that sets out the required health and/or social services that are required and that form the basis of the officer's opinion that the applicant may be medically inadmissible. Applicants may then respond with their own medical evidence challenging the medical officer's opinion, accept the medical opinion but submit a plan that details how they will secure the proposed services, the cost of the services and how they will pay for the services, or seek a waiver of medical inadmissibility on H&C grounds. Depending on the applicant's response, immigration and visa officers may be required to seek a further opinion from the medical officer, verify the details of the plan proposed by the applicant, or seek further information from the applicant. Applicants may also need to provide extensive evidence of why they merit a waiver. This protracted process adds considerable processing time and expense to all parties involved as responding to a procedural fairness letter can take months, if not years.[33]

HALCO represents many clients applying for permanent residence on H&C grounds. These applications are based in part on the HIV-related hardship they would face in their country of origin, including discrimination, stigma and inadequate health care. Despite requesting an excessive demand waiver in the initial application, our clients must still wait to be asked to complete the medical exam and then wait again for the procedural fairness letter, only to repeat the waiver request and wait for a decision. This process alone often takes one to three years.[34] This additional cost and processing time has a tangible impact on applicants' lives. For example, H&C applicants are not able to sponsor their children until they are permanent residents. HALCO recently represented a client whose child turned 19 before the client became a

[31] This statistical model is called "gamma distribution."
[32] Coyte and Battista, *supra* note 29.
[33] Excessive demand, *supra* note 1. This webpage provides a detailed flowchart that demonstrates the full complexity of the excessive demand assessment, including the many levels of decision-making involved.
[34] Some of HALCO's clients have even been required to complete additional medical exams even though they already received an excessive demand waiver.

permanent resident. The child therefore could no longer be sponsored as a dependent child.[35] Had this client *not* been subjected to the additional year of delay caused by the excessive demand process, she could have obtained permanent resident status in time to sponsor her child.

Recommendation

The excessive demand provision represents a continuing history of discriminatory laws targeting people with disabilities. It discriminates and perpetuates negative stereotypes against people living with HIV by arbitrarily focusing only on the cost of their medications and ignoring the many contributions made by people living with HIV to Canadian society. The excessive demand provision also contravenes the Charter and international human rights law and is contrary to the practices of many other countries that do not have similar provisions denying migration solely on the basis of HIV status. Moreover, the provision undermines the ultimate objectives of IRPA and creates a cumbersome and inefficient process that ultimately does little to reduce health care costs, which are unpredictable and which, in the case of people living with HIV, are likely to decline in the future. Further incremental change will not remedy the inherent flaws associated with the excessive demand regime.

We urge the Government of Canada to remove excessive demand inadmissibility from the IRPA by repealing section 38(c) of the IRPA.

[35] This case occurred during the period when the age of dependent child was lowered to 19 years from August 1, 2014 to October 24, 2017. The age of dependent has now increased to age 22 (*Immigration and Refugee Protection Regulations*, SOR/2002-227).

EXHIBIT "D"

This is Exhibit "D" as mentioned in the Affidavit of Sandra Ka Hon Chu, solemnly affirmed before me by videoconference from Toronto, this 1st day of February 2024.

Anne-Rachelle Boulanger
Anne-Rachelle Boulanger (Feb 1, 2024 16:34 EST)

A Commissioner, etc.

April 26, 2021

VIA ELECTRONIC MAIL: IRCC.MHBDGO-BDGDGMS.IRCC@cic.gc.ca

Jennifer Lew, Acting Director
Migration Health Policy and Partnerships Division
Migration Health Branch
Immigration, Refugees and Citizenship Canada
250 Tremblay Road
Ottawa, ON K1A 1L1

Dear Jennifer Lew,

Re: ***Canada Gazette*, Part I: Regulations Amending the Immigration and Refugee Protection Regulations (Excessive Demand) (March 27, 2021)**

Introduction

The HIV & AIDS Legal Clinic Ontario ("HALCO") and the HIV Legal Network (formerly the Canadian HIV/AIDS Legal Network) make this representation with respect to Canada Gazette, Part I, Volume 155, Number 13: Regulations Amending the Immigration and Refugee Protection Regulations (Excessive Demand).

HALCO is the only community legal clinic in Canada that provides services to people living with HIV. Immigration and refugee law is an important focus of the clinic's work and HALCO has regularly represented, and continues to represent, individuals living with HIV who have been alleged to be medically inadmissible to Canada due to excessive demand. The HIV Legal Network is a national organization in Canada that works exclusively on legal and policy issues related to HIV and AIDS, and is one of the world's leading expert organizations in this field. The HIV Legal Network has an extensive history of conducting work on a wide range of legal and policy issues related to the human rights of people living with HIV or AIDS, including in the area of HIV-related stigma and discrimination and immigration law and policy as it relates to HIV.

While the public policy changes made in 2018 to excessive demand in relation to medical inadmissibility — and in particular the decision to raise the threshold by threefold — are a step in the right direction (as are the proposed regulations to codify the 2018 policy[1]), the excessive demand regime (i) still violates the *Canadian Charter of Rights and Freedoms* ("Charter"); (ii)

[1] Immigration, Refugees and Citizenship Canada, News Release, "Government of Canada brings medical inadmissibility policy in line with inclusivity for persons with disabilities" (16 April 2018), online: www.canada.ca/en/immigration-refugees-citizenship/news.html.

contributes to stigma and discrimination against people with disabilities, including people living with HIV; (iii) is inconsistent with international human rights law and Canada's obligations pursuant to such law; (iv) is a cumbersome and inefficient process to administer; and (v) undermines the objectives of the *Immigration and Refugee Protection Act* ("IRPA"). Incremental changes will not resolve these problems. As we have consistently recommended, we urge the Government of Canada to repeal the excessive demand regime altogether. This is aligned with the recommendation of the Standing Committee on Citizenship and Immigration to eliminate the policy.[2]

Background

In 2002, the *Immigration and Refugee Protection Act* ("IRPA") came into force, which stipulates that foreign nationals are inadmissible to Canada on health grounds if their health condition might reasonably be expected to cause an "excessive demand" on health or social services, or if they have an inadmissible family member (i.e., an inadmissible spouse or dependent child). The IRPA also introduced two important incremental changes to the excessive demand regime. First, the IRPA created exceptions to excessive demand inadmissibility, exempting accepted refugees and protected persons, their spouses, common-law partners and dependent children as well as spouses, common-law partners and dependent children sponsored through family class sponsorships. Second, IRPA's associated Regulations set out a comprehensive definition of excessive demand, which is now defined as:

a) a demand on health services or social services for which <u>the anticipated costs would likely exceed average Canadian per capita health services and social services costs</u> over a period of five consecutive years immediately following the most recent medical examination required under paragraph 16(2)(b) of the Act, unless there is evidence that significant costs are likely to be incurred beyond that period, in which case the period is no more than 10 consecutive years; or

b) a demand on health services or social services that would <u>add to existing waiting lists and would increase the rate of mortality and morbidity in Canada</u> as a result of an inability to provide timely services to Canadian citizens or permanent residents [emphasis added].

Immigration, Refugees and Citizenship Canada ("IRCC") sets the excessive demand threshold annually by multiplying the per capita cost of Canadian health and social services by the number of years used in the medical assessment for the individual applicant. The excessive demand threshold as of 2020 is $7,068.[3]

Despite the IRPA's attempts to clarify the definition of excessive demand, courts were tasked with providing further guidance on how immigration officers must apply the medical inadmissibility provisions. In *Hilewitz v. Canada (MCI)* and *De Jong v. Canada (MCI),* the Supreme Court of Canada determined that immigration officers must conduct an individualized

[2] House of Commons, Standing Committee on Citizenship and Immigration, Building an Inclusive Canada: Bringing the Immigration and Refugee Protection Act in Step with Modern Values (December 2017) (Chair: Robert Oliphant) at page 40. [Standing Committee Report]

[3] "Excessive demand on health and social services." Excerpt from the Immigration, Refugees, and Citizenship Canada website, http://www.cic.gc.ca/english/resources/tools/medic/admiss/excessive.asp ["Excessive demand"]

assessment that takes into account the specific circumstances of the applicant, instead of a generic assessment based on a health condition.[4] The specific circumstances were limited to a consideration of social services in the decision.

In the case of health services, these individualized assessments are relatively limited. The decisions in *Companioni v. Canada (MCI)* (Federal Court) and *Lawrence v. Canada (MCI)* (Federal Court of Appeal) clarified the need for the excessive demand assessment to include a consideration of whether an applicant has a viable private insurance plan for healthcare costs.[5]

In 2018, a new medical inadmissibility policy was introduced by the Government of Canada, which increased the excessive demand threshold to three times its previous level and amending the definition of social services to exclude special education, social and vocational rehabilitation services, as well as personal support services.[6] This has brought the 2020 threshold to $21,204.[7]

As of 2019, the average cost of antiretroviral medication regimens is between $13,000 and $19,000 per year for treatments.[8] Though this range may fall below the proposed threshold for excessive demand, some people living with HIV may still face complications associated with their status, necessitating a more expensive and robust treatment regime. Furthermore, many clients of HALCO also often face a higher risk of living with other comorbidities, such as renal failure, neurocognitive disorders, and drug-resistant strains of HIV. As such, this may render some people living with HIV an "excessive demand," or require them to undergo lengthy and numerous immigration medical exams (IMEs).

The Case for Repealing Excessive Demand in Medical Inadmissibility

Excessive demand is discriminatory and violates the Charter

The Charter guarantees equality before and under the law and the right to the equal protection and equal benefit of the law without discrimination, including on the basis of disability.[9] Section 3 of the IRPA specifically mandates that decisions taken under the Act must be consistent with

[4] *Hilewitz v Canada (MCI),* 2005 SCC 57; *De Jong v Canada* (MCI), 2005 SCC 57.
[5] *Companioni v. Canada (MCI)*, 2009 FC 1315 (Federal Court); *Lawrence v Canada (MCI)*, 2013 FCA 257. In Ontario, applicants are required to exhaust their private insurance before drawing on the province's public drug-funding program. Therefore, an individual with private insurance may not be medically inadmissible due to excessive demand, and their permanent residence application could be accepted.
[6] "Government of Canada brings medical inadmissibility policy in line with inclusivity for persons with disabilities", News Release from Immigration, Refugees, and Citizenship Canada website, https://www.canada.ca/en/immigration-refugees-citizenship/news/2018/04/government-of-canada-brings-medical-inadmissibility-policyin-line-with-inclusivity-for-persons-with-disabilities.html
[7] Excessive Demand, *supra*.
[8] Toronto People With AIDS Foundation, "Single Tablet Regimens for HIV Treatment – What You Need to Know" (October 16, 2019), online at: https://www.pwatoronto.org/single-tablet-regimens-for-hiv-treatment-what-you-need-to-know/.
[9] *Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982,* being Schedule B to the *Canada Act (1982)* UK, 1982, c. 11.

the Charter, including its principles of equality and freedom from discrimination. The excessive demand regime violates the Charter by discriminating against people with disabilities.[10]

While the excessive demand regime may appear neutral on the surface because it does not single out any particular medical condition and focuses instead on the *cost* of an applicant's medical condition, cost is not a neutral factor. IRCC could still reject permanent residence applications from people with disabilities due to their alleged use of health services. As a result, people with disabilities are unfairly disadvantaged by a law that appears neutral. This form of indirect discrimination is still discrimination.[11]

Discrimination is inherent to the excessive demand regime itself. No amount of individualized assessments can diminish the reality that the excessive demand regime reduces an applicant living with disabilities to the cost of their health care. The reductive analysis of the excessive demand regime contributes to ableist and anti-HIV stigma. In the *Hilewitz* decision, the Supreme Court of Canada recognized that even "exclusionary euphemistic designations" can conceal prejudices about disability.[12] The excessive demand regime conceals out-dated prejudices that many people living with disabilities are a burden on Canadian society. It is also reflected in the Gazette's description of the concern among provinces and territories that eliminating the excessive demand regime would have "the potential to create an even stronger draw factor for applicants and dependants with high medical needs."[13]

Moreover, by offering no opportunity for decision-makers to assess the potential contributions that an applicant may make to Canadian society, the excessive demand regime erases those many contributions. In *Hilewitz,* the Supreme Court recognized that "no doubt" that "most immigrants, regardless of the state of their resources when they come to Canada, eventually contribute to this country in a variety of ways."[14] United Nations ("UN") agencies, including the Joint United Nations Programme on HIV/AIDS ("UNAIDS") and the International Organization for Migration, have highlighted the positive impact of antiretroviral medication on the longevity and productivity of people living with HIV. People living with HIV participate in the labour force, pay taxes and contribute to their communities in many ways. Support networks formed by individuals participating in AIDS service organizations or by allowing parents and grandparents to reunite in Canada may also ultimately reduce government costs. Consideration of the anticipated contributions of newcomers with HIV is particularly important given the increasingly manageable nature of the medical condition and longer lifespans of people living with HIV.[15] As

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[10] HIV is recognized as a disability. For example, the Ontario Human Rights Commission *Policy on HIV/AIDS-related discrimination* states "AIDS (Acquired Immunodeficiency Syndrome) and other medical conditions related to infection by the Human Immunodeficiency Virus (HIV) are recognized as disabilities within the meaning of the Code." This policy was approved on 27 November 1996 and is available at www.ohrc.on.ca/en/policy-hivaids-related-discrimination.

[11] *Andrews v Law Society of British Columbia,* [1989] 1 SCR 143, 1989 CanLII 2 (SCC).

[12] *Hilewitz, supra* note 13 at para. 48.

[13] *Canada Gazette*, Part I, Volume 155, Number 13: Regulations Amending the Immigration and Refugee Protection Regulations (Excessive Demand) (March 27, 2021) online at: https://canadagazette.gc.ca/rp-pr/p1/2021/2021-03-27/html/reg1-eng.html at page 5 [Regulations Amending Excessive Demand].

[14] *Ibid,* para. 39.

[15] Battista, M. "HIV and Medical Inadmissibility in Canadian Immigration Law" Canadian Bar Association Immigration Law Conference (2013) at page 10. Online at: http://www.cba.org/CBA/cle/PDF/IMM13_paper_battista.pdf.

UNAIDS' International Task Team on HIV-Related Travel Restrictions acknowledged, "HIV-related travel restrictions on entry, stay and residence … do not rationally identify those who may cause an undue burden on public funds."[16]

However, we do not advocate a "net fiscal benefit" approach. Such an approach would maintain all of the complications of the current excessive demand assessment, but would be even more onerous for both applicants and decision-makers. Applicants would still be required to complete the IME, but, depending on their condition, may still have to respond to the procedural fairness letter to confirm the amount of their health care costs as well as provide evidence of the "fiscal benefit" they would provide to Canadian society. Officers would be required to not only complete the medical assessments but also somehow confirm the accuracy of a submission with respect to the applicant's net fiscal benefit. More importantly, a net fiscal benefit analysis would dehumanize applicants by reducing their potential contribution to society solely to quantifiable factors.

Excessive demand violates Canada's international law obligations

The UN has repeatedly called upon countries to eliminate HIV-related restrictions on entry, stay and residence. International law prohibits States from discriminating against people on the basis of their health status. In 2006, for example, the Office of the United Nations High Commissioner for Human Rights and UNAIDS published the *International Guidelines on HIV/AIDS and Human Rights*, which describe HIV-related discrimination in the context of travel regulations, entry requirements, immigration and asylum procedures as a violation of the right to equality before the law.[17] In 2011, the UN General Assembly encouraged Member States to eliminate HIV-related restrictions on entry, stay and residence.[18] UNAIDS reiterated this call in 2014, highlighting that countries can make a difference in the fight against HIV by ending all restrictions on the entry, stay and residence of people living with HIV.[19] These calls are in line with international law, which prohibits States from discriminating against a person in the enjoyment and exercise of their human rights on the basis of their health status (which includes HIV status).[20]

In ratifying the *Convention on the Rights of Persons with Disabilities* in 2010, Canada signalled a commitment to uphold the rights of persons with disabilities, including the right to non-discrimination, full and effective participation and inclusion in society, and equality of

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[16] UNAIDS, *Report of the International Task Team on HIV-related Travels Restrictions: Findings and Recommendations*, December 2008, p. 5.
[17] Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS, *International Guidelines on HIV/AIDS and Human Rights 2006 Consolidated Version*, s. 131.
[18] UN General Assembly, *Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS*, A/RES/65/277, July 8, 2011, para. 79.
[19] UNAIDS, *The Gap Report*, 2014, p. 169. Available at: http://www.unaids.org/en/resources/documents/2014/20140716_UNAIDS_gap_report.
[20] UN Commission on Human Rights has confirmed that "other status" in non-discrimination provisions in international human rights texts should be interpreted to cover health status, including HIV/AIDS. UN Commission on Human Rights, The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS), Resolutions 1995/44, ESCOR Supp. (No. 4) at 140, U.N. Doc. E/CN.4/1995/44 (1995); and 1996/43, ESCOR Supp. (No. 3) at 147, U.N. Doc. E/CN.4/1996/43 (1996).

opportunity.[21] The Convention obligates State Parties to "take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities" and to "refrain from engaging in any act or practice that is inconsistent with the present Convention and to ensure that public authorities and institutions act in conformity with the present Convention."[22]

Article 18 of the Convention specifically calls on State Parties to "recognize the rights of persons with disabilities to liberty of movement, to freedom to choose their residence and to a nationality, on an equal basis with others" and ensure that persons with disabilities have the right to acquire and change a nationality. In fuelling stigma and preventing people living with HIV from becoming legal residents, the excessive demand regime prevents people living with HIV from exercising their rights to education,[23] employment[24] and the highest attainable standard of physical and mental health.[25]

Excessive demand causes operational problems

i. Excessive demand inadmissibility does not effectively control health care costs

The excessive demand regime does not achieve its purported goal of controlling health care costs. First, excessive demand inadmissibility does not apply to spouses, dependent children or refugees but primarily to economic class applicants, other family class sponsorships, and humanitarian and compassionate ("H & C") applications.

More importantly, health care costs are not predictable. An applicant may be medically admissible but suffer a catastrophic accident the day after becoming a permanent resident, or develop costly comorbidities associated with a disability, including HIV.

ii. Arbitrary focus on health care costs

The excessive demand provision places arbitrary focus on the use of health care services while ignoring other costs. All potential immigrants to Canada will access, to varying degrees, publicly funded services. This arbitrary focus on health care costs further undermines the rationale of saving government resources and highlights the discriminatory nature of the excessive demand provision.

iii. Cumbersome and inefficient process causes delays

The excessive demand assessment imposes a costly and inefficient process on both the federal government and applicants. As part of the process, the government is required to obtain opinions from medical officers and produce procedural fairness letters for applicants. Applicants then respond by obtaining their own expert medical evidence regarding their health and actual

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[21] Article 3 of the *Convention on the Rights of Persons with Disabilities*.
[22] *Ibid*, Article 4a.
[23] Article 13 of *International Convention on Economic, Social and Cultural Rights* and Article 24 of the *Convention on the Rights of Persons with Disabilities*
[24] Article 6 of *International Convention on Economic, Social and Cultural Rights* and Article 27 of the *Convention on the Rights of Persons with Disabilities*
[25] Article 12 of *International Convention on Economic, Social and Cultural Rights* and Article 25 of the *Convention on the Rights of Persons with Disabilities*.

medical costs. Applicants may need to provide extensive evidence of why they merit a waiver of medical inadmissibility on H&C grounds. As noted above, after applicants provide submissions, immigration officers may need to obtain a new medical opinion or seek further evidence from the applicants. This protracted process adds considerable processing time and expense to all parties involved.

HALCO represents many clients applying for permanent residence on H&C grounds. These applications are based, in part, on the HIV-related hardship applicants would face in their country of origin, including discrimination, stigma and inadequate health care. Typically they are asked to complete several IMEs. Many of HALCO's overseas clients do not live in jurisdictions where panel doctors can conduct IMEs, and therefore must travel to a different country several times to complete the exams. In HALCO's experience, if a client receives a procedural fairness letter addressing excessive demand, having to provide a response often lengthens processing times and exacerbates stress for applicants.

It becomes difficult for applicants attempting to overcome medical inadmissibility to navigate the complicated framework associated with assessing excessive demand criteria. Formatting waivers for excessive demand, replying to procedural fairness letters and determining that IRCC's cost information and analysis is correct requires retaining legal counsel.

This additional cost and processing time has a real impact on the lives of applicants. For example, H&C applicants are not able to sponsor their children until they are permanent residents. HALCO has represented clients whose children turned 22 and "aged out" before the clients became permanent residents and therefore could no longer be sponsored as dependent children.[26] Had these clients not been subjected to the additional year of delay caused by the excessive demand process, they would have obtained permanent resident status in time to sponsor their children. Instead, they face severe hurdles to family reunification, and in some cases, permanent family separation ensued.

iv. Processing excessive demand

Due to the requirement to perform an individualized assessment articulated by the Supreme Court in *Hilewitz*, there is now a procedural fairness process in place for every case where there may be an excessive demand inadmissibility. In all cases where excessive demand medical inadmissibility is an issue, visa or immigration officers are required to obtain a medical officer's opinion and then prepare a procedural fairness letter that sets out the required health care, social services and/or outpatient medication that are required and that form the basis of the officer's opinion that the applicant may be medically inadmissible. Applicants may then respond with their own medical evidence challenging the medical officer's opinion, or accept the medical opinion but submit a plan that details how they will secure the proposed services, the cost of the services and how they will pay for the services.

Depending on the applicant's response, the immigration and visa officers may be required to

[26] Currently, the *Immigration and Refugee Protection Regulations*, SOR/2002-227, s. 1(1), define a dependent child as a biological or adopted child under the age of 22 and who is not a spouse or common law partner. Children over the age of 22 can be sponsored only if they depend substantially on a parent's financial support due to a physical or mental condition.

seek a further opinion from the medical officer, verify the details of the plan proposed by the applicant, or seek further information from the applicant. Thus, responding to a procedural fairness letter can be a lengthy and complex process that can take months, if not years. Furthermore, obtaining medical evidence and mitigation plans can prove to be both time consuming and costly, disadvantaging low-income people who may not possess the financial means to collect the necessary documentation.[27] The analysis provided through *Hilewitz* and subsequent decisions mentioned above frame people with disabilities (including those living with HIV) as financial burdens, and favour those who can overcome this burden through personal wealth or access to wealth. This fails to consider equality values that speak to the contributions and importance of people living with disabilities broadly have to society — values that the Government of Canada itself emphasized in the proposed regulations.[28]

Excessive demand undermines the objectives of the IRPA

The excessive demand provision prevents Canada from pursuing the maximum social, cultural and economic benefits of immigration, as the vast majority of applicants refused on the basis of excessive demand are economic class immigrants; that is, the very immigrants that the Canadian government claims it most wants to attract. The excessive demand provision also impedes family reunification and successful integration of newcomers, as it prevents Canadian citizens and permanent residents from being reunited with their parents, grandparents and certain other family members in Canada. Finally, the excessive demand provision contributes to long processing times, even for applicants who are not medically inadmissible or who receive waivers from excessive demand.

The relevant objectives, as set out in Section 3 of the IRPA, are as follows:

(a) To permit Canada to pursue the maximum social, cultural, and economic benefits of immigration
(b) To enrich and strengthen the social and cultural fabric of Canadian society
(c) To support the development of a strong and prosperous Canadian economy
(d) To see that families are reunited in Canada
(e) To promote the successful integration of permanent residents in Canada
(f) To support, by means of consistent standards and prompt processing, the attainment of immigration goals

These objectives govern the multiple immigration programs set out in the IRPA. To immigrate to Canada, individuals must meet the requirements of one of these programs, be it through the economic class, family sponsorship, or an H&C application. Each of these programs is connected to one of the objectives of the IRPA.

Economic class applicants

Although the Standing Committee on Citizenship and Immigration recommended the full repeal of the excessive demand regime, the proposed amendments stop short of repealing section 38(1)(c) of the IRPA. One of the reasons cited in the Gazette is the cost that would be incurred

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[27] Excessive demand, *supra* note 11.

[28] *Canada Gazette*, Part I, Volume 155, Number 13: Regulations Amending the Immigration and Refugee Protection Regulations (Excessive Demand) (March 27, 2021) online at: https://canadagazette.gc.ca/rp-pr/p1/2021/2021-03-27/html/reg1-eng.html at page 5 [Regulations Amending Excessive Demand].

by the provinces and territories if the excessive demand analysis of inadmissibility is repealed.[29] However, excessive demand criteria continue to disproportionately impact economic migrants who contribute significantly to the economy of individual provinces and territories. It is also worth noting that, since the introduction of the 2018 policy tripling the threshold, there has been a "limited increase in costs for health and social services."[30]

Prospective economic class immigrants are affected most adversely by excessive demand medical inadmissibility. The vast majority of applicants refused on the basis of excessive demand are economic class immigrants. These are the very immigrants that the Canadian government claims it most wants to attract. If the excessive demand criterion was repealed, economic class applicants would still need to meet the remaining criteria to become permanent residents, including demonstrating that they have skills which are in demand in Canada.

For example, HALCO frequently advises international students who become infected with HIV during their studies in Canada. These students are often pursuing graduate studies, gaining valuable work experience in Canada through co-op and summer placements, and seeking to put their skills and talents to use in Canada. Some of these students may have their applications for permanent residence refused due to 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. In another example, Provincial Nominees living with HIV could be denied residence due to health care costs to be incurred by the province that nominated their application. The province has no opportunity to advocate that Nominees be accepted despite their health care costs.

Family class applicants

Some family class applicants, such as parents, grandparents, orphaned nieces and nephews, or family members of "lonely Canadians," remain subject to the excessive demand inadmissibility.[31] This undermines the IRPA's goals of family reunification and promoting the integration of newcomers. Reuniting families reduces stress, promotes mental health and productivity, and increases support networks. Parents and grandparents in particular are stigmatized as 'drains' on Canadian society. However, they make important contributions to society by, for example, providing practical support such as free childcare which allows people with children to return to work rather than rely on social assistance — a particularly important contribution since Canada does not have a national child care strategy, and high fees and long wait lists persist for daycare. This becomes even more beneficial during the COVID-19 pandemic, as people struggle to balance childcare duties and work.

Humanitarian and compassionate (H & C) applicants

H&C applicants are only approved if they can demonstrate that they would experience undue, undeserved or disproportionate hardship in their country of citizenship. HIV-positive applicants

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[29] *Ibid.*
[30] *Ibid* at page 3.
[31] The "lonely Canadian" sponsorship refers to sponsorships under section 117(1)(h) of the *Immigration and Refugee Protection Regulations*. Under 117(1)(h), Canadian citizens or permanent residents with (i) no close family members in Canada, and (ii) no family members eligible to be sponsored as members of the family class are allowed to sponsor a relative who would not otherwise be eligible to be sponsored.

submitting H&C applications frequently raise HIV-related hardship in their country of origin, such as discrimination, stigma and lack of adequate health care. Many of these applications are based largely on health-related hardship.

Requiring these applicants, who may have comorbidities associated with their HIV status, to overcome excessive demand does not reduce health care costs, yet it adds to the processing time of their immigration application. This undermines the IRPA's objective of promoting the integration of newcomers. Those who are unable to demonstrate that they would face serious hardship will not be approved, regardless of their health status.

Other classes

Applicants in other programs can also be affected by excessive demand inadmissibility. For example, on April 14, 2021 the Minister of Immigration, Refugees and Citizenship announced a new pathway to permanent residency for what is estimated to be more than 90,000 temporary workers and international graduates. These applicants are still subject to the excessive demand criteria for medical inadmissibility. IRCC's stated purpose of this new pathway is strengthening Canada's economy, as well as prioritizing those who have been at the frontlines of providing essential services throughout the COVID-19 pandemic.[32]

HALCO's clients have worked throughout the pandemic at warehouses, as Uber drivers, as personal support workers, and at long-term care facilities. These same clients are more vulnerable to the transmission of COVID-19 and its variants due to being immunocompromised; in fact, many of them contracted COVID while providing these services. These same clients, who may be dealing with health complications associated with their HIV-positive status, may still be required to respond to procedural fairness letters regarding medical inadmissibility. After months of working at the frontlines and risking their health, these clients may face further hinderances to the approval of their applications for permanent residence.

Recommendation

Increasing the excessive demand threshold is an inadequate "band aid" solution that does not resolve the problems with the excessive demand regime. The cost threshold model itself (at least theoretically) permits a visa officer to reject an applicant if their health care costs exceed the threshold by even one dollar. An increased cost threshold would not prevent applicants from being required to undergo the lengthy medical inadmissibility procedural fairness process. Raising the excessive demand threshold would also fail to address the underlying human rights concerns inherent in the excessive demand regime.[33]

The excessive demand provision represents a continuing history of discriminatory laws targeting people with disabilities. It discriminates and perpetuates negative stereotypes against people

[32] "New pathway to permanent residency for over 90,000 essential temporary workers and international graduates". News Release from Immigration, Refugees, and Citizenship Canada website, https://www.canada.ca/en/immigration-refugees-citizenship/news/2021/04/new-pathway-to-permanent-residency-for-over-90000-essential-temporary-workers-and-international-graduates.html.

[33] P. Coyte and M. Battista, "The economic burden of immigrants with HIV/AIDS: When to say no?" *J for Global Business Advancement* 3,1 (2010).

living with disabilities by arbitrarily focusing only on the cost of their health care and ignoring the many contributions of people living with disabilities, including HIV, to Canadian society. The provision creates a cumbersome and inefficient process that ultimately does little to reduce health care costs, which are unpredictable. Finally, the excessive demand provision contravenes international law. Further incremental change will not remedy this discrimination and stigmatization, as confirmed by the 2017 report by the Standing Committee on Immigration and Citizenship.

The excessive demand rule is a vestige of years of immigration policies that have excluded people with disabilities with the stated goal of protecting the public purse. No amount of individualized assessments can cure the fact that the excessive demand regime reduces applicants living with HIV and other disabilities to a single characteristic: the cost of their health care.

Therefore, we urge the Government of Canada to remove the excessive demand inadmissibility from the IRPA by repealing section 38(c) of the IRPA.