Submission to Immigration, Refugees and Citizenship Canada on Medical Inadmissibility

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Executive Summary

In Canada, people seeking permanent resident status or temporary residence as students or workers can be rejected on the basis of their HIV status due to the "excessive demand" provision of Canada's laws governing medical inadmissibility. Relying on the purportedly neutral criteria of the cost of health services, this law renders any applicant who would require more than $6450 per year's worth of health or social services inadmissible to Canada. Due to the high cost of antiretroviral medications, the health care costs of many people living with HIV are higher than the current threshold.

A person living with HIV will be medically inadmissible to Canada unless they (a) fit within one of the exceptions to the excessive demand rule, (b) are able to reduce the public burden of their medications by switching to generic drugs or obtaining private insurance, or (c) obtain an exemption from the excessive demand rule on humanitarian and compassionate (H&C) grounds.

We recommend that the excessive demand provision be repealed, for the following reasons:

- **The excessive demand provision is discriminatory**: The excessive demand regime violates the *Canadian Charter of Rights and Freedoms* ("Charter") by discriminating against prospective Canadians on the basis of their disability and relying on outdated and discriminatory attitudes about people living with HIV and other disabilities.[3] The excessive demand regime focuses solely on alleged use of health services as grounds for exclusion and ignores the important contributions that people with HIV make to Canadian society. 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 to a single characteristic: the cost of their medications.

- **The excessive demand provision poses many operational problems:** The excessive demand regime has created a cumbersome, inefficient process that ultimately does little to control health care costs and therefore cannot be justified. Relatively few medically inadmissible applicants are refused residence and, more importantly, future health care costs are inherently unpredictable. Health care costs for many people living with HIV will decrease as generic versions of more medications become available. An applicant living with HIV could also become eligible for private insurance through an employer. The excessive demand threshold itself is also based on inappropriate statistical analyses, resulting in a threshold that is much too low. As a result, the excessive demand provision

[3] 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.

results in unfair and arbitrary denials, and subjects those who are ultimately approved to processing delays.

- **The excessive demand provision undermines the objectives of the *Immigration and Refugee Protection Act***: 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 excessive demand provision violates Canada's international law obligations and is not in line with other countries' practices:** The United Nations (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. The excessive demand regime also violates the UN *Convention on the Rights of Persons with Disabilities*. Finally, many other countries do not have such laws, policies or known practices that deny migration based solely on HIV status.

Introduction

The HIV & AIDS Legal Clinic Ontario (HALCO), the Canadian HIV/AIDS Legal Network and COCQ-SIDA welcome this opportunity to provide our submission with respect to the current review of medical inadmissibility, which focuses on the need to repeal the excessive demand provision.[4]

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[4] The **HIV & AIDS Legal Clinic (Ontario)** (www.halco.org) is the only community-based legal clinic in Canada serving low-income people living with HIV. HALCO staff practice a broad range of law, including privacy, immigration, health, human rights, tenancy, and income maintenance, and engage in public legal education, law reform, and community development initiatives. Since its inception, the clinic has handled over 50,000 requests for legal services, delivered hundreds of workshops, presented numerous briefs to various government committees, and intervened in matters at courts including the Supreme Court of Canada and Court of Appeal for Ontario.

The **Canadian HIV/AIDS Legal Network** (www.aidslaw.ca) is a charitable, not-for-profit organization that promotes the human rights of people living with, at risk of or affected by HIV or AIDS, in Canada and internationally, through research and analysis, litigation and other advocacy, public education and community mobilization. It is the only national organization working exclusively on HIV-related legal issues in Canada, and one of the world's leading organizations in the field, with an extensive body of human rights-based research and analysis on a range of legal and policy issues related to HIV. Since its inception, it has delivered hundreds of workshops for various audiences, presented numerous briefs to various legislative committees, and intervened in proceedings before the Supreme Court of Canada, several provincial Courts of Appeal, the European Court of Human Rights and numerous UN human rights treaty bodies. The Legal Network is an NGO in Special Consultative Status with the Economic and Social Council of the United Nations.

The current excessive demand provision is the result of many years of incremental change: there are now significant exceptions to excessive demand inadmissibility; the provision focuses exclusively on applicants' potential health care costs as opposed to their diagnosis; applicants are offered an opportunity to respond; and an individualized assessment of their circumstances takes place. These incremental changes have failed to address the underlying issues with the excessive demand regime itself. The unique circumstances of people living with HIV highlight the many problems with the excessive demand regime and the need to repeal this provision.

In this submission, we will outline how the excessive demand regime violates the Charter and contributes to stigma and discrimination, undermines the objectives of the *Immigration and Refugee Protection Act* (IRPA), is a cumbersome and inefficient process to administer, and is inconsistent with international law and the practice of other countries. As further incremental changes will not resolve these problems, we recommend repealing the excessive demand regime.[5]

HIV and AIDS in Context

Among the characteristics defining the HIV epidemic, two are relevant for the purposes of this submission: (a) the rapid advances in treatment responses and prognoses of people living with HIV and (b) widespread stigma and discrimination towards people living with HIV.

In the initial years of the HIV epidemic, the virus was untreatable. However, with the advent of "Highly Active Antiretroviral Therapy" (HAART), HIV is now a chronic illness, manageable with appropriate monitoring and medications. Today, people with HIV can live long, healthy lives. In industrialized countries like Canada, studies indicate that life expectancy for people living with HIV has continued to improve over recent years.[6] Indeed, the life expectancy of some groups of people living with HIV is approaching that of the general population, and the main causes of death for people living with HIV are similar to those of HIV-negative people.[7]

The **COCQ-SIDA** brings together various community-based HIV/AIDS organizations to sparks, promote and support a concerted action in the province of Quebec. The coalition encourages and advocates for community action in the fight against HIV/AIDS. The COCQ-SIDA unites and mobilizes people and consolidates actions and resources to address the different issues that affect PLWHA and the different populations at risk of contracting HIV while respecting and maintaining the autonomy of each member organization. COCQ-SIDA has a specific program dedicated to the defense of the human rights of people living with HIV/AIDS.

[5] This brief does not address the mandatory HIV test in the immigration medical exam or the partner notification policy, which requires all applicants in the family sponsorship and dependent refugee classes who test positive for HIV to voluntarily disclose their HIV status to their spouse or partner in Canada within 60 days, or withdraw their application. After 60 days have elapsed, Immigration, Refugee and Citizenship Canada (IRCC) will formally notify the spouse or partner in Canada before proceeding with the application. While mandatory HIV testing and the partner notification policy raise issues that are beyond the scope of this brief, we note that these policies constitute human rights violations, and we call on IRCC to remove the HIV test from the immigration medical exam and eliminate the partner notification policy.

[6] M. Battista, "HIV & Medical Inadmissibility in Canadian Immigration Law," paper presented at the Canadian Bar Association National Immigration Law Conference, 2013, Montréal.

[7] M. Loutfy et al., "Canadian consensus statement on HIV and its transmission in the context of criminal law," *Canadian Journal of Infectious Diseases and Medical Microbiology* 25,3 (2014): 135–140.

Nevertheless, 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.[8] Recent research reveals that actual transmission risks for people with undetectable viral loads may be zero or close to zero.[9]

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.[10]

The Excessive Demand Regime

Canada has excluded immigrants with disabilities since before Confederation.[11] It was not until 1976, however, that the *Immigration Act* introduced the excessive demand regime. Instead of excluding people with disabilities on the basis of their diagnoses as in the past, the *Immigration Act* instead excluded people with disabilities based on the cost of their diagnoses. As cost is a purportedly neutral factor, policy-makers made this shift to "remove the reliance on stereotypical assumptions that made persons with disabilities automatically excludable."[12]

In 2002, the *Immigration and Refugee Protection Act* (IRPA) came in force. The IRPA was the first significant update to Canada's immigration laws since the 1976 *Immigration Act*.

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[8] Estimates of transmission risk generally range between 0.4% and 1.4% though can vary depending on risk factors such as viral load level or type of sex. A risk of 1% means one transmission for every 100 exposures. J. Wilton, "Putting a number on it: The risk from an exposure to HIV", CATIE, Fall 2012. Available at www.catie.ca/en/pif/summer-2012/putting-number-it-risk-exposure-hiv.

[9] A recent study of 1166 couples serodifferent couples (one member of the couple is HIV negative and one is HIV positive) having condomless sex found no instances of within couple HIV transmission, where the HIV positive partner had an undetectable viral load, over a median follow-up period of 1.3 years. Further follow-up is needed to provide more precise estimates of risk. See A. J. Rodger, V. Cambiano, T. Bruun et al., "Sexual Activity Without Condoms and Risk of HIV Transmission in Serodifferent Couples When the HIV-Positive Partner is Using Suppressive Antiretroviral Therapy," *JAMA* 316,2 (2016): 171–181.

[10] Interagency Coalition on AIDS and Development (ICAD), *Fueling the Epidemic: HIV-Related Stigma and Discrimination,* March 2012; EKOS Research Associates Inc., *2012 HIV/AIDS Attitudinal Tracking Survey: Final Report*, October 2012. Available at www.ekospolitics.com/articles/038-12.pdf.

[11] The 1859 *Act Respecting Emigrants and Quarantine* prevented the admission of immigrants with physical or mental disabilities who were believed to impose financial burdens on the state or charitable institutions, followed by the 1910 *Immigration Act* which introduced "prohibited classes" of immigrants, stipulating an absolute prohibition of individuals with mental disabilities (such as "idiots, imbeciles, feeble-minded persons, epileptics, and insane persons"), while individuals who were "physically defective" (including "immigrants who are dumb or blind") were still allowed to immigrate if they could prove sufficient support. The 1927 *Immigration Act* removed the exception for people with physical disabilities. Individuals in the prohibited classes were absolutely banned from coming to Canada, and the list of prohibited classes was expanded to include individuals who were either "mentally or physically defective to such a degree as to affect their ability to earn a living." As a result, from the years 1927 to 1976, individuals with physical and mental disabilities were prohibited from immigrating to Canada.

[12] A. Klein, *HIV/AIDS & Immigration: Final Report*, 2001. Available at www.aidslaw.ca/site/hiv-and-immigration-final-report/?lang=en.

The excessive demand provision remained much the same in the IRPA as it had been in the 1976 *Immigration Act,* although the drafters removed any explicit references to "disability".[13] Section 38 of the IRPA now states 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. Under section 42 of the IRPA, foreign nationals can also be inadmissible if they have an inadmissible family member (i.e., an inadmissible spouse or dependent child).

However, the IRPA introduced two important incremental changes to the excessive demand regime. First, the IRPA created significant exceptions to excessive demand inadmissibility. Accepted refugees and protected persons, their spouses, common-law partners and dependent children; and spouses, common-law partners and dependent children sponsored through family class sponsorships are all now exempt from medical inadmissibility.

Second, IRPA's associated Regulations set out, for the first time, a comprehensive definition of excessive demand. Excessive demand is now defined as

> (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 are contributed by governments, including the services of family physicians, medical specialists, chiropractors, hospital care, etc. "Social services" include home care, residential services, social services, and vocational rehabilitation services and for which the majority of funding is provided by the government.

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 current excessive demand threshold is $6450.[14]

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[13] Section 19 of the 1976 *Immigration Act* stated that foreign nationals were inadmissible to Canada if they were "suffering from any disease, disorder, disability, or other health impairment […] which, in the opinion of a medical officer […] would cause or might reasonably be expected to cause excessive demand on health or social services."
[14] "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"]

Excessive demand in the courts: right to an individualized assessment

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),* 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.[15] 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, these 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,[16] as promises to pay for health services are unenforceable, since a permanent resident has the same right to access provincially-funded health care as any other resident once they are admitted to Canada. A subsequent Federal Court decision in *Companioni v. Canada (MCI)* further clarified the need for the excessive demand assessment to include a consideration of whether an applicant has a viable private insurance plan.[17] 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.

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 seek a further opinion from the medical officer, verify the details of the plan proposed by the

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[15] *Hilewitz v. Canada (MCI),* 2005 SCC 57 (Supreme Court of Canada).
[16] *Deol v. Canada (MCI)*, 2002 FCA 271 (Federal Court of Appeal). Social services, on the other hand, are treated differently. In *Hilewitz,* Justice Abella 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.
[17] *Companioni v. Canada (MCI)*, 2009 FC 1315 (Federal Court).

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.[18]

Excessive demand and HIV

In 2002, the Canadian government instituted mandatory HIV testing as part of the immigration medical exam (IME) that all permanent resident applicants and some temporary resident applicants must undergo. Prior to 2002, immigration officers learned that an applicant was HIV positive through questions on the application forms and through the IME.

The HIV test was the first medical test to be added to the IME in over 50 years.[19] Initially, Canada's Minister of Citizenship and Immigration stated that her department was considering excluding all HIV-positive immigrants on both public health and excessive demand grounds. After widespread outcry, the Minister changed her position to make clear that prospective immigrants with HIV, after receiving counselling, need not be excluded from immigrating to Canada under public health grounds. Prospective immigrants are still excluded from Canada under the excessive demand regime.[20]

Due to the high cost of antiretroviral medications, people living with HIV are generally medically inadmissible. As noted above, the excessive demand threshold is $6450 per year. The cost of antiretroviral medications can vary greatly. In HALCO's experience, clients who are medically inadmissible typically have antiretroviral medication regimens that cost between $12,000 to $15,000 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 (e.g., 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);
- they can obtain an 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 they have private insurance, usually through an employer, that covers a sufficient portion of their medications).

Despite the IRPA's exceptions, the availability of H&C relief, and the possibility of cost mitigation through generic medication and private insurance, the fact remains that applicants are still refused permanent residence in Canada solely due to the cost of their HIV medications.

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[18] Excessive demand, *supra* note 11. This webpage provides a detailed flowchart that demonstrates the full complexity of the excessive demand assessment, including the many levels of decision-making involved.
[19] L. Bisaillon, "Disease, Disparities and Decision Making: Mandatory HIV Testing of Prospective Immigrants to Canada," *BioéthiqueOnline* 2,10 (2013).
[20] Klein, *supra* note 5, p. i.

The Case for Repealing Excessive Demand

I. 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, whether physical or mental.[21] Section 3 of the IRPA specifically 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. As a result, people living with HIV are unfairly disadvantaged by a law that appears neutral. This form of indirect discrimination is still discrimination.[22] Furthermore, the discriminatory impact of the excessive demand regime is not rationally connected to its stated purpose of controlling costs. As described below, excessive demand does not effectively control health care costs.

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.[23] The excessive demand regime conceals outdated prejudices that people living with HIV, like other people with disabilities, are a burden on Canadian society.

By reducing people living with HIV solely to the cost of their medications, the excessive demand regime erases the many contributions that people with HIV make to Canadian society. 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."[24] People living with HIV participate in the labour force, pay taxes and contribute to their communities in many ways. A medically inadmissible person could be more productive than the average Canadian, and contribute more to the gross national product than they cost in terms of health services, yet they would still be found to cause an "excessive demand."

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[21] *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.
[22] *Andrews v. Law Society of British Columbia,* [1989] 1 SCR 143, 1989 CanLII 2 (SCC).
[23] *Hilewitz, supra* note 13 at para. 48.
[24] *Ibid.,* para. 39.

UN agencies, including the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the International Organization for Migration (IOM), have 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."[25]

The excessive demand regime, however, offers no opportunity for decision-makers to assess the potential contributions that an applicant may make to Canadian society. Decision-makers are not permitted to assess whether applicants have the potential to make contributions that could offset their costs to the Canadian health care system. Consideration of the anticipated contributions of newcomers with HIV is particularly important given the increasingly manageable nature of the disease and longer lifespans of people living with HIV.[26]

People living with HIV also contribute to their communities in many non-financial ways. Support networks formed by individuals participating in AIDS service organizations or allowing parents and grandparents to reunite in Canada may also ultimately reduce government costs. For example, a parent or grandparent living with HIV (and parents and grandparents with other health conditions) may provide childcare, support that will allow residents to participate in the labour force.

In sum, the excessive demand regime has a discriminatory impact on people living with HIV and is not rationally connected to controlling health care costs. Excessive demand also stigmatizes people living with HIV as burdens on society while erasing the many contributions that people living with HIV make to society. A further incremental change will not remedy this discrimination and stigmatization.

II. Excessive demand causes operational problems

The excessive demand regime has resulted in a cumbersome, inefficient process that ultimately does little to control health care costs. Relatively few medically inadmissible applicants are refused residence and, more importantly, long-term health care costs are inherently unpredictable. The excessive demand threshold is also based on inappropriate statistical analysis that has yielded a threshold that is much too low. The excessive demand provision is therefore not rationally connected to its goal of controlling health care costs, while imposing deleterious effects on applicants.

<u>Excessive demand inadmissibility does not effectively control health care costs</u>

[25] *Ibid.*, para. 49; UNAIDS, *The Gap Report 2014*, 2014, p. 103. Available at http://www.unaids.org/en/resources/documents/2014/20140716_UNAIDS_gap_report; UNAIDS and IOM, *Statement on HIV/AIDS Related Travel Restrictions*, June 2014, p. 9.

[26] Battista, *supra* note 1, p. 10.

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 H&C applications. The fact that excessive demand health inadmissibility only applies to some applicants limits the actual health care cost savings. In fact, according to the IRCC's estimates, only 900–1000 cases per year are refused due to excessive demand inadmissibilities.[27]

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 of Canada. In the case of people living with HIV, the main concern is the cost of prescription medication. This may seem like a predictable cost; however, an applicant's medication costs could easily decrease. Antiretroviral medications frequently become available in generic forms, drastically reducing an individual's health care costs. One of HALCO's clients recently switched to generic forms of the antiretroviral drugs Kivexa and Viramune. Her annual medication costs decreased dramatically, from over $9000 to approximately $3000. Her costs are now well within the excessive demand threshold. Another common medication, Atripla, costs approximately $18 000 per year in a brand-name formulation, while a generic formulation costs approximately $2800 per year.

Persons living with HIV could also obtain a job that offered private health insurance after they become permanent residents, which would disqualify a significant portion of their medical costs from public health care coverage. Thus, many people living with HIV find that their public health care costs decrease over time.

This analysis is in line with UNAIDS' International Task Team on HIV-Related Travel Restrictions, which state that "HIV-related travel restrictions on entry, stay and residence (…) do not rationally identify those who may cause an undue burden on public funds."[28]

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. Compare the situation of a skilled worker who has four young children, all of whom attend public schools. Media reports estimate that provincial governments spend roughly $10 700 to $13 000 per year to educate a child in elementary or secondary school.[29] A provincial government would pay over $40 000 a year to support this family's education costs, but they would not be considered to pose an excessive demand on public resources. However, a single person living with HIV with medication costs of $15 000 per year would be found to cause an

[27] Telephone conversation with Michael MacKinnon, Senior Director at the Migration Health Branch, IRCC, October 4, 2016.

[28] UNAIDS, *Report of the International Task Team on HIV-related Travels Restrictions: Findings and Recommendations*, December 2008, p. 5.

[29] A. McNeely, "Public school spending up dramatically in Canada despite falling enrolment: Fraser Institute," *National Post,* February 11, 2015. Available at http://news.nationalpost.com/news/canada/public-school-spending-up-dramatically-in-canada-despite-falling-enrolment-fraser-institute; "A numerical exploration of education in Canada," *CBC News,* August 5, 2010. Available at www.cbc.ca/news/a-numerical-exploration-of-education-in-canada-1.922061.

excessive demand. 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.

As noted above, the excessive demand regime does not allow for any assessment of an individual's potential contributions to Canadian society, including economic contributions that could offset an individual's health care costs. In the past, advocates have argued that the excessive demand regime should be reformed to ensure that the individualized assessment accounts for these contributions. Australia, for example, has proposed assessing an individual's "net benefit" to determine whether applicants' contributions to the economy will outweigh their health care costs.[30]

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 would 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.

The excessive demand cost threshold is too low

"Excessive demand" is defined as a demand that would likely exceed average Canadian per capita health and social services. As noted above, the 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.[31]

Health care economists have criticized this threshold as arbitrary because it is "neither a reasonable nor statistically appropriate interpretation of the term 'excessive' demand used in IRPA".[32] For a demand to be truly "excessive," it should be *statistically greater* than that of Canadians. Statistical analysis reveals that the current threshold is too low, as it does not accurately determine which applicants would actually use a statistically greater amount of health care than Canadians.

IRCC's method of determining the excessive demand threshold is inappropriate because it is based on statistical models where there is no variation in health care costs. In this model, all Canadians incur the same annual costs for health care, a claim that is simply not true.[33]

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[30] Australian Government, *Australian Government response to the Joint Standing Committee on Migration report: Enabling Australia Inquiry into the Migration Treatment of Disability*, November 2012.
[31] Battista, *supra* note 1, p. 10.
[32] 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).
[33] 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.

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 employed by IRCC.[34] These analyses demonstrate that even the purportedly objective excessive demand cost threshold is a difficult standard to fairly and accurately administer. Applicants are erroneously assessed as causing an excessive demand even though their health care use would not be statistically greater than average Canadian use of health care. This assessment results in arbitrary and unfair refusals.[35]

Increasing the excessive demand threshold would be an inadequate "band-aid" solution that would not resolve the 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. Again, the cost threshold model itself at least theoretically permits refusal if an individual's health care costs exceeds 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.

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 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 an immigration medical exam, after which they receive the procedural fairness letter, to which they respond by requesting a waiver of the requirement to be medically admissible. In HALCO's experience, the process takes at least one year before an applicant obtains a decision on a request for a medical inadmissibility waiver. After obtaining the waiver and approval in principle, applicants may still be required to complete additional immigration medical exams even though they have already obtained a medical waiver.

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

[34] This statistical model is called "gamma distribution."
[35] Coyte and Battista, *supra* note 28.

residents. HALCO has represented clients whose children turned 19 before the clients became permanent residents and therefore could no longer be sponsored as dependent children.[36] 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 permanent family separation.

In sum, the excessive demand regime discriminates against people living with HIV. This discrimination cannot be justified on the basis of health care cost savings, given that it does not effectively control health care costs and imposes unfair and arbitrary refusals, and unnecessary delays to the applicants who are ultimately accepted.

III. Excessive demand undermines the objectives of the IRPA

The excessive demand regime further undermines the objectives of the IRPA. The objectives, as set out in Section 3 of the Act, 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 a H&C application. Each of these programs is connected to one of the objectives of the IRPA.

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. 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.

[36] 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 19, who is not a spouse or common law partner. Children over the age of 19 can be sponsored only if they depend substantially on a parent's financial support due to a physical or mental condition.

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. 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.[37] 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.

Humanitarian and compassionate applicants

Humanitarian and compassionate (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

[37] 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.

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, including through the vicarious inadmissibility provisions. For example, HALCO has been contacted on numerous occasions by live-in caregivers whose children overseas tested positive for HIV during the IME. 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 processed.[38] They were devastated to learn that they had been unable to protect their children, now young adults, from contracting HIV during the period of separation. 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.

IV. Excessive demand violates Canada's international law obligations and is not in line with other countries' practices

Excessive demand violates Canada's international law obligations

In 2011, the UN General Assembly encouraged Member States to eliminate HIV-related restrictions on entry, stay and residence.[39] 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.[40] 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).[41]

In ratifying the *Convention on the Rights of Persons with Disabilities* in 2010, Canada signaled 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.[42] 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

[38] On October 24, 2016, the processing time for live-in caregiver applications on the IRCC website was 51 months.
[39] 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.
[40] UNAIDS, *The Gap Report*, 2014, p. 169. Available at http://www.unaids.org/en/resources/documents/2014/20140716_UNAIDS_gap_report.
[41] 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).
[42] Article 3 of the *Convention on the Rights of Persons with Disabilities*.

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."[43]

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,[44] employment[45] and the highest attainable standard of physical and mental health.[46]

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.[47] 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.[48] 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 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 countries."[49] Similarly, in 2010, bolstered by human rights arguments against its HIV-specific travel ban, the U.S. lifted all restrictions affecting people with HIV wanting 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.[50]

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[43] *Ibid.*, Article 4a.
[44] Article 13 of *International Convention on Economic, Social and Cultural Rights* and Article 24 of the *Convention on the Rights of Persons with Disabilities*
[45] Article 6 of *International Convention on Economic, Social and Cultural Rights* and Article 27 of the *Convention on the Rights of Persons with Disabilities*
[46] Article 12 of *International Convention on Economic, Social and Cultural Rights* and Article 25 of the *Convention on the Rights of Persons with Disabilities*.
[47] UNAIDS. 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.
[48] NAM aidsmap, *Immigration and asylum law*, January 2014. Available at http://www.aidsmap.com/Immigration-and-asylum-law/page/1255093/#item1255521.
[49] 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.
[50] 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.

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 of people living with HIV to Canadian society. The provision 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. Finally, the excessive demand provision contravenes international law and is not in line with the practices of many other countries, which do not have similar provisions denying migration solely on the basis of HIV status.

Therefore, we urge the Government of Canada to remove the excessive demand inadmissibility from the IRPA by repealing section 38(c) of the IRPA.