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Denied the Right to Health Care: Regulatory Changes to Canada's Medical Inadmissibility Provision

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Abstract

In June 2018, Immigration, Refugees, and Citizenship Canada (IRCC) enacted changes to the medical inadmissibility provision (section 38(1)(c)) of the Immigration and Refugee Protection Act (IRPA) in the form of a temporary public policy. These consisted of raising the cost threshold for defining "excessive demand," and narrowing the scope of "social services" eligible to be deemed a burden to the state when considering temporary and permanent residency applications to Canada. Reasons cited for the proposed changes included promoting the inclusion of applicants with disabilities (such as children in need of special education) and of applicants requiring costly prescription drugs (such as HIV-positive individuals). Although impacts at this stage are preliminary, these amendments are expected to greatly decrease the number of medical inadmissibility findings issued to permanent and temporary residence applicants on a yearly basis. This reform occurred in the context of mounting societal and political pressures calling for a more humanitarian approach to immigration policy. It illustrates important tensions underlying the state's obligation to protect the collective good of society while navigating the ethical implications of exclusionary immigration measures.

En juin 2018, Immigration, Refugiés et Citoyenneté Canada (IRCC) a apporté des changements à la politique d'interdiction de territoire pour motifs sanitaires (section 38(1)(c)) de la Loi sur l'immigration et la protection des réfugiés, sous la forme d'une politique publique temporaire. Ces changements consistaient à augmenter le seuil de coûts servant à définir un "fardeau excessif," ainsi qu'à réduire le périmètre de définition des "services sociaux" susceptibles d'être perçus comme représentant une charge financière pour l'État lors de l'évaluation des demandes de statut de résidence temporaire ou permanente au Canada. La promotion de l'inclusion des individus souffrant de handicaps (tels que les enfants ayant besoin d'un enseignement spécialisé) et des personnes nécessitant des ordonnances coûteuses (telles que les personnes séropositives) faisaient parie des raisons invoquées pour les changements proposés. Bien qu'il soit trop tôt pour en mesurer les effets, ces modifications pourraient considérablement réduire le nombre d'interdictions de territoire pour motifs sanitaires émises chaque année à l'encontre des demandeurs de résidence permanente et temporaire. Des pressions sociales et politiques croissantes pour une approche plus humanitaire de la politique d'immigration canadienne ont créé un contexte favorable pour cette réforme. Celle-ci illustre les tensions importantes entre l'obligation de l'État de protéger le bien-être collectif de la société et les implications éthiques des pratiques d'immigration restrictives.

Key Messages

- The excessive demand prohibition of Canada's medical inadmissibility provision has been a continued topic of debate over the last few decades.
- Changes to the policy have been proposed and enacted by the IRCC, and include raising the cost threshold for excessive demand and revising the definition of "social services" that contribute to the excessive demand threshold to focus exclusively on social services closely related to health use.
- Although the policy reform is projected to have a positive impact on groups that have historically been victims of social exclusion from the state, much remains to be done to promote inclusivity in Canada's immigration policy.

Messages-clés

- *L'interdiction de territoire pour fardeau excessif (sanitaire) est au centre de nombreux débats depuis plusieurs dizaines d'années.*
- *Des changements à la politique ont été proposés et adoptés par IRCC, et consistent en l'augmentation du seuil de coûts servant à définir un "fardeau excessif," ainsi qu'en une réduction du périmètre de définition des "services sociaux" susceptibles d'être perçus comme représentant une charge financière pour l'État, afin que ceux-ci comprennent seulement les services sociaux étroitement liés aux soins de santé.*
- *Bien que ces modifications sont susceptibles d'avoir un impact positif sur certains groupes que l'État a historiquement tenus en marge de la société, il reste encore beaucoup à accomplir pour promouvoir l'inclusion dans la politique d'immigration au Canada.*

1 BRIEF DESCRIPTION OF THE HEALTH POLICY REFORM

On 1 June 2018, Immigration, Refugees and Citizenship Canada (IRCC) proposed changes to the medical inadmissibility provision of the *Immigration and Refugee Protection Act* (IRPA). This health reform specifically aimed to address the excessive demand prohibition of the medical inadmissibility provision, as stipulated in subsection 38(1)(c) of the Act:[1]

> 38(1): A foreign national is inadmissible on health grounds if their health condition: [. . .] (c) might reasonably be expected to cause excessive demand on health or social services. (Immigration and Refugee Protection Act 2001)

The proposed amendments were enacted in the form of a temporary public policy, whereby two major modifications were made to definitions found in the concomitant *Immigration and Refugee Protection Regulations* (IRPR). These modifications consisted of:

1. Raising the cost threshold for defining "excessive demand," previously comparable to the average Canadian per capita cost of health and social services (approximated to $5,700 CAD per year for the year 2017), to *three times* the average Canadian per capita cost of health and social services (from $6,665 CAD per year to roughly $20,000 CAD per year, as per the most recent estimates);
2. Revising the definition of "social services" to focus exclusively on social services closely related to health use, thus decreasing the scope of expenses eligible to be considered a financial burden to the state (in particular, removing references to special education, social and vocal rehabilitation services and personal support services for the disabled) (IRCC 2018a; 2018b).

2 HISTORY AND CONTEXT

The IRPA, approved by Parliament in 2001 and implemented in 2002, represents Canada's most current legislation with regards to immigrant health (Vineberg 2014). However, an examination of Canadian policy history dating back to early days of immigration reveals deep-seated and tireless efforts by the Canadian government to systematically ban certain groups from entering the state, under the pretexts of reducing the financial burden caused by certain immigrants and protecting Canada's public health care system. Although the excessive demand prohibition in its current wording was first implemented 40 years ago, the Canadian government has resorted to the use of similar provisions for over 150 years (*Policy Options Politiques* 2018). In 1848, the *Act to make better provision with respect to emigrants* first established a provision with the explicit aim of mitigating the financial

[1] Subsections (a) and (b) refer to threats to public health and public safety, respectively, as grounds for medical inadmissibility.

burden of immigrant health care on the state. This Act required that ships' masters provide a bond of £20 to defray any costs incurred by the province or municipality for the medical care of passengers arriving with certain medical conditions, described in official legislation as those found to be "lunatic, idiotic, deaf and dumb, blind or infirm" (Vineberg 2014). Subsequent policy formulations have continued to incorporate a focus on the calculation of costs relating to immigrant health care as a means of defining medical inadmissibility.

Nonetheless, immigration health policy has not remained completely static over the last few centuries. Most notably, the 1976 Immigration Act catalyzed an important shift from the prohibition of specific diseases and conditions (which formerly included trachoma, epilepsy, tuberculosis and mental illness, among others) to more general categories of prohibitions (Vineberg 2014). Despite this significant change in Canadian immigration policy, however, archaic ideas and provisions from earlier policies have maintained a profound (albeit more subtle) influence in more recent policies on medical inadmissibility. The current discourse used to determine the admissibility of immigrants relies heavily on fearmongering and alarmism, purporting to protect the interests of Canadian citizens from immigrant overuse of health or social services by painting them as "threats" to society. The assessment is largely based on Western conceptions of disease and productive abilities, reinforcing the colonial divide between the global North and South and pointing to the enduring legacy of ableism in Canadian immigration policy (El-Lahib 2015; 2016). Historically, the practice of favouring able-bodied individuals for entry into the country is known to have particularly disadvantaged individuals with developmental disabilities (Beiser 2005).

The inclusion of the medical inadmissibility provision in Canada's more recent formulations of the IRPA has been a continued topic of debate over the last few decades. Many cases of immigrants having been denied entry based on excessive demand have been highly publicized by the media, receiving widespread attention from the public. As a result of mounting legal pressures, the medical inadmissibility provision of the IRPA was revised soon after its inception to allow for the exemption of certain family-class applicants and, more recently, for the consideration of individualized assessments (whereby applicants can contest such decisions with a proposed "mitigation plan" for the management of the disease or condition) (Wilton, Hansen, Hall 2017). The main intent of the provision, however, has been sustained to this day. Consequently, medical inadmissibility findings continue to be issued to close to one thousand permanent and temporary residence applicants every year (IRCC 2018a).

3 GOALS OF THE REFORM

3.1 Stated

In a statement released by the Canadian government a few months ahead of the official implementation of the temporary public policy, the proposed changes were framed as addressing the central issue of inclusion (IRCC 2018a). The IRCC estimated that this revised

policy would decrease the number of annual medical inadmissibility findings by roughly 75% (*CBC News* 2018). More distinctly, the government's explicit intent with regards to this policy reform consisted of promoting the inclusion of applicants with disabilities (including children in need of special education) and of applicants requiring expensive publicly-funded prescription drugs (consisting in large part of HIV-positive individuals) seeking to immigrate to Canada (IRCC 2018a). Individuals from these two major groups would have been rendered inadmissible under the previous policy formulation due to the medical costs and burden of care associated with these conditions. As such, they represent a dominant focus of this policy amendment. This political priority is reflected in the changes prescribed by the policy reform itself, whereby the first (raising the permissible cost threshold) stands to greatly benefit HIV-positive individuals, and the second (removing social services from consideration) stands to greatly benefit individuals with developmental disabilities. This is likely a result of the major lobbying efforts of disabilities and HIV/AIDS organizations, whose key involvement in the development of this temporary policy is later discussed.

3.2 Implicit

Underlying the Canadian government's stated aim to combat the social exclusion of these particular groups is an economic rationalization of the policy reform. Mosoff (1998) has previously described how certain groups of people have been consistently and systematically banned from entering the state based on "utilitarian" models of disease and social dependence, which have historically guided Canada's immigration policies. Under such models, immigrants with disabilities or health conditions are viewed as posing a financial threat to the Canadian welfare system. Despite the unrelenting prominence of such views, certain policy circles have emphasized the ability of individuals belonging to these groups to contribute to the Canadian economy beyond costs imposed on the health care system (Canada, Parliament, House of Commons 2017). A recent report concluded that enhancing access to the Canadian labour market for people with disabilities could generate an increase of nearly seventeen billion dollars in Canada's GDP by the year 2030 (Conference Board of Canada 2018). It is likely that similar economic considerations, broadly focused on monetizing individual worth, were weighted by the state in the development of this policy reform. This is evidenced by the fact that despite the newly implemented changes, an explicit cost calculation remains cited as a criterion for medical inadmissibility.

The fact that the revised policy stops short of instituting a repeal of the excessive demand prohibition of the medical inadmissibility provision also carries certain implications. In proposing interim modifications, the government is effectively acting to prolong the consultation process with stakeholders, including provincial and territorial governments (*CBC News* 2018). Although immigration is regulated at the federal level, provincial and territorial perspectives must be carefully incorporated into this decision due to potential impacts on jurisdictional budgets for health care and social services (Canada, Parliament, House of Commons 2017). Such a consultation process is likely to be very time-intensive,

requiring that changes be introduced in an incremental and coordinated manner.

4 FACTORS THAT INFLUENCED HOW AND WHY

4.1 The issue came onto the government's agenda: problems, proposals and politics

Several high profile and widely circulated legal proceedings contributed to sensitizing the general public to the problematic nature of the excessive demand prohibition. These included the case of David Hilewitz, a citizen of South Africa who had been refused permission to enter Canada as a permanent resident in the investor category on the basis that he had a son with a developmental delay (Hilewitz v. Canada 2004); and the case of Charanjit Kaur Deol, whose father was denied a permanent resident visa due to advanced degenerative osteoarthritis in both knees likely to require surgical treatment in the near future (Sapru v. Canada 2011). Amid growing public decry, community organizations and law firms advocating for migrant rights played a key role in further increasing the visibility of the issue and rallying the community around an organized movement. This concerted action contributed in large part to shaping the governmental agenda.

In 2016, the Canadian government announced that it was reviewing all elements of the medical inadmissibility provision (IRCC 2018a). This likely represented an attempt by the majority Liberal government to catalyze a transition away from the non-immigrant friendly policies established under the previous Conservative government. A House of Commons Standing Committee on Citizenship and Immigration was mandated to perform a comprehensive examination of federal government policies and guidelines regarding the medical inadmissibility of immigrants over the months of October and November 2017. As a result of this exercise, the Liberal-dominated committee formulated a set of recommendations and interim measures, including, eventually, the complete repeal of section 38(1)(c) of the IRPA (Canada, Parliament, House of Commons 2017). This proposed course of action precipitated the adoption of the issue at the parliamentary level by the Liberal government. These efforts were headed by Canada's Immigration Minister, Ahmed Hussen, who positioned himself as a strong proponent of the need for reform in this area.

4.2 The final decision was made or not made: interests, ideas and institutions

The involvement of civil society in this policy reform was largely driven by the interests of HIV/AIDS and disability associations, both of which represented groups disproportionately burdened by the excessive demand prohibition. In a letter to the federal government, Carranza LLP Law Firm, an immigrant law firm, and No One is Illegal Toronto, a migrant justice organization, denounced this provision as discriminatory and responsible for constructing disabled people and their families solely as a drain on resources (Macdonald

2017). In addition, the prohibition was widely perceived as anti-poor because an individual applicant's financial means could factor into the decision. Some pointed to how this may exacerbate economic disparities since less affluent immigrants were unable to challenge court assessments by proposing mitigation plans to cover medical costs, and thus had a higher overall possibility of being denied entry (*Policy Options Politiques* 2018). Furthermore, the use of a singular (rather than age- or gender-adjusted) benchmark to determine medical inadmissibility disadvantaged both older immigrant populations, who are likely to require more health services than the population at large, and women in need of reproductive health care services (Wilton, Hansen, Hall 2017; Sapru v. Canada 2011). Together, these equity considerations informed a wider human rights approach to policy reform.

Under this approach, national and international legal frameworks were drawn on to invalidate the policy in its current formulation. The medical inadmissibility provision was found to be incompatible with several international treaties to which Canada is bound, including the United Nations Convention on the Rights of the Child and the Convention on the Rights of Persons with Disabilities. The policy was also shown to violate Section 15 of the *Canadian Charter of Rights and Freedoms* (Canada, Parliament, House of Commons 2017; *Policy Options Politiques* 2018). At the institutional level, the enactment of the policy reform thus came to be seen as necessary to bring the policy in line with the country's domestic and international human rights obligations.

Largely perceived as a product of an outdated neoliberal state ideology, many have also argued that the excessive demand prohibition reflects a clash in commonly-held Canadian moral values (Mosoff 1998). According to public consultations carried out to inform the development of the Canadian Index of Wellbeing, these include diversity, inclusion, and economic security. Polls have also demonstrated that the majority of Canadians feel universal access to publicly-funded health care services should be a top priority for ensuring quality of life (Canadian Index of Wellbeing 2016). This widespread perspective is reflected in the *Canada Health Act*, which outlines national principles for the provision of health care referred to as "Canadian fundamental values." Most notably, the principle of accessibility stipulates that financial or other barriers to the provision of health care services should be alleviated by the state—thus standing in direct contradiction to the costs-based assessment criteria of the excessive demand prohibition (Canada, Parliament, Senate 2002). However, while these values may be commonplace, they are not unanimously agreed upon by the Canadian population. Amid a growing political rhetoric of anti-immigrant sentiments worldwide, recent surveys have noted a steady increase in anti-immigrant attitudes among Canadians (Environics Institute for Survey Research 2019). Nonetheless, it appears that the Trudeau government's explicit interest in championing the values of openness, compassion, and equity played an important role in countering this trend to influence the final decision (*New York Times* 2015).

5 HOW THE REFORM WAS ACHIEVED

5.1 Policy instruments

As previously mentioned, the two modifications outlined by the policy reform were appended to the IRPA as a temporary public policy. This temporary public policy has allowed officials to make exceptions to the medical inadmissibility provision when considering applications for temporary or permanent residency pending or received on or after 16 April 2018, and will hold until the proposed changes are reflected in the IRPR in a more permanent fashion (IRCC 2018b).

5.2 Implementation plan

Many political figures, including Immigration Minister Ahmed Hussen, view these amendments to the excessive demand prohibition as a stepping-stone to the complete elimination of the excessive demand prohibition of the IRPA. Consultations regarding key aspects of the issue are said to be underway (*CBC News* 2018). To date, however, no distinct plan for how the policy reform will be carried out beyond these changes has been shared with the public. Several stakeholders, including New Democratic Party immigration critic Jenny Kwan and a coalition of disability, HIV/AIDS and immigrant rights groups, have expressed dissatisfaction with the changes, referring to these as "minor tweaks to a deeply flawed regime" (*CBC News* 2018). The temporary policy has also been met with a certain degree of opposition from Conservative groups and parties. Conservative immigration critic Michelle Rempel has stated that costs relating to these changes are likely to be high, with potentially detrimental effects on provincial and territorial health care systems throughout the country. It thus remains unclear whether this policy reform will be able to catalyze further advancements in immigration policy outside the realm of support of a majority Liberal government.

6 EVALUATION

6.1 Process of evaluation

The federal government has alluded to the fact that further research will be conducted to determine whether provinces and territories could potentially be compensated for extra costs arising as a result of the policy changes (*CBC News* 2018). Given the recent nature of this policy reform, however, no formal evaluation plan exists at this time.

6.2 Impact evaluation

The impacts to date are highly preliminary. The temporary policy has itself allowed for several cases of medical inadmissibility to be overturned as "exceptions" in the months

following the reform (IRCC 2018b). It still remains to be seen whether the projected impacts of the reform (in terms of reducing the number of cases deemed medically inadmissible) will materialize once the amendments are formally incorporated into the IRPR.

7 STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

Table 1: SWOT analysis of the reform

Strengths	Weaknesses
• Promotes inclusion of certain immigrant groups previously disadvantaged by the excessive demand prohibition. • Aligns with what are believed to be commonly-shared Canadian values and national/international human rights conventions.	• Modifications limited to minor changes from the perspective of certain groups of key proponents, including HIV/AIDS and immigrant rights associations. • Explicit cost calculation remains cited as a criterion for medical admissibility. • No stratification for age groups, gender or other factors applied to cost thresholds.
Opportunities	**Threats**
• Has permitted for exceptions to be made to medical inadmissibility findings in the months following the reform. • Anticipated decrease in the number of unsuccessful immigration applications on the grounds of medical inadmissibility once the policy is formally instated. • May eventually lead to the complete abolishment of the excessive demand prohibition of the medical inadmissibility provision.	• May impose constraints on health care budgets; inter-governmental coordination required to manage the effects of the federal policy on provincial health care systems. • Discrimination and equity issues likely to persist in immigration policy due to the continued existence of the medical inadmissibility provision itself. • General dissatisfaction among stakeholders may point to need for further reform. • Reform largely reliant on the sustained influence of the Liberal party; as a temporary policy, the reform runs the risk of being overturned if a more conservative and less immigrant friendly government is elected.

8 REFERENCES

Beiser M. 2005. The health of immigrants and refugees in Canada. *Canadian Journal of Public Health* 96(2): S30-S44.

Canada, Parliament, House of Commons. 2017. Building an inclusive Canada: bringing the immigration and refugee protection act in step with modern values: report of the Standing Committee on Citizenship and Immigration. 42nd Parl, 1st Sess, Rept 15. https://www.ourcommons.ca/Content/Committee/421/CIMM/Reports/RP9322080/cimmrp15/cimmrp15-e.pdf

Canada, Parliament, Senate. Standing Senate Committee on Social Affairs Science and Technology. 2002. The health of Canadians—the federal role: final report volume six—recommendations for reform. 37th Parl, 2nd Sess, Vol 6. https://sencanada.ca/content/sen/committee/372/soci/rep/repoct02vol6-e.htm

Canadian Index of Wellbeing. 2016. How are Canadians really doing? The 2016 CIW national report. Waterloo, ON: Canadian Index of Wellbeing and University of Waterloo.

Conference Board of Canada. 2018. Widespread economic benefits to be gained from making workplaces more accessible for people with disabilities, 23 February. https://www.newswire.ca/news-releases/widespread-economic-benefits-to-be-gained-from-making-workplaces-more-accessible-for-people-with-disabilities-674936343.html

CBC News. 2018. Liberals loosen rules that exclude immigrants on medical grounds, 16 April. https://www.cbc.ca/news/politics/liberal-immigration-medical-inadmissibility-1.4621256

El-Lahib Y. 2015. The inadmissible "other": discourses of ableism and colonialism in Canadian immigration. *Journal of Progressive Human Services* 26(3): 209-228. https://doi.org/10.1080/10428232.2015.1063355

El-Lahib Y. 2016. Dominant health discourses in action: constructing people with disabilities as the "inadmissible other" in Canadian immigration. *Disability Studies Quarterly* 36(3). https://doi.org/10.18061/dsq.v36i3.5055

Environics Institute for Survey Research. 2019. Canadian public opinion about immigration and refugees, 29 April. https://www.environicsinstitute.org/docs/default-source/project-documents/focus-canada-spring-2019/environics-institute---focus-canada-spring-2019-survey-on-immigration-and-refugees---final-report.pdf?sfvrsn=8dd2597f_2

Hilewitz v. Canada (Minister of Citizenship and Immigration), [2004] 1 FC 696, 2003 FCA 420 (CanLII). http://canlii.ca/t/1fwzx, as of October 8 2018.

Immigration and Refugee Protection Act, SC 2001, c 27, s 38(1)(c). http://canlii.ca/t/53bgk

Immigration and Refugee Protection Regulations, SOR/2002-227, s1(1).http://canlii.ca/t/53bgl

IRCC (Immigration, Refugees and Citizenship Canada). 2018a. Changes to medical inadmissibility policy. Immigration, Refugees and Citizenship Canada. https://www.canada.ca/en/immigration-refugees-citizenship/news/2018/04/changes-to-medical-inadmissibility-policy.html

IRCC (Immigration, Refugees, and Citizenship Canada). 2018b. Temporary public policy regarding excess demands on health and social services. Immigration, Refugees, and Citizenship Canada. https://www.canada.ca/en/immigration-refugees-citizenship/corporate/mandate/policies-operational-instructions-agreements/excessive-demand-june-2018.html

Macdonald S. 2017. Letter to the Standing Committee on Citizenship and Immigration RE: Repeal section 38(1) c of the Immigration and Refugee Protection Act. Ottawa. http://www.ourcommons.ca/Content/Committee/421/CIMM/Brief/BR9268114/br-external/ScottMacdonald-e.pdf

Mosoff J. 1998. Excessive demand on the Canadian conscience: disability, family and immigration. *Manitoba Law Journal* 26: 149-177.

New York Times. 2015. Trudeau's Canada, again: with support from President Obama and the legacy of his father on his side, Justin Trudeau sets out to redefine what it means to be Canadian, 8 December. https://www.nytimes.com/2015/12/13/magazine/trudeaus-canada-again.html?_r=0

Policy Options Politiques. 2018. Medical inadmissibility rules make Canada a laggard, 30 April. http://policyoptions.irpp.org/magazines/april-2018/medical-inadmissibility-rules-make-canada-a-laggard/

Sapru v. Canada (Citizenship and Immigration), 2011 FCA 35 (CanLII). http://canlii.ca/t/2flwr

Vineberg R. 2014. Healthy enough to get in: The evolution of Canadian immigration policy related to immigrant health. *Journal of International Migration and Integration* 16(2): 279-297. https://doi.org/10.1007/s12134-014-0339-3

Wilton R, Hansen S, Hall E. 2017. Disabled people, medical inadmissibility, and the differential politics of immigration. *The Canadian Geographer / Le Géographe Canadien* 61(3): 389-400. https://doi.org/10.1111/cag.12361