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# Medical Inadmissibility, and Physically and Mentally Disabled Would-be Immigrants: Canada's Story Continues

*Canadian immigration law has always viewed potential immigrants with physical or mental disabilities or impairments as undesirable citizens. Medical conditions and speculations about fiscal matters have served as markers to identify morally and physically desirable or undesirable citizens, cloaking wide-spread social prejudice, eugenic informed general distain for human difference, and the role of society in creating experiences of impairment.*

*This article dissects Canada's legislation from pre-1900 to 2019. It shows how our current laws inherited historic prejudices, despite Canada prohibiting discrimination against the disabled and signing the* CRPD*. The most recent changes are a significant step toward recognizing a social model of disability, but the outcome does not end discrimination. Canada perpetuates the narrative that exclusions are necessarily to sustain Canada's health care system, thus externalizing and individualizing draws, while failing to acknowledge the systemic strains arising from matters like state failure to aggressively pursue population health initiatives and insufficiently regulated pharmaceutical pricing.*

*Le droit canadien de l'immigration a toujours considéré les immigrants potentiels ayant une déficience physique ou mentale comme des citoyens indésirables. Les conditions médicales et les conjectures sur des questions fiscales ont servi de marqueurs pour identifier les citoyens moralement et physiquement désirables ou indésirables, masquant des préjugés sociaux très répandus, le rejet général de la différence humaine marqué par un éclairage eugénique, et le rôle de la société dans la création d'expériences d'invalidité.*

*Cet article dissèque la législation canadienne d'avant 1900 jusqu'à 2019. Il montre comment nos lois actuelles ont hérité de préjugés historiques, malgré l'interdiction par le Canada de la discrimination contre les personnes handicapées et la signature de la* CRDPH*. Les changements les plus récents constituent un pas important vers la reconnaissance d'un modèle social du handicap, mais ne mettent pas fin à la discrimination. Le Canada perpétue le discours selon lequel les exclusions visent nécessairement à soutenir le système de soins de santé du Canada, en externalisant et en individualisant les sélections, tout en ne reconnaissant pas les tensions systémiques découlant de questions comme l'incapacité de l'État à mettre en œuvre de façon dynamique des initiatives de santé publique et la réglementation insuffisante des prix des médicaments.*

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*Introduction*
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*Introduction*

In April 2018, Canada's federal government announced that it had decided "to eliminate" the medical inadmissibility policy from our immigration regime.[1] This was to bring our practices in line with contemporary Canadian values, and to engender consistency with the *Convention on the Rights of Persons with Disabilities* (*CRPD*),[2] that Canada signed in 2007 and ratified in 2010. The *CRPD* requires equality for persons with disabilities, including taking actions to enable full and effective participation and inclusion in society.[3] To achieve these obligations, states must adopt legislative or other measures that implement these rights, and must repeal or revise legislation or policies which are inconsistent with the *CRPD*'s obligations.[4]

Canadian law has long had provisions that specifically consider, or require, rejecting potential immigrants based on grounds that are linked to health conditions and perceived intellectual and physical disabilities. Although the announced goal was eliminating the policy, the government news release indicated that this would not happen immediately. Rather, further collaboration with provinces and territories was required to understand the effects of a repeal, because these levels of government hold responsibility for providing access to health and social services for their residents. In the short term, however, the federal government committed

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: *Newsroom—Immigration, Refugees and Citizenship Canada* <www.canada.ca/en/immigration-refugees-citizenship/news.html>.
2. *Convention on the Rights of Persons with Disabilities*, 30 March 2007, 2515 UNTS 44910 (entered into force 3 May 2008) [*CRPD*].
3. *CRPD*, *ibid*, art 3.
4. *CRPD*, *ibid*, art 4.

to immediately implementing interim changes to "bring the policy in line with Canadian values on supporting the participation of persons with disabilities in society, while continuing to protect publicly funded health and social services."[5]

The Canadian immigration regime has many unique features. One is that the Minister has statutory authority to grant exemptions unilaterally to potential immigrants on public policy grounds, where the immigrant is otherwise inadmissible pursuant to some term of the legislative regime.[6] Acting under this power, a new policy on medical inadmissibility was formally revealed and implemented on 1 June 2018,[7] with its termination date being when the contemplated changes to the *Immigration and Refugee Protection Act* (*IRPA*) and *Immigration and Refugee Protection Regulations* come into force.

The new policy does introduce some significant changes. As returned to below, under the current regime, when assessing a potential immigrant who seeks to immigrate as a member of the economic class,[8] the regime requires a calculation of that person's likely use of public health and social services, as well as the use by accompanying family members. Prior to 1 June 2018, a person would be deemed inadmissible on medical grounds if they were assessed as likely to have a draw on health or social services that was above the national average per capita draw, over a 5 or 10 year period following the medical exam for immigration screening. The new policy raises the fiscal medical inadmissibility bar to $19,812/year; that is, three times the deemed average of $6,604.[9] It also narrows the list of social services that will be included when making the calculation. In particular, Canada will now exclude the costs of providing a potential immigrant or their family member with publicly supported special education, social

5. Immigration, Refugees and Citizenship Canada, *supra* note 1.

6. *Immigration and Refugee Protection Act*, SC 2001, c27, s 25(2) [*IRPA*].

7. Immigration, Refugees and Citizenship Canada, *Temporary Public Policy Regarding Excessive Demand on Health and Social Services* (Public Policy update), (1 June 2018), online: *Immigration, Refugees and Citizenship Canada Public Policies* <www.canada.ca/en/immigration-refugees-citizenship/corporate/mandate/policies-operational-instructions-agreements/excessive-demand-june-2018.html>.

8. Section 12 of the *IRPA* identifies three classes under which a person can immigrate. They are the family class, where the key criteria is having a family relationship with a Canadian citizen or permanent resident, the economic class, which turns on the applicant's potential to become economically established, and the refugee class, which encompasses persons who meet criteria for asylum.

9. Immigration, Refugees and Citizenship Canada, *Excessive demand on health services and on social services* (Operational instructions and guidelines), online: *Immigration, Refugees and Citizenship Canada Publications and Manuals* <www.canada.ca/en/immigration-refugees-citizenship/corporate/publications-manuals/operational-bulletins-manuals/standard-requirements/medical-requirements/refusals-inadmissibility/excessive-demand-on-health-social-services.html>.

and vocational rehabilitation services, and personal support services. The reason that Canada provided for narrowing the list of social services was that "these services should…be seen as investments that enable participation and inclusion."[10]

The language of inclusion and participation signals a foundational shift in Canada's approach to disability and immigration. It would seem to suggest implementing a social model of disability. Within a social model, disability is the product of social, structural and environmental barriers, which cause persons with physical or mental impairments to be unable to effectively participate in society on an equal basis with others.[11] As disability is the result of public practices, there is a collective social obligation to address disabling barriers.

Despite this positive shift, the new policy does not completely embrace a social model of disability. The policy still operates to preserve and perpetuate some problematic norms and narratives about human worth. These norms and narratives have their roots in Canada's historic practices, which reflected stereotyping, social stigma, and eugenics-informed thinking, about what makes a person a worthwhile citizen and what deserves moral or social condemnation. These roots are ugly. Writing with regard to the disability provisions, Judith Mosoff observes that "the same ideological mechanisms which keep Canadians with disabilities and their families 'outsiders' to the benefits of the Canadian state operate in a more direct way to keep people with disabilities outside Canada."[12] This article joins the scholarship on how migration law brings social values and prejudices into high relief.[13] It shines a light on how historic logics continue to quietly inform current practice, and identifies and denounces their persistent and prejudicial vestigial structural influences.[14] To this end, I first discuss the evolution of the medical inadmissibility regime,

10. *Temporary Public Policy, supra* note 7.

11. *CPRD*, *supra* note 2 at Preamble. See also Paul Harpur, "Embracing the New Disability Rights Paradigm: The Importance of the Convention on the Rights of Persons with Disabilities" (2012) 27:1 Disability & Society 1. For a discussion of how the social model of disability is becoming prominent in the decisions of the Supreme Court of Canada, see Ravi Malhotra, "Has the Charter Made a Difference for People with Disabilities? Reflections and Strategies for the 21st Century" (2012) 58 SCLR (2d) 273.

12. Judith Mosoff, "Excessive Demand on the Canadian Conscience: Disability, Family and Immigration" (1999) 26 Man LJ 149 at para 2.

13. See, e.g., Lindsay Ferguson, "Constructing and Containing the Chinese Male: Quong-Wing and the King and the Saskatchewan Act to Prevent the Employment of Female Labour" (2002) 65 Sask L Rev 549.

14. See, e.g., the exposé of race and gender devaluing through the evolution of domestic worker programs, even when the programs appeared to have developed neutral or objective criteria, in Audrey Macklin, "Foreign Domestic Worker: Surrogate Housewife or Mail Order Servant?" (1992) 37:3 McGill LJ 681.

the values that it has advanced, and how prejudices were buried under what appear to be structurally neutral frameworks. I then reflect on the regime that was in place prior to June 2018, before turning to how the new policy fails the disabled community by continuing to perpetuate a fiscal calculus of human worth and leaving the heart of the problematic historic framework in place.

## I. *The historic unwanted immigrant*

The admissibility of would be immigrants has historically turned, in part, on matters such as whether the applicant was perceived to have a health condition or physical or mental disability which were identified as flagging them as undesirable or burdensome citizens. This approach reflected, in part, what has come to known as a 'medical' model of disability. Under this view or model, any mental or physical barriers to full societal participation are taken as resulting from individualized and private deficits or defects. Thus it is the individual who is the source of the problem, and society may or may not exercise discretion to 'help' the individual, with such help being laced with a scent of charity. A related and overlapping model, the 'economic model', makes the costs of inclusion the primary concern.[15] Its focus is thus on supporting people with disabilities to enter the workforce, so that they will be less likely to draw upon public support.[16] These contrast with the social model, where participatory deficits are identified as arising due to the interaction of impairments with social structures and assumptions about normalcy. This approach places the onus on the public and society to shift their expectations about who populates the polity, and make decisions and structure society to remove barriers, accordingly.[17]

Early legislation, which was in place until 1906, squarely reflected a medicalized model, and was coupled with a moralizing ideology. It erected blunt bars against potential migrants who had mental illnesses, or perceived physical or intellectual disabilities, framed within the stigmatizing language of being a "lunatic, Idiot, Deaf and Dumb, Blind or Infirm Person."[18] The legislation also precluded the landing of persons with any "loathsome, dangerous or infectious disease or malady,"[19] with the

15. Mosoff, *supra* note 12 at para 6.
16. *Ibid* at para 36.
17. Tom Shakespeare, "The Social Model of Disability" in Lennard Davis, ed, *The Disability Studies Reader* (New York: Routledge, 2013) 214 at 216.
18. *An Act respecting Emigrants and Quarantine*, CSC 1859, c 40, s 10(2).
19. *Ibid.*

term "loathsome" being borrowed from American practice.[20] According to a 1910 American publication, drafted to guide medical exams of would-be immigrants, a "loathsome disease" is "a disease which excites abhorrence in others by reason of the knowledge of its existence,"[21] essentially coming down to highly socially stigmatized diseases such as syphilis.[22]

The bar against those with perceived mental or physical impairments provided for exceptions under two circumstances that signalled part of the bar's driving ideology. The exceptions were if the individual was accompanied by family who could be expected to provide for them, or if a $300 bond was posted on their behalf. This second exception imposed a rather daunting disability head tax, given that the average income for an industrial worker in Canada in 1901 was about one-tenth of this amount, a mere $35 a year.[23] There was thus an assumption that these individuals could never be self-supporting, which in some instances may have been true given the social prejudice of the time, but it is clearly an unreasonable universalization.

In 1910, Canada began distinguishing perceived mental illness or intellectual disabilities from physical disabilities. Fiscal concerns also fell into the shadows, and other ideological concerns surfaced more expressly. In particular, Canadian law now vilified mental or intellectual disabilities by imposing an absolute ban on persons who were "idiots, imbeciles, feeble-minded persons, epileptics, insane persons, and persons who had been insane within five years previous."[24] (At this time, epilepsy was understood to be an inheritable mental illness.[25]) The impenetrable bar against those with a "loathsome disease, or with a disease which is contagious or infectious, or which may become dangerous to public health" remained firmly in place. Canada also introduced new bars against those convicted of crimes involving "moral turpitude," "prostitutes," and persons

20. Angus McLaren, "Stemming the Flood of Defective Immigrants" in Barrington Walker, ed, *The History of Racism and Immigration in Canada: Essential Readings* (Toronto: Canadian Scholars' Press, 2008) 189 at 195.

21. As cited in Amy Fairchild, *Science at the Borders: Immigrant Medical Inspection and the Shaping of the Modern Industrial Labour Workforce* (Baltimore: John Hopkins University Press, 2003) at 23.

22. See, Donna Manfredi & Judith Riccardi, "AIDS and United States Immigration Policy: Historical Stigmatization Continues with the Latest Loathsome Disease" (1992) 7:2 St John's J Leg Comment 707.

23. "Census of Canada, 1901" (last modified 19 February 2019), online: *Library and Archives Canada* <www.bac-lac.gc.ca/eng/census/1901/pages/about-census.aspx>.

24. *Immigration Act (An Act respecting Immigration)*, SC 1910, c 27, s 3(a).

25. Ena Chadha, "'Mentally Defectives' Not Welcome: Mental Disability in Canadian Immigration Law, 1859–1927" (2008) 28:1 Disability Studies Quarterly (text associated with footnote 56).

who "procure prostitutes,"[26] where both crime and prostitution were seen as evidence of "feeble-mindedness"[27] and thus a mental impairment.

Finally, Canada maintained a presumptive bar against those who are "dumb, blind or otherwise physically defective" unless a Board of Inquiry concluded that they were not likely to become a "public charge" due to having an accompanying family, showing sufficient funds in hand or having a "legitimate mode of earning a living." This third exception thus permitted admission to disabled persons who had already learned, for example, a specific trade. Such scrutiny was not extended to those who appeared able-bodied on landing, who did not have to refute a presumption that they were incapable of being self-supporting.

This early treatment showed concerns with contagion resulting in a bar against those with perceived infectious diseases. It illustrates an assumption that those with a physical impairment would become a public charge, but offered such individuals or their families something of an opportunity to refute that presumption. It also shows unmitigated disdain for those with mental illnesses or intellectual impairment, or those whose disease met with moral condemnation from others. The entry of these people was blocked regardless of whether they had a family to care for them, a means to earn a livelihood, or the ability to post a bond. Unlike other would-be immigrants who, if rejected, could pay $20 to bring an appeal to the Minister, those who were denied entry on the basis of a loathsome disease or being an "idiot, imbecile, feeble-minded" an epileptic or insane, had no right of appeal.[28]

The exclusion of those with mental or intellectual disabilities or who had a socially stigmatized disease was divorced from any basis in fiscal concerns about individuals becoming a public charge. The simple truth is that no amount of money was enough to purchase the mentally impaired or mentally ill, or those with a socially condemned disease, a dispensation from their social stigma.

There were only two modifications of note to the medical inadmissibility provisions between 1910 and 1955. The first was to introduce a bar in 1919 against those who were not already excluded under another listed category, if they were either "mentally or physically defective to such a degree as to affect their ability to earn a living."[29] In this manner, the attempt to name all specific offending conditions, impairments, or diagnoses was

26. *Supra* note 24, ss 3(d)-(f).
27. Angus McLaren, *supra* note 20 at 196.
28. *Immigration Act, supra* note 24, ss 18 & 19.
29. *An Act to Amend the Immigration Act*, SC 1919, c 25, s 3.

supplemented by a catch-all phrase which went back to fiscal concerns. At this point, those with perceived physical disabilities could be banned, regardless of family support. As I have written elsewhere, this muddled treatment is in part about how stereotypes engender panic. It is also about the gross devaluation of persons, which was contemporaneously being fostered by the eugenics movement.[30] This movement sought to eradicate those people who were deemed to have weaker genetic stock. What was perceived as mental illness or disability was understood at this time to be inheritable, and often triggered by immorality[31] or a tendency towards immorality[32] (which was also seen as inheritable). All of this was drawn upon to justify the forced sterilization of persons deemed "mentally defective" or physically disabled,[33] and so of course such people would not be desirable as new immigrants. Health and medical conditions served as markers to identify morally and physically desirable citizens, standing in for a combination of fiscal concerns, wide-spread prejudice, and eugenics-informed general disdain for human difference.[34]

Another new element, which has persisted to the present day, was introduced in 1952. This provision barred the entire family if one member was deemed inadmissible. Persons with physical disabilities could nonetheless gain entry if they had family that was already in Canada, and who also posted a bond on their behalf.[35] However, if a family member was an "idiot" or was "insane," or had a loathsome disease, then the whole family was blocked.[36] Presumably Canada did not want their genetic stock taking hold on Canadian soil.

Our prohibitions remained essentially the same until 1976. Labels or diagnosis could completely determine admissibility, with no regard to

30. For a discussion of how eugenics informed arguments were used to foster support for legislative reform in the context of sexual sterilization of those who were deemed "mentally defective," see Timothy Caulfied & Gerald Robertson, "Eugenic Policies in Alberta: From the Systematic to the Systemic?" (1996) 35:1 Alta L Rev 59.

31. Constance MacIntosh, "Wealth Meets Health: Disabled Immigrants and Calculations of 'Excessive Demand'" in Jocelyn Downie & Elaine Gibson, eds, *Health Law at the Supreme Court of Canada* (Toronto: Irwin Law, 2007) 293 at 303-304.

32. *Ibid.*

33. Jennifer Chandler, "The Impact of Biological Psychiatry on the Law: Evidence, Blame and Social Solidarity" (2017) 54:3 Alta L Rev 831 at paras 47-48.

34. For similar assessments of these provisions, see Judith Mosoff, *supra* note 12; Robert Menzies, "Governing Mentalities: The Deportation of 'Insane' and 'Feebleminded' Immigrants Out of British Columbia from Confederation to World War II" (1998) 13 CJLS 135; Rose Voyvodic, "Into the Wasteland: Applying Equality Principles to Medical Inadmissibility in Canadian Immigration Law" (2001) 16 J L & Soc'y 115; Ena Chadha, *supra* note 25.

35. *Immigration Act*, RSC 1952, c 325, s 5(c).

36. *Ibid*, s 5(o).

cost, availability of treatment, or the severity of a person's impairments.[37] As discussed in the next section, the changes which were introduced in 1976 directly inform today's legislation, including the 2018 policy.

II. *The contemporary undesirable immigrant*

In 1976, our legislation was revised. Gone was reference to "loathsome diseases." Instead Canada just had a bar for those who were a danger of public health or safety,[38] ostensibly doing away with viewing health as reflecting moral character and instead focusing on health conditions as issues of public safety and well-being. That said, it is notable that the conditions that have been listed as threats to public health have had a high preponderance of sexually transmitted infections such as syphilis, despite the limited evidence supporting screening for syphilis due to public health risks.[39] Canada also stopped compiling a list of undesirable health conditions or statuses, and instead introduced a fiscal calculation model, and with this a veneer of ideological neutrality. Potential immigrants would now be assessed to determine if they had a "disease, disorder, disability or other health impairment" that "might reasonably be expected to cause excessive demands…on health or…social services."[40] This provision attracted some litigation. The first case to challenge the constitutionality of the provision on Charter grounds was *Chesters v Canada (MCI)*.[41] This decision continues to be referenced for its finding that the excessive demands provision withstands constitutional scrutiny, despite changes to the wording of the provision in 2001.[42]

*Chesters* was brought by a woman with multiple sclerosis, which had in turn resulted in multiple physical disabilities. She sought to immigrate as

37. Mosoff, *supra* note 12 at 155.

38. *Immigration Act*, 1976, SC 1976–77, c 52, s 19(1)(a)(i).

39. Canada currently only screens for active TB or untreated syphilis. In the 2015 evaluation of the immigration health screening program, the rationale for screening for syphilis was described as unclear. Questions were raised about why Canada does not screen for polio, measles, Hep A and Hep B, avian flu, and gonorrhoea, nor seek confirmation of key vaccinations, as such screening would address illnesses with more significant consequences for public health. Immigration, Refugees and Citizenship Canada, *Evaluation of the Health Screening and Notification Program: Evaluation Division* (November 2015) at 17-20.

40. *Immigration Act*, 1976, SC 1976-77, c 52, s 19(1)(a)(ii).

41. *Chesters v Canada (MCI)*, 2002 FCT 727 [*Chesters*].

42. See *Covarrubias v Canada (Minister of Citizenship and Immigration)*, 2005 FC 1193 at para 57 and *Barlagne v Canada (Minister of Citizenship and Immigration)*, 2010 FCJ 651 at para 63. The provisions withstood a more recent section 15 claim in *Deol v Canada (Minister of Citizenship and Immigration)* 2002 FCA 271 at paras 49-64. However, in *Deol* the Charter claim also attracted concerns about standing, as the claimed discrimination was not against the applicant, but rather the person they were sponsoring the immigrate. The other lead decision on the excessive demands provision is *Hilewitz v Canada; De Jong v Canada*, 2005 SCC 57. This decision turned on statutory interpretation and did not revisit the question of the constitutionality of the provisions.

a member of the family class, and was declined due to a finding of medical inadmissibility. Ms Chesters appealed this decision. She argued that the provision violated her Charter rights on multiple grounds, including the right to equality of treatment. In particular, she claimed that on its very face it identified a class of people—those with disabilities—for extra scrutiny and exclusionary treatment. In the alternative, she argued that if the provision was not discriminatory on its face, that it resulted in adverse effects discrimination, because it affects a distinct group of people, those with disabilities, who are already vulnerable to discrimination.[43] The court rejected her claim on all grounds, with the reasoning on each argument circling back to Heneghan J.'s organizing principle, which was that Canada has the right to determine who may enter Canada. With regard to her specific arguments, Justice Heneghan found that the "section in question focuses on excessive demands, not disease, disorder or disability."[44] On the basis of this, she concluded that there were no listed nor analogous grounds upon which discrimination had occurred. Heneghan J further went on to determine there was a lack of evidence to demonstrate any adverse impacts on those with disabilities, and so the adverse impact claim also failed.[45]

Ms Chesters brought several other arguments. One was based on how the excessive demands calculation fails to consider an individual's broader circumstances, including their education, job history, work plans, and life status.[46] Thus, she argued, "the process by which her medical assessment was conducted was procedurally flawed because it was based on an arbitrary process which improperly relied on stereotyped reasoning concerning persons with disabilities."[47] The court did not discuss this argument. The court merely noted that employment potential was not legally relevant when determining the admissibility of family class immigrants. This decision has subsequently been cited to support summarily dismissing section 15 challenges to the excessive demands provisions.[48]

The *Chesters* decision is problematic on several levels. First, Heneghan J.'s reading of the provision is questionable, given that it did indeed identify just three specific grounds for scrutiny, one of which was disability. Second, while the court correctly stated that Canada is entitled to establish entry standards, the court over-reached in bluntly concluding

43. *Chesters*, *supra* note 41 at paras 61-63.
44. *Ibid* at para 125.
45. *Ibid* at para 119.
46. *Ibid* at para 57.
47. *Ibid* at para 57.
48. See discussion in footnote 42, *supra*.

that Canada therefore has the right to require an assessment of 'potential excessive demands on health services.' The error here is that this right is a qualified one. In particular, Canada's discretion is not unfettered. At the time the decision was made, it was restrained by the Charter and a common law interpretive presumption of respecting the values and principles of international law.[49] With the 2001 *IRPA*, the Act is to be construed and applied in a manner that "complies with international human rights instruments to which Canada is a signatory."[50] Third, Ms. Chesters' claim that the excessive demands assessment is grounded in the stereotyped reasoning that people with disabilities will presumptively be a draw on the public purse, and not reasonably contribute to that purse through their work, was an important argument to consider, given the history of this provision. The court's answer, to assert that economic contributions were not legally relevant when assessing family class applicants, was inappropriately dismissive and inconsistent with the fact that the negative decision was based entirely on cost concerns. Heneghan J's response served to perpetuate the problematic prejudices from which this provision was born, and failed to question the structure of our grounds for exclusion.

In 2001, perhaps in response to the *Chesters* lawsuit which was on going at the time, the wording of this provision was changed to remove the explicit focus on impairments and disabilities. In particular, it came to state that a person is inadmissible on health grounds "if their health condition…might reasonably be expected to cause excessive demands on health or social services."[51] This was the first time since the 1800s that Canadian immigration legislation did not explicitly identify people with mental or physical impairments or disabilities as undesirable citizens. That said, the focus remains on draws to health and social services from health conditions, and not, for example, draws that may result from lifestyle choices such as heavy smoking or high-risk sports. This is an example of how the historic logics linger, continuing quietly to shape contemporary practice, despite their insertion into the regime only having occurred due to social prejudice and stereotypes.

The process for assessing whether a "health condition" will likely result in excessive demands has developed some rigor over time. The current practice involves all would-be immigrants undergoing a mandatory medical exam, performed by a doctor who has been designated by the Canadian government for this purpose. These physicians send the results

49. *Baker v Canada (Minister of Citizenship and Immigration)*, [1999] 2 SCR 817 at paras 69-71.
50. *IRPA*, *supra* note 6, s A(3)(iii)(f). See also *De Guzman v Canada,* 2005 FCA 436.
51. *IRPA*, *ibid,* s 38(1)(c). The term 'health condition' is not defined.

of the exam to one of four regional medical offices. The results are then reviewed by a Citizenship and Immigration Canada Medical Officer. Cases where inadmissibility may be an issue are forwarded to a Medical Officer at the Centralized Medical Admissibility Unit in Ottawa.[52] The Medical Officer will "assess the severity of the illness and the degree of service that will be required to treat it" which involves identifying all anticipated social services and health treatments relating to the person's diagnosis, usually for the five year period following the exam.[53]

The Medical Officer then provides an opinion letter to the Visa Officer, who must assess it for its reasonableness. If the Visa Officer concludes the excessive demand thresholds are crossed, the officer must send a procedural fairness letter to the applicant, informing them of the findings and the right to challenge the findings.

There have been three major changes to the excessive demand provisions, one of which is the new policy. These are all discussed below.

The first major change was brought about by litigation over how to interpret and calculate 'excessive demands.' After the term was introduced in 1976, a definition grew out of the caselaw, which was then codified in the 2001 regulations. It states that excessive demand is a demand on health services or social services which is expected to exceed average Canadian per capita costs over either a five or ten year period after their medical exam, or else could be expected to cause a demand which would add to existing waiting lists.[54] This figure was calculated based on the services or health care that the person would have a right to access as a resident of a Canadian province. 'Excessive' demand is thus $1.00 over the deemed average demand, and apparently adding one person to a waiting list. This narrow reading of 'excessive' stands in sharp contrast to a definition that had been proposed, but un-proclaimed, in 1992. It would have found demands only became 'excessive' when they were five times the average annual per capita costs.[55] Apparently, the lack of implementation of this approach was due to provincial concerns about the costs they could incur.[56]

In 2005, two would-be immigrant families, whose applications were denied due to each family including a child with an intellectual disability, brought a challenge to the Supreme Court of Canada. Their challenge was

52. 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 9-10.
53. *Ibid* at 13.
54. *Immigration and Refugee Protection Regulations* SOR/2002-227, s 1(1)(a).
55. *Immigration Act*, SC 1992, c 45, s 11 (never proclaimed into force) at para 19(1)(ii)(a).
56. Margaret Somerville & Sarah Wilson, "Crossing Boundaries: Travel, Immigration, Human Rights and AIDS" (1998) 43:4 McGill LJ 781 at 806.

not about the excessive demand provision violating equality rights nor its arbitrariness. Rather it was with regard to how excessive demands were calculated and so turned on proper statutory interpretation. In *Hilewitz v Canada; De Jong v Canada,* the families argued the provision should be read to turn on whether a person is likely to actually draw upon public social services, not merely whether they would qualify for or be expected to need them. The Court agreed that the statute required an individualized assessment that took into account the reasonable likelihood of the individual using public sources for their social service supports, instead of, for example, the family paying for a child to attend a private school, or the family hiring private assistance for respite care.[57] In other words, the families successfully argued that personal wealth should once again play a role in assessing whether a person with mental or physical disabilities would be a societal burden and thus an undesirable citizen. This decision only considered social services because that was at issue for these families. The Court did not explicitly consider how to approach whether a person was likely to use health services. Given that the Court was persuaded by arguments about social services being available privately, or through cost-recovery programs, it would seem that the logic of *Hilewitz* could extend to health services that are available on a private basis.[58]

While the decision brought welcomed respite for some, it continued to perpetuate a medical and economic model of disability and illness, reducing the potential immigrant to a source of costs created by exclusionary policies and practices. It turned on whether the family or the state would likely bear responsibility for subsidizing the individual's ability to effectively participate in society or otherwise pay to overcome societal barriers. This was despite the Court having received arguments from the intervenor Canadian Association for Community Living, which

57. *Hilewitz v Canada*; *De Jong v Canada*, *supra* note 42 at para 54-57. The case in which this was determined only considered persons applying to immigrate under immigration classes that required considerable net worth. Subsequent cases clarified that this individualized assessment was required for all applicants. See *Colaco v Canada (Minister of Citizenship and Immigration)*, 2007 FCA 282 at para 9.

58. There have been a few cases where parties unsuccessfully argued that *Hilewitz* applied in terms of health care costs, including *Srivastava v Canada (MCI)*, [2008] IADD 1574 and *Doel v Canada (MCI)*, 2002 FCJ 949 (CA). In these cases, the decision turned on the operation of the *Canada Health Act*, which requires provinces to provide access to publicly funded health care. The decisions did not consider the growing prevalence of private health care, which may expand exponentially if parties who are challenging provincial barriers to private health care are successful. See, for example, the on-going litigation in British Columbia brought by Cambie Surgeries Corporation, where Cambie recently obtained an injunction preventing the enforcement of new provincial legislation prohibiting charging for medically necessary services pending the outcome of the litigation. *Cambie Surgeries Corporation v British Columbia (Attorney General)*, 2018 BCSC 2084.

was represented by ARCH, a legal clinic that advocates for people with disabilities. ARCH grounded the submissions in how the legislation must be read in line with equality values and the contributions of those with disabilities to society. They also argued that the accessibility barriers which impaired persons experience in schools and the workplace are produced by societal decisions about who to count as its members. However, the Court avoided these principled arguments to make its determination as solely a matter of statutory interpretation.[59]

In its discussion, the Court characterized the history of our immigration exclusion practices as having long reflected concerns about limited fiscal resources. This rational sounding and measured characterization was asserted as the dominant narrative of our story of medical exclusions. The narrative only modestly reflected how Canadian history also demonstrates moral and societal prejudices about the type of person who has certain types of diseases or disabilities. It avoided any meaningful engagement with the Canadian practice of marking those with psychosocial or intellectual/mental impairments as flat out socially undesirable citizens, who ought to be *de facto* excluded. Indeed, as discussed above, the predecessor legislation did not exclude those with psychosocial and intellectual disabilities on fiscal grounds—it explicitly excluded them because they had such disabilities. Submissions were also made that the Court was required by the statute's interpretive provisions to interpret the clause to be consistent with Charter values, and thus go beyond positioning disability as something to be viewed in terms of fiscal deficits.[60] The Court did not recognize or speak to these submissions. As a result, its set of reasons did nothing to displace the notion that potential immigrants ought to be subjected to a calculus which only recognizes their likely economic drain upon society and not their likely economic, social, political and cultural contributions to society, nor their fundamental human rights to not be subjected to prejudicial discrimination. What it did, rather, was have the perverse outcome of allowing wealthy families to bring disabled family members, while excluding families of more modest means.[61] This is a disturbing reflection of our society's values.

Following *Hilewitz*, when families seek to immigrate and one family member is identified as potentially medically inadmissible due to excessive

59. *Hilewitz*, *supra* note 42 at para 42. See also Catherine Dauvergne, "How the Charter has failed Non-Citizens in Canada: Reviewing Thirty Years of Supreme Court of Canada Jurisprudence" (2013) 58:3 McGill LJ 663 at para 62.

60. Constance MacIntosh, *supra* note 31 at 312.

61. Judith Mosoff rhetorically condemned such an outcome long before the *Hilewitz* decision. *Mosoff, supra* note 12 at para 40.

demands, the family is now invited to prepare a mitigation plan for the government, which in the words of the Ministry of Immigration, Refugees and Citizenship Canada, is to try "to demonstrate that they will not be a burden on Canada."[62] The language of 'burden' remains hurtfully front and centre. The medical/economic model strips the individual of what they give to society and family, leaving them as unwanted charity cases who must refute the assumption that they are an inherently problematic human being.

In the mitigation plan, the family is to identify the private sources they will draw upon for support, and how they will afford them. If the plan is found reasonable, and any likely public costs remain below the per capita average, then the individual will be found to not be inadmissible after all—the presumption of being a burden is rebutted. In practice, this has meant that Canada will only grant entry to those disabled persons, or persons with illnesses, who can pay their own way. Neoliberal values have returned Canada to the turn of the century model, which was born of eugenics and deep social prejudice. Membership in Canada turns on being a market citizen and economic participation,[63] with mitigation plans reflecting a personalized head tax.

The proposed mitigation plans are not directly enforceable. There are two intertwined reasons for this. First, as noted with concern by the Evaluation Division of Immigration, Refugees and Citizenship ("ED"), "there is no in-Canada enforcement mechanism to ensure that migrants are following their mitigation plans."[64] Enforcement would require addressing some interjurisdictional issues. To benefit from fiscal transfers under the *Canada Health Act*, provinces have enacted legislation to provide all permanent residents with equal access to the same provincial health services.[65] Thus, a province cannot deny access to insured services to any person who is eligible for those services.[66] Similarly, when it comes to social services, access rights turn on provincial residency.[67] This places the federal government at jurisdictional arms-length. Although no evidence

62. Immigration, Refugees and Citizenship Canada, *Evaluation of the Health Screening and Notification Program: Evaluation Division* (November 2015) at 22.
63. Valentina Capurri, "The Montoya Case: How Neoliberalism Has Impacted Medical Inadmissibility in Canada and Transformed Individuals into 'Citizens Minus'" (2018) 38:1 Disability Studies Quarterly.
64. *Supra* note 62 at 23.
65. *Canada Health Act*, RSC 1985, c C-6, s 7.
66. Eligibility for provincially insured services turns on residing in the province for a prescribed period of time, which can be no more than three months. *Canada Health Act*, *ibid*, s 2.
67. For example, *Employment Support and Income Assistance Regulations* NS Reg 174/2018, s 14(3).

appears to have surfaced to suggest that families have strayed from mitigation plans, the ED has expressed alarm over Canada's inability to directly enforce them. In a report released in 2015, they suggested requiring families to post bonds. This practice would expressly revive our historic disability headtaxes. An alternative, which was suggested by the Immigration Law Section of the Canadian Bar Association, was to require permanent residents who entered with mitigation plans to provide evidence that they only drew from private sources for support when seeking to renew their permanent resident status.[68] If the evidence indicates they drew on public support after all, then the family could be deemed to have misrepresented their intentions. Misrepresentation, in turn, is grounds to revoke their permanent residency status,[69] and so deportation would then follow.

Both existing practices, and the above suggested changes, reflect a troubling moral order. Immigrants are already largely selected based on factors that are intended to predict economic success. They are expected to work, and so to pay taxes. (Indeed, under another provision, they can lose their right to remain in Canada if they become destitute.[70]) However, some families are welcomed on a promise that they will not seek to draw upon the health and social services that their taxes are paying for. They are essentially expected to pay twice, with their income going to personally supporting family needs and their taxes being given to serve the needs of other permanent residents who did not arrive with pre-existing conditions or were able-bodied upon their arrival, and Canadian citizens. If Canada were to add the suggested bond requirement, then they would be paying three times. The burden on the individual family is not just an economic one, it is a moral burden as well. Their presence is deemed legitimate only insofar as they are willing to exist in Canada as not-quite deserving citizens. The cost of 'inclusion' as a citizen is accepting discrimination.

A second significant change came about through the 2001 *IRPA* having introduced a category-based exception to the excessive demand provision. Prior to 2001, the excessive demands provisions applied to all would-be immigrants. After 2001, the provision ceased to apply to persons who are sponsored to immigrate as a member of the family class, as either the spouse or the dependent child of a Canadian citizen or permanent resident

68. *Supra* note 62; Permanent residency status has a five year term. To renew, an individual must file an application, which includes evidence to show that they have complied with certain terms. *IRPA*, *supra* note 6, ss 28(1) and 27(2).
69. *Ibid*, *IRPA*, s. 40(1)(a).
70. *IRPA*, *supra* note 6 at s 39.

(as well as in the case of those granted asylum).[71] It continued to apply to those seeking to immigrate under the economic class and other sponsored members of the family class such as adult siblings and parents. Like the removal of the word 'disability' from the medical inadmissibility clause, this change also came about while the *Chesters* case was advancing through the courts, which as noted above involved a woman who sought to immigrate as a member of the family class.

The idea of such an exemption had been floated a few years previously, and was a central recommendation of a 1997 federal government report, *Not Just Numbers*, which emphasised that family reunification is a cornerstone of the Canadian immigration system. The Report condemned how the medical inadmissibility provision separated Canadians from family members, writing:

> …the excessive demand provision applied to spouses and dependent children [of Canadians and permanent residents] is, in our view, inhumane, slow and expensive to administer…few Canadians would accept that the government separate them permanently from their new wife or new husband, or their six-year-old child, on the grounds that they are deaf and mute, or developed cancer or a heart condition.[72]

Despite this reform operating narrowly and being consistent with our immigration regime's historic and continuing adoption of family reunification as a core principle,[73] the Evaluation Division flagged this different treatment as problematic in their 2015 assessment. The issue was not that it created an unprincipled distinction between those who were immigrating as economic immigrants, versus those who had immediate family members in Canada, nor that it failed to embrace other family members of Canadians such as their parents or orphaned underaged siblings. Their concern was that this policy opened the door to burdensome immigrants.

In their discussion of the provision, the ED stressed that the excessive demands provision is important for preventing migrants from imposing an "undue burden on health and social services in Canada."[74] The ED expressed concern that the exception resulted in a situation where "burden is still transferred to Canada." They further speculated that people who would otherwise be medically inadmissible to Canada "may apply under

71. *IRPA*, *ibid*, s 38(2)(a).
72. Canada, Minister of Employment and Immigration, *Not Just Numbers: A Canadian Framework for Future Immigration* (Ottawa: Minister of Public Works & Government Services, 1997) at 50.
73. See for example *Immigration Act*, SC 1976-77, c 52, s 3(c); *IRPA, supra* note 6 at s 3(1)(d).
74. *Supra* note 62 at 22.

the family class in order to overcome their potential inadmissibility."[75] The implication here is that there is something inappropriate about persons with health conditions or physical or psychosocial or intellectual disabilities meeting a legislated exemption that is intended to support the right of family reunification, a right which is also robustly supported in international law.[76] That said, the suggestion that people may become married to, or get adopted by, a Canadian or permanent resident to fit into the exemption represents what can only be speculation which is intended to have an inflammatory impact. It hints of a desperate interest in finding grounds to exclude the disabled. Indeed, the ED noted they had no evidence to support this concern, yet concluded it warranted being flagged in their report.

The ED's commitment to avoiding the entry of burdensome immigrants, their discursive erasure of the social, cultural, economic and political contributions of all immigrants, and their silence on the value of family unification or the need to be consistent with international human rights law, echo the Supreme Court's reasoning from a decade earlier in *Hilewitz*. As I have written elsewhere with regard to the *Hilewitz* decision:

> It is hard to imagine the Court would permit such a limited calculation of worth to be made about a Canadian citizen with a disability….Where non-citizens are involved the starting point is seen as a choice about admission, not a choice about how existing members ought to be treated in the interest of achieving social equality….[N]on-citizens are seen to be seeking the bestowal of a discretionary privilege, not the recognition of what must be changed for their inherent social rights to be realized.[77]

As flagged at the beginning of this article, the third change of note occurred in June of 2018. Parliamentary attention had been brought to the excessive demands provision during a review of whether Canadian laws were consistent with the United Nations *Convention on the Rights of Persons with Disabilities*. While the initial review took place before Canada ratified the Convention in 2010,[78] Parliament did not return to the issue until 2016. At this time, federal and provincial governments began consultations concerning the impacts of the provision. In 2017, the

75. *Ibid* at 23.
76. The right to family unification is recognized in several international human rights instruments which Canada has ratified. These include the *Convention on the Rights of the Child*, GA Res 44/25, UNGAOR, Supp No 49, UN Doc A/44/49 (1989), arts 7-10; and the *Universal Declaration of Human Rights*, GA Res 217A (III), UNGAOR, 3rd Sess, Supp No 13, UN Doc A/810 (1948) , art 16(3).
77. MacIntosh, *supra* note 31 at 313.
78. *Building an Inclusive Canada*, *supra* note 52.

Standing Committee on Citizenship and Immigration was charged with undertaking a study.[79]

1. *The future undesirable citizen*

The Standing Committee on Citizenship and Immigration tabled its report on the medical inadmissibility excessive demands provision in December, 2017. It was titled *Building an Inclusive Canada: Bringing the Immigration and Refugee Protection Act in Step with Modern Values*.[80] Through written submissions and hearing, the Committee was exposed to extensive arguments that the excessive demands provision was inconsistent with the equality guarantees of the *Charter*.[81] This position is at odds with the scant caselaw, described above, which has considered the Constitutionality of the provision.

It is important to note that 15 years passed between when the decision was rendered in *Chesters* and this report was published. During this time period societal understanding about disabilities and prejudicial stereotypes has grown. The four year negotiations process for the United Nations *Convention on the Rights of People with Disabilities* (*CRPD*) started in 2002,[82] the year that *Chesters* was released. It had the fastest negotiation process for any UN treaty, with a record number of first day signatories in 2006, showing that there was a growing recognition of the impact of discrimination against persons with disabilities and increasing public and state support for inclusion. The submissions that the Committee received reflected and were informed by this changed context, and there were growing expectations on Canada, given its ratification of the *CRPD* in 2010, to comply with it. More broadly, it has been observed in multiple forums that the ratification has engendered a significant and generalized paradigm shift towards a social understanding of disability.[83]

In its Report, the Committee concluded that while the medical inadmissibility provision "is no longer explicitly discriminatory, the

79. Canada, Parliament, House of Commons, Standing Committee on Citizenship and Immigration, *Minutes of Proceedings*, 42nd Parl, 3rd Sess, No 74 (16 October 2017).

80. *Building an Inclusive Canada*, *supra* note 52.

81. *Ibid* at 22-25.

82. United Nations, "Convention on the Rights of People with Disabilities (CRPD)" online: *United Nations—Disability* <www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html>.

83. See *Hinze v Great Blue Heron Casino*, 2011 HRTO 93. In general see Sheila Wildeman, "Protecting Rights and Building Capacities: Challenges to Global Mental Health Policy in Light of the Convention on the Rights of Persons with Disabilities" (2013) 41:1 J L Med Ethics 48; Steven Hoffman, Lathika Sritharan & Ali Tejpar, "Is the United Nations Convention on the Rights of People with Disabilities Impacting Mental Health Laws and Policies in High-Income Countries? A Case Study of Impacts in Canada" (2016) 16:28 BMC Intl Health & Human Rights, online: <bmcinthealthhumrights.biomedcentral.com/articles/10.1186/s12914-016-0103-1>.

provision still has adverse effects on people with disabilities." This affirmed that the evidence base that had been put before them made out adverse effects discrimination, unlike the evidence base that was apparently presented in *Chester*. They went on to note that there are "broadly held concerns that, without repeal," the provisions "unjustifiably violate human rights" which is "inconsistent with the modern values Canadians associate with contemporary human rights protections."[84]

The Committee further found that one of Canada's obligations under the *CRPD* is to abolish discriminatory legislation and to refrain from any act that is contrary to the *CRPD*. They concluded this obligation extended to non-citizens engaging with the Canadian immigration system. In particular, that the *CRPD* "captures indirect discrimination, such as a decision [to refuse admission] based on costs, as in reality persons with disabilities are disproportionately impacted by such legislation."[85]

Based on these findings, the Committee recommended that the provision be repealed. However, this recommendation was a qualified one. They contemplated a delay, and identified a series of interim measures that ought to be put in place while the federal government continued to consult with the provincial and territorial governments on the impact of a repeal. These interim measures foregrounded addressing the training and qualification of medical officers, and also the decision-makers who are charged with evaluating the reasonableness of the medical officers' recommendations. These recommendations responded to submissions that indicated decisions were being made inconsistently, sometimes with inadequate or no reasons, had incorrect cost data, and that the guidelines given to these officers were inconsistent with guidance from the courts about how to interpret the relevant provisions.[86]

The Committee also called for publishing "plain language" operation manuals and guidelines on IRCC's website regarding medical inadmissibility, so that potential immigrants who are informed that they have been flagged for medical inadmissibility will be informed "of the findings they must address to overcome a finding of excessive demand."[87] They also recommended revising how cost estimates are made, including removing services which had been listed but are not in fact publicly funded, and revising how the dollar figure is formulated to accurately reflect provincial, territorial and federal data. The final interim recommendation

84. *Building an Inclusive Canada*, *supra* note 52 at 1.
85. *Ibid* at 24.
86. *Ibid* at 29-31.
87. *Ibid* at 42-43.

of note was to extend immediately an exception to non-citizens who were already employed in Canada. This recommendation was provoked by the situation of live-in caregivers,[88] who earn the right to apply for permanent residency for themselves and their families following the culmination of a several year work term in Canada. At that point, the caregiver is screened once again for admissibility, and their family members are all screened for medical inadmissibility. The Committee heard evidence of live-in caregivers or their children being rejected on medical inadmissibility grounds after the worker had already fulfilled their work term as they sought to claim their reward, due to the worker's health having changed or a family member's health condition. This outcome betrayed the workers, who had earned the right to seek permanent residency by sacrificing their own family to care for the children of others and for persons with high medical needs in Canada. The Committee clearly was moved by the unfairness of this outcome.

The Report's recommendations unfortunately lack a suggested timeline to complete the consultations and enact a repeal, despite there already having been two years of on-going consultations. As well, the recommended 'interim measures' are both costly and a bit contradictory —if the required outcome is elimination, then it is odd to put significant resources into improving the training of the medical and visa officers who make the assessments, changing how costs are calculated, and also rewriting manuals and guidelines to make them 'reader friendly' for the public. These sorts of recommendations only make sense if it is reasonable to expect that the repeal will be a long time coming—or may not come at all. This is a troubling proposition in light of the Committee having identified the provisions as resulting in indirect discrimination against vulnerable populations including those with disabilities.

The Minister responded to the Report,[89] and subsequently issued a policy. Unlike the commitment that the government made in the news release, to "eliminate" the excessive demands branch of the medical

88. Recent changes to this program have revoked the live-in requirement. It remains focused on foreign workers proving in home care for children and for persons with medical needs. See Department of Citizenship and Immigration, *Ministerial Instruction: Caring for Children Class*, Canada Gazette Vol 148, No 48 (29 November 2014) and Ministerial Instruction, *Caring for People with High Medical Needs Class*, Canada Gazette, Vol 148, No 48 (29 November 2014).

89. Government Response, Minister of Immigration, Refugees and Citizenship, House of Commons, online: <www.ourcommons.ca/DocumentViewer/en/42-1/CIMM/report-15/response-8512-421-328>.

inadmissibility policy,[90] this time the government did not commit to repealing the provision. It only committed to undertaking a data gathering and consultation process to determine the impacts of eliminating the provision. No timeline was indicated for how long this data gathering would go for, nor the likely length of time for the consultations.

The Minister did adopt some of the recommended 'interim' changes, including a plain-language review of department "products" and exploring options for supplementing training. While rejecting the recommendation to extend the exemption to persons already working in Canada, the Minister indicated an intention to modify how excessive demands are calculated and the cost threshold. These modifications were described at the beginning of this paper. They include tripling the cost threshold, to promote "fairness" by facilitating access for persons who require health and social services "at a relatively low cost." The second major modification is to remove social services from the cost calculation, which "are critical for promoting inclusion" and "[i]nstead of treating these as costs that must be borne by society, these should instead be seen as investments to enable participation and inclusion."

The policy includes two lists which clearly indicate what should and should not be included when making cost calculations for social services, presumably founded on the above identified policy objectives. The list of services for which the cost is included in the demand calculation is:

Social services closely related to health services:

- Social services that are provided by a health professional:
  - home care (by a nurse, physiotherapist, respiratory therapist, etc.),
  - palliative care,
  - psychological counseling and
  - the provision of devices related to those services.
- Medical aids, appliances, and prostheses.

Social services that provide constant supervision and care for those who are not able to integrate into society:

- Residential facilities (long-term care, substance abuse services, etc.)
- Day facilities providing constant supervision (respite care, etc.)[91]

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90. 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/2018/04/government-of-canada-brings-medical-inadmissibility-policyin-line-with-inclusivity-for-persons-with-disabilities.html>.

91. Minister of Immigration, Refugees and Citizenship Canada, *Temporary Public Policy Regarding Excessive Demand on Health and Social Services* (1 June 2018).

The list of services which will not count when determining excessive demand is:

- special education services (preparation of an individualized education plan, educational assistants, etc.)
- social and vocational rehabilitation services (rehabilitation facilities, occupational therapy, behavioural therapy, speech-language therapy, etc.)
- personal non-professional support services means services such as assistance with activities of daily living (bathing, dressing, feeding, etc.), meal preparation, house cleaning, etc.
- provision of devices related to those services.[92]

On the one hand, this list is heartening. The items which are excluded from the cost calculations are all associated with matters which support enabling people with physical and intellectual impairments to participate in society. That said, psychological counselling, respite care and home care are also key supports, and so it is not that Canada has stopped discriminating, it is that Canada is now discriminating against a smaller number of people with disabilities or health conditions.

Health supports, like pharmaceuticals, remain included in the health care cost calculations, despite medications being necessary for many people to regulate the nature of their disabilities. So while Canada no longer counts the cost of supporting a child with ADHD participating in education, Canada hangs on to the cost of medication which might be required to regulate the ADHD, so that the child can meaningfully and successfully participate in education, as well as the cost of respite care which a family member might need so as to properly support the child.

More to the point, the Minister describes the new policy as taking "steps to bring the excessive demands policy in line with our values around inclusion and participation, while at the same time maintaining the balance between facilitating the arrival of skilled immigrants and protecting Canada's publicly funded health care system"[93] The message here is that our values tolerate discrimination on the basis of intellectual

92. *Ibid.*

93. House of Commons, "Response to the Standing Committee on Citizenship and Immigration" by Ahmed Hussen (Minister of Citizenship and Immigration), online: <www.ourcommons.ca/DocumentViewer/en/42-1/CIMM/report-15/response-8512-421-328>.

and physical disabilities.[94] Otherwise, there would be no 'balancing' to perform. If our priority was just capping public health and social service costs, then Canada would also be eliminating immigrants who make lifestyle choices which can be predicted to likely have health care costs down the line, such as smokers or obese people, youth who play ice hockey, rugby or ringette (which are the sports with the highest concussion rates in Canada),[95] women who plan to have children, and any child who is under the age of one.[96] Indeed, anyone who plans to live until they are 65 is statistically likely to come to incur higher than average health care costs, with the figures escalating quickly to averaging to over $20,000 per year for persons over 80.[97] The suggestion of prohibiting women who plan to start a family, or families that include infants, on the grounds that they are statistically likely to incur higher health care and social services costs and thus are a burden on society, would likely provoke a strong sense of wrongful discrimination in the minds of many. The same suggestion, when the person is physically impaired on the other hand, leads to a discussion about finding the right balance—Canada starts with the notion that a disabled person is a problem. This is to say, the provisions continue the obsession with preventing those with existing identifiable physical and psychosocial/intellectual conditions or disabilities from becoming citizens, while giving a free rein to those whose live style choices—or even predicted life span—will likely incur higher costs. The cost justification, and the reference to 'balancing,' shows the troubling and continuing normalization of positioning disabled persons as a presumptive category of unwanted citizens.

There is also a matter of willful blindness when it comes to concerns about controlling spending. The calculations assume immigrants will actually receive the health care or social service supports which the medical officers anticipate them needing. Statistics Canada's data reveals that immigrants experience heightened difficulty accessing specialized

94. Indeed, the Canadian Charter of Rights and Freedoms contemplates that it may be permissible for the state to discriminate against people on such grounds. While section 15 of the Charter guarantees equality rights, such rights can be infringed if a justification test is met. That test is a rigorous one. It is beyond the scope of this paper to assess whether the policy would withstand a Charter challenge. Rather, the point is draw out nuances concerning the policy, and the values and assumptions with it both relies on and perpetuates.

95. Public Health Agency of Canada, "Concussion in Sport," online: <www.canada.ca/en/public-health/services/diseases/concussion-sign-symptoms/concussion-sport-infographic.html>.

96. Provincial/Territorial government health spending on persons younger than age 1 was an estimated $11,037 per capita in 2015. See Canadian Institute for Health Information, *National Health Expenditure Trends, 1975–2017* (Ottawa: CIHI, 2017) at 23.

97. *National Health Expenditure Trends*, *ibid* at 27.

health and first contact services.[98] There is copious literature detailing the barriers that new immigrants face when seeking social services,[99] primary health care,[100] and mental health services.[101] For decades there have been initiatives to try to counter these trends, but the underutilization persists.[102] For the Minister to suggest that Canada needs to watch out for migrants causing a health care or social services demand crisis is somewhat disconnected with the reality of structural barriers and systemic underuse. It once again suggests that unfounded assumptions are being drawn upon as evidence to support policies that are really about excluding the disabled.

*Conclusion*

The decision to retain the excessive demands provision is disconnected from the reality of Canada's experiences when we practice inclusion. Sponsored spouses and dependent children, and those granted asylum, have all been exempted from the provision since 2001. No suggestion has been made that this has placed the sustainability of our health and social services system into jeopardy. The closest comment to this was the bizarre concern of the ED, described earlier but without any evidence, that immigrants who would be medically inadmissible may marry or get adopted so as to fit into the exemption. Indeed, the number of people who are ultimately declined on medical inadmissibility grounds is strikingly low. From 2013 to 2016 an average of 361 applicants a year were denied due to being found medically inadmissible on the grounds of excessive

98. Statistics Canada, *Health at a Glance: Difficulty accessing health care services in Canada*, by Janine Clarke, Catalogue no.82-624-X (Ottawa: Statistics Canada, 6 December 2016), online: <www150.statcan.gc.ca/n1/pub/82-624-x/2016001/article/14683-eng.htm>.

99. Miriam Stewart et al, "Challenges and barriers to services for immigrant seniors in Canada: 'you are among others but you feel alone'" (2011) 7:1 Int'l J Migration, Health & Social Care 16; Melissa Fellin et al, "Barriers and facilitators to health and social service access and utilization for immigrant parents raising a child with a physical disability" (2013) 9:3 Int'l J Migration, Health & Social Care 135.

100. S Ahmed et al, "Barriers to access to primary care by immigrant populations in Canada: a literature review" (2015) 18:6 J Immigrant & Minority Health 1.

101. A Durbin et al, "Mental health service use by recent immigrants from different world regions and by non-immigrants in Ontario, Canada: a cross-sectional study" (2015) 15:1 BMC Health Services Research 1; Mental Health Commission of Canada, *The Case for Diversity: Building the Case to Improve Mental Health Services for Immigrant, Refugee, Ethno-cultural and Racialized Populations*, (Ottawa: Mental Health Commission of Canada, 2016).

102. For example, in 2003 the author was appointed to Nova Scotia's Metropolitan Immigrant Settlement Association's "Task Force on Newcomer Access to Health Care in Nova Scotia" as a project mentor, and then served on the steering committee. Our mandate was to engage in research and consultation to help identify and address the reasons why recent immigrants experienced challenges with accessing health care. Several more recent initiatives are detailed in Anjana Aery, "Innovations to Champion Access to Primary Care for Immigrants and Refugees" (Toronto: Wellesley Institute: March 2017).

demands.[103] The cost to the IRCC to exclude some 361 people a year is estimated to be between $800,000 and $1,100,000 per year.[104] What justifies mobilizing and now sustaining this sort of apparatus against would be immigrants?

Part of the answer is stigma and scapegoating. Writing back in 2000, about Canada's proposal to require the mandatory exclusion of persons with HIV/AIDS from immigrating, the HIV/AIDS network drew on the work of bioethicist Barry Hoffmaster who commented:

> …the financial pressures being exerted on Canada's health care system make every avenue for controlling costs appealing, it is not clear how or whether these 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 these forces, and not deflected by worries about the 'excessive demands' that immigrants might impose on health care services.[105]

Excessive demands are present in the Canadian health care and social services system, and they do require attention. However, their sources are factors including insufficiently regulated drug promotion and pricing practices,[106] and state failure to aggressively pursue population health initiatives grounded in the social determinants of health.[107] The externalization of excessive demands—as something which is dangerously amplified by foreigners—is somewhat disingenuous.

Costs also arise due to the legacy of decades of discriminatory practices against those who are impaired. These practices have generated an extensive infrastructure and culture of exclusion, which is costly to

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103. *Building an Inclusive Canada*, *supra* note 52 at 26.
104. *Building an Inclusive Canada, ibid* at 15, 27.
105. B Hoffmaster & T Schrecker, "An Ethical Analysis of the Mandatory Exclusion of Refugees and immigrants who Test HIV-Positive" (Halifax: The Names Project, 2000) at 20, as cited in Alana Klein, *HIV/AIDS and Immigration: Final Report* (Canadian HIV/AIDS Legal Network) at 57.
106. Ray Moynihan & Alan Cassels, *Selling Sickness: How the World's Biggest Pharmaceutical Companies are Turning Us All Into Patients* (Vancouver: Greystone Books, 2006).
107. See for example, Dennis Raphael, Ann Curry-Stevens & Toba Bryant, "Barriers to addressing the social determinants of health: Insights from the Canadian Experience" (2008) 88:2 Health Policy 222; Jacqueline Low & Luc Theriault, "Health promotion policy in Canada: lessons forgotten, lessons still to learn" (2008) 23:2 Health Promotion International 200 at 200-202.

remedy, but for both legal and moral reasons must be addressed. To target 361 immigrants a year, who themselves or their families are selected for their economic potential, for extra scrutiny on the basis of their or their family members' health conditions and physical and mental disabilities, misses the forest for the trees. As Judith Mosoff put it over a decade ago, "immigration rules that govern the ways an outsider becomes an insider reflect the moral priorities of the nation."[108] Our rules suggest that our moral priorities continue to be unduly swayed by scapegoating practices and values that were born in an era of eugenics. They further suggest that Canada remains comfortable viewing the impaired as outsiders who will only begrudgingly be permitted to belong.

108. Mosoff, *supra* note 12 at para 57.