

Canada's Refugee Health Law and Policy from a Comparative, Constitutional, and Human Rights Perspective

Ruby Dhand* & Robert Diab**

*Under the Interim Federal Health Program (IFHP), Canada has provided healthcare coverage for immigrants in financial need, including refugees, for over half a century. Until recently, the program provided migrants with comparable coverage to that available to Canadians on social assistance. In 2012, the government amended the IFHP to significantly reduce coverage for certain classes of migrants, including some on the basis of their country of origin, and removed coverage from others altogether. This article briefly describes the changes in migrant healthcare coverage in Canada, and compares it with analogous coverage in the United States, the United Kingdom, and Australia. The comparison demonstrates that Canada's recent changes to healthcare coverage fall below a common standard of coverage in these comparator countries. The paper then explores arguments made for and against the constitutionality of the revised IFHP in *Canadian Doctors for Refugee Care v Canada*, and the consistency of the plan with Canada's obligations under international human rights law. The authors contend that despite the reluctance of courts thus far to recognize a positive duty on the part of the state to provide health benefits as a means of protecting Charter rights, facets of this case present unique and compelling reasons for doing so. Finally, the paper argues that restoring coverage to levels prior to 2012 would bring Canada in closer conformity to the values and principles expressed in various international human rights treaties.*

* Assistant Professor, Faculty of Law, Thompson Rivers University.

** Assistant Professor, Faculty of Law, Thompson Rivers University. The authors would like to thank the Law Foundation of British Columbia for its generous support of this research, along with Christopher Albinati and Taylor-Marie Young for their many helpful insights and valuable

-
- I. INTRODUCTION
 - II. NATURE OF THE CHANGE TO REFUGEE HEALTH COVERAGE
 - A. Context for the Program
 - B. Changes to the IFHP in 2012
 - III. REFUGEE HEALTH COVERAGE IN A COMPARATIVE PERSPECTIVE
 - A. The United States
 - B. The United Kingdom
 - C. Australia
 - IV. CONSTITUTIONAL AND HUMAN RIGHTS CONCERNS
 - A. Section 7
 - B. Principles of Fundamental Justice
 - C. Section 12
 - D. Section 15
 - E. Section 1
 - F. International Humanitarian Law and Norms
 - V. CONCLUSION
-

I. Introduction

Following the Second World War, Canada began to offer healthcare coverage for certain groups of immigrants brought to Canada with government assistance. It did so through a series of orders in council that gradually expanded the scope of coverage to all classes of immigrants who could not afford coverage independently.¹ Coverage for migrants in the early stages of their arrival has thus been generally provided not through provincial healthcare plans but through what has become known as the Interim Federal Health Program (IFHP).²

Until 2012, the program provided refugees, refugee claimants, and other migrants with comparable coverage to that available to Canadians

contributions as research assistants.

1. The history of the program is explored in greater detail in Part II.
2. As explored below, for certain periods, provincial and territorial health plans have offered coverage for certain classes of migrants that overlapped with eligibility under the IFHP.

receiving social assistance.³ This included coverage for non-emergency hospital and doctor visits, vaccines and other preventive medicine, and basic dental and eye care. In June of 2012, the government amended the IFHP to significantly reduce coverage for certain classes of refugees and refugee claimants, including some on the basis of country of origin.⁴ The government also removed coverage from other categories of migrants altogether.⁵ Coinciding with this, Parliament passed a series of legislative amendments to the process for refugee determination under the *Immigration and Refugee Protection Act*,⁶ with a more expeditious means of resolving claims by migrants from certain “Designated Countries of Origin” that had higher historical rates of failed claims.⁷

Under the revised 2012 IFHP, those previously eligible for a wide range of basic health benefits have been divided into four tiers of coverage, with all but 14 percent of those eligible for coverage now placed in the three lower tiers.⁸ Those in the first tier continue to enjoy coverage previously available, while those in the second tier are covered for visits to doctors or hospitals only if the matter is “of an urgent or essential

-
3. Government of Canada, “Health care – Refugees”, online: Citizenship and Immigration Canada <<http://www.cic.gc.ca/english/refugees/outside/arriving-healthcare.asp>> [“Health care - Refugees”].
 4. *Order Respecting the Interim Federal Health Program, 2012*, SI/2012-26, (2012) C Gaz II, online: Justice Laws Canada <<http://laws-lois.justice.gc.ca/eng/regulations/SI-2012-26/FullText.html>>. The order was registered on April 25, 2012 and came into force on June 30, 2012.
 5. *Ibid.*
 6. SC 2001, c 27 [IRPA].
 7. Bill C-31, *Protecting Canada’s Immigration System Act*, 1st Sess, 41st Parl, 2012 (assented to 28 June 2012) [Bill C-31]. For an overview of the amendments in Bill C-31, see Government of Canada, “Protecting Canada’s Immigration System”, online: Citizenship and Immigration Canada <<http://www.cic.gc.ca/english/refugees/reform.asp>>.
 8. Government of Canada, “Interim Federal Health Program: Summary of Benefits”, online: Citizenship and Immigration Canada <<http://www.cic.gc.ca/english/refugees/outside/summary-ifhp.asp>> [“Summary of Benefits”]. The proportion of claimants in each tier is documented in the Memorandum of the Attorney General of Canada and Minister of Citizenship and Immigration, at paras 13-15 [Respondents’ Memorandum] in *CDRC, CARL, Garcia, Rodriguez et al v Canada (AG and MCI)*, Federal Court file T-356-13 [*CDRC et al v Canada*]; the trial level decision in this case is explored in more detail below.

nature,”⁹ and for medicine or vaccines “only if needed to prevent or treat a disease that is a risk to public health or to treat a condition of public safety concern.”¹⁰ Those in the third tier are provided the same coverage as those in the second tier with the exception that hospital and doctor visits are covered not where urgent or essential but only where necessary to “diagnose or treat a disease posing a risk to public health or to treat a condition of public safety concern.”¹¹ Failed claimants and migrants awaiting a pre-removal risk assessment are now placed in a fourth tier in which previous eligibility under the IFHP has been removed altogether (*i.e.* even if they suffer a condition that poses a risk to public health or safety).¹² The new scheme allows for discretionary coverage in individual cases, but limits their placement in this instance to either the second or third-tier of coverage. The new framework thus entails an effective withdrawal of coverage for most forms of preventive and, in many cases, emergency care for some 86 percent of migrants who previously enjoyed coverage.

Part II of this article briefly explores the history and scope of the IFHP, and then describes the changes in Canada's migrant healthcare coverage and their practical impact. Part III compares Canada's coverage with analogous plans in the United States, the United Kingdom, and Australia. Drawing on this overview, we argue that while various impediments to healthcare can be found in these other jurisdictions, for the most part, Canada's revised plan falls below a common standard of coverage among these comparator countries.

In Part IV, we explore the constitutionality of the revised IFHP and its consistency with Canada's obligations under international human rights law. We do so by exploring arguments raised in an action brought by two individual immigrants directly affected by the changes, along with the Canadian Association of Refugee Lawyers and Canadian Doctors for Refugee Care (the Applicants).¹³ Among the central issues in this case is whether the decision to remove coverage from certain classes of migrants

9. “Summary of Benefits”, *ibid.*

10. *Ibid.*

11. *Ibid.*

12. *Ibid.*

13. *CDRC et al v Canada*, *supra* note 8.

violates sections 7, 12, and 15 of the *Canadian Charter of Rights and Freedoms*,¹⁴ and if so whether the decision constitutes a reasonable limit on those rights under section 1. In making these claims, the Applicants invited the Court to depart from a growing body of case law in which courts have resisted recognizing a positive state duty under the *Charter* to provide a benefit essential for security of the person or for survival, including healthcare.¹⁵ The Applicants relied in part on the Supreme Court's affirmation in *Gosselin v Quebec*¹⁶ that the *Charter* might be applied in this way under "special circumstances." In July 2014, Mactavish J of the Federal Court rendered a decision at the trial level, dismissing the section 7 claim, but finding the revised IFHP scheme contrary to sections 12 and 15, and not a reasonable limit on those rights under section 1 of the *Charter*.¹⁷ Setting out an overview of this decision, we highlight relevant factual findings under sections 12 and 15 that are likely to frame the reconsideration of the case on appeal. We also argue that in dismissing the section 7 claim, Mactavish J failed to recognize facets of the present case that distinguish it from earlier case law on the question of a positive duty under section 7. For reasons to be explored, we suggest that the present facts come closer than earlier case law to presenting the "special circumstances" that the majority in *Gosselin* contemplated as necessary to justify the imposition of a positive duty under section 7. Finally, the

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

15. These include *Masse v Ontario (Ministry of Community and Social Services)* (1996), 134 DLR (4th) 20 (Div Ct) [*Masse*], leave to appeal to CA refused, [1996] OJ No 1526 (QL), leave to appeal to SCC refused, [1996] SCCA No 373; *Clark v Peterborough Utilities Commission* (1995), 24 OR (3d) 7 (Gen Div), appeal dismissed as moot (1998), 40 OR (3d) 409 (CA); *Auton (Guardian ad litem of) v British Columbia (AG)*, 2004 SCC 78 [*Auton*]; *Grant v Canada (Attorney General)* (2005), 77 OR (3d) 481 (SC) [*Grant*]; *Wynberg v Ontario* (2006), 82 OR (3d) 561 (CA) [*Wynberg*]; *Sagharian v Ontario (Education)*, 2008 ONCA 411 [*Sagharian*]; *Flora v Ontario Health Insurance Plan*, 2008 ONCA 538 [*Flora*]; *CCW v Ontario Health Insurance Plan* (2009), 95 OR (3d) 48 (Div Ct) [*CCW*]; *Tanudjaja v Attorney General (Canada) (Application)*, 2013 ONSC 5410 [*Tanudjaja*].

16. *Gosselin v Quebec (Attorney General)*, 2002 SCC 84 [*Gosselin*].

17. *Canadian Doctors For Refugee Care v Canada (Attorney General)*, 2014 FC 651 [*Canadian Doctors*].

paper briefly examines relevant international human rights law that may assist in a *Charter* analysis of the issues raised in this case.

II. Nature of the Change to Refugee Health Coverage

A. Context for the Program

To place the nature and import of the recent changes to refugee health coverage into context, we begin with a brief overview of the origins and scope of Canada's healthcare scheme for immigrants before 2012.¹⁸

The Interim Federal Health Program can be traced to a 1946 Order in Council that authorized medical coverage for some 4,000 ex-members of the Polish Armed Forces whom the federal government had selected for assistance with immigration.¹⁹ In 1949, through a further order, the government extended coverage to immigrants generally, authorizing the Department of Citizenship and Immigration "to pay hospital accounts and maintenance expenses of immigrants who may become suddenly ill after being admitted at the port of entry and prior to their arrival at destination, in such cases where immigrants lack the financial resources to bear these expenses themselves."²⁰ In 1952, the plan was extended to cover the costs of "medical and dental care, hospitalization, and any expenses incidental thereto" not only to indigent immigrants in need of care upon entry or arrival at destination, but also to those waiting for work placements to begin.²¹ And in 1957, a further order amended the scheme to extend coverage more generally to "a person who at any time is subject to Immigration jurisdiction or for whom Immigration

18. The following account draws upon a summary of the origins of the IFHP in *Toussaint v Canada (Attorney General)*, 2010 FC 810 at paras 31-39 [*Toussaint*]; Memorandum from Canadian Doctors for Refugee Care et al, at paras 4-17 [Applicants' Memorandum] in *CDRC et al v Canada*, *supra* note 8; Mactavish J's decision in *Canadian Doctors*, *ibid* at paras 32-56.

19. *Toussaint*, *ibid* at para 32, citing Order in Council PC 1946-3112 of July 23, 1946.

20. *Ibid* at para 34, citing Order in Council PC 1949-41/3888 of August 4, 1949.

21. *Ibid* at para 35, citing Order in Council PC 1949-4/3263 of June 6, 1952.

authorities feel responsible.”²² The 1957 order would continue to be the primary authority for the program rather than being entrenched in later immigration or healthcare legislation.²³

Prior to 2012, the program offered immigrants a level of health coverage roughly equivalent to that provided to citizens or permanent residents on social assistance.²⁴ This included coverage for hospital and doctor visits and prescriptions, as is generally the case under provincial plans; but it also covered certain dental procedures and limited eye care, as in some plans for those receiving social assistance.²⁵ In these latter respects, it offered benefits not available to working citizens or permanent residents under most provincial plans. Coverage was also meant to last for a limited and short duration, until a person began working or obtained eligibility under provincial or territorial programs.²⁶

Until 1995, the bulk of IFHP funding was spent on care for “indigent landed immigrants,” but this began to shift in 1995 to “refugee claimants, refugees, and others in humanitarian need.”²⁷ In 1995 and 1996, Ontario and Quebec, respectively, ceased to provide coverage for refugee claimants under their plans.²⁸ This caused not only a shift in the balance of funding between refugees and non-refugees, but also a significant rise in the number of qualified persons falling within the scope of the IFHP.²⁹ In 1999, the scope of coverage under the plan was further extended to include applicants seeking a Pre-Removal Risk Assessment and victims of human trafficking.³⁰ By 2012, the program serviced a

-
22. *Ibid* at para 36, citing Order in Council PC 1957-11/848 of June 20, 1957.
 23. Respondents’ Memorandum, *supra* note 8 at para 10.
 24. Applicants’ Memorandum, *supra* note 18 at para 10; “Health care - Refugees”, *supra* note 3.
 25. Respondents’ Memorandum, *supra* note 8 at para 8, relying upon the Affidavit of Sonia Le Bris, sworn August 29, 2013, Acting Director of Migration Health Policy and Partnerships, Health Branch, CIC at paras 7-13 [Le Bris Affidavit].
 26. *Ibid*.
 27. *Ibid* at para 12, citing Le Bris Affidavit at paras 18-21.
 28. *Ibid*.
 29. *Ibid*.
 30. *Ibid*.

larger number of immigrants (some 126,000 persons, by one estimate),³¹ and also covered them for a longer average period – close to three years in the government's estimate.³² The cost of reimbursement to hospitals, doctors, and other providers, along with medication and other fees rose significantly. In 1996-97, the IFHP cost \$18 million and by 2011-12 it was \$83 million.³³

Yet, as litigants challenging the validity of changes to the scheme have noted, from a broader perspective, the cost of the program was relatively low. It carried an annual per-capita cost of \$552 or roughly 10 percent of the annual per capita cost of healthcare for Canadians of \$5,401.³⁴ The Applicants also note that the \$83 million cost of the program comprises “only 4/100ths of one percent of total health expenditures in Canada, or about 60 cents per taxpayer per year.”³⁵

Prior to changes in 2012, the IFHP provided the same suite of coverage to various classes of immigrants, including pending, successful, and *failed* refugee claimants, along with government and privately sponsored refugees, and those awaiting a pre-removal risk assessment. Coverage lasted until a person became eligible under a provincial plan or departed from Canada.³⁶ However, as the government has indicated in the course of litigation, the earlier IFHP did not apply to persons without status in Canada, or to persons with failed or abandoned or ineligible claims who had not sought a pre-removal risk assessment. On this basis, the government has argued that the 2012 revision to the IFHP did not *introduce* a distinction in terms of coverage among migrants.

31. Applicants' Memorandum, *supra* note 18 at para 14, citing the Affidavit of Allison Little Fortin, sworn August 29, 2013, Director of the IFHP, Health Branch, CIC at para 8 [Little Fortin Affidavit].

32. Respondents' Memorandum, *supra* note 8 at para 13, citing Little Fortin Affidavit at para 75 and Le Bris Affidavit at para 39.

33. *Ibid.*

34. Applicants' Memorandum, *supra* note 18 at para 8, citing the Affidavit of Mitchell Goldberg at para 18.

35. *Ibid.*, citing Le Bris Affidavit at para 39.

36. *Ibid.* at para 7, citing Government of Canada, “Audit of the Control Framework for the Interim Federal Health Program” (2004), online: Citizenship and Immigration Canada <<http://www.cic.gc.ca/english/resources/audit/ifh.asp>>.

B. Changes to the IFHP in 2012

By an order in council on April 25 of 2012, which came into effect on June 30, 2012, the government shifted its policy with respect to coverage significantly.³⁷ Coverage would now be tiered, placing immigrants into four categories, with those in the second and third tiers losing many of the benefits and services they enjoyed earlier, and those in the fourth losing all. In response to criticism of the new scheme, the government passed an order in council on June 18, 2012, restoring some benefits to persons in the second and third tier.³⁸ What follows summarizes the current plan.³⁹

The first tier of coverage, referred to in the government documentation as “Expanded Health-Care Coverage,” applies to government-assisted refugees, privately sponsored refugees who receive income support through the Resettlement Assistance Program (or its Quebec equivalent), and to victims of human trafficking for the duration of the period in which they hold a “Temporary Resident Permit.”⁴⁰ Persons in this group receive the equivalent level of coverage to what the program offered to all immigrants prior to 2012. This includes hospital and doctor services; laboratory, diagnostic, and ambulance services; and also “supplemental health benefits,” such as prescribed medications, limited dental and vision care, prosthetics, home care, and psychological counselling. As the government’s brief in the current *Charter* challenge notes, this tier of coverage extends to 14 percent of IFHP beneficiaries.⁴¹

The second tier, titled “Health Care Coverage,” applies to privately sponsored refugees not receiving government income support (or the bulk of privately sponsored refugees), and “Other Protected Persons,”⁴² until they qualify for provincial or territorial coverage. “Other Protected Persons” include refugee claimants not from a Designated Country of

37. *Order Respecting the Interim Federal Health Program*, *supra* note 4.

38. *Order Amending the Order Respecting the Interim Federal Health Program*, PC 2012-945, (2012) C Gaz II (of 28 June 2012).

39. “Summary of Benefits”, *supra* note 8.

40. *Ibid.*

41. Respondents’ Memorandum, *supra* note 8 at para 35, citing Little Fortin Affidavit at paras 47-55.

42. “Summary of Benefits”, *supra* note 8.

Origin (see below for the definition); refugees whose claims have been accepted; immigration detainees; and persons who have received a positive Pre-Removal Risk Assessment. This tier provides the following services “only if of an urgent or essential nature”: hospital, physician, or nurse services; laboratory, diagnostic and ambulance services; and medication or vaccine “only if needed to prevent or treat a disease that is a risk to public health or to treat a condition of public safety concern.”⁴³ As a result, persons in this group are no longer covered in the ordinary course for prescription medication including insulin, anti-epileptics, anti-asthma or psychiatric medication.⁴⁴ The government’s factum notes that 62 percent of all IFHP beneficiaries (*i.e.* of persons in the first three tiers) fall within this category.⁴⁵

The third tier is comprised of refugee claimants from a “safe” or Designated Country of Origin (DCO)⁴⁶ and rejected claimants.⁴⁷ Persons in this group receive what is termed “Public Health or Safety Health-Care Coverage,” which provides the same coverage as in the second tier except that whereas in that category, the listed services aside from medications and vaccines (*i.e.* hospital and doctor visits, diagnostic and ambulance services) are covered only where they are of “an urgent or

43. *Ibid.*

44. Applicants’ Memorandum, *supra* note 18 at para 10.

45. Respondents’ Memorandum, *supra* note 8 at para 36, citing Little Fortin Affidavit at paras 56-61.

46. Following amendments in Bill C-31 to the *Immigration and Refugee Protection Act* in June 2012, the Minister may designate a source country to be “safe,” triggering an accelerated process for determining refugee claims, along with the tiered health coverage described above. See s 58 of Bill C-31, *supra* note 7, amending s 12 of Bill C-11, *An Act to Amend the Immigration and Refugee Protection Act and the Federal Courts Act*, 3rd Sess, 40th Parl, 2010 (assented to 29 June 2010). Thirty-seven countries have been deemed safe, including Hungary and Mexico – which are, as the Applicants in this case note, a source of significant numbers of refugee claimants in recent years.

47. A rejected claimant is defined as a person whose claim has been rejected by the Immigration and Refugee Board and whose right to judicial review and appeal of that right have been exhausted: Government of Canada, “Information Sheet for Interim Federal Health Program Beneficiaries”, online: Citizenship and Immigration Canada <<http://www.cic.gc.ca/english/refugees/outside/ifhp-info-sheet.asp>>.

essential nature,” here both medicine or vaccines *and* other health services are provided “only if needed to diagnose, prevent or treat a disease posing a risk to public health or to diagnose or treat a condition of public safety concern.”⁴⁸ This category entails no coverage for preventive care, and no medication or services except where a condition poses a risk to public health or safety. Thus, it excludes coverage for any disorder that is non-communicable, including diabetes, asthma, epilepsy, heart conditions, trauma, blood infections, non-violent psychoses, and pregnancy.⁴⁹ Twenty-four percent of IFHP beneficiaries are within this category.⁵⁰

Finally, a fourth group comprises refugee claimants who have withdrawn or abandoned their claims or have not been found eligible to make a claim, along with applicants for a pre-removal risk assessment without a valid claim. Prior to June of 2012, persons in this group were covered by the IFHP while awaiting the outcome of a pre-removal risk assessment (PRRA).⁵¹ They now receive no coverage under the IFHP, even if their condition poses a risk to public health or safety.⁵²

To be clear as to the nature of the difference between the plan before and after the June 2012 changes, it might help to consider a common practical scenario. Both before and since 2012, refugee claims brought by migrants from certain DCO countries such as Mexico and Hungary have been refused in a number of cases, but at least some have been successful.⁵³ Thus, for example, prior to 2012, if a pregnant woman were to arrive from a DCO country with a valid and compelling claim for asylum, she would receive coverage for routine visits to a doctor for pre-natal care and medicine. Today, falling under the third tier of coverage, she would not be covered for routine visits or medicine, given that she

48. “Summary of Benefits”, *supra* note 8.

49. Applicants’ Memorandum, *supra* note 18 at para 10.

50. Respondents’ Memorandum, *supra* note 8 at para 37, citing Little Fortin Affidavit at paras 62-70.

51. Applicants’ Memorandum, *supra* note 18 at para 10.

52. “Summary of Benefits”, *supra* note 8; Applicants’ Memorandum, *ibid*; Respondents’ Memorandum, *supra* note 8 at para 26, citing Little Fortin Affidavit at para 82.

53. The DCO category is premised on a higher rate of failed claims from these countries, but not on an absolute rate of failure or a prohibition on claims from DCO migrants.

does not suffer from a potentially communicable disease or a condition that poses a danger to public safety.

But even once a finding is made at the Immigration and Refugee Board that a pregnant woman from a DCO is a successful refugee claimant, she would only move up to the second tier of coverage. Thus, she would still not be covered for a *routine* visit to a doctor or for medication, since the second tier covers visits only of an “urgent or essential nature,” and medicine only where it is necessary to treat a communicable disease or a condition that poses a danger to public safety. In short, the plan removes coverage for many *preventive* forms of medicine that are necessary to address matters short of emergencies but critical for life or security of the person.

In responding to the constitutional challenge to the changes to the IFHP, the government questioned the severity of the situation in which persons in the lower three tiers now find themselves. Citing the availability of a range of provincial social welfare programs, such as Ontario Works, and significant numbers of community health centres that provide free health services, the government suggested that the loss of IFHP coverage can often be addressed by other means.⁵⁴ It also cited evidence that a number of provinces had expanded their healthcare plans in response to the IFHP reforms, including Quebec, which provides affected persons much of what was reduced under the 2012 reforms.⁵⁵ And in the last resort, the Respondents noted that emergency medical care at any hospital is available to everyone in Canada unconditionally.⁵⁶

54. Respondents' Memorandum, *supra* note 8 at paras 40-41, citing Little Fortin Affidavit at paras 89-92, 94.

55. *Ibid* at para 44.

56. *Ibid* at para 44, citing Little Fortin Affidavit at para 92. Note, however, that in the 2011 Federal Court of Appeal decision in *Toussaint v Canada (Attorney General)*, 2011 FCA 213 at para 59 [*Toussaint Appeal*], the Crown disputed whether the exclusion of an undocumented migrant from coverage under the IFHP deprived access to emergency care on the basis that “in Ontario, where the appellant lives, hospitals cannot deny emergency medical treatment to anyone, when to do so would endanger life”: *Public Hospitals Act*, RSO 1990, c P 40. Yet, at the trial level, Justice Zinn had found, *supra* note 18 at para 91, that “the applicant’s exclusion from IFHP coverage has exposed her to a risk to her life as well as to long-term, and potentially irreversible, negative health consequences,”

In the Federal Court's decision in *Canadian Doctors*, Mactavish J accepted the Appellants' contention that these various sources remain inadequate to address the critical needs of many migrants.⁵⁷ Refugee claimants generally do not qualify for provincial healthcare plans due to residency requirements and varying definitions of residency in provincial legislation.⁵⁸ Some refugee claimants, failed claimants, and Pre-Removal Risk Assessment applicants are eligible for provincial social assistance, but these provide supplemental benefits (medication, dental and eye care) rather than the comprehensive care normally provided under primary provincial healthcare plans.⁵⁹ Moreover, due to sponsorship undertakings, privately-sponsored refugees are precluded from obtaining social assistance for a year after their arrival, and claimants from Designated Countries of Origin are not eligible for a work permit for the first 180 days in Canada.⁶⁰ In other words, it is not clear how many refugees are expected to address a lack of coverage for critical or emergency assistance.

Justice Mactavish held that, in a broader sense, the government's position on alternative sources of care "takes no account of the extreme human cost incurred as individuals search for sources of potentially life-saving medical care."⁶¹ Many claimants face language barriers or have limited education, posing further impediments to access.⁶² Justice Mactavish was also critical of the assumption that community health centres or refugee centres could function as a surrogate for the wide range of walk-in care that would otherwise have been available under the IFHP,

amounting to a deprivation of security of the person under section 7. The Federal Court of Appeal upheld this finding at para 66, despite overturning the lower court decision on other grounds. See below for further discussion of both decisions.

57. *Canadian Doctors*, *supra* note 17 at paras 261-99.
58. Applicants' Memorandum, *supra* note 18 at para 15 (see *e.g.* the definition of "residency" in section 1.1 of RRO 1990, Reg 552 of Ontario's *Health Insurance Act*, RSO 1990, c H6 [Regulation 552], the definition of "resident" in section 1 of the British Columbia *Medicare Protection Act*, RSBC 1996, c 286 and the definition of "deemed residency" in section 2 of the *Medical and Health Care Services Regulation*, BC Reg 426/97).
59. Applicants' Memorandum, *supra* note 18 at para 15.
60. *Ibid.*
61. *Canadian Doctors*, *supra* note 17 at para 263.
62. *Ibid* at para 266.

given the “severely restricted” medical assistance typical in these essentially charitable institutions.⁶³ She also noted that neither emergency care nor the limited coverage available through social assistance could provide for a wide range of preventive care through routine doctor visits, prenatal care, or diagnostic tests.⁶⁴ Finally, the availability of discretionary coverage was also a poor substitute for a range of reasons that include the exclusion in such cases of coverage for medication, the inability to address emergency situations, the confusion surrounding knowledge of how to apply, and the general uncertainty as to whether one could obtain discretionary coverage.⁶⁵

III. Refugee Health Coverage in a Comparative Perspective

Before examining the merits of the revised IFHP in terms of the *Charter* and Canada's obligations under international human rights law, in this section we briefly survey the extent of coverage in the United States, the United Kingdom, and Australia. The overview demonstrates that while migrants face obstacles to healthcare coverage or treatment in these comparator countries, with one exception, Canada's revised IFHP falls below a basic level of coverage common to each of them for both refugee claimants and failed or non-status migrants.

A. The United States

Healthcare services are provided to refugees and asylum seekers through the Office of Refugee Resettlement, which is overseen by the federal Department of Health and Human Services.⁶⁶ The Office administers

63. *Ibid* at para 273.

64. *Ibid* at paras 277-81.

65. *Ibid* at paras 287-93.

66. US migration law distinguishes “refugees” from “asylees.” Refugees are individuals who seek asylum status from outside of the United States, while asylees do so from within. We refer to both in what follows as “refugee claimants.” For a summary of the benefits available through programs administered by the Office of Refugee Resettlement, see US, Office of Refugee Settlement, “Fact Sheet: ORR BENEFITS-AT-A-GLANCE”, online: An Office of Administration for Children & Families <http://www.acf.hhs.gov/sites/default/files/orr/orr_fact_sheet_benefits_

the Refugee Medical Assistance program to claimants, regardless of their status for up to eight months. This federally-funded program provides coverage from the time a claimant enters the United States and meets the requirements to file a claim, or is granted status by either US Citizenship and Immigration Services or the Office of Refugee Resettlement.⁶⁷

Under the Refugee Medical Assistance program, refugee claimants are provided access to emergency and non-emergency care found “medically necessary.”⁶⁸ Once coverage under the program expires, those who meet immigration status requirements under the *Affordable Care Act*⁶⁹ have access to Medicaid, the Children’s Health Insurance Program,⁷⁰ and other healthcare coverage options.⁷¹ “Mandatory benefits” under the federal Medicaid program provide refugee claimants with coverage that includes “inpatient and outpatient hospital services; early, periodic, screening, diagnostic and treatment services, nursing facility services; home health services, physician services; [and] rural health services.”⁷²

The United States thus offers a higher level of basic healthcare coverage to refugee claimants than Canada does, and it also does so without distinction on the basis of country of origin. Moreover, in

at_a_glance.pdf>.

67. “Access to Care” (2011), online: Refugee Health Technical Assistance Center <<http://refugeehealthta.org/access-to-care/>>.
68. See State Letter #04-12 from Nguyen Van Hanh, PhD, Director, Office of Refugee Resettlement (18 June 2004) to State Refugee Coordinators, National Voluntary Agencies, and Other Interested Parties, filed 30 June 2008, effective 1 August 2008.
69. *The Patient Protection and Affordable Care Act*, Pub L No 111–148, 124 Stat 119 (2010), and the *Health Care and Education Reconciliation Act of 2010*, Pub L No 111–152, 124 Stat 1029 (2010), collectively are referred to as the *Affordable Care Act [ACA]*; s 1411(a)(1) of the *ACA* (eligibility for the health insurance “exchanges” and the related affordability tax credits).
70. The Children’s Health Insurance Program was reauthorized by the *Children’s Health Insurance Program Reauthorization Act of 2009*, Pub L No 111-3, 123 Stat 8 at 214.
71. Office of Refugee Settlement, “Health Insurance – Beyond the First Eight Months”, online: An Office of Administration for Children & Families <<http://www.acf.hhs.gov/programs/orr/health>>.
72. Centers for Medicare & Medicaid, “Medicaid Benefits”, online: Medicaid.gov <<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html>>.

contrast to migrants in Canada's fourth tier under the IFHP who now receive no coverage even in cases of emergency, undocumented migrants in the US not eligible for Medicaid or the Children's Health Insurance Program may still access emergency medical care under the *Emergency Medical Treatment and Active Labor Act*⁷³ until their medical condition is "stabilized."⁷⁴ "[C]omprehensive primary care"⁷⁵ services are also available to these migrants on a sliding fee through Federally Qualified Community Health Centres and Migrant Health Centres, which are not-for-profit, but federally funded organizations.⁷⁶

A further significant element in US coverage for migrants concerns the care extended to pregnant women and children regardless of immigration status. Under the *Children's Health Insurance Program Reauthorization Act*,⁷⁷ persons in this category enjoy coverage for "mandatory benefits"⁷⁸ under Medicaid but also optional benefits such as therapy, counseling, immunizations and family planning.⁷⁹

There is, therefore, no equivalent in US law to the third or fourth categories of Canada's IFHP, which limit DCO and Rejected Refugee Claimants to coverage for services necessary to "diagnose, prevent or treat a disease posing a risk to public health or to diagnose or treat a condition of public safety concern"⁸⁰ – or, in the case of migrants who have withdrawn or abandoned refugee claims or are awaiting a pre-removal risk assessment, no coverage at all.

B. United Kingdom

In the United Kingdom, healthcare coverage for refugees and asylum-

73. 42 USC § 1395dd (1986).

74. *Ibid.*

75. Michael K Gusmano, "Undocumented Immigrants in the United States: U.S. Health Policy and Access to Care" (3 October 2012), online: The Hastings Centre <<http://www.undocumentedpatients.org/issuebrief/health-policy-and-access-to-care/#refmark-16>>.

76. *Ibid.*

77. *Supra* note 70.

78. *Ibid.*

79. *Ibid.*

80. "Summary of Benefits", *supra* note 8.

seekers is administered by the National Health Service (NHS).⁸¹ The NHS Constitution specifies the “rights and responsibilities” of the NHS, along with its guiding principles. Among the key principles relevant here is one that states that “[a]ccess to NHS services is based on clinical need, not an individual’s ability to pay. NHS services are free of charge, except in limited circumstances sanctioned by Parliament.”⁸² Healthcare coverage is provided to refugees and asylum claimants awaiting determination of their claims, and includes both routine medical care through clinical or hospital visits and specialist care, along with medicine, dental, and eye care.⁸³ However, the Court of Appeal for England and Wales has held that failed claimants are deemed not to pass the ordinary residence test that triggers eligibility for healthcare coverage in the UK, nor are they to be considered exempt from charges for care when they spend more than a year in the UK.⁸⁴

In May of 2014, the government passed Bill 110, the *Immigration Act 2014*, which made a series of revisions to healthcare coverage for migrants.⁸⁵ The government claims that changes are necessary in light of challenges it has faced in recovering service charges for Secondary Medical Care services for undocumented migrants – services that are offered by medical specialists for acute healthcare conditions.⁸⁶ The bill

-
81. UK, Department of Health, *The NHS Constitution: The NHS belongs to us all* (2013), online: National Health Service <<http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx>>.
82. *Ibid* at 3.
83. “The National Health Service, Information Leaflet”, online: National Archives <http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4122698.pdf>.
84. *R(YA) v Secretary of State for Health*, [2009] EWCA Civ 225.
85. (UK), c 22; see also Home Office, “Immigration Act 2014”, online: GOV.UK <<https://www.gov.uk/government/collections/immigration-bill>>.
86. UK, Home Office, *Controlling Immigration – Regulating Migrant Access to Health Services in the UK: Consultation document*, online: GOV.UK <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226744/consultation-health.pdf> [*Controlling Immigration – Regulating Migrant Access*]; see also UK, Home Office, *Immigration Bill, Factsheet: Overview of the Bill*, online: GOV.UK <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/249251/>

also seeks to deter illegitimate claimants by limiting access to healthcare in an analogous fashion to the revised IFHP in Canada.⁸⁷ Portions of the law yet to come into force will charge undocumented migrants, denied refugee claimants, and short-term visitors (defined as those in the UK for less than six months) for healthcare services.⁸⁸ However, the NHS has indicated in its “implementation plan” that:

[T]reatment which is considered by clinicians to be **immediately necessary (which includes all maternity treatment)**, must never be withheld from chargeable patients, even if they have not paid in advance ...

Treatment which is not immediately necessary, but is nevertheless classed as **urgent** by clinicians, since it cannot wait until the overseas visitor can return home, should also be provided, even if a payment or deposit has not been secured. Providers are nonetheless strongly encouraged to obtain a deposit ahead of treatment deemed urgent if circumstances allow. However, if this proves unsuccessful, the treatment should not be delayed or withheld for the purposes of securing payment.⁸⁹

Thus, by contrast to Canada, no urgent medical care or maternity treatment is to be withheld due to coverage issues. Though, as with Canada, routine visits to doctors or hospitals, and other forms of preventive care, are soon to be withdrawn from sizable numbers of migrants.

C. Australia

As in Canada and the United Kingdom, migrants and refugee claimants in Australia are eligible for certain levels of healthcare coverage depending on their refugee status or visa category.⁹⁰ Pursuant to the *Migration*

Overview_Immigration_Bill_Factsheet.pdf>.

87. *Controlling Immigration – Regulating Migrant Access*, *ibid* at 1.

88. *Ibid*; UK, Home Office, *Immigration Bill, Factsheet: National Health Service* (clauses 33-34), online: GOV.UK <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/249315/Factsheet_08_-_Health.pdf>.

89. UK, Department of Health, *Visitor & Migrant NHS Cost Recovery Programme: Implementation Plan 2014-2016* (Crown Copyright, 2014) at 5, online: GOV.UK <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/329789/NHS_Implementation_Plan_Phase_3.PDF> [emphasis in the original].

90. Australian Government, Department of Immigration and Border Protection, “Medicare”, online: Department of Immigration and Border Protection <<http://www.immi.gov.au/Help/Pages/health/medicare.aspx>>

Regulations 1994,⁹¹ coverage is provided through the Humanitarian Program for Refugees, which is overseen by the Department of Immigration and Citizenship.⁹² The program has two distinct sections: offshore resettlement (providing refugee protection for those applying from overseas) and onshore protections (providing refugee protection for those applying within Australia).⁹³ After the application process, individuals who are granted a “protection visa,” “refugee visa” or “special humanitarian visa”⁹⁴ are able to access Medicare.⁹⁵ This includes primary and secondary healthcare services (*i.e.* referrals to specialists) that are also available to Australian citizens and permanent residents.⁹⁶ Early health assessments, interventions and trauma services are also accessible to these individuals.⁹⁷

Asylum claimants are eligible to apply for Medicare within six months of their arrival in Australia. Migrants without status who have been in Australia longer than six months, were denied refugee status, or entered Australia unlawfully are not entitled to Medicare, unless certain exceptions apply.⁹⁸ These include applicants who are unaccompanied

[“Medicare”].

91. (Cth).

92. *Ibid*; Department of Immigration and Border Protection, *Australia’s Humanitarian Program* (Information Paper 2014-2015), online: Department of Immigration and Border Protection <<http://www.immi.gov.au/media/publications/refugee/ref-hum-issues/pdf/humanitarian-program-information-paper-14-15.pdf>> [*Humanitarian Program*].

93. *Humanitarian Program, ibid.*

94. Australian Medical Students’ Association (AMSA), “Refugees, Asylum Seekers and Internally Displaced Persons”, online: AMSA <<http://agh.amsa.org.au/student-centre/gh-factsheets/refugees-asylum-seekers-and-internally-displaced-persons>> [“Refugees, Asylum Seekers and Internally Displaced Persons”]; “Medicare”, *supra* note 90.

95. “Refugees, Asylum Seekers and Internally Displaced Persons”, *ibid.*

96. *Migration Regulations 1994, supra* note 91.

97. *Ibid*; Ignacio Correa-Velez, Sandra M Gifford & Sara J Bice, “Australian health policy on access to medical care for refugees and asylum seekers” (2005) 2:23 *Australia and New Zealand Health Policy* 23.

98. Department of Immigration and Border Protection, *Assistance for Asylum Seekers in Australia* (Fact Sheet 62), online: Department of Immigration and Border Protection <<http://www.immi.gov.au/media/fact-sheets/62assistance.htm>>; Correa-Velez, Gifford & Bice, *ibid.*

minors, the elderly, or families with children under 18.⁹⁹ Australian law thus excludes coverage from certain classes of migrants, but offers a more generous and humane set of exceptions.

IV. Constitutional and Human Rights Concerns

In *Canadian Doctors For Refugee Care v Canada*,¹⁰⁰ Mactavish J entertained a series of arguments against the constitutional validity of the revised 2012 IFHP and its consistency with Canada's obligations under international human rights law. In what follows, we briefly describe the circumstances of the individual applicants and the grounds of their challenge. We then focus our analysis on Mactavish J's treatment of the *Charter* arguments and of international human rights law. Our primary intention here is twofold. One is to argue that while the Court declined to find a violation of section 7, the challenge on this ground was not adequately addressed – with the Court overlooking facets of this case that distinguish it from earlier invitations to find a positive duty under section 7 in the healthcare context. The second point is to highlight ways in which the Court's decision offers a novel resolution to the constitutional claims through its analysis under sections 12 and 15.

The individual Applicants in the case are two individuals, Daniel Garcia Rodriguez and Hanif Ayubi.¹⁰¹ Rodriguez is a failed refugee claimant, though his spouse – who was a successful claimant – had been in the process of sponsoring him for permanent residence at the time the application was filed. As a failed claimant, Rodriguez was placed in the third tier of IFHP care, depriving him of coverage for an urgent operation in August of 2012 to repair a detached retina.¹⁰² Prior to the July changes, the operation would have been covered. His doctor wrote the Ministry

99. Department of Immigration and Border Protection, *Bridging E Visas for Illegal Maritime Arrivals* (Fact Sheet 65), online: Department of Immigration and Border Protection <<http://www.immi.gov.au/About/Pages/media/fact-sheet-65.aspx>>.

100. *Supra* note 17.

101. Along with Rodriguez and Ayubi, the application was brought by two advocacy groups: the Canadian Association for Refugee Lawyers and Canadian Doctors for Refugee Care. See *ibid.*

102. Applicants' Memorandum, *supra* note 18 at para 20.

of Immigration seeking discretionary coverage on the basis that further delay would risk blindness, but the Ministry declined on the grounds that Rodriguez was in Canada illegally.¹⁰³ Doctors performed the surgery on August 20th to avoid further risk, recovering only a fraction of the cost.¹⁰⁴

Ayubi, the other Applicant, came to Canada from Afghanistan in 2001, made an unsuccessful claim for refugee status, but remained in Canada due to a moratorium on removals to Afghanistan. As a type 1 diabetic, he had been receiving insulin and medical care prior to 2012, but lost coverage for medicine under the revised scheme and could not afford either the necessary insulin or the blood tests to monitor his condition. He sought and was eventually granted discretionary IFHP coverage for medical services but not for medication. As the Applicants' memoranda of argument noted, "he is being kept alive on free samples of insulin obtained by a community health centre due to the charity of the drug manufacturer."¹⁰⁵ The government argued that the IFHP is entirely discretionary or *ex gratia* and not grounded in any statutory obligation, rendering the decision of whether to continue funding it – and to what degree – purely a matter of policy.¹⁰⁶ For the Applicants, the program may have begun as an *ex gratia* program, but over the passage of time, it ceased to be one by virtue of the embrace of a national publically funded healthcare system for citizens, residents, and in some cases foreigners – together with treaty obligations under international human rights law that prohibit discriminatory treatment of refugees among other non-

103. *Ibid.*

104. *Ibid.*; Respondents' Memorandum, *supra* note 8 at para 50 (the Respondents concede that Rodriguez was eligible for only "public health and public safety" coverage beginning in August of 2012, but note that he became eligible for Ontario's Health Insurance Plan in November of that year).

105. Applicants' Memorandum, *supra* note 18 at para 22 (the memorandum also indicates that Ayubi requires other medication that he is not receiving and that the insulin he does receive gratuitously does not always match his prescription).

106. Backgrounder to the *Order Respecting the Interim Federal Health Program, 2012*, *supra* note 4 (appended to the Order), cited in Applicants' Memorandum, *supra* note 18 at para 36; Respondents' Memorandum, *supra* note 8 at para 70.

citizens.¹⁰⁷ The Applicants also argued that the 2012 revisions to the IFHP were *ultra vires* because the prerogative of the federal executive in the fields of immigration and healthcare had been extinguished due to the passage of the *Canada Health Act (CHA)*¹⁰⁸ and the *Immigration and Refugee Protection Act (IRPA)*.¹⁰⁹ As the Ontario Court of Appeal held, “once a statute occupies ground formally occupied by the prerogative, the prerogative goes into abeyance. The Crown may no longer act under the prerogative, but must act under and subject to the conditions imposed by the statute.”¹¹⁰ In this case, the Applicants contended, the passage of *IRPA* and the *CHA* extinguished any remaining prerogative over refugee healthcare “expressly or by necessary implication.”¹¹¹ The government’s response to this second claim was that neither statute at issue deals *in particular* with healthcare for immigrants and refugees, and therefore Crown prerogative in this area may only be extinguished by explicit legislative directive or by necessary implication of the *words in the statute*.¹¹²

Justice Mactavish took issue with both parties’ positions. The IFHP was neither entirely *ex gratia*, nor had the prerogative been extinguished.¹¹³ Since it was created, it had given rise to obligations to pay healthcare providers who had agreed to provide coverage under the plan. And due to the lack of federal legislation addressing the question of healthcare to refugees, claimants, or failed claimants, “the Crown’s prerogative power

107. Applicants’ Memorandum, *supra* note 18 at para 36 (see the discussion below of Article 7 of the Refugee Convention of 1951, and other obligations under international law).

108. RSC, 1985, c C-6 [*CHA*].

109. *Supra* note 6; Applicants’ Memorandum, *supra* note 18 at para 38.

110. *Black v Canada (Prime Minister)* (2001), 199 DLR (4th) 228, cited in Applicants’ Memorandum, *supra* note 18 at para 44.

111. Applicants’ Memorandum, *supra* note 18 at para 45.

112. In support of this latter proposition, the Respondents cite section 17 of the *Interpretation Act*, RSC 1985, c I-21: “[n]o enactment is binding on Her Majesty or affects Her Majesty or Her Majesty’s rights or prerogatives in any manner, except as mentioned or referred to in the enactment.” They also cite *Khadr v Canada (AG)*, 2006 FC 727 (in which Phelan J surveyed Canadian and English authority on the point, concluding that Crown prerogative “can only be abolished or exhausted by clear words in a statute or by necessary implication from words in a statute” at para 91).

113. *Canadian Doctors*, *supra* note 17 at paras 394-402.

to spend in an area not addressed by statute remains intact,” rendering the 2012 orders in council *intra vires*.¹¹⁴ However, this did not relieve the government from judicial scrutiny over modifications to the program, including *Charter* conformity.¹¹⁵ Although Mactavish J dispensed with the Applicants’ section 7 claim, she found violations of sections 12 and 15 of the *Charter*, and held that they were not reasonable under section 1. We consider each section in turn.

A. Section 7

Section 7 guarantees everyone in Canada “the right to life, liberty, and security of the person and the right not to be deprived thereof except in accordance with the principals of fundamental justice.”¹¹⁶ The Applicants in *Canadian Doctors* had argued that changes to the IFHP had deprived them of rights to life and security of the person, and that they had done so in a manner that was contrary to the principles of fundamental justice for being arbitrary and grossly disproportionate to the government’s stated intentions.¹¹⁷ The rights were violated because the withdrawal of coverage had rendered affected migrants unable to pay for critical care, placing them at risk of serious illness or death, and subjecting them to “severe psychological distress.”¹¹⁸ Justice Mactavish agreed with the Respondents’ submission that the Applicants’ claim was tantamount to asserting a positive obligation on the part of the government to provide healthcare funding (or some essential social benefit) under section 7 – a claim that several courts have thus far resisted. Relying primarily on a series of decisions that include *Flora*¹¹⁹ and *Toussaint*,¹²⁰ which dismissed attempts to assert a positive right to healthcare under section 7, Mactavish J conceded that rights to life and security of the person may be engaged by the facts before the Court, but suggested that the weight of authority prevents the Court in this case from making the finding that those rights

114. *Ibid* at para 401.

115. *Ibid* at para 402.

116. *Charter*, *supra* note 14.

117. Applicants’ Memorandum, *supra* note 18 at paras 86-97.

118. *Canadian Doctors*, *supra* note 17 at para 499.

119. *Flora*, *supra* note 15.

120. *Toussaint* Appeal, *supra* note 56.

have been deprived.¹²¹

Yet Mactavish J's decision on the issue of section 7 fails to address a broader argument that the Applicants sought to advance in this case – an argument that may be best addressed at the appellate level, and perhaps at the Supreme Court of Canada in particular. The argument was that the facts in this case present a unique set of circumstances that may constitute the closest approximation to what the Supreme Court contemplated in *Gosselin v Quebec (Attorney General)*¹²² when it first articulated the possibility that section 7 may, in “special circumstances,” give rise to a positive duty on the part of the state. While Mactavish J distinguished the facts at bar from those in earlier Supreme Court decisions including *Chaoulli*¹²³ and *PHS Community*,¹²⁴ she discerned no substantive difference between the present case and a series of other cases in which litigants sought the recognition of a duty to provide an essential benefit under section 7.¹²⁵ To make clear how this case can be distinguished from the facts in those earlier decisions, and why it may meet the *Gosselin* test in ways that earlier cases have failed to, we begin by briefly revisiting the Supreme Court's considerations in *Gosselin*.

In decisions preceding *Gosselin*, without holding so explicitly, the Supreme Court had contemplated the possibility that section 7 might protect “economic rights fundamental to human life or survival.”¹²⁶ Dicta in other cases had also expressed a reluctance on the part of individual members of the court to read section 7 too restrictively; for example, in *Singh v Minister of Employment and Immigration*,¹²⁷ Justice Wilson cited a Law Reform Commission of Canada paper for the assertion that “the right to security of the person means not only protection of one's physical integrity, but the provision of necessities for its support.”¹²⁸ *Gosselin*

121. *Canadian Doctors*, *supra* note 17 at para 497.

122. *Supra* note 16.

123. *Chaoulli v Quebec (Attorney General)*, 2005 SCC 35 [*Chaoulli*].

124. *Canada (Attorney General) v PHS Community Services Society*, 2011 SCC 44 [*PHS Community* or *Insite*].

125. *Canadian Doctors*, *supra* note 17 at paras 547-58.

126. *Irwin Toy Ltd v Quebec (Attorney General)*, [1989] 1 SCR 927 at 1003.

127. [1985] 1 SCR 177.

128. *Ibid* at 207. For other examples, see the discussion in Martha Jackman, *The Implications of Section 7 of the Charter for Health Care Spending in*

involved a challenge to the constitutionality of a differential funding scheme under Quebec's social assistance legislation, giving rise to the issue of whether section 7 guaranteed a minimal level of social assistance to safeguard the right to life or security of the person by providing for basic needs. In declining to recognize this claim on the facts before the Court, McLachlin CJC, writing for the majority, explicitly affirmed the broader possibility that section 7 could form the basis for a positive state duty to protect rights to life and security of the person.

As the Chief Justice noted, much of the prior jurisprudence had suggested that section 7 was only meant to guard against a deprivation of life, liberty, or security of the person that occurs as a result of a person's "interaction with the justice system and its administration."¹²⁹ But in McLachlin CJC's view, section 7 need not be applied in such narrow terms: "[a]n adjudicative context might be sufficient" to implicate section 7, she stated, but the Court had "not yet determined that one is necessary."¹³⁰ Even if section 7 does apply to cases where the administration of justice is not implicated, it would remain to be decided whether section 7 should protect *economic* rights essential for survival. Put otherwise, the Court would have to decide whether section 7 places a positive obligation on the state to "ensure that each person enjoys life, liberty or security of the person."¹³¹

The Chief Justice affirmed that it might, asserting that "[o]ne day s. 7 may be interpreted to include positive obligations."¹³² Invoking Lord Sankey's dicta in *Edwards v Attorney-General for Canada*,¹³³ she held that "the *Canadian Charter* must be viewed as 'a living tree capable of growth and expansion within its natural limits'."¹³⁴ The Chief Justice provided a first step in this direction by setting out a framework for assessing a claim for a breach of section 7 based on a positive state obligation to provide for

Canada (Ottawa: Commission on the Future of Health Care in Canada, 2002) at 5 [Jackman, *The Implications of Section 7*].

129. *New Brunswick (Minister of Health and Community Services) v G(J)*, [1999] 3 SCR 46 at para 65, cited in *Gosselin*, *supra* note 16 at para 77.

130. *Gosselin*, *ibid* at para 78.

131. *Ibid* at para 79.

132. *Ibid* at para 82.

133. [1930] AC 124 [*Edwards*].

134. *Gosselin*, *supra* note 16 at para 82, citing *Edwards*, *ibid* at 136.

some essential benefit. An applicant must demonstrate:

(1) that the legislation affects an interest protected by the right to life, liberty and security of the person within the meaning of s. 7; (2) that providing inadequate benefits constitutes a “deprivation” by the state; and (3) that, if deprivation of a right protected by s. 7 is established, this was not in accordance with the principles of fundamental justice.¹³⁵

Despite a powerful dissent by Arbour J, who was disposed to move in this direction in *Gosselin* itself (with L'Heureux-Dube J concurring), McLachlin CJC held that the facts in that case were not sufficient to meet the test she set out, but wrote:

I leave open the possibility that a positive obligation to sustain life, liberty, or security of the person may be made out *in special circumstances*. However, this is not such a case. The impugned program contained compensatory ‘workfare’ provisions and the evidence of actual hardship is wanting. The frail platform provided by the facts of this case cannot support the weight of a positive state obligation of citizen support.¹³⁶

The majority in *Gosselin* thus affirmed the possibility that the provision of inadequate benefits could constitute a *deprivation* under section 7 – and on this basis, section 7 could compel the state to provide an essential benefit.¹³⁷ But it would require “special circumstances” and “evidence

135. *Ibid* at para 75.

136. *Ibid* at para 83 [emphasis added].

137. In her dissenting opinion, Arbour J held that “every suitable approach to *Charter* interpretation, including textual analysis, purposive analysis, and contextual analysis, mandates the conclusion that the section 7 rights of life, liberty and security of the person include a positive dimension” at para 357. She thus read section 7 to include two distinct parts: “a free-standing right to life, liberty and security of the person” (at para 386) and a right not to be deprived of those rights except in accordance with the principles of fundamental justice. She also held, however, that where the state fails to fulfill its positive obligation to provide for life, liberty, or security of the person by inaction – rather than by a law or action that “curtails” one of these rights – it is not necessary to engage in an analysis of whether the state’s inaction was contrary to fundamental justice, but only to assess whether the violation could be justified under section 1. In this case, she found that “a minimum level of welfare is so closely connected to issues relating to one’s basic health (or security of the person), and potentially even to one’s survival (or life interest), that it appears inevitable that a positive right to life, liberty and security of the person must provide for it” at para 358. The violation could not be justified under section 1.

of actual hardship” compelling enough to support the obligation. The groundwork was therefore laid for the finding of a positive state duty under section 7, but significantly, what McLachlin CJC had in mind by the phrase “special circumstances” remained unclear. *Gosselin* invited future courts to entertain constitutional challenges to deprivations of coverage for essential services, but offered no guidance as to when the test of “special circumstances” is made out.

Despite this ambiguity at the core of *Gosselin*, later courts have moved slowly in the direction of fulfilling its promise. A number of cases have held that (a) state involvement that *hinders* access to healthcare engages section 7, (b) the hindrance amounts to a deprivation, and in some cases, (c) the deprivation is contrary to the principles of fundamental justice. However, in no case after *Gosselin* has a court held that a state refusal to *fund* a benefit constituted a deprivation under section 7 in a manner that is contrary to fundamental justice.¹³⁸ Yet, the case law suggests that this may be a small step from points reached thus far. The differences between the facts in those cases and the present case are important for assessing why this case might meet the *Gosselin* test.

For three members of the Supreme Court in *Chaoulli v Quebec (Attorney General)*¹³⁹ (including McLachlin CJC), the prohibition in Quebec’s *Hospital Insurance Act*¹⁴⁰ on access to private insurance for treating life-threatening illnesses had engaged section 7. Evidence had clearly demonstrated that long wait-times in the public system for critical treatment had placed the applicant’s life or security of the person in jeopardy.¹⁴¹ Finally, the deprivation was contrary to the principles of fundamental justice for being arbitrary. On the evidence, the prohibition on private insurance was not necessary for advancing the legislation’s primary objective of maintaining the quality of the publically funded

138. One exception to this is the trial decision in *Toussaint*, *supra* note 18 (explored in more detail below), in which the exclusion of coverage from the IFHP of a non-status migrant (*i.e.* a refusal to fund her) amounted to a deprivation under section 7; but the deprivation was held to be not contrary to the principles of fundamental justice.

139. *Supra* note 123.

140. CQLR c A-28.

141. *Supra* note 123 at paras 119, 123.

healthcare system. Notably, however, *Chaoulli* involved a law that served as a *barrier* to accessing private care. The present case, by contrast, turns on the validity of a refusal to continue *providing* a benefit.¹⁴²

In some respects, the Supreme Court's decision in *PHS Community*, involving the government's decision to close a safe-injection site for heroine addicts in Vancouver, offers a closer analogy to the facts in the present case.¹⁴³ Among the issues in that case was the validity under section 7 of a ministerial exercise of discretion under the *Controlled Drugs and Substances Act*¹⁴⁴ to exempt healthcare workers and users of the site from the law's criminal prohibition on the possession of controlled substances. The Applicants had argued that the federal Minister of Health's refusal to renew an existing exemption amounted to a violation of section 7, given the likely impact of the refusal on the medical condition of the program's clientele. The evidence had established that the program clearly had much success in saving lives and avoiding further harm to a vulnerable population. The refusal had engaged clients' rights under section 7 given that without the exemption, the *CDSA's* prohibition on possession hindered access to a form of assistance by healthcare professionals that reduced the risk of death or serious illness for those suffering from a drug addiction.¹⁴⁵ Writing for the Court, Chief Justice McLachlin invoked *Morgentaler*,¹⁴⁶ *Rodriguez*,¹⁴⁷ and *Chaoulli*¹⁴⁸ in affirming the proposition

142. The minority's approach to the constitutional protection of access to health care in primarily negative terms (a right not to be hindered from accessing care rather than a right to be provided a minimal level of care) has been the subject of extensive critical commentary. See e.g. Colleen M Flood, Kent Roach & Lorne Sossin, eds, *Access to Care: Access to Justice – The Legal Debate Over Private Health Insurance in Canada* (Toronto: University of Toronto Press, 2005); Jeff A King, "Constitutional Rights and Social Welfare: A Comment on the Canadian *Chaoulli* Health Care Decision" (2006) 69:4 Mod L Rev 631; Martha Jackman, "The Last Line of Defence for [Which?] Citizens': Accountability, Equality and the Right to Health in *Chaoulli*" (2006) 44:2 Osgoode Hall LJ 349.

143. *Supra* note 124.

144. SC 1996, c 19 [*CDSA*].

145. *Supra* note 124 at para 93.

146. *R v Morgentaler*, [1988] 1 SCR 30 [*Morgentaler*].

147. *Rodriguez v British Columbia (Attorney General)*, [1993] 3 SCR 519 [*Rodriguez*].

148. *Supra* note 123.

that “[w]here a law creates a risk to health by preventing access to health care, a deprivation of the right to security of the person is made out ... Where the law creates a risk not just to the health but also to the lives of the claimants, the deprivation is even clearer.”¹⁴⁹ The refusal to renew the exemption amounted to a deprivation, and one that was not in accordance with fundamental justice on the grounds that it was arbitrary, grossly disproportionate, and overbroad. It was arbitrary in part given the evidence that the site had saved lives and not increased crime, and the decision to refuse the exemption bore no relation to the CDSA’s objective of maintaining public health and safety.

As with the *Insite* case, the present challenge to the 2012 IFHP involves a decision to remove a benefit that results in adverse health consequences for those affected. A key difference is that in the *Insite* case, the Minister of Health decided to *exempt* the operation of a law (drug possession) rather than to *fund* a benefit (for example, the site itself). The question here is whether the refusal to fund refugee healthcare can be said to constitute a deprivation of life or security of the person on the basis that removing coverage is tantamount to depriving affected persons of access to care.

The Applicants argue that denying coverage amounts to “erecting a barrier to essential health services” since many if not most refugee claimants come to Canada in exigent circumstances, cannot afford to pay for care, and philanthropic funding may not be available consistently.¹⁵⁰ Denying coverage also entails a “deprivation” of security of the person comparable to the facts in *Chaoulli*, on the basis that at least one applicant is suffering from a potentially life-threatening illness (diabetes).¹⁵¹ On this reading, the first two stages in the *Gosselin* test would be made out.

The government, by contrast, argues that section 7 is not engaged because “it does not cause a deprivation of medical care, nor prevent or prohibit access to it.”¹⁵² Refugee claimants, failed claimants, and those ineligible for IFHP coverage can obtain care through other means

149. *PHS Community*, *supra* note 124 at para 93.

150. Applicants’ Memorandum, *supra* note 18 at para 75.

151. *Ibid.*

152. Respondents’ Memorandum, *supra* note 8 at para 101.

described above (community health centres, philanthropic programs, or emergency services at hospitals). On this view, migrants are deprived of healthcare only if clearly hindered by law or if removal of coverage has the effect of hindering access to *any* necessary care. The state has not deprived migrants of care because they still have *some* means of access. The Applicants' claim is, in the government's view, primarily economic. And, as the government contended, a wide range of authority holds that despite the possibility left open in *Gosselin*, courts have not recognized that section 7 imposes a positive obligation to provide a benefit necessary to protect life or security of the person – and have been especially reluctant to apply section 7 “when the benefit involves an economic component.”¹⁵³ Curiously, however, in *Canadian Doctors*, Mactavish J rejected the proposition that because migrants still had access to other avenues of care – community health centres, charity, emergency services – they were not *deprived* of care.¹⁵⁴ She also found that these other avenues are inadequate for a host of reasons, leaving at least some indigent migrants at risk of serious illness and in many cases “tremendous psychological strain.”¹⁵⁵ But she was reluctant to find that this deprivation of care endangering life and security of the person was therefore a possible deprivation of life and security of the person *under section 7*.

The Court in *Canadian Doctors* would have been justified in taking this further step on the basis that none of the authorities on which the government relies contemplate the guarantee of a *minimal* level of healthcare for a group analogous to refugees who come to Canada under exigent circumstances. The government's authorities for limiting section 7 to a negative duty can be distinguished into three categories of cases with each entailing a clearly different kind of claim from that in the present case. One consists of cases in which claimants have sought recognition of a social or economic right to social assistance or housing, with courts refusing to recognize a positive duty to provide a minimal level of social assistance.¹⁵⁶ A key factor here is that a minimal level of

153. *Ibid* at paras 102-03, citing *Masse, Flora, CCW, Sagarian, Wynberg, Grant*, and *Tanudjaja*, *supra* note 15; *Toussaint*, *supra* note 18.

154. *Canadian Doctors*, *supra* note 17 at paras 261-86.

155. *Ibid* at paras 285, 295-99.

156. See *e.g.* *Masse, Grant*, and *Tanudjaja*, *supra* note 15.

assistance is already available throughout Canada. In deciding not to recognize a section 7 claim in this context, courts are essentially resisting the invitation to set a *minimal* amount of assistance, given that a certain level of assistance is, for the foreseeable future, something close to a social and political certainty.

A second group contemplates coverage for prescriptions or treatment for autism and analogous conditions – matters impinging on security of the person but not life-threatening.¹⁵⁷ Finally, three cases that have the closest application (and are cited in *Canadian Doctors*) are ones in which applicants suffering life-threatening illnesses brought section 7 challenges to compel state funding.¹⁵⁸ However, the claimants in each of these cases are in distinctly different positions from those directly affected by changes to the IFHP. And the applicants in two of the cases were asking courts to recognize financial obligations on the part of the state of a different nature.

The first of these cases, *Toussaint v Attorney General of Canada*,¹⁵⁹ is significant because it involved a challenge under section 7 to the validity of the IFHP's exclusion from coverage (prior to 2012) of a foreign national who suffered a life-threatening illness. In contrast to the present case, Ms. Toussaint was a citizen of Grenada who visited Canada in 1999 and chose to outstay her visa, remaining illegally. From 1999 to 2006, she worked and could afford health care. At that point her health declined severely, preventing her from working and requiring greater care than she could afford. She received various treatments in hospital in 2007 and 2008, as her condition worsened, and she was unable to pay the bills she was incurring. In 2009, her condition, which included diabetes, a kidney disorder, and renal dysfunction, became life-threatening; yet she was able to obtain only emergency care and limited medication.¹⁶⁰ Justice Zinn

157. See *e.g. Auton* (a decision primarily concerning section 15, though a violation of section 7 was alleged and dismissed), *Wynberg*, and *Sagharian*, *supra* note 15.

158. *Flora* and *CCW*, *supra* note 15; *Toussaint*, *supra* note 18.

159. *Ibid.*

160. *Ibid* at para 91. On the urgency of the Applicant's condition, Zinn J cited affidavit evidence of a doctor for the finding that "[i]f she were to not receive timely and appropriate health care and medications in the future, she would be at very high risk of immediate death (due to recurrent blood

found that in light of the applicant's condition, the IFHP's exclusion of coverage to non-status aliens deprived her of the right to security of the person under section 7. But his Lordship refused to accept that the deprivation was contrary to fundamental justice.

The Federal Court of Appeal affirmed the decision but upheld the holding that the Appellant's exclusion from coverage amounted to a deprivation under section 7.¹⁶¹ On the question of whether the deprivation was in accordance with fundamental justice, the Court went a step further than Zinn J by suggesting that the operative cause of the deprivation was not the IFHP's exclusion, but rather, the limitation in Ontario's health insurance plan to non-status aliens, together with the Appellant's voluntary choice to remain in Canada without legal status.¹⁶² As Stratas JA asserted, the "provision of public health coverage and the regulation of access to it is primarily the responsibility of the provinces and the territories, with the federal government playing a role in funding, the setting of standards under the *Canada Health Act* ... and, occasionally, regulation in specific areas under its criminal law power."¹⁶³ If a deprivation under section 7 occurred here, it was because the provincial plan did not extend "far enough to cover all of her medical needs."¹⁶⁴ The Court also affirmed the lower court's finding that the IFHP's exclusion was not arbitrary, citing Zinn J's dicta from the decision below that there is:

... nothing arbitrary in denying financial coverage for health care to persons who have chosen to enter and remain in Canada illegally. To grant such coverage to those persons would make Canada a health-care safe-haven for all who require health care and health care services. There is nothing fundamentally

clots and pulmonary embolism), severe medium-term complications (such as kidney failure and subsequent requirement for dialysis), and other long-term complications of poorly-controlled diabetes and hypertension (such as blindness, foot ulcers, leg amputation, heart attack, and stroke)."

161. *Toussaint* Appeal, *supra* note 56 at para 61.

162. *Ibid* at para 72. On the requirement that the claimant establish that an impugned law is the operative cause of a deprivation under section 7, the Court cited *TrueHope Nutritional Support Limited v Canada (AG)*, 2011 FCA 114 at para 11.

163. *Toussaint* Appeal, *supra* note 56 at para 72.

164. *Ibid* at para 70.

unjust in refusing to create such a situation.¹⁶⁵

In distinction to *Toussaint*, however, the present case does not involve applicants who came to Canada in a fully voluntary sense or chose to remain without status. A more complex question is whether limits in provincial and territorial coverage are also the operative cause of a deprivation on the part of refugees covered under the pre-2012 IFHP.

On one reading, they are. As in *Toussaint*, any deprivation under section 7 that claimants in this case suffer is due primarily to the failure of provincial and territorial plans to make up the shortfall in coverage – on the assumption that provinces and territories bear primary responsibility for regulating access to and coverage of health care *for refugees*. But Stratas JA may have oversimplified the question of federal jurisdiction over health care, and of jurisdiction over refugee health in particular. Under section 95 of the *Constitution Act, 1867*,¹⁶⁶ immigration is a matter of concurrent jurisdiction, with the federal government having paramount authority in the event of a conflict.¹⁶⁷ Section 91(25) provides the federal government exclusive jurisdiction over “naturalization and aliens.”¹⁶⁸ However, in *Schneider v The Queen*,¹⁶⁹ the Supreme Court held that:

‘[H]ealth’ is not a matter which is subject to specific constitutional assignment but instead is an amorphous topic which can be addressed by valid federal or provincial legislation, depending on the circumstances of each case on the nature or scope of the health problem in question.¹⁷⁰

Sections 91(11) and 92(7) of the *Constitution Act, 1867*¹⁷¹ address the operation of quarantine and hospitals, but the Constitution is otherwise silent on the subject of healthcare. Provincial responsibility for the

165. *Ibid* at para 69; Stratas JA noted at para 71 that the “record reveals no attempt by the appellant to assert section 7 or 15 of the *Charter* against provincial legislation that limits her access to health care.”

166. (UK), 30 & 31 Vict, c 3, reprinted in RSC 1985, App II, No 5.

167. Nancy Miller Chenier, *Federal Responsibility for the Health Care of Specific Groups* (Ottawa: Parliamentary Information and Research Service, 2004) at 11.

168. *Ibid*.

169. [1982] 2 SCR 112.

170. *Ibid* at 142. See also Martha Jackman, “Constitutional Jurisdiction Over Health in Canada” (2000) 8 Health LJ 95 [Jackman, “Constitutional Jurisdiction Over Health”].

171. *Supra* note 166.

delivery of most health services is understood to derive from powers over property and civil rights in section 92(13) and matters of a merely local or private nature in section 92(16).¹⁷² The federal government's spending power over healthcare and criminal law power in matters impinging upon health are also well established.¹⁷³ A further potential source that may apply to refugee health is found at the outset of section 91, which provides Parliament the power to "make laws for the peace, order and good government of Canada, in relation to all matters not coming within the classes of subject by this Act assigned exclusively to the legislatures of the provinces."¹⁷⁴ The Supreme Court has held that the POGG power is available where a matter not addressed elsewhere in the division of powers is a matter of national concern, is "singular" or "indivisible" in nature, and is not amenable to being addressed in a more efficient manner by the provinces individually.¹⁷⁵ If refugee health care falls within the purview of the federal government, then by contrast to Stratas JA's holding in *Toussaint*, changes to the IFHP would serve as a more direct and thus operative cause of a deprivation of security of the person for the individual applicants in this case.

In the second case, *Flora v Ontario Health Insurance Plan*,¹⁷⁶ the appellant was diagnosed with liver cancer but found ineligible for a liver transplant in Ontario under a set of criteria commonly applied by doctors throughout the province, given the size and number of tumors in his liver. He then sought and obtained a transplant in England where the criteria for such a procedure were more generous. The transplant saved his life, but cost \$450,000. He applied under the Ontario Health Insurance Plan (OHIP) for reimbursement and was declined. The Health

172. Martha Butler & Marlisa Tiedemann, *The Federal Role in Health and Health Care* (Ottawa: Parliamentary Information and Research Service, 2011) at 1.

173. *Ibid* at 2-3. See also *Eldridge v British Columbia (Attorney General)*, [1997] 3 SCR 624 at para 15 [*Eldridge*]; *Reference Re Canada Assistance Plan (BC)*, [1991] 2 SCR 525 at 567; Jackman, "Constitutional Jurisdiction Over Health", *supra* note 170 at 97.

174. *Constitution Act, 1867*, *supra* note 166.

175. *R v Crown Zellerbach*, [1988] 1 SCR 401 at 431-32; Butler & Tiedemann, *supra* note 172 at 4.

176. *Supra* note 15.

Services Appeal and Review Board upheld the decision on the basis that the treatment did not meet the criteria for “insured service” under section 28.4(2) of Regulation 552 of the *Health Insurance Act*,¹⁷⁷ because the transplant was not “generally accepted in Ontario as appropriate for a person in the same medical circumstances.”¹⁷⁸ The Ontario Superior Court of Justice dismissed an appeal of this decision, and the dismissal was upheld by the Court of Appeal.¹⁷⁹

Before the latter Court, Flora had noted that an earlier version of the regulation had allowed funding for his treatment on the basis of “medical necessity” rather than what was “generally accepted” as “appropriate.” Flora argued that the amended law allowing for discretionary coverage violated section 7 because denying him coverage deprived him of access to life-saving treatment. He also argued more generally that “s. 7 imposes a positive obligation on the state to provide life-saving medical treatments, thus obviating the need for a finding of state action amounting to deprivation.”¹⁸⁰ Justice Cronk, on behalf of a unanimous Court of Appeal, held that Flora had “failed to demonstrate that the Regulation constituted a deprivation by the state of his rights to life or security of the person.”¹⁸¹

The Court arrived at this conclusion by distinguishing the facts from those in *Chaoulli*,¹⁸² *Morgentaler*,¹⁸³ and *Rodriguez*.¹⁸⁴ In each of those cases, the impugned provision placed the appellant in a situation in which his or her life or security of the person was affected or threatened: in *Morgentaler*, the mandatory therapeutic abortion committee system had this effect; in *Rodriguez*, the criminal prohibition on assisted suicide did so; and in *Chaoulli*, the prohibition on private healthcare forced people in critical condition onto waitlists.¹⁸⁵ By contrast, the regulation in *Flora* “does not prohibit or impede anyone from seeking

177. Regulation 552, *supra* note 58.

178. *Ibid*, s 28.4(2).

179. *Flora*, *supra* note 15.

180. *Ibid* at para 93.

181. *Ibid* at para 95.

182. *Supra* note 123.

183. *Supra* note 146.

184. *Supra* note 147.

185. *Flora*, *supra* note 15 at paras 98-100.

medical treatment” or limit the kind of treatment available.¹⁸⁶ It provides for coverage of some out-of-country treatments, but does not violate section 7 for its failure to cover *all* of them. On the question of a broader positive duty under section 7, Cronk JA cited McLachlin CJC’s dicta in *Gosselin*, and conceded that “s. 7 may one day be interpreted to include positive obligations in special circumstances where, at a minimum, the evidentiary record discloses actual hardship.”¹⁸⁷ But to this point, he noted, “the protection afforded by s. 7... has not been extended to cases – like this one – involving solely economic rights.”¹⁸⁸ Thus, in this case, absent evidence of “actual hardship,” or a loss of coverage that actually threatens a person’s life or security of the person, the claim was perceived to be “solely economic.” In distinction to this case, however, refugees or rejected claimants denied coverage under the IFHP do face actual hardship given the special circumstances that bring them to Canada (duress, endangerment, and persecution), their inability to pay, and a critical medical condition.

A third relevant case is *CCW v Ontario Health Insurance Plan*,¹⁸⁹ in which the three appellants had been denied coverage for out-of-country treatment due to a failure to obtain prior approval from the General Manager of the Ontario Hospital Insurance Plan. The appellants argued, *inter alia*, that the requirement of prior approval amounted to a deprivation of the right to life or security of the person under section 7. They also sought to draw an analogy between the requirement for prior approval and the prohibition on private health insurance in *Chaoulli*. Both required patients to wait for treatment in the public system, joining lengthy queues that created life-threatening conditions. At least one appellant in *CCW* risked serious injury or death if he did not leave Canada to seek treatment immediately, and could not obtain prior approval for coverage given his lack of timely access to his doctor.

Justice Swinton dispensed with the section 7 claim by citing *Flora* for the proposition that there is no deprivation under section 7 because of

186. *Ibid* at para 101.

187. *Ibid* at para 105.

188. *Ibid* at para 106.

189. *Supra* note 15.

the province's decision to limit funding in ways that do not hinder access or limit forms of treatment to which one has access. Nor does the law, at present, impose a positive obligation on the state to provide a "financial benefit that is not otherwise required by law"¹⁹⁰ – or, as Cronk JA held in *Flora*, not in the absence of evidence of "actual hardship."¹⁹¹ This case was also unlike *Morgentaler* or *Chaoulli* where the legislative regime at issue prevented a person from obtaining necessary treatment. Here, as Swinton J noted, there was "no evidence that the appellants suffered a delay in obtaining necessary medical services because of the legislation."¹⁹²

As with *Flora*, *CCW* can be distinguished from the present case by an absence of "actual hardship" that can be tied directly to the legislative provision. The denial of coverage in this case results in a financial hardship. But for the Applicants challenging the IFHP regime, the denial of coverage is a direct cause of the threat to life or security of the person. It serves as a direct cause in a way that has no direct analogy in these or any of the other cases on which the government seeks to rely. In distinction to the "minimal level of basic service" cases, the Applicants might have access to no alternate coverage – aside from emergency coverage at hospitals. This would mean that a person's right to life is not infringed under section 7, but the limitation of coverage to this level still leaves the question of whether a person is deprived of security of the person for suffering a serious or life-threatening illness and having to wait for a visit to the emergency ward to receive treatment. Moreover, unlike *Flora*, *CCW*, and other OHIP cases in which section 7 has been invoked, in the case of refugee claimants the issue is not strictly monetary. Their situation cannot be reduced to a strict inability to pay. It is an inability that flows from a position *as a refugee* or a person *in need of protection*. These may constitute the "special circumstances" contemplated in *Gosselin* by virtue of meeting the standard of "actual hardship" articulated in that case.

B. Principles of Fundamental Justice

If revisions to the IFHP result in a deprivation of life or security of the

190. *Ibid* at paras 98-100.

191. *Supra* note 15 at para 105.

192. *CCW*, *supra* note 15 at para 101.

person under section 7, the application must also meet the third part of the test in *Gosselin*: establishing that rights were deprived in a manner contrary to the principles of fundamental justice. Two principles on which the appellant seeks to rely are arbitrariness and gross disproportionality.

Writing for a minority in *Chaoulli*,¹⁹³ McLachlin CJC and Major J offered a definition of arbitrariness in the context of section 7 that has been cited approvingly by the Court in later decisions:

In order not to be arbitrary, the limit on life, liberty and security requires not only a theoretical connection between the limit and the legislative goal, but a real connection on the facts ... The question in every case is whether the measure is arbitrary in the sense of bearing no real relation to the goal and hence being manifestly unfair. The more serious the impingement on the person's liberty and security, the more clear must be the connection. Where the individual's very life may be at stake, the reasonable person would expect a clear connection, in theory and in fact, between the measure that puts life at risk and the legislative goals.¹⁹⁴

Chief Justice McLachlin defined gross-disproportionality in the *Insite* decision in terms of “state actions or legislative responses to a problem that are so extreme as to be disproportionate to any legitimate government interest.”¹⁹⁵

The Applicants in the IFHP challenge contend that the 2012 changes were both arbitrary and grossly disproportionate in light of the objectives of the new plan set out in a press release issued at the time the changes were announced.¹⁹⁶ One objective was “fairness to Canadians,” or to put in place a scheme that provided no greater benefits to refugee claimants than those available to most Canadians. It was assumed to be superior in the sense of providing limited dental and eye care benefits, which are not commonly included in provincial and territorial plans for citizens and residents. However, the same coverage is extended to those on social assistance in most provinces and to those eligible under Quebec's provincial plan – and this group is a more appropriate comparator to

193. *Supra* note 123.

194. *Ibid* at para 131, cited in *AC v Manitoba (Director of Child and Family Services)*, 2009 SCC 30, and *PHS Community*, *supra* note 124.

195. *Ibid* at para 133.

196. Applicants' Memorandum, *supra* note 18 at para 88.

refugees.¹⁹⁷ And thus, if it is not correct to assume that the earlier IFHP offered *superior* coverage to what is available to other Canadians, the Applicants argue that it is arbitrary to deprive persons of a right to life or security of the person on this ground. They also argue that denying coverage is arbitrary because the new plan does not equalize coverage in the name of fairness but removes it altogether (for certain classes of non-citizen).¹⁹⁸ These arguments are consistent with Mactavish J's analysis of the government's objectives under section 1 (explored further below), in which she dismissed the notion that the pre-2012 IFHP entailed an unfairness in coverage between migrants and working Canadians.¹⁹⁹

A second objective of the revised IFHP was to remove an incentive for foreigners who may come to Canada in bad faith or who intend to remain in Canada after a failed refugee claim. Yet, as the Applicants note, the government has offered no support for the proposition that withdrawing coverage from certain groups would deter fraudulent claims.²⁰⁰ In her section 1 analysis, Mactavish J agreed with this, asserting that the "deterrence argument is founded to a large extent on a subjective perception held by unidentified individuals."²⁰¹ It is also grossly disproportionate in the sense that by changing the plan and withholding health care coverage from one refugee claimant so as to deter another amounts to "a particularly egregious instance of treating a human being instrumentally as merely a means to an end."²⁰²

A further objective was cost savings, but the Applicants argue that the cost implications of the program render the changes to the IFHP both arbitrary and grossly disproportionate in relation to this stated goal. The Applicants tendered affidavit evidence from various stakeholders in support of the claim that "hospitals, clinics and even health practitioners have largely been forced to absorb the cost of treating refugees where the patients could not pay or fundraising came up short."²⁰³ The

197. *Ibid* at para 159.

198. *Ibid* at para 91.

199. *Canadian Doctors, supra* note 17 at paras 946-47.

200. Applicants' Memorandum, *supra* note 18 at para 92.

201. *Canadian Doctors, supra* note 17 at para 1019.

202. Applicants' Memorandum, *supra* note 18 at para 93.

203. *Ibid* at para 95.

changes affect cost transfers, but not cost savings. They are also grossly disproportionate in the sense that government estimates indicate that the per capita cost of the IFHP was \$552 or roughly 10 percent of the per capita cost for health care for Canadians, or 60 cents per taxpayer per year.²⁰⁴ As the Applicants contend, “the IFHP spent little on each recipient, but delivered crucial, life sustaining benefits.”²⁰⁵ Assessing this issue under the minimal impairment component of section 1, Mactavish J had found that there was “no reliable evidence” before the Court “of the extent to which the 2012 changes to the IFHP will, on their own, result in cost savings at the federal level.”²⁰⁶

A final objective was that the changes were meant to “safeguard public health and safety.”²⁰⁷ But given the reduced scope of health coverage for many groups that may carry a wide range of illnesses, including mental illnesses, this goal would seem to be undermined by the changes rather than supported. Moreover, operational changes to the administration of the IFHP may lead to delays in providing eligibility certificates to new arrivals who may have communicable diseases, thus reducing public safety.²⁰⁸ In her treatment of this issue under section 1, Mactavish J concurred: deterring DCO migrants from seeking or obtaining healthcare, she found, “potentially jeopardize[s] public health.”²⁰⁹

The Applicants also argue that the possibility of discretionary relief under the plan – a possibility preserved in the 2012 IFHP – does not rectify the deprivation of rights explored earlier. First, the discretion to raise a person's status from the third or fourth to the second tier would still leave him or her without coverage for essential medication for any condition that is non-communicable.²¹⁰ More to the point, discretion is practically moot given that in many cases, care is needed urgently and discretionary coverage is time consuming and involves a bureaucratic

204. *Ibid.*

205. *Ibid.*

206. *Canadian Doctors*, *supra* note 17 at para 1012.

207. Backgrounder to the *Order Respecting the Interim Federal Health Program, 2012*, *supra* note 106.

208. Applicants' Memorandum, *supra* note 18 at para 97.

209. *Canadian Doctors*, *supra* note 17 at para 954.

210. Applicants' Memorandum, *supra* note 18 at para 99.

process that is “opaque, unpublicized, [and] paper-driven.”²¹¹

In summary, we have argued in this part of the paper that the facts in the current challenge to the revised IFHP render this case better suited than any earlier jurisprudence to the *Gosselin* test for a positive state duty under the *Charter*. But we note that the *Gosselin* test runs counter to a considerable body of *Charter* case law – both before and since *Gosselin* – reflecting a deep resistance to a positive interpretation of rights. As Martha Jackman writes:

Since the inception of the *Charter*, judges in Canada have, with rare exceptions, adopted a deferential, negative rights based approach to socio-economic rights, including the right to health care. In clear contradiction of Canada’s obligations under the *International Covenant on Economic, Social and Cultural Rights* and other international human rights treaties, they have frequently held that governments have no affirmative duty to ensure that individuals, particularly those who are members of socially or economically disadvantaged groups, do in fact have the means to enjoy *Charter* rights to life, liberty, security of the person and equality.²¹²

This tendency may well extend to the final disposition in the present case. We anticipate that at the Federal Court of Appeal, there will be a strong impetus to apply the law on section 7 as presently configured, limiting its application to instances where access to health care is hindered (rather than where coverage is not provided). In one sense, this would be a simple function of *stare decisis*.²¹³ But it would also reflect a lack

211. *Ibid.* As the Applicants note, as of September 2013, no information had been published about how to apply for discretionary coverage, what criteria would be used to assess the application, and no reasons were required for a decision. The Applicants draw an apt comparison here between discretionary coverage under the IFHP and the hospital committee process for approving access to abortions under the *Criminal Code* regime challenged in *Morgentaler*, *supra* note 146. The Supreme Court in that case held, at 72, that the scheme was “manifestly unfair” in relation to the stated objective of the legislation (providing a “procedural structure for bringing into operation a particular defence to criminal liability”).

212. Martha Jackman, “Charter Review As a Health Care Accountability Mechanism in Canada” (2010) 18 Health LJ at 27.

213. In *Tanudjaja v Attorney General (Canada) (Application)*, *supra* note 15, the Ontario Superior Court summarily dismissed a claim under section 7 of a positive state duty for housing benefits primarily on the basis of the weight of authority against such an application of the *Charter*.

of clarity as to how lower courts should apply the test contemplated in *Gosselin*. In the absence of greater clarity as to when a case meets the test of “special circumstances” that merit a finding of a positive state duty under section 7, as McLachlin CJC had contemplated, the question may need to return to the Supreme Court of Canada for further clarification.

C. Section 12

Section 12 of the *Charter* states that “everyone has the right not to be subjected to any cruel and unusual treatment or punishment.”²¹⁴ The Applicants in *Canadian Doctors* argued that the changes to the IFHP resulted in a denial of “life sustaining health care” that constituted a form of “cruel and unusual treatment” under section 12. The government submitted that while the IFHP may provide for healthcare “treatment,” migrants were not “subjected” to the program and section 12 is concerned only with “mandatory matters imposed by the state.”²¹⁵ The government also argued that the IFHP “does not prevent anyone from obtaining medical care: rather it offers and funds some health services for eligible beneficiaries, who can access them if they choose, at state expense.”²¹⁶

Justice Mactavish began by noting that most section 12 jurisprudence concerned punishment rather than treatment, with limited authority as to the scope of “treatment” for the purposes of that section.²¹⁷ But as Mactavish J noted, the Supreme Court in *Rodriguez*²¹⁸ affirmed the possibility that “treatment” could include “that imposed by the state in contexts other than that of a penal or quasi-penal nature.”²¹⁹ In considering the meaning of “treatment” under section 12 in a challenge to section 241(b) of the *Criminal Code*, which prohibits “assisted suicide,”²²⁰ Sopinka J, for the majority in *Rodriguez*, held:

There must be some more active state process in operation, involving an exercise of state control over the individual, in order for the state action in

214. *Supra* note 14.

215. *Canadian Doctors*, *supra* note 17 at para 574.

216. *Ibid.*

217. *Ibid* at para 578.

218. *Supra* note 147.

219. *Ibid* at para 182.

220. *Ibid.*

question, whether it be positive action, inaction or prohibition, to constitute “treatment” under s. 12.²²¹

Drawing on this interpretation, Mactavish J held that while refugee claimants are in a distinct situation from that of Ms. Rodriguez, in seeking Canada’s protection, claimants are “effectively under the administrative control of the state.”²²² Their “rights and opportunities” can be “limited in a number of different ways” including their entitlement to benefits and their claims for protection.²²³ A further relevant distinction here was the fact that whereas Ms. Rodriguez had been subject to a law of general application, the decision to amend the IFHP “intentionally targeted an admittedly vulnerable, poor and disadvantaged group for adverse treatment ... for the express purpose of inflicting predictable and preventable physical and psychological suffering.”²²⁴ The government’s actions in both respects brought the IFHP changes within the scope of the word “treatment” for the purposes of section 12.

In *R v Smith*,²²⁵ the Supreme Court held that treatment or punishment will be found to be “cruel and unusual” under section 12 if it is “so excessive as to outrage [our] standards of decency.”²²⁶ Among the factors to be considered are whether treatment exceeds what is necessary to achieve a legitimate purpose, whether there are adequate alternatives, whether it accords with public standards, whether it shocks the general conscience, and whether it is “unusually severe and hence degrading to human dignity and worth.”²²⁷

When applying the factors to this case, Mactavish J found that the amendments to the IFHP have not “achieved a legitimate aim.”²²⁸

221. *Ibid.*

222. *Canadian Doctors*, *supra* note 17 at para 585.

223. *Ibid.* Justice Mactavish noted that recognizing “treatment” as the government decisions to withhold social benefits from migrants was consistent with foreign jurisprudence, including *R v Secretary of State for the Home Department, ex parte Adam*; *R v Secretary of State for the Home Department ex parte Limbuela*; *R v Secretary of State for the Home Department ex parte Tesema (Conjoined Appeals)* [2005] UKHL 66.

224. *Canadian Doctors*, *supra* note 17 at para 587.

225. [1987] 1 SCR 1045.

226. *Ibid* at para 83.

227. *Ibid* at para 44.

228. *Canadian Doctors*, *supra* note 17 at para 617.

There was not enough evidence to prove that the changes have deterred illegitimate claims or reduced the costs of the program.²²⁹ They are also “arbitrary,”²³⁰ “have limited social value,”²³¹ are highly criticized by key stakeholders including provincial governments, medical associations and non-governmental organizations,²³² and therefore do not “accord with public standards of decency and propriety.”²³³ Significantly, Mactavish J found that there was “substantial evidence ... not just of philosophical differences with a government policy choice, but of real outrage on the part of informed, affected individuals and groups at what has been done through the 2012 changes to the IFHP.”²³⁴ The effects were “especially evident insofar as they affect children.”²³⁵ Citing numerous examples given in evidence of cases in which children suffering from serious conditions including pneumonia, asthma, and suicidal depression were denied care, she held that the amendments to the IFHP “potentially jeopardize the health, and indeed the very lives, of these innocent and vulnerable children in a manner that shocks the conscience and outrages our standards of decency.”²³⁶

Finding a violation of section 12 on the basis of administrative control amounting to cruel treatment, Mactavish J offered a novel basis on which to capture the violation of dignity and humanity in this case. Notably, it did so in a manner that avoided the thornier debate about whether the *Charter* imposes a positive duty on the part of the state to provide a social benefit. And given the extensive factual findings supporting her application of the test in *Smith*, the holding on section 12 – at least with respect to the issue of cruelty – would appear to be on firm evidentiary ground.

229. *Ibid.*

230. *Ibid* at para 618.

231. *Ibid* at para 620.

232. *Ibid* at para 624.

233. *Ibid* at para 635.

234. *Ibid.*

235. *Ibid* at para 637.

236. *Ibid* at para 691.

D. Section 15

Section 15(1) of the *Charter* states that “[e]very individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age, mental or physical disability.”²³⁷ Section 15(2) qualifies this by stating: “[s]ubsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.”²³⁸

The Applicants in this case argued that the changes to the IFHP have created a “health care hierarchy.”²³⁹ Contrary to section 15, the 2012 IFHP discriminates on the basis of (a) national or ethnic origin and (b) immigration status.²⁴⁰ It does so on the basis of national or ethnic origin by providing a lower level of health care insurance to refugee claimants from DCO countries versus those from non-DCO countries.²⁴¹ And it does so on the basis of immigration status by offering certain migrants lesser coverage than those of immigrants or Canadians. For example, both individual Applicants, Ayubi and Rodriques, were denied similar coverage afforded to other migrants and Canadians, despite having obtained legal status.²⁴²

In response, the government argued that any discriminatory effect of the cuts was based not on the IFHP but on distinctions among categories of migrants in the *Immigration and Refugee Protection Act*, including those from Designated Countries of Origin.²⁴³ The government also pointed to earlier jurisprudence in which courts have rejected the argument that “immigration status” is an analogous ground under section 15 of the

237. *Supra* note 14.

238. *Ibid.*, s 15(2).

239. *Canadian Doctors*, *supra* note 17 at para 694; Applicants’ Memorandum, *supra* note 18 at para 64.

240. *Canadian Doctors*, *supra* note 17 at para 696.

241. *Ibid.*

242. *Ibid.*

243. *Ibid.* at para 699.

Charter.²⁴⁴ Moreover, the government submitted, the “right to state-funded health care”²⁴⁵ is not accessible to all Canadians equally.²⁴⁶

In *R v Kapp*²⁴⁷ the Supreme Court held that the purpose of subsection 15(1) of the *Charter* is:

[P]reventing governments from making distinctions based on the enumerated or analogous grounds that: have the effect of perpetuating group disadvantage and prejudice; or impose disadvantage on the basis of stereotyping.²⁴⁸

In *Quebec (AG) v A*,²⁴⁹ the Supreme Court set out a two-part test for establishing a section 15 violation. Challengers must show that

- i. the law creates a distinction based on an enumerated or analogous ground, and
- ii. the distinction creates a disadvantage by perpetuating prejudice or stereotyping.²⁵⁰

The analysis underlying the test considers whether the state action has a “discriminatory impact”²⁵¹ and whether “the state conduct widens the gap between the historically disadvantaged group and the rest of society, rather than narrowing it.”²⁵²

Justice Mactavish dismissed the claim that the revised IFHP discriminated on the basis of immigration status, but held that it did violate section 15(1) on the basis of national origin.²⁵³ The IFHP drew a distinction between refugee claimants from DCO countries and those from other countries, limiting the former to “Public Health or Public Safety (PHPS) benefits.”²⁵⁴ Her analysis relied in part on *Eldridge v British Columbia (Attorney General)*,²⁵⁵ in which the Supreme Court held that the state does not have to provide any particular social benefit; but if a

244. *Ibid* at para 702.

245. *Ibid* at para 703.

246. *Ibid*.

247. 2008 SCC 41 [emphasis removed].

248. *Ibid* at para 25.

249. 2013 SCC 5.

250. *Ibid* at para 162.

251. *Ibid* at para 332.

252. *Ibid*.

253. *Canadian Doctors*, *supra* note 17 at para 696.

254. *Ibid* at para 735.

255. *Supra* note 173.

government chooses to provide a benefit, “it is obliged to do so in a non-discriminatory manner.”²⁵⁶ The Court in *Eldridge* further reasoned that “in many circumstances, this will require governments to take positive action, for example by extending the scope of a benefit to a previously excluded class of persons.”²⁵⁷

Justice Mactavish also dismissed the government’s argument that the “IFHP is an ameliorative program directed at improving the situation of groups that are in need of assistance in order to enhance substantive equality.”²⁵⁸ The government had contended that the purpose of the distinctions drawn by the 2012 IFHP were in part to assist refugee claimants by allocating more funding to migrants whose claims have longer processing times and therefore stay in Canada for longer periods.²⁵⁹ The government relied on this approach to section 15(2) in *Alberta (Aboriginal Affairs and Northern Development) v Cunningham*,²⁶⁰ in which the Supreme Court held that “[a]meliorative programs, by their nature, confer benefits on one group that are not conferred on others.”²⁶¹ There will not be a violation of subsection 1(2) “if they serve or advance the object of the program, thus promoting substantive equality.”²⁶² But Mactavish J rejected the claim that increasing processing times for some migrants would advance the goal of substantive equality – since shorter processing times for refugee claimants from DCO countries will entail inequalities in health coverage and other discriminatory effects.²⁶³ As Mactavish J noted, “[i]t does not follow that a refugee claimant from Mexico (a DCO country) who arrives in Canada about to give birth necessarily requires less health care than does a pregnant refugee claimant who has to come to Canada from Sri Lanka (a non-DCO country).”²⁶⁴

By drawing a distinction between the level of health care insurance coverage provided to DCO countries versus non-DCO countries,

256. *Ibid* at para 73.

257. *Ibid*.

258. *Canadian Doctors*, *supra* note 17 at para 779.

259. *Ibid* at para 780.

260. 2011 SCC 37.

261. *Ibid* at para 53.

262. *Ibid*.

263. *Canadian Doctors*, *supra* note 17 at para 796.

264. *Ibid* at para 804.

the 2012 IFHP was also found to perpetuate a prejudice in the form of depriving coverage from seriously ill claimants,²⁶⁵ and it was found that the discrimination against DCO claimants “perpetuates negative attitudes about them.”²⁶⁶ The denial of health insurance coverage continues to enhance the marginalization faced by refugee claimants from DCO countries such as the Roma from Hungary and the LGBTQ communities in Mexico.²⁶⁷

E. Section 1

In light of the finding that changes to the IFHP violate sections 12 and 15 of the *Charter*, the Court in *Canadian Doctors* had to assess whether the violation constitutes a reasonable limit on the rights in accordance with section 1 of the *Charter*. To meet this test, the government had the onus of establishing, first, that the impugned measure has a pressing and substantial objective, and second, that it meets a general proportionality test.²⁶⁸ At this second stage, the court must assess whether the objective bears a rational connection to the chosen measure, whether the measure minimally impairs the violated rights, and whether the deleterious effects of the program are proportionate to its salutary objectives, thus justifying the limit on the rights in question.²⁶⁹ If appellate courts uphold the findings that *Charter* rights have been violated in this case, Mactavish J's factual findings supporting her analysis under section 1 will be relevant on appeal.

Justice Mactavish identified the objectives of the revised 2012 IFHP by citing a press release accompanying the announcement of the changes in April of 2012.²⁷⁰ These included “cost containment,” “fairness to Canadian taxpayers,” “the protection of public health and safety,” and the need to defend the “integrity of Canada's immigration system.”²⁷¹ Citing the Supreme Court's decision in *Newfoundland (Treasury Board)*

265. *Ibid* at para 813.

266. *Ibid* at para 830.

267. *Ibid* at para 837.

268. *R v Oakes*, [1986] 1 SCR 103 at 138-39.

269. *Ibid* at 139.

270. *Canadian Doctors*, *supra* note 17 at para 892.

271. *Ibid*.

v NAPE,²⁷² Mactavish J noted that while cost alone would not ordinarily constitute a pressing and substantive objective, it may when “wrapped up with other public policy considerations,”²⁷³ as was the case here. She found that “fairness to Canadians” might also have constituted a pressing and substantial objective, but found that a lack of fairness to Canadians with respect to the pre-2012 IFHP had not been established.²⁷⁴ It was implausible, in her view, to suggest that the earlier framework was unfair to working Canadians because migrants under that framework had received benefits such as eye and dental care that were only available to Canadians on social assistance. Given their indigent status and precarious position as refugees or migrants, and their willingness to abide by immigration and refugee laws, the provision of benefits to these individuals was not unfair.²⁷⁵ Protecting public health and safety was found to be a pressing and substantial objective, and in light of evidence of abuse of the refugee system, so too was the goal of protecting the integrity of Canada’s immigration system.²⁷⁶

Moving to the rational connection test, Mactavish J agreed there was a reasonable connection between the withdrawal of coverage to certain classes of migrants under the new framework and the goal of reducing costs to the program.²⁷⁷ But given her earlier finding of a lack of unfairness to Canadians in the earlier coverage under the program, she found no rational connection between the removal of coverage and the goal of addressing the alleged unfairness. As she put it, Canadians are “not treated any more fairly because refugee claimants from DCO countries, and failed refugee claimants who are still in compliance with Canadian immigration and refugee laws, are now denied any health insurance coverage whatsoever.”²⁷⁸ She also found that although aspects of the new scheme bore a rational connection to the goal of protecting public health and safety, removing all coverage from persons in the

272. 2004 SCC 66.

273. *Canadian Doctors*, *supra* note 17 at para 909, citing *ibid* at para 69.

274. *Ibid* at para 912.

275. *Ibid* at paras 913-21.

276. *Ibid* at paras 929-32.

277. *Ibid* at para 945.

278. *Ibid* at para 949.

fourth tier – including coverage for conditions that pose a risk to public health and safety – removed any rational connection to the stated goal with respect to this aspect of the plan.²⁷⁹ Finally, Mactavish J refused to recognize a rational connection between the new plan and the goal of protecting the integrity of the immigration system by virtue of the lack of evidence that changes to coverage remove a material incentive to illegitimate claimants or that the changes will encourage the quicker departure of failed claimants.²⁸⁰

Given her finding that the objectives of fairness to Canadians and protecting public health and safety were not substantial and not rationally connected to the IFHP in at least one case, Mactavish J found that the revised plan also failed the minimal impairment test in those respects.²⁸¹ However, she also found that it failed the minimal impairment test in seeking to advance the goals of cost containment and protecting the integrity of the immigration system. Although she accepted the government's evidence that changes to the plan would result in the "substantial" savings of \$70 million in the first three years of the new program and \$15 million each year after that, it was not clear that "the anticipated reduction in program spending is entirely, or even primarily, attributable to the 2012 changes to the IFHP."²⁸² In light of the fact that other recent legislation including the *Balanced Refugee Reform Act*,²⁸³ the *Protecting Canada's Immigration System Act*,²⁸⁴ and the *Faster Removal of Foreign Criminals Act*,²⁸⁵ have helped speed up the refugee determination process and deterred abuse of the system, the government had failed to prove what cost savings were due to the IFHP changes in particular. She concluded on this point that there was "no reliable evidence before this Court of the extent to which the 2012 changes to the IFHP will, on their own, result in cost savings at the federal level."²⁸⁶ But even if there were

279. *Ibid* at para 962.

280. *Ibid* at paras 964-70.

281. *Ibid* at para 994.

282. *Ibid* at para 999.

283. SC 2010, c 8.

284. SC 2012, c 17.

285. SC 2013, c 16.

286. *Canadian Doctors*, *supra* note 17 at para 1012.

such evidence, it would be necessary to establish that those savings could not have been obtained in a less infringing manner.²⁸⁷ The Applicants, however, were able to point to at least two less infringing measures that helped save costs in a “real and substantial manner” – the recent return to a full complement of adjudicators at the Immigration and Refugee Board, and carrying out speedier removals once claims are rejected, both resulting in shorter eligibility periods under the IFHP.²⁸⁸ Finally, given her finding that the government had failed to establish that the 2012 changes had removed an incentive for persons from Designated Countries of Origin to make illegitimate claims, and that this very assumption was based on subjective “perceptions” and “beliefs,” Mactavish J held that the government had not met the burden of proving that there were no less infringing ways of protecting the integrity of the immigration system.²⁸⁹

Justice Mactavish then considered whether the 2012 changes to the IFHP were proportionate in their deleterious effects to the program’s salutary goals, and whether attaining these goals outweighed the breach of the rights at issue.²⁹⁰ She made the significant findings that the revised IFHP was “causing significant suffering to an already vulnerable, poor and disadvantaged population,” and that the changes are “causing illness, disability, and death.”²⁹¹ The effects are both serious in terms of their quality and quantity, being felt “by a significant number of individuals, given the thousands of people who come to the country each year, seeking its protection.”²⁹² The salutary objectives of the IFHP do not outweigh its deleterious effects for various reasons.²⁹³ Removing coverage from those seeking a PRRA and who might pose a risk to public health or safety did nothing to advance the goal of protecting public health. Given that the earlier plan was not unfair to Canadians, the objective of being fairer to Canadians could not be said to outweigh the deleterious effects of the new plan. With no clear indication of how much money the program is

287. *Ibid* at para 1013.

288. *Ibid* at paras 1014-15.

289. *Ibid* at paras 1018-27.

290. *Ibid* at para 1044.

291. *Ibid* at paras 1048-49.

292. *Ibid* at para 1050.

293. *Ibid* at paras 1052-74.

saving the federal government – and the fact that there is still a “real cost to Canadian taxpayers to providing [various] alternative forms of health care” to which migrants are forced to turn, it is also not possible to say that cost of benefits outweigh the deleterious effects.²⁹⁴ Finally, lacking evidence that health coverage was a source of abuse of the system on the part of claimants from Designated Countries of Origin, it was not clear that the integrity objective outweighed the suffering of migrants deprived of benefits. The revised IFHP had failed to be justified under section 1 and was therefore not a reasonable limit on sections 12 and 15 in this case.²⁹⁵

F. International Humanitarian Law and Norms

The current challenge to the constitutional validity of the 2012 changes to the IFHP also involves a consideration of Canada's commitments under international human rights law. As Martha Jackman has noted, although Canada has ratified various treaties containing health-related protections, these have not been explicitly recognized in Canadian law and do not offer a basis for granting remedies for rights violations.²⁹⁶ Yet, as Jackman also notes, the Supreme Court has affirmed in *Baker*,²⁹⁷ *Canadian Foundation*,²⁹⁸ and *Hape*²⁹⁹ that international human rights law may serve as a guide for interpreting *Charter* rights as well as domestic law and policy, giving rise to a preference for applications of the law that are consistent with the values and principles in treaties and covenants at issue.³⁰⁰ The parties in this case debate the scope and proper

294. *Ibid* at para 1061.

295. *Ibid* at para 1087 (Justice Mactavish declared the 2012 IFHP orders in council invalid pursuant to s 52 of *The Constitution Act, 1982*, Schedule B to the *Canada Act 1982* (UK), 1982, c 11, but since those OICs had repealed the pre-2012 IFHP, she suspended the operation of the declaration for 4 months. The Attorney General has filed a Notice of Appeal).

296. Jackman, “The Implications of Section 7”, *supra* note 128 at 12.

297. *Baker v Canada (Minister of Immigration)*, [1999] 2 SCR 817 [*Baker*].

298. *Canadian Foundation for Children, Youth and the Law v Canada (Attorney General)*, [2004] 1 SCR 76 [*Canadian Foundation*].

299. *R v Hape*, 2007 SCC 26.

300. *Baker*, *supra* note 297 at para 70; *Canadian Foundation*, *supra* note 298 at para 31; *Hape*, *ibid* at paras 53, 56, 68.

application of treaty rights to refugee health coverage in Canada, a debate that was not resolved in Mactavish J’s treatment of international law in *Canadian Doctors*.³⁰¹ Justice Mactavish conceded that relevant portions of international law cited by the Applicants have not been incorporated into Canadian law and lacked the force of law, but she acknowledged the role of international law as an interpretative aid to *Charter* rights and drew on that law for this purpose.³⁰² What follows is a brief overview of provisions that Mactavish J considered and additional relevant provisions of international law.

The Applicants highlighted two sources of conflict between the new IFHP and the provisions of the 1951 Vienna Convention – a primary source for international refugee law.³⁰³ Article 3 of the Convention requires that contracting states “apply the provisions of this Convention to refugees without discrimination as to race, religion or country of origin.”³⁰⁴ This would appear to prohibit the IFHP’s differential coverage of claimants from DCO countries as a form of discrimination based on country of origin.³⁰⁵ Similarly, Article 7 states that “[e]xcept where this Convention contains more favourable provisions, a Contracting State shall accord refugees the same treatment as is accorded to aliens generally.”³⁰⁶ Prior to the changes in 2012, refugees received comparable coverage to that available to other immigrants, permanent resident holders, and temporary residents, including students or foreign workers. The changes to the IFHP now set apart certain refugees from other immigrants in terms of health coverage.³⁰⁷

The Applicants also invoked the 1990 *Convention on the Rights of the Child*,³⁰⁸ which Canada ratified in 1992. Article 6(2) calls upon signatory states to “ensure to the maximum extent possible the survival and

301. *Supra* note 17 at paras 441-75.

302. *Ibid* at para 474.

303. UN General Assembly, *Convention Relating to the Status of Refugees*, 28 July 1951, 189 UNTS 137.

304. *Ibid*.

305. Applicants’ Memorandum, *supra* note 18 at para 142.

306. *Supra* note 303.

307. Applicants’ Memorandum, *supra* note 18 at para 149.

308. 20 November 1989, 1577 UNTS 3, 28 ILM 1456, (entered into force 2 September 1990).

development of the child.”³⁰⁹ Article 2(1) calls upon parties to “respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child’s or his or her parent’s or legal guardian’s race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.”³¹⁰ And finally, Article 3(1) of the Convention states that “[i]n all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.”³¹¹

Justice Mactavish also noted the European Union’s *Reception Directive* of 2013, which details standards in that jurisdiction for the “reception of applicants for international protection.”³¹² Article 19 of the Directive requires Member States to “ensure that applicants receive the necessary health care which shall include, at least, emergency care and essential treatment of illnesses and of serious mental disorders.”³¹³ Article 21, dealing with “vulnerable persons” more generally, mandates that states must

take into account the specific situation of vulnerable persons such as minors, unaccompanied minors, disabled people, elderly people, pregnant women, single parents with minor children, victims of human trafficking, persons with serious illnesses, persons with mental disorders and persons who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence ...³¹⁴

While this latter provision contemplates a softer form of protection, both articles set out standards that clearly prohibit the discriminatory treatment contemplated in the 2012 IFHP regime.

Martha Jackman has highlighted two further international human rights instruments that support a rights-based approach to improving

309. *Ibid.*

310. *Ibid.*

311. *Ibid.*

312. EC, *Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 laying down standards for the reception of applicants for internal protection (recast)*, [2013] OJ, L180/96.

313. *Ibid.*

314. *Ibid.*

healthcare access.³¹⁵ Article 25(1) of the *Universal Declaration of Human Rights* of 1948 states that “everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including ... medical care.”³¹⁶ Ratified by Canada in 1978, the 1966 *International Covenant on Economic, Social and Cultural Rights* relates implicitly to health care coverage in two of its articles.³¹⁷ Article 12(1) sets out “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”³¹⁸ Article 12(2)(d) calls upon signatories to the Covenant to take necessary measures to “assure to all medical service and medical attention in the event of sickness.”³¹⁹

V. Conclusion

Changes in 2012 to health care coverage for refugees and other migrants have marked a significant departure from earlier levels of coverage, with profound practical consequences for migrants dealing with a wide range of critical conditions. The changes to coverage have also, for the most part, set Canada apart from the approach taken in the United States, the United Kingdom, and Australia, and raise questions in relation to Canada’s obligations under international human rights law. In *Canadian Doctors*, the Federal Court held that the revised plan violates sections 12 and 15 of the *Charter* and the violations cannot be justified under section 1. However, the Court declined to find a violation of section 7 on the basis of a reluctance to recognize a positive duty on the part of the state to provide healthcare benefits under the *Charter*. An appeal of this decision is pending, giving rise to the possibility of revisiting the issue of a positive duty under section 7. This article has argued that while earlier courts have been consistently reluctant to recognize such a duty, the facts

315. Jackman, “The Implications of Section 7”, *supra* note 296 at 12-13; see also Jackman, “Constitutional Jurisdiction Over Health”, *supra* note 170 at 110.

316. GA Res 217 (iii), UNGAOR, 3rd Sess, Supp No 13, UN Doc A/810, (1948) 71.

317. 16 December 1966, 993 UNTS 3, 6ILM 368 (entered into force 3 January 1976).

318. *Ibid.*

319. *Ibid.*

in the present case offer a compelling and unique basis for doing so. Whatever the outcome of this case, however, the current challenge to the constitutionality of the IFHP represents a kind of limit case – combining some of the most vulnerable claimants in some of the most desperate situations – thus promising to lend greater clarity as to the possible scope of the *Charter* as a tool for protecting fundamental socio-economic and human rights.