HIV and Medical Inadmissibility in Canadian Immigration Law

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> "Where states prohibit people living with HIV from longer-term residency due to concerns about economic costs, States should not single out HIV/AIDS, as opposed to comparable conditions, for such treatment and should establish that such costs would indeed be incurred in the case of the individual alien seeking residency."[1]
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> - International Guidelines on HIV/AIDS and Human Rights, para. 128

1. Introduction

In many ways, HIV is a model disease for testing Canada's immigration policies regarding medical inadmissibility. It is a disease which has evolved greatly since the time of its first appearance, it crosses all demographic profiles, and it is a disease which still attracts significant levels of stigma and discrimination.

This paper will canvas Canada's policies and practices regarding the processing of HIV positive applicants for permanent resident status and review strategies for overcoming medical inadmissibility findings.

2. The nature of HIV

Globally, the number of persons estimated to be living with HIV is over 35 million, with approximately 2.5 million new infections annually.[2]

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[1] Office of the United Nations High Commisioner for Human Rights, *International Guidelines on HIV/AIDS and Human Rights*, para. 128
[2] UNAIDS World AIDS Day Report, 2012

Although researchers have traced the Human Immunodeficiency Virus (HIV) back to the 1930's, the first case of HIV was diagnosed in Canada in 1982 and the first AIDS related death was reported the following year.[3] A total of 74,174 cases have been reported in Canada since HIV reporting began. Since 2008, there has been a steady decrease in the number of newly reported cases in Canada.[4]

One of the defining characteristics of HIV is the evolution of the disease as well as the rapid advances in treatment responses and prognosis of people infected with HIV.

Studies regarding the likely prognosis of people with HIV in industrialized countries like Canada indicate that life expectancy for people living with HIV has continued to improve over recent years.[5] It is widely recognized that HIV-associated opportunistic infections and malignancies requiring hospitalizations have dramatically declined since the advent of combination anti-retroviral therapy.[6] Far from being the death sentence that it was in the early 1980's, HIV is now considered to be a chronic disease that is manageable with appropriate monitoring and medication.

3. Stigma and Discrimination based on HIV status

While many diseases evoke compassion and sympathy, a unique characteristic of HIV infection is the stigma and discrimination that the disease and people living with the disease attract. Reasons for stigma and discrimination against people with HIV include:

- misinformed beliefs that HIV is highly contagious leading to unreasonable fears regarding the risk of transmission,

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[3] Public Health Agency of Canada, *A Brief History of HIV/AIDS in Canada*, http://www.phac-aspc.gc.ca/aids-sida/info/1-eng.php

[4] Public Health Agency of Canada, *At a Glance – HIV/AIDS in Canada: Surveillance Report to December 31st, 2011*, http://www.phac-aspc.gc.ca/aids-sida/publication/survreport/2011/dec/index-eng.php

[5] *Life expectancy of individuals on combination antiretroviral therapy in high-income countries: a collaborative analysis of 14 cohort studies*, Lancet. 2008 Jul 26;372(9635):293-9

[6] *Declining morbidity and mortality among patients with advanced human immunodeficiency virus infection*, New England Journal of Medicine, 1998, v. 338: pp. 853-60

- the association of HIV with stigmatized behaviours, such as homosexuality, drug addiction, prostitution and promiscuity,
- the belief that people with HIV infected themselves through irresponsible personal behaviour.[7]

The consequences of discrimination can range from loss of employment, denial of accommodation, estrangement from family and friends, substandard health care and feelings of hopelessness and worthlessness in the person living with HIV.[8]

A recent national survey in Canada revealed that 83% of men worry about being stigmatized because of HIV, while 68 % fear rejection by their sexual partners.[9]

An awareness of the stigma and discrimination surrounding HIV/AIDS provides an important context for assessing Canada's policies and practices regarding the immigration processing of HIV positive applicants. In *Hilewitz,*[10] the Supreme Court of Canada drew attention to Canada's history of being overly restrictive in its immigration policies toward people with disabilities. The Court acknowledged that these unjustified restrictions concealed prejudices about disability.[11]

Unfortunately, aspects of Canada's policies regarding immigration and HIV rely on outdated assessments regarding the progression of the disease and lead to overly restrictive practises which provide insufficient weight to the particular circumstances of individuals, such as their anticipated contributions.

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[7] HIV/AIDS Stigma and Discrimination, www.avert.org/hiv-aids-stigma.htm

[8] Supra.
[9] Male Call Canada Technical Report, April 7, 2013, www.malecall.ca
[10] Hilewitz v. Canada (Minister of Citizenship and Immigration) 2005 SCC 59, para. 41-53
[11] Supra, para. 48

4. Citizenship and Immigration Canada's HIV Policies

The immigration medical examination (IME) requires an HIV test for all applicants aged 15 years of age and older, and children younger than 15 years of age if certain risk factors are present, such as being born to an HIV positive mother.[12]

For HIV positive applicants who are the subject of sponsorship by a Canadian spouse, common law or conjugal partner, HIV is not an obstacle because they are exempt from excessive demands criteria.[13]

CIC's policy of partner notification requires that an HIV positive applicant in the family or refugee dependent categories sign a document allowing the sponsor/partner to be notified of the applicant's HIV status.[14] The policy states that all applicants with HIV in those classes who test positive for HIV are allowed 60 days to withdraw their application or to "voluntarily" disclose their HIV status to their spouse/partner living in Canada. After 60 days, the department will formally notify the spouse/partner in Canada and provide them with an additional 60 days to withdraw their sponsorship application. The policy acknowledges that while there is no legislative authority to force disclosure, it is designed to facilitate CIC's commitment to public health and safety.

As stated above, one of the unique features of HIV is the rapid advances in treatment regimes to manage the disease. Despite this, the current policy for assessing the admissibility of HIV positive applicants was developed in 2002.[15]

While the policy makes it clear that HIV positive applicants should be assessed for inadmissibility both according to public health/safety and excessive demands grounds,

[12] Operations Directorate, Health Branch, Immigration Medical Examination Instructions, Revised January 11, 2013, attached as Appendix "C"
[13] IRPA, s. 38(2)
[14] Automatic Policy Notification Policy, OP 15, section 12.2, Appendix M
[15] Operational Processing Instruction 2002-004, Medical Assessment of HIV Positive Applicants, attached as Appendix "A"

HIV positive applicants can only be considered a risk to public safety under the unusual circumstance in which an HIV-infected person is a sexual offender.[16]

With respect to assessing admissibility based on excessive demands, the policy acknowledges that the concern is principally related to the high cost of drug therapy to treat HIV. It states that "any applicant currently receiving ARV (anti-retroviral medication) is inadmissible based on excess demand."

With respect to HIV positive applicants who are not receiving drug treatment, the policy instructs officers to assess an applicant's admissibility based upon their eligibility for ARV treatment. Applicants with CD4 counts (which generally measure the health of the immune system) less than 350 and applicants with a viral load (which measures the strength of the disease) of more than 55, 000 are deemed inadmissible due to their eligibility for ARV treatment in Canada.

The current HIV policy does not reflect the standards set out by the Supreme Court in *Hilewitz*[17]. In *Hilewitz*, the Supreme Court of Canada found that medical inadmissibility decisions require individualized assessments of the particular circumstances presented by individual applicants for Canadian permanent residence. The Court also found:

- medical officers must assess likely demands on public services, not mere eligibility for them;
- it is impossible to determine "demands" without a consideration of an applicant's ability and intention to pay for services;
- the legislative threshold is reasonable probability, not remote possibility. Therefore, it must be more likely than not based on an applicant's circumstances that excessive demands will arise.

[16] *Supra*, Annex A, p. 5
[17] *Supra*, footnote 9

The Court required that the applicant's ability and willingness to attenuate the burden on publicly provided services had to be considered.

The Federal Court has determined that the reasoning of the Court in *Hilewitz* applies to health services such as the cost of out-patient drugs. In *Companioni*[18], the Court specifically found that officers must consider the capacity of applicants to cover the costs of health services such as prescription medication:

> "As Canadians, we tend to assume that we enjoy universal, government funded health care. While in large measure that assumption is true in that hospital care and the services of doctors, nurses and so on are government funded, there are exceptions. Messrs. Companioni and Grover intend to reside in Ontario. The general rule in that province is that the cost of out-patient drugs is not government funded. It follows that the cost of such drugs is not a demand on health services….In my opinion, the principles enunciated in *Hilewitz* are equally applicable in any consideration as to whether the cost of out-patient drugs would constitute an excessive demand on health services."[19]

In *Companioni*, the Court affirmed previous jurisprudence which determined that undertakings by applicants not to access publicly funded health regimes are not enforceable and therefore such undertakings cannot in themselves offset a concern about potential excessive demand. However, the Court did determine that evidence of an available insurance plan to cover the cost of prescription medication such as HIV could be sufficient to overcome concerns about excessive demands on such health services.[20]

In *Rashid*[21], the Court affirmed the finding in *Companioni* that private insurance plans could offset concerns about excessive demands costs related to prescription medication. However, the Court dismissed the application on the basis that the Applicant did not provide any evidence of an insurance plan, and instead relied on personal undertakings not to access health services.

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[18] *Companioni v. Canada (Minister of Citizenship and Immigration)*, 2009 FC 1315
[19] *Companioni*, supra, para. 6, 10
[20] Supra, para. 30, 27
[21] *Rashid v. Canada (Citizenship and Immigration Canada)* 2010 FC 157

In contrast to the legal standards set out in the jurisprudence, the current HIV policy focuses on the disease rather than individual assessments. Officers are instructed to determine inadmissibility based solely on disease markers, to the neglect of non-medical factors which may offset the anticipated costs of the disease.[22]

5. Challenging Inadmissibility Findings Based on HIV Status

The fairness letters associated with potential findings of excessive demand related to HIV status typically state concerns in overly broad terms. A recently received fairness letter is typical:

> "The natural progression of HIV infection is characterized by continuation and gradual deterioration. He will require ongoing specialist management for care, follow-up and treatment. In order to slow progression of his medical condition, he will require life-long treatment with anti-retroviral medications. As his condition further deteriorates, he will likely require emergency visits, repeat hospitalization, and ultimately palliative care in a hospice or at home with home care nursing support. These medications and services are publicly funded and expensive."[23]

This statement of concerns is generic and contradicts current medical evidence regarding the effectiveness of HIV treatment regimes, as stated above. If properly managed, HIV is not characterized by inevitable deterioration, and the need for emergency hospitalizations, palliative and hospice care is increasingly rare.

The above fairness concerns also contradict the department's own description of HIV, as stated in its immigration medical examination instructions:

> "ART does not cure HIV infection but controls viral replication within a person's body and allows an individual's immune system to strengthen and regain the power to fight off infections. **With ART, people living with HIV can live healthy and productive lives**."[24] [Emphasis added]

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[22] *Sapru v. Canada (Minister of Citizenship and Immigration)* 2011 FCA 35, para. 36; *Diaz Ovalle v. Canada (Minister of Citizenship and Immigration)* 2012 FC 507 at para. 9

[23] CIC Fairness letter, attached as Appendix "B"

[24] Immigration Medical Examination Instructions, supra note 11

Therefore, the goals of responding to fairness letters regarding HIV status are twofold: first, to confine cost expectations to the potential cost of medication, and second, to establish that the applicant has or will have an insurance plan in place to cover the cost of medication.

Regarding the accurate assessment of potential costs, the first step is to obtain a copy of the applicant's medical file through an Access to Information request. Once the file is obtained, an HIV specialist physician should be retained to assess the file and the applicant's current health status in order to eliminate projected costs related to hospitalization and palliative/hospice care, and to confine projected costs as much as possible to the cost of HIV drug treatment. The physician should clearly state what the anticipated annual cost of medication would be.

Regarding the establishment of a plan to mitigate costs[25], the first step is to research the provincial policy regarding coverage of prescription medication. A good summary of provincial drug coverage can be found here:

http://www.catie.ca/en/treatment/canadian-drug-programs

The wider the scope of provincial drug coverage, the more difficult it will be to establish that a private plan can be used to mitigate costs. It should also be noted that most provinces do not provide health care to foreign students, and therefore no issue of medical inadmissibility should arise in those cases.

Once it is established that provincial drug coverage can be substituted for private insurance plans, proof of coverage of the private insurance plan should be provided as comprehensively as possible. Proof of enrolment in the plan should be provided, along with evidence that the plan covers the prescribed HIV medication.

[25] OB 063, September 24, 2008

6. Requests for Exemptions on Humanitarian and Compassionate Grounds and Temporary Resident Permits

We have therefore seen that establishing proof of insurance coverage is critical to overcoming medical inadmissibility findings for people with HIV. In the event that no private insurance plan is available, or as an alternative argument, requests for exemption from medical inadmissibility criteria on humanitarian and compassionate grounds should be considered. Section 9.2 of OP4 provides some guidance with respect to such requests, identifying the following considerations:

> • What is the cost of the treatment or care, if available?
> • When the health inadmissibility is one that affects health or social services, what arrangements are there to cover treatment, care and other costs (e.g. private insurance,family finances, public health coverage, etc.)?
> • Is the applicant likely to become self-supporting?
> • Is there a risk the person will require public assistance? and
> • The extent of the applicant's anticipated need for health or social services in relation to the average demand for these services by Canadian residents?[26]

Given the prevalence of stigma and discrimination worldwide against people with HIV, any evidence of such treatment from the applicant or from publicly available documentary sources are highly relevant. Family connections to Canada and the best interests of a child are also relevant considerations.

Particularly in the case of inland humanitarian and compassionate applications, temporary resident permits should be requested if there is an issue of hardship if the application is refused.

7. Future Strategies

On a broader level, there is a potential for developing strategies to challenge an overly broad or discriminatory application of IRPA's medical inadmissibility provisions.

[26] OP 4, section 9.2

First, the test itself is formulated in an overly broad fashion, capturing any cost which exceeds the average per capita health cost of Canadians. Theoretically, an anticipated health cost of even one dollar more than the average per capita health cost is captured by the test. This test does not correspond to Parliament's intention of capturing *excessive* cost and a methodology of defining an "excessive" cost could be developed.[27]

Second, the test as currently formulated gives no weight to the anticipated contributions of immigrants, measured on a financial or social basis, and whether any anticipated costs are mitigated by anticipated contributions. The Supreme Court in *Hilewitz* expressed "no doubt" that most immigrants, regardless of the state of their resources when they come to Canada, eventually contribute to Canada in a variety of ways.[28] A fair assessment of demand should include a consideration of these contributions. A consideration of the anticipated contributions of newcomers with HIV is particularly important given the increasingly manageable nature of the disease and longer healthy lifespans of people with HIV.

Finally, the medical inadmissibility provisions of Canada's immigration laws have not been fully tested on constitutional grounds. The history of the discriminatory application of medical inadmissibility provisions as described by the Supreme Court in *Hilewitz*, combined with the continued inconsistency in making individualized assessments could ground to a challenge under s. 15 of the Charter. Given the authority over health spending allocated to the provinces in the constitution, it is also arguable that the federal Minister's exclusive power to refuse the admission of an immigrant to a province based upon the anticipated demands on health spending within that provinces raises division of power issues.

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[27] See for example, Coyte, Peter, "The economic burden of immigrants with HIV: When to say no?" http://www.hivimmigration.ca/wp-content/uploads/2011/07/2009-Medical-Inadmissibility-Study-report.pdf

[28] *Hilewitz*, supra, para. 39

8. Conclusion

The concept of "excessive demand" necessarily carries a degree of subjectivity. Subjective assessments are vulnerable to prejudice and unjustified assumptions, which have a particular impact on people with stigmatized diseases such as HIV. In order to ensure that the objectives of Canada's immigration legislation are met, including the objectives of compliance with the Charter and international law as well as maximizing the economic benefits of immigration, it is necessary to be vigilant that the medical admissibility standards are applied in a fair and justifiable manner to people with HIV.