Court File No. : A-407-14

FEDERAL COURT OF APPEAL

**ATTORNEY GENERAL OF CANADA and
THE MINSITER OF CITIZENSHIP AND IMMIGRATION**

Appellants
(Respondents in the Federal Court)

and

CANADIAN DOCTORS FOR REFUGEE CARE, THE CANADIAN ASSOCIATION OF REFUGEE LAWYERS, DANIEL GARCIA RODRIGUES, HANIF AYUBI and JUSTICE FOR CHILDREN AND YOUTH

Respondents
(Applicants in the Federal Court)

RESPONDENTS' WRITTEN SUBMISSIONS

OVERVIEW

1. In a lengthy and carefully considered judgement, Justice Mactavish held that radical changes to a federal health insurance plan for persons seeking refuge protection in Canada placed the lives and health of these persons at risk. Based on the uncontradicted evidence she made clear findings of fact and ruled that, in instituting these changes, the Governor in Council placed lives at risk and purposefully targeted a poor, vulnerable and disadvantaged group, intentionally setting out to make their lives even more difficult than they already are in an effort to force them to leave Canada more quickly or deter others from coming here. Granting the Appellants' stay motion would perpetuate this harm through a lengthy appeal process.

PART ONE – THE FACTS

2. For more than 50 years, the Government of Canada has funded comprehensive health insurance coverage for refugee claimants and others who have come to Canada seeking its protection through the Interim Federal Health Program (IFHP). In 2012, the

Governor in Council passed two Orders in Council which significantly reduced the level of health care coverage available to many such individuals, and all but eliminated it for others pursuing risk-based claims. The changes affected 4 different categories of persons: government assisted refugees (GARs) which retained the former coverage level; non-DCO claimants who retained health care coverage for hospital and doctor's visits, but lost medication coverage; DCO-claimants and rejected claimants, who lost medication and health care coverage except for conditions that pose a threat to public health and safety, and PRRA-only applicants who had no coverage whatsoever even for communicable or dangerous health conditions.[1]

3. The IFHP changes were challenged by the Respondents. In support of the challenge, the Respondents introduced wide-ranging affidavit evidence regarding the effects of the changes to the IFHP. The evidence addresses serious concerns of provincial governments and some 21 national medical associations regarding the modifications. The Respondents' evidence also detailed systemic consequences of the changes, including widespread confusion among medical professionals as to coverage and negative effects on overall health care spending and efficacy. Furthermore, individual applicants provided evidence as to the negative consequences they had personally suffered as a result of the changes to the IFHP. Finally, six additional case studies of affected individuals were introduced as further evidence of the "serious impact on the physical health and psychological well-being of numerous individuals" ultimately accepted by Justice Mactavish.[2]

4. Justice Mactavish found that the changes violated sections 12 and 15 of the Charter, and that "the Canadian government has intentionally set out to make the lives of these disadvantaged individuals even more difficult than they already are".[3] Her declaration to this effect was suspended for four months.

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[1] These coverage categories are known as respectively, **Expanded Health Care Coverage, "EHCC", Health Care Coverage "HCC"** and **Public Health and Public Safety Coverage "PHPSC";** *See* Respondents' Stay Motion Record, Affidavit of Meb Rashid, Tab 1, pages 3-4, para 15.
[2] *Canadian Doctors for Refugee Care et al. v. Canada (Attorney General) et al*, 2014 FC 651 paras 88-250.
[3] *Canadian Doctors, supra,* paras 689-691,076-1077, 1079-1083.

5. The Respondents rely on the findings of Justice Mactavish and the evidence filed herein. Some of the affidavit evidence Justice Mactavish has been reproduced in this motion. Further, numerous new affidavits by both health care practitioners and experts have been filed in support of this motion. These affidavits offer up-to-date evidence about ongoing harm as a result of the health care cuts and they offer evidence about likely outcomes of not implementing Justice Mactavish's Order.

PART TWO – ISSUES

6. The issue(s) raised on this motion is/are as follows:

1. Should this Court decline to hear the stay motion?
2. Should the Court stay the judgement of Justice Mactavish pending the determination of the appeal?
3. If the Court stays the judgement of Justice Mactavish pending the determination of the appeal, should this court provide an exemption for children?

PART THREE – ARGUMENT

A. THIS COURT SHOULD DECLINE TO HEAR THE STAY MOTION

7. The Respondents object to the consideration of the stay at this late date and ask the Court to consider the following.

8. The Decision of Justice Mactavish was rendered on July 4, 2014. The Appellant Minister indicated his intention to appeal on the very day the decision was rendered. The Respondents wrote to the Appellants on July 15, 2014 and expressed their concern about the delay in proceeding with the appeal and the fact that a last minute application for a stay would be prejudicial to those affected by the decision. The Appellants responded that they would proceed as they deemed fit.[4] The Notice of Appeal was issued on September 22, 2014, almost three months after the decision. It was only served on the Respondents on September 30, 2014 when the stay motion was served.

[4] Respondents' Motion Record, Affidavit of Mitchell Goldberg, Tab 2, Exhibit "B", pages 62-63.

9. By waiting to the last minute to file the Notice of Appeal and the application for a stay, the Appellants are seeking to compel the Court to extend the time period. The motion will only be heard on October 30, 2014, days before the expiry of the order. In the interim the Appellant has not taken any steps to implement the decision. There is nothing in the material filed that justifies a delay of almost three months between the decision of the Court and the filing of the material. As a result the Respondents object to the consideration of the stay at this late date and ask that the Court exercise its discretion to decline to hear the stay.

10. In *Shi v. Canada*[5], the Federal Court noted that an applicant should not enjoy a strategic advantage by bringing last-minute stay motions before the Court. Likewise, this Honourable Court noted in *El Ouardi v. Canada (Solicitor General)*[6] :

> In the case of a late application for a stay, a motions judge must be given considerable leeway in dealing with the matter. In cases of late stay applications, a requirement to consider the merits could result in an automatic stay because of the need to give the Minister time to respond or the time necessary for the Court to decide the matter. Therefore, in cases of late stay applications, I doubt there is an obligation on the Court to consider the merits in all cases, especially where the application is very late as in this case. Certainly, the motions judge should consider the reason for the lateness of the application.

11. Given that due to the delay by the Minister the motion will only be heard days before Justice Mactavish's Judgment comes into effect, the delay is highly prejudicial. The Appellants' stay application should be considered equally "last minute" in the context of interests at stake in this case and its complexity.

12. In her decision Justice Mactavish explained the reason for only granting a four month suspension. She noted:

> 1095 While it is true that I have no evidence with respect to the administrative and policy consequences that would flow from a general declaration of invalidity, I am prepared to accept as a matter of common sense that it is inevitable that a certain degree of administrative disruption will result from my decision. I am also concerned that this disruption could potentially exacerbate the harm suffered by those seeking the protection of Canada. It is thus appropriate to give the Governor in Council a period of time in which to act in response to this decision.
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> 1096 At the same time, I am also mindful of the fact that the changes to the IFHP that were effected through the 2012 OICs are having a devastating impact on those seeking the protection of Canada. Indeed, I have found as a fact that lives are being put at risk.

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[5] *Shi v. Canada*, 2007 FC 534 at 6.
[6] *El Ouardi v Canada* 2005 FCA 42 at 6.

> 1097 Balancing these competing considerations, I have concluded that it is appropriate to suspend the operation of my declaration for a period of four months.

13. The evidence before the Court indicates that despite this ruling and the order of the Court below, the Government of Canada has not taken any actions towards the implementation of the Court's order. Moreover, despite the early request from counsel for the Respondents to discuss a schedule for the early determination of the issues and for expediting the appeal, the Appellants waited until the last possible moment to file the Appeal. No explanation for this delay of almost three months has been provided.

14. By waiting until almost the last moment to Appeal, the Appellants have exacerbated the situation set out in the reasons. The stay will now be heard just days before the expiry of the four month suspension. No efforts have been made by the Government to implement the order. The Government appears to assume that it will obtain the stay as a matter of right and indeed is acting in contempt of the Court order by failing to make any efforts to comply with it and in essence ensuring through its delay that it is not in a position to comply if the Court denies the stay. The Appellants do not come to the Court with clean hands.

15. It is submitted that the interests at play here are just as important, if not more so, than those that motivated the Court to decline to hear the stays in the cases cited where the Court has declined to do so due to a lack of clean hands. The Court should apply the same reasoning here and decline to issue the stay and issue directions that the Appellants immediately comply with the order of Justice Mactavish.

B. THIS COURT SHOULD DISMISS THE STAY MOTION

16. The three stage test established in *RJR-MacDonald* applies to applications for stays in *Charter* cases. An applicant must demonstrate a serious question to be tried, that it will suffer irreparable harm if the relief is not granted, and finally that the balance of convenience will weigh in its favour. Balance of convenience will often determine the result in applications involving *Charter* rights. [7] The issue of public interest is considered

[7] *RJR-MacDonald Inc v Canada (Attorney General)*, [1994] 1 SCR 311 at paras 41, 49, 57-75.

at both the second stage as an aspect of irreparable harm to the government's interests and the third stage as part of the balance of convenience.

B1. SERIOUS ISSUE TO BE TRIED

17. The Respondents do not dispute that section 12 issue raised on appeal is serious in that it is neither frivolous nor vexatious.[8] Nonetheless, the conclusions of Justice Mactavish were well-grounded in fact and in law and will not be easily displaced on appeal. In the final analysis, no Court in any state party to the Refugee Convention has ever upheld deliberate impairment of the basic means of survival of asylum seekers, as a deterrent or otherwise.[9]

B2. IRREPARABLE HARM

18. Irreparable harm refers to the nature of the harm suffered rather than its magnitude. It is harm which either cannot be quantified in monetary terms or which cannot be cured.[10] The Respondents acknowledge that, when considering the suspension of legislation based on a *Charter* violation, public interest plays an important factor as an aspect of irreparable harm to the interest of the government, at both this stage as well as the third stage of the stay test.[11] Where legislation is in violation of *Charter* rights, the Courts have held that public interest creates an assumption in favour of the government maintaining the impugned legislation pending an appeal[12]. However, the assumption was qualified by the Supreme Court of Canada when it acknowledged that "the government does not have a monopoly on the public interest" in *Charter* cases[13]. Moreover, the assumption that the public interest operates to create an assumption of irreparable harm is rebuttable. This Court should only grant a stay at the request of the Attorney General

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[8] *RJR-MacDonald ,supra* at para 50, [1994] SCJ No 17 [*RJR*].

[9] *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* [2005] UKHL 66; Bundesverfassungsgericht (BverfG-Federal Constitutional Court), Case no. 1 BvL 10/10, July 18,2012, (Ger.)

[10] *RJR-MacDonald ,supra* , paras 59 and 58

[11] *RJR-MacDonald Inc* para 81.

[12] *RJR* at para. 71-72; *Bedford v Canada (Attorney General)*, 2010 ONCA 814, 330 DLR (4th) 162 at para. 68.

[13] *RJR* at para 65

where it is satisfied, after a careful review of the facts and circumstances of the case, that the public interest and interests of justice warrant a stay.[14]

19. The Appellants have failed to rebut the assumption of irreparable harm that could flow as a result of granting this motion. A key factor in the irreparable harm stage is that the Appellants must adduce clear and non-speculative evidence that irreparable harm will follow if the motion for a stay is denied. It is insufficient to demonstrate that irreparable harm is "likely" to be suffered.[15] The Appellants have failed to adduce sufficient evidence regarding the public interest element of irreparable harm.

20. The three forms of irreparable harm asserted by the Appellants rest on speculation and not on fact. The Appellants assert: 1) that the Order struck down the authority for a remedial program leaving a policy void 2) that uncertainty will be created as to who is covered for what services under a recast IFHP and 3) that there will not have been sufficient time for a careful policy review with respect to a recast IFHP. However, the evidence establishes that none of these putative harms will result if a stay is refused.

a) Refusing a stay will not create a policy void

21. The Appellants contend that a suspension of the 2012 OIC would result in "tens of thousands of individuals" being left without federally funded health insurance benefits. This is mere speculation because there is insufficient evidence in the Shankar affidavit

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[14] *Frank v Canada (Attorney General)*, 2014 ONCA 485 at paras 27 and 29, and paras 14, 18 and 16, where the Court stated: "However, I cannot agree with the Attorney General that there is a *presumption* approaching an automatic right to a stay in every case where a court of first instance has ruled legislation to be unconstitutional. As Lamer J. also held in *RJR-MacDonald*, at p. 343, that "the government does not have a monopoly on the public interest." See also *Bedford*, at para. 73: "The Attorney General does not have a monopoly on the public interest, and it is open to both parties to rely upon the considerations of public interest, including the concerns of identifiable groups." Further, as indicated by the Federal Court in *Sauvé v. Canada (Chief Electoral Officer)* "where the Crown is the applicant, and by implication the legislation has already been found to be unconstitutional, they do not benefit from an assumption of irreparable harm at stage two. However, public interest, as an aspect of irreparable harm, may be demonstrated at a lower standard. It is, nonetheless, in the discretion of the Court, to determine at this stage whether the alleged harm to the public interest, as an aspect of irreparable harm, is sufficient in the context of the case to satisfy stage two.[14](Emphasis added)

[15] *Canada (Attorney General) v United States Steel Corp*, 2010 FCA 200 at para 12; *British Columbia Teachers' Federation v British Columbia*, 2014 BCCA 75 at para 28.

that complex new administrative processes are required to implement Justice Mactavish's Order. Moreover, if such a consequence would flow, that would be entirely from the choices of the Appellants, not from the Order of the Federal Court itself.

22. The Respondents submits that there are 3 possible options to ensure no legislative void is created: 1) restore the pre-2012 IFHP coverage, 2) expand the current "expanded health care coverage" (EHHC), 3) reimburse the provinces for coverage.

1) Restore Pre-2012 Coverage:

23. The 2012 OIC specifically repeals the 1957 OIC and striking down the 2012 OIC would reinvigorate the 1957 OIC. The 1957 OIC indicates that the government of Canada is:

> authorized to pay costs of medical and dental care, hospitalization, and any expenses incidental thereto, on behalf of:(a) an immigrant, after being admitted at a port of entry and prior to his arrival at destination, or while receiving care and maintenance pending placement in employment, and (b) a person who at any time is subject to Immigration jurisdiction or for whom the Immigration authorities feel responsible and who has been referred for examination and/or treatment by an authorized Immigration officer,in cases where the immigrant or such a person lacks the financial resources to pay these expenses, chargeable to funds provided annually by Parliament…"[16]

24. Thus if the 2012 OIC is struck down, the 1957 would be reinstated. With the 1957 reinvigorated, the Appellants are authorized to set a policy for payment of such costs. It is not clear why the Appellants would fail to resurrect the former policy, since the 1957 OIC would be in effect. The Federal Court's decision makes it clear that the 1957 OIC is constitutionally compliant. The Appellants' argument in this regard is based on the presumption that the Appellants would *not* "act in response" to Justice Mactavish's decision, as she directed that they do.

25. An obvious option is to revert back to the policies and procedures in relation to the former IFHP that were set out in various written documents over the years. Just prior to June 30, 2012 the IFHP policies and procedures were contained in Section 4 of the IR3

[16] 1957 OIC, Respondents' Motion Record, Goldberg Affidavit, Tab 2, Exhibit "A", page 60.

Policy Manual of Citizenship and Immigration Canada (CIC). At earlier points, the IFHP policies and procedures were contained in Operations Memoranda, such as Operations Memorandum IP 98-16 of December, 1998. Thus, if the 2012 OIC remains struck down, the former policies put in place pursuant to the 1957 OIC are readily available and ascertainable. There appears to be no legal barrier to reinstituting the former IFHP by issuance of an Operations Memorandum or Operational Bulletin, valid until such time as the appeal process in the within case has reached its final conclusion. Service providers, including CIC and Blue Cross Medavie, would not need to be re-trained. This is because the program would be similar to that which existed prior to the 2012 changes. Physicians and other medical care providers are familiar with the program as it was in place previously. [17]

2) Expand the Current EHCC

26. Another option is to expand mechanisms currently in place. Medical coverage currently restricted to "expanded health care coverage" or "EHCC", could be applied across the board. This offers equivalent care to the pre-2012 IFHP.[18] The current system would simply continue so that no retraining, etc. would be required. All CIC and Blue Cross Medavie staff could be informed that an IFH certificate ensures that people have access to "expanded health care". A mailing could be sent out to IFH recipients and another to physicians stating that the IFH program has reverted to previous coverage grids until further notice (similar to the mailing that was sent out 6 weeks prior to the 2012 changes taking effect). All references on the CIC website to "health care coverage" or "public health/safety coverage" could be deleted. [19]

3) Reimburse the Provinces

27. Finally, in the alternative, there is an option of the Federal Government announcing that it will reimburse the provinces for health care services provided to

[17] Respondents' Motion Record, Rashid Affidavit , Tab 1, page 11, para 43.
[18] Respondents' Motion Record, Goldberg Affidavit, Tab 2, pages 53b, 54, paras 11, 12.
[19] Respondents' Motion Record, Rashid Affidavit, Tab 1, page 11, para 44.

refugees and persons in the refugee stream pending the appeal process or until a new IFHP program is instituted.[20]

Conclusion:

28. The issues in the Shankar affidavit regarding difficulties in developing and administrative process are without any basis because the complicated administrative processes outlined in the Shankar affidavit are not necessary. There is no "policy void" created by the coming into effect of Justice Mactavish's Order and no new policy needs to be developed. Rather what has happened is that the Appellant has failed in the four months since the decision to take any steps to ensure it could comply with the Court order despite the explicit direction of the Court.

b. Refusing a stay will not create uncertainty as to who is covered under the IFHP

29. The Appellants assert that Justice Mactavish's judgement and declaration of the invalidity of the 2012 OIC will create a policy void with respect to the *scope* of health care insurance benefits. According to the Appellants, to enforce the judgment would create confusion with respect to the services and products covered, and provinces, territories, and private IFHP providers will not know if they will be reimbursed for their services. The Appellants maintain that to issue a stay would prevent any such confusion.

30. The Respondents submit that this argument is illogical. The factual findings of Mactavish, J. and the evidence presented on this motion show that it is the *current* IFHP that is the source of continuing confusion on the part of health care providers. In contrast, it is the former IFHP in place for decades that is the simpler and more familiar system for the thousands of health care providers who deal with refugees.

[20] Respondents' Motion Record, Rashid Affidavit, Tab 1, page 12, para 46.

31. Reactivation of the previous policy instruments would make the system simpler, not more confusing. The 2012 IFHP changes caused significant confusion among healthcare providers. This confusion continues today. Patients who qualify for coverage have been turned away, or forced to pay upfront due to uncertainty over who is and who is not covered. Many physicians still cannot navigate the complicated benefit grids. Alternatively, simply extending EHCC-level coverage to all categories of persons in the refugee stream by means of a new OIC would likewise make the system simpler. It would mean no different tiers, no different basket of services and no possibility of having coverage reduced if a patient's refugee claim were rejected.[21]

32. Any policy reversal is disruptive to some extent; however, the Appellants are speculating that irreparable harm will flow from the lack of a stay. As long as there is an announcement to recipients and health care providers that the former IFHP was being restored pending appeal or that the expanded coverage will apply to all, the evidence indicates that the transition will be smooth and this is restoration supported by national medical associations.[22]

c) Four months was ample time for revision of the IFHP

33. There is insufficient evidence to support the Appellants' contention that the four month suspension of invalidity does not allow for a proper reconsideration and possible revision of the IFHP. They assert that CIC may decide to formulate a new policy, requiring authority from the Cabinet level. Once authority is granted, this starts the chain of a policy implementation, including a process involving various revisions, updates of CIC IFHP materials, internal review and approval processes, training for first-contact officers on eligibility requirements, and contract negotiations with their claims administrator, Medavie Blue Cross.[23] The Respondents have 3 concerns about this issue.

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[21] Respondents' Motion Record, Rashid Affidavit, Tab 1, pages 5-6, 11, paras 19, 21, 22, 43.
[22] Ibid, Exhibit "D", pages 43-52.
[23] Appellants' Motion Record, Appellants' Written Representations, pages 1052-1053.
Appellants' Motion Record, Affidavit of Craig Shankar, paras 9-25, pages 275-281.

34. First, the Appellants fail to present concrete evidence of any steps taken since the declaration of invalidity on July 4, 2014. Craig Shankar merely states that CIC and Health Branch "…initiated a comprehensive review of the judgement, and consulted with various government departments." and concludes that "potential policy options needed to be developed and proposed".[24]

35. Second, CIC, as a government agency has the flexibility to relatively rapidly modify its operational practices in response to court rulings, world events, natural disasters or other events. It has done so in the past, and there is nothing that should bar it from doing the same in this case.[25] More importantly, the government repealed and replaced the 1957 OIC on April 5, 2012 and a new IFHP was operational on June 30, 2012. During these 3 months an amendment was made (on June 28, 2012 by Order in Council P.C. 2012-945) that restored coverage to Government Assisted Refugees (GARS) at the same level as the previous IFHP, through the creation of the completely new coverage level of "expanded health care coverage". In fact, the Respondents have presented evidence that this latter change may have been effected in as little as 16 days.[26]

36. Finally, no new policy is required, as submitted above. Therefore, the former operational systems could be put back in place fairly quickly.

37. In conclusion, the Respondents failed to present evidence that 4 month period has been insufficient to provide what appears to be readily available and obvious remedies. Instead the evidence discloses a lack of concern over compliance with the Court order.

Public Interest Factors

38. The Appellants have failed to establish that the irreparable harm will flow from public interest factors. The Appellants justify the health care cuts for the following

[24] Appellants' Motion Record, Affidavit of Craig Shankar, para 10; page 276.
[25] Respondents' Motion Record, Goldberg Affidavit, Tab 2, page 54, para 12.
[26] Ibid, Exhibit "E", June 12, 2012 email from Debra Presse to Sonia LeBris; pages 84-101.

reasons: cost containment, deterrence of bogus claims from European countries and other safe places, promotion of public health and safety, and equity—i.e. to ensure that refugees and refugee claimants did not receive better public health coverage than Canadians. However, Justice Mactavish found as fact, and the Respondents have established on this motion, that these goals are not sufficiently pressing to counterbalance harm to individuals. The Appellants have not presented any further evidence in this motion regarding these objectives as they relate to public interest.

39. Canada does *not* have a significant problem with abusive claims to begin with—thus retaining the modified IFHP serves virtually no purpose in this regard. The percentage of manifestly unfounded (no credible basis) is very low—under 3%. There is no influx of claims from safe, Western democracies, and in any event the evidence establishes that, with the exception of the United States, such countries have comparable publically funded health care systems of their own, so a comprehensive IFHP is unlikely to be a significant "pull factor".[27] The Appellants have failed to offer any evidence in this motion to counter this assessment.

40. There is similarly no affront to the public interest to return to providing rejected claimants with health insurance until they are landed or leave the country. As noted by Justice Mactavish, rejected claimants are not necessarily the same as "bogus" claimants[28] and in any event may be applying for complementary forms of protection[29] which gives them a legitimate right to be present in Canada in the context of their application for protection and does not threaten the integrity of the system. Furthermore, it is, likewise, both unfair and inaccurate to characterize all failed refugee claimants from DCO countries as "bogus" refugees. Difficult conditions exist in both Hungary and Mexico, two notable countries on the DCO list.[30]

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[27] *See* Respondents' Motion Record, Goldberg Affidavit, Tab 2, Exhibits "F" and "G", pages 103-133; Respondents' Motion Record, Rashid Affidavit, Tab 1, page 12, para 47.
[28] *Canadian Doctors*, *supra*, para 841
[29] Respondents' Motion Record, Goldberg Affidavit, Tab 2, pages 54a, 55, para17.
[30] *Canadian Doctors*, *supra,* para 843, 844, Respondents' Motion Record, Goldberg Affidavit, Tab 2, pages 54a, 44, paras 17-18.

41. With respect to child refugees in particular, there is no certainly no affront to the public interest in providing them with health insurance. As noted by Justice Mactavish, Canada has long recognized its obligations to act in the best interests of children and to ensure to the maximum extent possible, their survival and development; and "it is surely antithetical to the values of our Canadian Society to visit the sins of parents on their innocent children" who have no choice in where they live and are the innocent victims of world events and family choices.[31]

42. In terms of cost-containment, there is now some confirmation that the cost of health services to refugees and refugee claimants has simply been downloaded from federal taxpayers onto provincial taxpayers. For instance, the Ontario government has now quantified some costs associated with having to deal with the illnesses of thousands of de-insured refugee claimants at about 2 million dollars.[32] Dr. Michael Rachlis, in his updated affidavit for this motion, reviews the issue of net public sector cost containment and concludes that the modifications to the IFHP do not necessarily further the public interest of achieving savings to taxpayers. On the contrary, his conclusions are that costs are simply shifted to the provincial sector and it is even possible that de-insuring the refugee population actually increases taxpayer burden. Furthermore, there is no financial crisis in Canada that would justify keeping the IFHP cuts in place; the evidence shows a budget surplus projected and that health care expenditures have plateaued or gone down when calculated as a percentage of GDP. [33] Furthermore, the per capita cost of the IFHP was *de minimis* to begin with ($46.00 per month)[34] and overall costs will go down as the number of claims fall and time frames are shortened. [35] Again, no evidence has been presented on this motion to state otherwise.

43. Regarding so-called "fairness" to Canadians if a stay were granted and the changes to the IFHP were kept in place, Justice Mactavish found as a fact and the

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[31] *Canadian Doctors*, *supra* paras 638, 659 – 669.
[32] Respondents' Motion Record, Goldberg Affidavit, Tab 2, Exhibit "I" page 160-162.
[33] Respondents' Motion Record, Goldberg Affidavit, Tab 2, Exhibits "J" and "K", pages 164-172.
[34] Ibid, Exhibit "L", pages 174-175.
[35] Statistics indicate that claims are down from nearly 25,000 in 2011 to just over 10,000 in 2013, *see* Respondents' Motion Record, Goldberg Affidavit, Tab 2, Exhibit "G" pages113, 128.

evidence on this motion establishes that the former IFHP did *not* provide better health care coverage to refugees and refugee claimants than received by Canadians in the first place. Accordingly, there would be no particular public interest threatened if the modifications were suspended. The Appellants have failed to provide evidence in support of this motion that would indicate otherwise.

44. Public health and public safety is flagged as a concern by the Respondents. However, in this regard the public interest would be *better* served by *reviving* health coverage pending appeal. As noted by Justice Mactavish and established in the evidence on this motion, the modified IFHP failed to extend even Public Health and Public Safety coverage (PHPS) to PRRA-only applicants. This category of persons have ineligible refugee claims, but may still be asserting a well-founded fear of persecution that is to be assessed by a PRRA officer and were covered under the former IFHP. As Richard Goldman explains in his update regarding "BB" [36](whose case was considered by Justice Mactavish at paragraph 241ff), PRRA-only applicants may have contagious diseases or violent psychoses, but now lack IFHP coverage for the medications needed to treat these conditions, despite the fact that they pose a risk to public health and safety. This is an exceedingly dangerous situation from a public health standpoint, particularly in light of the recent Ebola outbreak in West Africa.[37] Granting a stay would allow this untenable situation to continue—which is clearly not in the public interest.

45. Additionally, in limiting health care coverage to some categories of child refugees, the protection of Canadian society and other Canadian children is compromised and there a risk to the general health and safety of the Canadian public. For example, as found by Justice Mactavish, refugee children who do not receive EHCC do not have healthcare coverage for conjunctivitis, head lice, scabies, diarrhea, and a cough not related to tuberculosis. None of these conditions are covered under the current PHPS category. Meanwhile, all of these can jeopardize the health of other children in daycares

[36] Respondents' Motion Record, Affidavit of Richard Goldman, Tab 11, pages 240-242, paras 4-17.
[37] Respondents' Motion Record, Rashid Affidavit, Tab 1, page 5, para17.

and schools, along with those who are in regular contact with them such as teachers, caregivers and parents.[38]

46. In conclusion, the Appellants have failed to meet the test for irreparable harm when considering public interest factors.

B3. BALANCE OF CONVENIENCE

47. This branch requires the court to determine which of the two parties will suffer the greater harm from the granting or refusal of a stay, pending a decision on the merits.[39] Public interest must be taken into account when a suspension pursuant to a *Charter* violation is at play. If the Court finds that both parties are at risk of irreparable harm with the granting of a stay of Justice Mactavish's judgment, the task then falls on the Court to look at the *degree* of irreparable harm and whether the harm faced by one party is outweighed by the other.[40] The Respondents represent tens of thousands individuals.[41]

63. The evidence establishes that the balance of convenience in terms of maintaining the suspension of the IFHP 2012 ordered by Justice Mactavish tips in the Respondents' favour.

Minimal Disruption

64. The Respondents have established that there will be minimal disruption caused by the effect of the Order of Justice Mactavish, as explained above. If IFHP 2012 is suspended, then the system can revert back to the pre-IFHP 2012 procedures or rely on the existing expanded health care coverage. No dismantling of any scheme or significant costs is needed.[42]

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[38] *Canadian Doctors*, *supra*, paras 953, 956 – 958.
[39] *Bedford supra*, at para 12, 330 DLR (4th) 162
[40] *Bedford*, *supra*, at para. 75
[41] For example, in 2011 the IFHP covered 126,000 people; see Appellants' Motion Record, Affidavit of Alison Fortin, para 8, page 290.
[42] Respondents' Motion Record, Rashid Affidavit, Tab 1, pages 11-12, paras 43-44.

65. Dr. Meb Rashid is familiar with both the pre-IFHP 2012 scheme and IFHP 2012 scheme. He explains, in his affidavit for this motion, the logistics of reverting back to the pre-IFHP 2012 scheme. His experience with the procedures confirm that any disruption to reverting back to the pre-IFHP 2012 would be minimal, particularly given the difficulties and complexities apparent with administering the IFHP 2012:

> The former IFHP functioned very well and was simple to use. There were rarely problems in terms of understanding who was covered and what treatment was covered. I still retain the physician guides and documentation relating to the former IFHP and, if it were reinstated in its pre-2012 form, I do not believe it would be a problem for care providers to revert to the old system. The old system did not require more than a very rudimentary understanding on the part of physicians. There were no different tiers, no different basket of services and no possibility of having coverage reduced if patient's refugee claim was rejected. Most doctors still do not understand the new system and their only skill set relates to the old system in any event.[43]

66. The health care community overwhelmingly prefers the pre-IFHP 2012 due to the straightforwardness of the old system and years of experience in using it.[44]

Harm to Refugees if Suspension is Extended

67. The Respondents recognize that courts must be sensitive to and cautious of making rulings that deprive activities of elected officials of their effect. However, the *Charter* charges the Court with the responsibility of safeguarding fundamental rights. For the courts to insist rigidly that all activities be enforced to the letter until the moment they are struck down as unconstitutional might in some instances be to condone the most blatant violation of *Charter* rights. Such a practice would undermine the spirit and purpose of the *Charter* and might encourage the Government to unduly prolong final resolution.[45]

68. The evidence on this motion establishes that the suspension of the 2012 IFHP longer than the 4-month period ordered by Justice Mactavish puts refugees at further risk of failing to have access to life-saving medications and necessary health care. Contrary

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[43] Respondents' Motion Record, Rashid Affidavit, Tab 1, page 11, para 43.
[44] Ibid, pages 11-12, para 44.
[45] *RJR-MacDonald, supra,* at paras 38-39.

to the assertions of the Appellants, the evidence before Justice Mactavish established the same thing. Accordingly, Justice Mactavish found that:

> [1096].…….(T)he changes to the IFHP that were effected through the 2012 OICs are having a devastating impact on those seeking the protection of Canada. Indeed, I have found as a fact that lives are being put at risk.
>
> [1097] Balancing these competing considerations, I have concluded that it is appropriate to suspend the operation of my declaration for a period of four months.

69. The Respondents present up-to-date evidence of continuing harm to refugees and refugee claimants across Canada.[46] Examples across the country follow.

70. **Alberta**: Dr. Coakley establishes that Alberta has not stepped in to fill the coverage gaps created by the changes to the IFHP. In this regard, the Respondents have provided an updated affidavit from Victor Wijenaike, a cancer patient whose treating physician describes his condition as "life-threatening" and who continues to struggle to receive the medications that he requires for his treatment (also considered by Justice Mactavish at paragraph 221ff). Mr. Wijenaike lost his medication coverage after the IFHP 2012 came into effect and he has resorted to receiving free samples from his physician or having to beg his family for money to buy his required medications. Mr. Wijenaike has gone months without receiving the medications that he requires due to unaffordability and his doctors being unable to get samples for him. Denying the stay and reverting back to the pre-IFHP 2012 scheme would mean that Mr. Wijenaike would have access to life-saving medications. Without the pre-IFHP 2012 scheme, he continues to be at risk of disruptions in his medication treatment that could have potentially life-threatening consequences.[47] He is at risk of not receiving the necessary health care, as are others in a similar situation.

71. **Saskatchewan**: Dr. Mahli Brindamour establishes that Saskatchewan has not stepped in to uniformly fill the coverage gaps created by the changes to the IFHP. In addition, the Respondents have re-filed the affidavit of Saleem Akhtar previously filed

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[46] *See* Affidavit of Respondents' Motion Record, Rashid Affidavit, Tab 1, pages 5-6, paras 18-25.
[47] Respondents' Motion Record, Affidavit of Victor Wijenaike, Tab 4, pages 198-199, paras 5-10.

before Justice Mactavish and considered by her at paragraph 215ff. Mr. Akhtar was a Christian refugee claimant from Pakistan who was diagnosed shortly after his 2012 arrival in Canada with an aggressive form of lymphoma requiring urgent treatment. Since he was a refugee claimant, the modified IFHP did not cover him for out-patient chemotherapy or anti-nausea drugs. He had to sell some of his possessions to cover the first round of chemotherapy, but this left him destitute. After a nun interceded on his behalf, his second round was donated by a hospital, and finally the government of Saskatchewan agreed to fund it, after his situation was brought to the attention of the Premier of Saskatchewan who found the modifications to the IFHP "unbelieveable."[48] At any time, other refugee claimants in Saskatchewan may face the same threats as Mr. Akhtar and may not be as lucky to attract the attention of the Premier or have the support of a kindly nun. Mr. Akhtar clearly would have died without chemotherapy medications; he was at serious risk of not receiving the necessary health care on account of the 2012 modifications to the IFHP.

72. **Nova Scotia:** Constance Macintosh establishes that Nova Scotia has not stepped in to uniformly fill the coverage gaps created by the changes to the IFHP. Gillian Zubizarreta, the Settlement Coordinator at the Halifax Refugee Clinic recounts the experiences of several of her current and recent refugee clients. One failed claimant with psychosis had PHPS coverage under the IFHP but was not deemed enough of a threat by the IFHP administrator to qualify for expensive anti-psychotic medication he was prescribed despite the fact that he had threatened his roommate. [49] Another failed claimant from a country that does not accept deportees struggled to obtain treatment for a tumour in his eye for several months, repeatedly being turned away from clinics because he had only PHPS coverage under the IFHP.[50] Several other clients who are failed refugee claimants or DCO claimants with only PHPS coverage under the IFHP have avoided seeking medical treatment due to fear of crippling medical bills and are even foregoing treatment for such things as chest pain, abdominal pain, severe headaches and loss of feeling on one side of the face—all potentially symptoms of life threatening or

[48] Respondents' Motion Record, Affidavit of Saleem Akhtar, Tab 6, Exhibit "A", page 207.
[49] Respondents' Motion Record, Affidavit of Gillian Zubizarreta, Tab 8, pages 223, 224, para 7.
[50] Ibid, page 224, para 8.

even contagious conditions.[51] Ms. Zubizarreta summarizes her experiences dealing with the impact of the IFHP cuts as follows:

> We are watching people suffer and come to us with so much anxiety and fear due to mounting medical bills. We find solutions on an ad hoc basis as best we can, but this is not enough. Also, I often wonder what clients would do if we were not here for them and, worse, who is suffering in silence? We will continue to work to find solutions, but the only sustainable solution is the reversal of the cuts and then the slow process of reversing all the damage done. [52]

Clearly, refugee claimants in Nova Scotia are at risk of not receiving the necessary health care and granting a stay would exacerbate this situation.

73. **British Columbia**: Dr. Susan Nouch, of the Bridge Clinic in Vancouver (the only clinic that will see refugees and refugee claimants regardless of level of IFHP coverage.) states that BC has not filled the coverage gap created by the 2012 modifications to the IFHP. She indicates that people in the refugee process lack access to essential prescription medication from pharmacies. She notes that the Bridge Clinic now has to scramble even to secure a small number of medications for these patients such antibiotics, heart medications, asthma medications, etc. The clinic does not stock all medications and sometimes runs out. The stock medications consist of free samples and medications acquired by provincial government when the IFHP cuts were first announced. According to Dr. Nouch, there is a significant risk of an adverse outcome related to the lack of essential care of treatment.[53] The affidavit of Laura Mansfield[54], social worker, describes the situation of her client "Sarah" a non-DCO claimant, who suffers from asthma, angioderma and severe allergies and requires regular medication intake in order to survive,[55] however such medications are no longer covered under the IFHP pursuant to the 2012 changes. Sarah's family of three has had to use some of their $401 monthly support budget from provincial income assistance to pay for medications, which has threatened their basic food needs. It is clear that refugee claimants in BC are at risk of not getting the necessary health care and granting a stay would allow this situation to subsist.

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[51] Respondents' Motion Record, Zubizarreta Affidavit, Tab 8, pages 225-226, paras 9-10.
[52] Ibid, pages 227-228, paras 13, 14, 16.
[53] Respondents' Motion Record, Affidavit of Susan Nouch, Tab 9, page 230, para 4.
[54] Considered by Justice Mactavish, *Canadian Doctors*, *supra*, at paragraph 234ff.
[55] Respondents' Motion Record, Affidavit of Laura Mansfield, Tab 10, Exhibit "A", page 237.

74. **Ontario**: although Ontario filled the IFHP gap in January 2014 with the Ontario Temporary Health Program (OTHP), life and health is still at risk in Ontario despite OTHP, because OTHP is not having its full intended effect. The chilling effect which the IFHP cuts had on access to medical care had become ingrained by the time OTHP was instituted. Most doctors do not understand the IFHP and given that OTHP is layered on top of the IFHP structure, many physicians do not understand it and refuse to accept IFHP patients. The complexity of the OTHP is also an issue; having to wait for the IFHP rejection, keep all paperwork, and then resubmit weeks to months later is also very cumbersome and a deterrent to use of the program. As well, OTHP has little if any effect in the common scenario of a person who forgoes care when asked to pay for it, and then becomes so ill that he or she has to present at emergency.[56]

75. The Respondent Mr. Ayubi, in his affidavit for this motion, presents a real-life example of harm despite OTHP. Although on track to be covered by OHIP and drug benefit programs by the time Justice Mactavish's declaration takes effect since his humanitarian application has been approved, Mr. Ayubi tried, in September 2012, to access medications using the OTHP. He was refused. Mr. Ayubi's health practitioner received a call from a pharmacy refusing to fill his prescription under OTHP, because the pharmacist found the IFHP-OTHP system too complex. Mr. Ayubi's two year struggle to obtain the necessary medications to treat his diabetes has caused significant risk to his health during the past two years when his blood pressure dropped to a dangerous level when he was given the wrong substitute medication. [57]

76. Alexander Cauderella and Emily Stewart present audit studies of walk-in clinics in the Greater Toronto Area. The results reveal not only the achievement of the intended result of the cuts, but also that they have further limited access to care for refugees with full IFHP coverage. Although there was no data available to compare rates of acceptance of IFHP coverage prior to the June 2012 cuts, the findings highlight restricted access to care for refugees. Furthermore, at least 11% of surveyed WICs openly reported changes in their policies that limited care *after* the IFHP cuts. In addition, six months after the

[56] Respondents' Motion Record, Rashid Affidavit , Tab 1, page 10, para 40.
[57] Respondents' Motion Record, Affidavit of Hanif Ayubi, Tab 14, page 305, para 10.

implementation of the OHTP, there was no corresponding improvement in access to healthcare. [58]

77. The Stewart study (of obstetrical walk-in clinics) demonstrates that refugee women in a large Canadian urban centres are systematically not receiving the prenatal care for which they are eligible due to lack of knowledge, confusion around the current set of IFHP policies, time-consuming administrative requirements to determine eligibility status, and a slow reimbursement process are barriers preventing refugee women from receiving adequate treatment from health professionals.[59]

78. Justice Mactavish found and the evidence on this motion establishes that confusion resulting from the inherent complexity of the new IFHP system and the administrative processes surrounding it has had a chilling effect on care.[60]

79. Furthermore, there are no viable alternatives for IFHP in any province that could in all instances provide care if stay is granted, as evidenced in the record on this motion and as found by Justice Mactavish[61].

80. For instance, reliance on hospital emergency rooms is not an adequate alternative to the IFHP going forward. Although they do provide care in emergency situations, emergency rooms are an extremely costly and inefficient way in which to deliver primary health care. In some provinces, the hospitals will attempt to recover the cost of medical services provided to uninsured patients. Patients still have to pay to fill the prescriptions that they receive through hospital emergency rooms—as hospitals do not dispense medications to outpatients. Moreover, the threat of receiving a medical bill will induce patients to delay or forgo care. [62] Community Health Centres (CHCs) in Ontario are also not an entirely adequate alternative to the IFHP going forward as there are a number of

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[58]Respondents' Motion Record, Affidavit of Alexander Cauderella, Tab 12, pages 251-252, paras 7-8.
[59] Respondents' Motion Record, Affidavit of Emily Stewart, Tab 13, page 273, para 6.
[60] *Canadian Doctors*, *supra,* paras 133-141; Respondents' Motion Record, Rashid Affidavit, Tab 1, pages 5-6, paras 18-25; Respondents' Motion Record, Zubizarreta Affidavit, Tab 8, page 226, para 11.
[61] *Canadian Doctors*, *supra,* paras 294ff
[62] Respondents' Motion Record, Rashid Affidavit, Tab 1, page 7; para 27; Respondents' Motion Record, Affidavit of Michael M. Rachlis, Tab 15, pages 311-312, para 7.

barriers preventing them being in a position to make up for all the gaps in care that have resulted from the cuts to the IFHP.[63]

81. Social assistance itself does provide some services such as prescription drug coverage in Ontario and in many provinces, where refugee claimants can access it. However, basic health care services, such as doctor's visits, hospitalizations and diagnostics are not provided through social assistance anywhere in Canada and therefore social assistance is therefore not a viable alternative to the IFHP and will not provide all the necessary care. Refugee claimants are generally not covered by provincial health care plans, although there are some exceptions in some provinces.[64] Ontario hosts the most refugees and refugee claimants are not covered by OHIP under any circumstances unless they have been accepted as refugees. Having a work permit does not entitle refugee claimants to OHIP. OHIP de-insured refugee claimants in 1995, hence the necessity for the IFHP in Ontario.[65] Provincial health insurance plans are not an alternative to the IFHP for any refugee claimant in Ontario or in most other provinces going forward and will not provide the necessary care.

82. Section 7 of the 2012 OIC allows for the Minister to provide IFHP coverage at his discretion. However, the evidence indicates that even highly involved doctors and refugee advocates are unaware of it, have never used it and are not aware of the process or criteria. [66] The protocols around using this provision are not public.[67] In any event, a provision which makes care dependent on an application to the Minister is ill-suited to emergency situations.[68] Justice Mactavish also found this provision to be of limited utility.[69] This provision will not provide necessary care going forward in all instances.

Suspension of the 2012 IFHP provides a public benefit

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[63] Respondents' Motion Record, Rashid Affidavit, Tab 1, pages 7-8, paras 28, 29.
[64] *Canadian Doctors*, *supra*, para 264.
[65] Respondents' Motion Record, Rashid Affidavit, Tab 1, pages 8-9, para 32.
[66] Respondents' Motion Record, Rashid Affidavit, Tab 1, page 8, para 30; Respondents' Motion Record, Zubizarreta Affidavit, Tab 8, page 226-227, para 12.
[67] Respondents' Motion Record, Goldberg Affidavit, Tab 2, page 57-58, para 27, Exhibit "O" page 193.
[68] Respondents' Motion Record, Rashid Affidavit, Tab 1, page 8, para 30; Appellants' Motion Record, Cross-Examination of Allison Little Fortin, page 899 lines 24-25, page 890 lines 1-5.
[69] *Canadian Doctors*, *supra,* paras 287-293.

83. As found by Justice Mactavish and established by evidence on this motion, the 2012 IFHP has serious gaps in coverage that present a risk to public health. PRRA-only applicants do not even receive PHPS coverage putting Canadians at risk. The PHPS benefit grids themselves do not cover common conditions such as lice and scabies found in schools. An increase in poor individuals without health insurance for early care increases use of emergency services and hospital beds.[70] Justice Mactavish noted, and the evidence on this motion establishes, that health care providers are expending valuable time and resources that could be used elsewhere to try to compensate for the inadequate coverage under the 2012 IFHP.[71] In these respects, the public would be better off if a stay were NOT granted.

Conclusion on balance of convenience:

84. The Canadian Medical Association, the College of Family Physicians, the Canadian Association of Emergency Physicians, the Canadian Paediatric Society, the Paediatric Chairs of Canada, the Canadian Nurses Association, and the Canadian Psychiatric Association, among others, have written to the Appellant Minister expressing their outrage and concern over the decision to appeal the decision of Justice Mactavish. [72] They identify a very significant risk of harm to both refugees and to public health and they are overwhelmingly in favor of restoring the former IFHP and allowing the current policy to lapse pending appeal. As Dr. Michael Rachlis states in his affidavit filed before this Court, "it is certain that the policy is causing illness, disability, and death." [73]

85. Timeliness of treatment is crucial, and, in particular, this applies to mental health issues. Dr. Laura Simich warns of mental health risks refugees face when not treated early upon arrival. Refugees are known to turn to substance abuse when not treated for mental health issues[74]. Dr. Simich explains:

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[70] Respondents' Motion Record, Rachlis Affidavit, Tab 15, page 311, para 7.
[71] *Canadian Doctors*, *supra*, paras 193, 194; Respondents' Motion Record, Affidavit of Dr. Susan Nouch, Tab9, page 231, paras 6-7.
[72] Respondents' Motion Record, Rashid Affidavit, Tab 1, Exhibit "D", page 43; *Canadian Doctors*, *supra*, paras 100 – 101 (for Paediatric references).
[73] Respondents' Motion Record, Rachlis Affidavit, Tab 15, page 323, para 39.
[74] Respondents' Motion Record, Affidavit of Laura Simich, Tab 16, pages 363-634, para 14.

> Having access to mental health care at the right moment is crucial. For refugees in particular, appropriately timed and provided mental health services can make a difference between successful adaptation or the inability to recover from loss and trauma. **Appropriate mental health interventions need to be available to refugees almost immediately after arrival in Canada** and must continue for several years, as the effects of trauma and chronic stress do not appear at the same time for every individual affected, and they may recur.[75] (emphasis added)

Harm to Children

86. Regardless of province, the current IFHP has severely curtailed the ability of innocent refugee children to access health care.[76] Justice Mactavish found this has resulted in a differential impact on refugee children who are particularly vulnerable if their healthcare needs remain unaddressed; and has exposed refugee children to unnecessary pain and suffering that potentially puts their lives at risk and can impact their ability to access social institutions such as schools and youth programs.[77]

87. The healthcare needs of children are unique and the lack of adequate healthcare can result in both short and long-term negative consequences on a child's health, development and later success.[78] Justice Mactavish provided numerous examples that demonstrate the harmful consequences for refugee children with HCC, PHPS or no coverage at all.[79]

88. Research establishes that refugee children without health care insurance access emergency care less often and with more serious health concerns; and are represented at more serious triage levels, suggesting there may have been a delay in seeking help for some of the children.[80] The top 3 diagnoses for admissions of refugee children through the emergency room at Sick Children's Hospital in Toronto ("SickKids") during a 12 month study period (6 months prior to the IFHP changes and 6 months following the IFHP changes) were sickle cell anemia with crisis, epilepsy (not intractable), and

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[75] Respondents' Motion Record, Simich Affidavit, Tab 16, pages 364-365, para 17.
[76] *Canadian Doctors*, *supra,* paras 638 and 639.
[77] Ibid at 353 and 658.
[78] Affidavit of Joanna Anneke Rummens, Tab 19, page 481-482, paras 11-12.
[79] *Canadian Doctors*, *supra,* paras 646 – 655.
[80] Ibid at paras 153 – 156; Respondents' Motion Record, Rummens Affidavit, Tab 16, page 482, paras 13-14.

appendicitis; these diagnoses, if left untreated, are fatal.[81] Of the 28 admissions that occurred during the study, 6 were from DCO, and between March 28 – August 20, 2013, 6 patients changed from IFHP coverage to uninsured.[82]

89. Andrea Evans establishes that the IFHP changes have created confusion surrounding funding rules at SickKids. The multi-tiered program and unspecified definitions of "essential and urgent" has left many clinicians, administrators and patients confused as to who would be covered for what health care, and that families with low socioeconomic status and limited health coverage often fear the impact of medical bills and delay seeking care. Further, institutions such as SickKids do not have the logistical emergency capacity during emergencies to call Medavie Blue Cross prior to assessing and treating a child refugee.[83]

90. Dr. Cecile Rousseau's affidavit establishes that refugee children are a high risk group that have been exposed to cumulative trauma and have more post traumatic disorder than other children; early intervention can effectively reduce the symptoms, the impairment and the effects of those that have long term consequences on child development and the *timing of intervention is of key importance* for the child's outcome. Dr. Rousseau indicates that the current IFHP, even for provinces which are covering for the reduction in services, is significantly reducing the access of children to mental health services due to widespread confusion that has fueled negative attitudes and prejudices towards asylum claimants, and this restricted access has serious short-term consequences in terms of suffering and cognitive impairment for refugee children and may have long term consequences in terms of their future social adaptation and learning potential.[84] Dr. Rousseau provides several vignettes of where refugee children suffered denials and/or delays in receiving care.[85]

THE THREE PRONGED TEST FOR A STAY HAS NOT BEEN MET

[81] Respondents' Motion Record, Affidavit of Andrea Evans, Tab 18, 464-465, paras 5 – 8.
[82] Ibid, page 465, paras 9 – 10.
[83] Ibid, page 465-466, paras 13 – 15.
[84] Respondents' Motion Record, Affidavit of Cecile Rousseau, Tab 17, pages 385-390, paras 9 – 16.
[85] Ibid, pages 391-392, para 20.

91. The Respondents submit that this case is analogous to the following cases where stays were NOT granted.

92. Firstly, the Supreme Court of Canada has made it clear that issues of health and personal safety outweigh most other considerations in the context of a stay application. In *RJR MacDonald*, supra, the question was whether an order declaring a legislative ban on tobacco advertising to be a justifiable limit on freedom of expression should stayed pending appeal by several tobacco companies. The Court found a legitimate public interest in the legislation and concluded by stating that "[t]he public interest in health is of such compelling importance that the applications for a stay must be dismissed…" This judgment strongly suggests that a stay should be denied in this case in the face of the evidence of tangible harm to health and well-being put forward by the Respondents.

93. In *Sauvé*, supra, the Federal Court dismissed a stay application made by the government seeking to suspend the declaration that section 51(e) of the *Canada Elections Act* barring inmates from voting was unconstitutional. The Court noted that the Government had adduced no evidence of irreparable harm in the context of a denial of a democratic right aside from one affidavit outlining the intent of the section and therefore concluded that:

> To grant the relief requested by the applicants, in this case, would effectively mean that, despite the declaration of invalidity of section 51(e) by this Court after a full trial of the action and prior to the Court of Appeal having considered this matter, that prisoners would have their right to vote suspended in the upcoming election. In my opinion, this runs contrary to the principles outlined in *Canada (Attorney General)* supra.[86]

The situation in the case at bar is strikingly similar. The Appellants have proffered no evidence of real and tangible harm if the 2012 IFHP is invalidated.

94. Likewise in *Frank v. Canada*[87] the Ontario Court of Appeal rejected the assumption of irreparable harm to the Crown and ruled that a stay of a decision striking down section 11 of the *Canada Elections Act* allowing limiting the voting rights of

[86] Sauvé, *supra*, at para 13.
[87] 2014 ONCA 485.

certain non-resident citizens was not warranted. The Court found that no legislative void was created because the judgment below merely *extended the right* to vote for non-residents citizens, rather than creating a regulatory void.[88] Similarly, Justice Mactavish's decision merely *extends the right* for those denied access following the 2012 OIC to receive the level of care they would have been entitled to previously under the 1957 OIC which will be reinstated when Justice Mactavish's order comes into effect.

95. In *Fontaine v. Canada*,[89] the Ontario Superior Court added two residential schools to the *Indian Residential Schools Settlement Agreement*. The Ontario Court of Appeal refused to stay the Court order. Even though Canada might pay compensation that, at the end of the day, should not be owing under the Agreement and which might be very difficult to recoup, entry of the stay would have prejudiced the aboriginal plaintiffs. It would have made it much more difficult for them to apply for compensation within the applicable time frame. Something of a parallel might be drawn between the *Indian Residential Schools Settlement Agreement* and provision of health care during the asylum process. Both promote recognition of human dignity and it is interesting to see how the Court weighed this interest against the government's interest in not providing compensation to persons it deemed not entitled.

96. *Bedford, supra* and *MCI v. Canadian Council for Refugees*[90] are distinguishable. A stay was issued in *Bedford* because repealing criminal prostitution laws would leave a legislative void and therefore have a harmful effect on a vulnerable population. The Court stated: "The evidence establishes that it is the short-term consequences of an inability to enforce this prohibition that will have the most deleterious impact on vulnerable communities such as Parkdale and Hintonburg."[91] Moreover, the Court found insufficient evidence, when balancing the harm of both parties, that suspension of the legislation pending appeal would benefit the public given the legislative void. Here, not only is there no legislative void, as submitted above, but the evidence establishes that there is a deleterious impact because of the constant threat of a lack of necessary health care and

[88] Frank, *supra*, at para 16, 18, 29.
[89] 2012 ONCA 206.
[90] 2000 FCA 40.
[91] Bedford, *supra*, at para 77.

the threat to public health from even PHPS coverage for PRRA-only applicants. In addition, as noted in *Frank*, supra, paragraph 16, the government filed a substantial volume of up-to-date evidence to demonstrate the very real and tangible harm that would result if the matter of prostitution were left completely unregulated. The government has not done so in the case at bar.

97. In *Canadian Council for Refugees*, the Federal Court of Appeal granted a stay of the Federal Court ruling declaring the *Canada-U.S. Safe Third Country Agreement* unconstitutional. Counterbalancing harm to refugees had not been established because the affidavit evidence was vague.[92] The same cannot be said of the Respondents' evidence on this motion.

EXEMPTION FOR CHILDREN

98. In addition to the above submissions, the Respondent JFCY submits that in the face of evidence of real and irreparable harm to the health and well-being of refugee children, the stay should not be granted in particular as it related to children. In her application of the *Charter*, the *Convention on the Rights of the Child*, and the "best interests of the child" legal principle to the facts before her[93], Justice Mactavish found that the "2012 modifications to the IFHP potentially jeopardize the health, and indeed the very lives, of these innocent and vulnerable children."[94] In the event this Court stays the order of Justice Mactavish, an exemption for refugee children should be made.[95]

48. The Respondent JFCY submits that the following finding by Justice Mactavish is significant and even more so regarding children: "the Canadian government has intentionally set out to make the lives of these disadvantaged individuals even more difficult than they already are".[96] The Court emphasized the potential of the impugned changes to "jeopardize the health and indeed the very lives of […] innocent and

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[92] *Canadian Council of Refuges, supra,* at paras 37-44.
[93] *Canadian Doctors, supra,* paras 637 – 670.
[94] Ibid at 1080.
[95] *Baier v. Alberta*, [2006] 2. S.C.R. 311, *Carter v. Canada (Attorney General)* 2012 BCCA 336.
[96] *Canadian Doctors, supra,* para 10.

vulnerable children in a manner that shocks the conscience and outrages our standards of decency".[97] A stay of her Order will only serve to exacerbate the deleterious consequences of the cuts on children.

PART FOUR – ORDER SOUGHT

99. The Respondents request an order:

a) Declining to hear the stay motion; or

b) In the alternative, dismissing the Applicants' motion for a stay and an order directing the Appellant to immediately comply with the order of Justice Mactavish by reinstating the coverage that existed prior to the 2012 OIC. .

100. In the alternative, if the motion for a stay is granted, the Respondent Justice for Children and Youth, requests an order exempting children under the age of 18.

101. Finally, in the event a stay is granted, the Respondents seek an order expediting the appeal.

ALL OF WHICH is respectfully submitted at Toronto, this 14th day of October 2014.

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LORNE WALDMAN

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MAUREEN SILCOFF

_____

EMILY CHAN
Solicitors for the Respondents

[97] *Canadian Doctors*, *supra,* paras 691 and 1080.