Registry No. T-356-13

FEDERAL COURT

B E T W E E N:

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

Applicants

and

**ATTORNEY GENERAL OF CANADA
MINISTER OF CITIZENSHIP AND IMMIGRATION**

Respondents

MEMORANDUM OF FACT AND LAW OF THE APPLICANTS, CANADIAN DOCTORS FOR REFUGEE CARE, THE CANADIAN REFUGEE LAWYERS ASSOCIATION, DANIEL GARCIA RODRIGUEZ AND HANIF AYUBI

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OVERVIEW

1. This case involves the legality of modifications made to the Interim Federal Health Program (IFHP). This program, which draws its authority from a 1957 Order in Council, provides temporary health insurance coverage for refugees and asylum seekers in Canada who cannot afford to pay for care.

2. Without advance notice or consultation and without any evidence that the IFHP was problematic, the governor in council repealed the 1957 Order and promulgated two new ones, dated April 5, 2012 and June 28, 2012 respectively. These Orders established a classification system for IFHP insurance recipients and reduced or eliminated coverage accordingly—in some categories retroactively.

3. This reduction or elimination of insured coverage has the predictable effect of depriving some refugees and asylum seekers, who are both vulnerable and indigent, of access to basic, primary, essential, life-sustaining medical care. No appropriate, realistic and reliable alternative means exists to obtain such care and treatment. The applicants submit that the denial of insured health coverage pursuant to the current IFHP is *ultra vires*, unfair, contrary to the Charter, and in breach of Canada's international obligations under the *1951 Convention relating to the Status of Refugees.* The applicants seek a declaration to remedy this deprivation.

PART I—STATEMENT OF FACTS

4. On June 20, 1957, the Government of Canada passed Order in Council OIC 1957-11/848, and provided as follows:

> The Board recommends that Order in Council P.C. 4/3263 of June 6, 1952, be revoked, and that the Department of National Health and Welfare be authorized to pay the 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 for the Immigration Medical Services of the Department National Health and Welfare.

5. The 1957 Order in Council eventually gave rise to what was later known as the Federal Interim Health Program, or IFHP. The IFHP gradually came to be applied to resettled refugees and asylum seekers after Canada signed the *1951 Convention relating to the Status of Refugees* and 1967 Protocol in 1969.

6. The scope and content of the IFHP was revised several times between 1957 and 2012. When responsibility for some coverage shifted from the provinces to the federal government, consultations with provincial health authorities and Memoranda of Understanding ensured co-ordination and continuity of coverage.[1]

7. The pre-2012 IFHP provided the same basket of health coverage to protected persons, government resettled refugees, privately sponsored refugees, refugee claimants, and refused refugee claimants without distinction until they either became eligible to receive provincial health care or left the country. The government repeatedly stated that coverage was not as extensive as that provided by provincial health plans.[2] Coverage was also available to refused refugee claimants awaiting removal.[3] IFHP eligibility certificates were issued

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[1] Affidavit of Sonia Le Bris, paras 7-21;References to consultations with provinces or stakeholders: Affidavit of Mitchell Goldberg, pp.29,30, 45 (Exhibit B); pp.50,53,56,59, 62, 64, 67, 69, 72, 75, 78, 80, 86, 98(Exhibit C).

[2] Goldberg Affidavit, Exhibit D, Operational memo at p. 102, IR3 Policy Manual at p. 122: Le Bris Affidavit, Exhibit 1: *Audit of the Control Framework for the Interim Federal Health Program:* on line at http://www.cic.gc.ca/english/resources/audit/ifh.asp

[3] Goldberg Affidavit pp. 102, 110, 122, 125(Exhibit "D" Operations memoranda, IR3 Policy Manual, *Handbook for Health Care Providers*).

promptly and were renewable.[4] IFHP coverage was not "gold plated"[5]: the IFHP provided roughly equivalent coverage to what low-income Canadians and Canadians on social assistance receive.[6]

8. The program functioned well with relatively few complaints from health care providers or insured persons.[7] The cost of the program was relatively low. In 2009, the annual per-capita cost per recipient under the IFHP was only $552, or about 10% the annual per-capita cost of health care for Canadians ($5401).[8] In the year 2011-2012 the 83 million cost of the IFHP represented only 4/100ths of one percent of total health care expenditures in Canada,[9] or about 60 cents per taxpayer per year.

9. On April 25, 2012, the federal Cabinet replaced the 1957 OIC with another order-in-council, *Order Respecting the Interim Federal Health Program, 2012* (hereinafter OIC), which went into effect June 30, 2012. The OIC significantly reduced the health care coverage offered through the IFHP. Subsequently, the federal Cabinet adopted another order-in-council amending the OIC on July 18, 2012. These amendments restored coverage for basic health services and supplemental services to government resettled refugees and victims of human trafficking, but maintained coverage cuts to others.

10. The current regime divides recipients into the following categories.

    - The **first class** (including government assisted refugees and victims of human trafficking, some privately sponsored refugees) qualify for "expanded health-care coverage" which is substantially equivalent to the

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[4] Ibid,: pp.111,112,124, 130 (Exhibit D).
[5] Goldberg Affidavit p. 310 (Exhibit O).
[6] Affidavit of Allison Little Fortin, para. 5.Basic health, vision and dental care and drug benefits.
[7] Goldberg Affidavit, para. 16; Affidavit of Dr.Denis Daneman, para 12; Affidavit of Dr. Meb Rashid para 36.
[8] Goldberg Affidavit, para 18 and p.187-188, 190 (Exhibit G—ATIP request, Can. Inst.for Health Info. statistics)
[9] Le Bris Affidavit, para 39.

benefits under the previous program and what low and no-income Canadians receive.[10]

- The **second class** (refugee claimants, most privately sponsored refugees, protected persons and detainees) qualify for "urgent and essential" health coverage. This class no longer has coverage for prescription medication. As a result, they no longer have access to insulin, anti-epileptics, anti-asthma or psychiatric medication.[11] They lost coverage for psychological counselling, medical equipment, and vision and dental care.

- The **third class** (Refugee claimants from a designated "safe" country of origin (DCO)[12] and rejected[13] refugee claimants) only receive coverage if their health status poses a danger to public health or safety. Thus, they have no medication coverage and no coverage for treatment of any non-communicable disease or disorder—including diabetes, asthma, epilepsy, heart conditions, trauma, blood infections, non-violent psychoses, pregnancy, etc.

- The **fourth class** (individuals ineligible or late to claim and only entitled to a pre-removal risk assessment—"PRRA only") were covered under the pre-2012 IFHP and now receive no coverage for any reason, even if they pose a risk to public health or safety.

11. Second class refugee claimants ('non-DCO claimants') lost pharmaceutical coverage retroactively and included refugee claimants in the IRB's so-called "backlog"—of which there were some 38,000 in December 2012.[14] Third class refugee claimants (refused claimants) also lost coverage and this category includes claimants whose country is on a removals moratorium list, claimants who may be being sponsored by husbands or wives, and claimants those seeking supplementary forms of protection under IRPA. The other group of third class refugees claimants come from DCO countries, of which there are 37 to date. Some of these countries have been a major source of refugee claims in Canada over the past decade—notably Hungary and

[10] Fortin Affidavit, para. 5.
[11] These medications can be obtained if the individual goes on social assistance, however.
[12] This became applicable on December 15, 2012 when the DCO list came into force.
[13] The 2012 OIC defines a "rejected" claimant as one where all appeals and reviews of negative IRB decisions have been dismissed (*Order Respecting the Interim Federal Health Program*, 2012 SI/2012-26, s. 1 "person whose refugee claim has been rejected").
[14] Cross examination of Mitchell Goldberg, page 26, lines 7-12. Lack of drug coverage causes considerable difficulty, see affidavit of Laura Mansfield (asthma), Affidavit of Saleem Akthar (chemo); Affidavit of Joszef Bari (anti-psychotics).

Mexico.[15] Although drug coverage is available through social assistance, it is not clear how third class claimants could get prescriptions without coverage for doctor's visits.

12. Third class refugee claimants (public health and safety coverage) and fourth class claimants (no coverage) may be upgraded to class two coverage (health care coverage) at the discretion of the Minister. However, there is no way to obtain medication coverage for conditions that do not threaten public health or safety,[16] and the procedure is inadequate to protect the health of persons affected by the coverage reductions.

13. The stated objectives of the modification to the IFHP were to protect the integrity of the refugee system, ensure that recipients did not receive coverage more generous than what Canadians receive, and to protect public health and safety.[17] Aside from a lack of evidence that the cuts met these objectives, there was no consideration or study of the effect that these modifications would have on the health of refugees and asylum seekers and no consideration or study of whether these individuals could access alternative sources of health care if they lacked the ability to pay.[18]

14. Just before the changes, there were 126,000 persons covered under the IFHP.[19] Most were refugees or asylum seekers falling into one of the four classes listed above. Refugee claimants tend to be economically disadvantaged.[20] Study after study has shown that a person who is poor and uninsured will have only precarious and contingent access to health care

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[15] Goldberg Affidavit, paras. 37-39. Cross examination of Sonia Le Bris, Exhibit 2.
[16] OIC section 7
[17] Goldberg Affidavit, p. 308 (Exhibit O, CIC news release, April 25, 2012.)
[18] Cross examination of A.Little Fortin, p. 29, lines 3-13; LeBris cross examination p. 48 line 29, p. 29 line 3.
[19] Fortin Affidavit, para 8.
[20] Affidavit of Michael Ornstein, para. 22;

services and may suffer adverse health effects.[21] In contrast, all Canadian residents are insured under provincial health care plans and residents of Quebec are insured under a universal Pharmacare plan. Furthermore, all Canadian residents who cannot afford essential, life sustaining prescription medications such as insulin are eligible for publically funded drug benefit programs.[22]

15. Refugee claimants generally do not qualify for provincial health care plans.[23] Although refugee claimants, rejected claimants and PRRA applicants may be eligible for provincial social assistance programs, these programs **do not provide** comprehensive health care benefits; they only provide drug benefits and supplementary benefits. PSRs may not receive social assistance for one year after their arrival.[24] DCO-claimants are not eligible for a work permit in

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[21] Affidavit of Michael Rachlis, paras 5, 6(a), 18-24; Affidavit of Joanne Anneke Rummens, paras 4-7.

[22] **Ontario**: *Ontario Drug Benefits Act*, *Ontario Drug Benefit Act Regulation*, ss.3.8-10 (Trillium Drug Program) **Quebec**: *An Act respecting Prescription Drug Insurance*, s. 15;*Regulation respecting the Basic Prescription Drug Insurance Plan*, s. 4); **BC**: *Pharmaceutical Services Act*, SBC 2012 c 22 (BC PharmaCare),;**Alberta**: *Income and Employment Supports Act*, SA 2003, c I-0.5; **Sask**:,*The Saskatchewan Assistance Plan Supplementary Health Benefits Regulations*, Sask Reg 65/66(Supplementary Health Program); **Manitoba**: *Employment and Income Assistance Regulation* 404/88 R; **NB**: *Prescription Drug Payment Act*, SNB 1975, c P-15.01, *Prescription Drug Regulation*, NB Reg 84-170; **NFLD**: *Income and Employment Support Act*, SNL 2002, c I-0.1, *Income and Employment Support Regulations*, NLR 144/04,(Newfoundland and Labrador Prescription Drug Program); **NS**: *Employment Support and Income Assistance Regulations*, NS Reg 25/2001(Pharmacare);**PEI**:. *General Regulations*, PEI Reg EC396/03 (*Social Assistance Act*)(Financial Assistance Drug Program).

[23] **Ontario**: *Regulation 552* of the *Health Insurance Act*, see ss. 1.1(1)(b)(3), 1.4(5), 1.4(6); **Quebec**: *Regulation respecting eligibility and registration of persons in respect of the Régie de l'assurance maladie du Québec*, RRQ, c A-29, r 1, see ss. 2 and 3; **British Columbia**: ***Medicare protection Act*, s.1 "resident";** *Medical and Health Care Services Regulation*, BC Reg 426/97, see s.2 ("deemed residency")—s.2(b) is interpreted in practice as applying to refugee claimants in possession of an open work permit (see affidavit of Laura Mansfield, paragraph 6.); **Saskatchewan:** *Medical insurance Act* 2(q), *Medical Insurance Regulations*, section 3; **Alberta:** *Alberta Health Care Insurance Act*, s.1(x), *Alberta Health Care Insurance Regulations*, s.5; **Manitoba**: *Health Services Insurance Act*: s.2(1), *Residency and Registration Regulation*, , s.8; **New Brunswick:** *Medical Services Payment Act*, s.1; *General Regulation*, 4(5); **Nova Scotia**: *Health Services and Insurance Act*, s.1, *M.S.I. Regulations*, s.2(1), 2(2); **Newfoundland:** *Medical Care Insurance Act*, 2(h);government website specifically notes that refugee claimants are excluded from eligibility: http://www.health.gov.nl.ca/health/mcp/mcp_applications.html; **Prince Edward Island**: *Health Services Payment Act,s.1(s), Health Services Payment Act Regulations (General Regulations),* s.8.

[24] Because of sponsorship undertakings see *Immigration and Refugee Protection Regulations*, ss. 153(1)(b);153(2);153(3);154.

the first 180 days of their presence.[25] There is no evidence that publicly-funded health care facilities for the uninsured exist in all provinces; where they do exist, they have limited capacity.[26]

16. Despite several briefing sessions carried out by CIC after the 2012 OIC was already promulgated, there was a great deal of confusion among health care providers (and sometimes even the insurer, BlueCross/Medavie) as to what was covered by the modified IFHP and who was eligible. Moreover, coverage levels can fluctuate over time.[27] Medical witnesses uniformly stated that they found the altered IFHP unintelligible.[28] No medical witness with an opposite opinion has been put forward by the government. Significant numbers of doctors, clinics and even hospitals began either turning away refugee claimants or demanding cash upfront – often for services that were still actually covered.[29] This has had a chilling effect on the ability of refugees and refugee claimants to access care.

17. In addition, and without prior warning, CIC began withholding the temporary 30 day IFHP eligibility certificates that previously filled the gap between the time inland claimants indicated the intention to make a refugee claim and CIC determined eligibility.[30] This measure is not specified in the 2012 OIC.

18. Once the revised IFHP came into force on June 30, 2012, the health status of refugee claimants and privately sponsored refugees in Canada began to be

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[25] *Immigration and Refugee Protection Regulations,* s. 206(2).
[26] Cross examination of Dr. Meb Rashid, p. 55 lines 4-25, p. 56 lines 1-18; Affidavit of Dr. Paul Caulford paras 8, 23; Caulford cross examination p. 22 lines 17-25, pp. 23-24; Little Fortin cross examination p. 31 lines 12-25, pp. 33-34, p. 35 lines 1-10; cross examination of Manavi Handa p. 20 lines 1-19, p. 21 lines 5-25, p. 22 lines 1-19, p. 28 lines 4-16; Le Bris cross examination p. 48 lines 9-25, p. 49 lines 1-3. Cross examination of Richard Goldman, p.19, lines 15-22.
[27] Handa cross-examination, p. 21 lines 9-15; Caulford cross-examination,p.64, line 17 to p.65, line 24.
[28] Caulford affidavit paras 23-25; Rashid affidavit paras 28, 30, 26, 37; Rashid cross examination pp. 21-26, pp. 151-154.
[29] Handa cross examination, pp. 17-18, 20; Caulford affidavit paras 10-11, 13-15, 17, 22; Rashid affidavit paras 31-34, 38, 51(patients 24, 30); Affidavit of Christopher Bradley, para 8.
[30] Affidavit of Dolores del Rico, para 9

adversely affected, as their interim federal health coverage was suddenly lost, or no longer available and medical professionals and philanthropic agencies struggled[31] to preserve these people's life or health in its absence. The Applicants have provided evidence of over 40 refugee claimants whose lack of appropriate medical care and treatment has been documented by health care providers. Moreover, CIC itself issued a document outlining possible coverage scenarios under the modified IFHP. This document explicitly foresees that, for **third class** individuals (DCO claimants and rejected claimants), the IFHP coverage for cardiovascular disease, diabetes, pregnancy or a medical emergency such as a heart attack will be "NONE".[32] As well, the document explicitly foresees that **second class** individuals[33] (non-DCO claimants) will have no medication coverage in connection with these conditions and post-discharge after medical emergencies.[34]

19. The two individual applicants are among those most seriously put at risk.

20. On August 13, 2012, the applicant, Daniel Garcia Rodriguez, was refused a sight-saving operation to repair a retinal detachment on the grounds that he no longer had healthcare coverage for such emergencies under the IFHP and could not afford the large fee[35] for the operation. While his wife's refugee claim was accepted, his was refused and so he fell into the third class despite the fact that his wife was in the process of sponsoring him. Prior to the changes, this operation would have been covered by the IFHP. As he was at risk of blindness, his doctor wrote to the respondent's medical service explaining the urgency of his situation and requesting help.[36] This request

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[31] Bradley affidavit, para 6; Rashid cross examination p. 128 lines 21-25, p. 129 lines 1-8; Cross examination of Christopher Bradley, p. 23 lines 5-14, p. 25 lines 4-10, p. 30 lines 11-25, p. 31 lines 1-6. Cross examination of Dr. Paul Caulford, p.60, line 13 to p.63, line 4.
[32] Goldberg Affidavit, p. 299-304(Exhibit M).
[33] Class two recipients also include PSRs, but this is not explicitly mentioned in the document.
[34] Goldberg Affidavit, pp.299-304.
[35] The cost could have been up to $10,000. Affidavit of Daniel Garcia Rodriquez, Exhibit A. Applicant Rodriguez was not far above the LICO figures: see Ornstein affidavit, para.21.
[36] Ibid.

was refused on the grounds that he was 'illegal' in Canada.[37] On August 20, 2012, his doctor agreed to perform the eye surgery at a fraction of the cost. Further delay could have resulted in blindness.[38] He also suffered severe psychological stress during the course of these events.[39] He seeks recognition that his rights were violated.

21. The applicant, Hanif Ayubi, remains in Canada pursuant to a moratorium policy.[40] The government has determined that removal to Afghanistan is too dangerous. He is therefore remains in Canada pursuant to the moratorium policy, despite refusal of his claim. He has been suffering from type 1 diabetes since the age of 10 and arrived in Canada in 2001 fearing primarily the Taliban but also deterioration in his health due to the war.[41]

22. Until June 30, 2012 he was receiving insulin and medical care under the IFHP.[42] After that date he lost coverage for these items, since he is classified as a rejected refugee. As a low–income person,[43] he was unable to pay for the necessary blood tests he needs to monitor his diabetes and its complications.[44] He was eventually granted discretionary IFHP coverage by the Minister for medical services but not for medication. Thus, he is being kept alive on free samples of insulin obtained by a community health centre due to the charity of the drug manufacturer.[45] However, he requires other medications (in addition to insulin) which he is not getting. As well, his insulin prescription does not always match the samples and he once suffered a dangerous drop in blood pressure as a result.[46] Mr. Ayubi's health has been put at risk and is suffering

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[37] Rodriquez Affidavit, Exhibit B.
[38] Ibid, paragraph 20.
[39] Ibid.
[40] Affidavit of Hanif Ayubi, para.4.
[41] Ibid, para.4, 5, 6.
[42] Ibid, para.7.
[43] Ibid, para.4; Cross examination of Hanif Ayubi, p. 15, lines 4-8, 14-15, 19, 23; p. 16, lines 21-25; p. 17, lines 1-2; Undertaking of Hanif Ayubi (Income Tax Returns).
[44] Ibid, para.10. Bradley Affidavit, para 5.
[45] Ayubi Affidavit, para. 8; Bradley Affidavit, para 5.
[46] Bradley cross examination, p. 27 lines 14-21.

psychological stress[47] and seeks a declaration that his rights have been and are still being violated.

PART II—ISSUES

23. The applicants raise the following issues:

1) Are the 2012 modifications to the IFHP unlawful because the 2012 OIC itself was *ultra vires*?
2) Are the modifications made to the IFHP unlawful because legitimate expectations were not met?
3) Is there a violation of section 7 of the Charter?
4) Is there a violation of Section 15 of the Charter?
5) Is there a violation of Section 12 of the Charter?
6) Is there a breach of Canada's obligations under the *Refugee Convention*?
7) Are the Charter violations saved by section 1 of the Charter?

PART III-STATEMENT OF LAW

PRELIMINARY QUESTION: PUBLIC INTEREST STANDING OF CDRC AND CARL

24. The individual litigants in the case at bar only represent one class of individuals who have experienced reduction in IFHP coverage, namely "rejected claimants". No PSRs, non-DCO claimants, DCO claimants or PRRA-only applicants have come forward publicly. As illustrated above, each class of refugee or asylum seeker has seen their IFHP coverage reduced or eliminated in different ways and therefore different legal issues may arise for each class. CDRC and CARL, seek to represent the interests of the individuals in these unrepresented coverage classes.

25. CDRC and CARL satisfy the test for public interest standing set out recently by the Supreme Court of Canada in *Downtown Eastside Sex Workers United Against Violence et al*[48] and considered again in *Manitoba Metis Federation*[49]

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[47] Ayubi Affidiavit, para. 14 and Exhibit A (Dr.'s letter); Bradley affidavit, para 5; Bradley cross examination p. 30 lines 16-21.
[48] 2012 SCC 45.

26. First, there can be little doubt that the case raises a **justiciable issue**.

27. Second, CARL and CDRC have a **real stake in the proceedings** based on their continuing interest, reputation, and level of engagement with the issues raised in this case.[50]

28. **CDRC** is a group of physicians specializing in the treatment of refugees and refugee health issues. It was formed on April 26, 2012 in response to the pending changes to the Interim Federal Health Program that were announced on April 25, 2012. CDRC and all doctors treating refugees and refugee claimants are **directly affected** by the changes to the IFHP and therefore the outcome of this litigation. These doctors are facing moral, ethical and professional dilemmas about whether to treat people who no longer have coverage and have no ability to pay and are even in mid-treatment in some cases, and may face serious health risks without the treatment.[51] It was on a similar basis that a physician was granted public interest standing in *Chaoulli v. Quebec (Attorney General)*.[52] Physicians also have a commitment to protect public health.

29. CDRC has a unique expertise and continuing interest and engagement in respect of the subject matter of this case. Its members include many physicians who have been in the forefront of providing medical care to refugees and have extensive practical knowledge of all matters relating to refugee health care generally and the real-life health implications of the IFHP coverage reductions in particular.[53] There is no other comparable organization in Canada in terms of continuing interest in the effects of the modifications to the IFHP. It is far more economical to allow the CDRC to pursue the within

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[49] 2013 SCC 14.
[50] *Sex Workers ,supra* at para. 43.
[51] Rashid Affidavit, para 22.
[52] 2005 SCC 35 at para 32.
[53] Rashid Affidavit, para 15-27.

application on behalf of individual doctors and patients than to have the issues raised in a piecemeal fashion down the road.

30. **CARL**, an association of refugee lawyers created and incorporated in 2011 in response to sweeping changes to the refugee system contemporaneous with the modifications to the IFHP, has been an active advocate for refugees. Its membership has extensive experience in refugee law. CARL has been granted intervener status in several major Supreme Court of Canada cases impacting refugees.[54] CARL has demonstrated a real stake in the outcome of the proceedings in view of its continuing engagement in protecting the legal rights of refugees. Standards of treatment for refugees and asylum seekers is the underlying issue in this case.

31. The proposed applications of both CDRC and CARL, which constitute comprehensive challenges to the IFHP changes raising transcendent issues, are **a reasonable and effective means of bringing the issues before the Court** because both CDRC and CARL have the expertise, capacity, resources, and ability to present these issues concretely in a well-developed factual setting.[55] CDRC and CARL share many of the attributes of the public interest organizations granted standing both in *Sex Workers* and *Construction and Specialized Workers' Union, Local 1611 v Canada (MCI)*[56] decided after by the Federal Court after *Sex Workers.*[57] The factual record that will be provided by accompanying Applicants, Rodriguez and Ayubi, as well as the 22 affidavits filed, is an important factor in granting public interest standing.[58]

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[54] Goldberg Affidavit, para 2-12.
[55] *Sex Workers supra,* at para. 51.
[56] 2012 FC 1353
[57] Downtown Eastside Sex Worker United Against Violence Society (SWUAV), although a small, grassroots organization, was a reasonable, effective, expert and capable litigant in the absence of current sex workers willing to challenge to the provisions of the Criminal Code in question. Similarly, the Construction and Specialized Workers' Union was found to be a capable and expert litigant in part because of the impracticalities of individual workers bringing forth the litigation due to financial concerns and the fact that employees will not want to launch litigation against possible future employers.
[58] In *Sex Workers*, a former sex worker (Sheryl Kiselback) was a co-litigant, allaying concerns about the absence of a factual foundation for the public interest claim at para 74.

32. Finally, there are considerable practical difficulties in the missing categories (PSRs, non-DCO claimants or DCO claimants) coming forward as litigants.[59] The evidence has established clear reasons for this.[60] These concerns are distinct from those inherent in the usual immigration proceedings at issue in the *Canadian Council for Churches*[61] case. Some are similar to the impracticalities recognized in the *CSWU* case. The Supreme Court of Canada has also determined that "even if there are other plaintiffs with a direct interest in the issue, a court may consider whether the public interest plaintiff will bring any particularly useful or distinct perspectives to the resolution of the issue."[62] Thus, granting public interest standing to CDRC and CARL is a reasonable and effective alternative and prevent immunity from judicial review.[63]

33. It should be noted that another public interest organization has been denied standing to challenge the IFHP cuts, expressly because it was recognized that CDRC and CARL would be able to provide a factual record of the impact of the cuts in the case at bar. In *Hospitality House Refugee Ministry Inc. v. Canada (AG)*,the Court noted:

> (A)another application seeking similar relief has been filed with the Court, which is based on the actual impact of the Order on sponsored refugees (see *Canadian Doctors for Refugee Care, et al v Canada (Attorney General)*...(T)here is another proceeding underway in which these issues can be determined on the basis of a proper factual record. Accordingly, I cannot conclude that this application

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[59] Nonetheless, CARL in particular worked extensively to find individual litigants to challenge the IFHP cuts. This included emailing lawyers, advocates, doctors, nurses and social workers, and in-person appeals at large medical conferences. CDRC also assisted in these efforts. Some adversely affected individuals were willing to come forward on a limited basis, such as by telling their story via affidavit, but for the reasons above, most would not join the litigation efforts (Goldberg Affidavit, para. 10).

[60] Goldberg Affidavit, p. 26 lines 13-25, p. 17, p. 28 lines 1-2, p. 29 lines 15-25; p. 30, p. 33 lines 17-25; p. 35 lines 1-2; p. 35 lines 1-22; p. 117 lines 1-13, 16-26; p. 118 lines 1-24; p. 119 lines 6-14; Rashid affidavit, paras 26, 50; Affidavit of Jeffrey Rosekat, paras 33-37.

[61] *Canadian Council of Churches v. Canada (Minister of Employment and Immigration)*, [1992] 1 S.C.R. 236

[62] *Manitoba Metis Federation supra* at para 43.

[63] *Public Mobile Inc. v Canada (A.G.),* 2011 FCA 194 at para. 57

> represents a reasonable and effective means of bringing the Charter issues at stake before the Court…[64]

34. It is respectfully submitted that it would not be consistent for the Court to deny standing to Hospitality House on the grounds that CDRC and CARL have brought forward a reasonable and effective application, and then subsequently find CDRC and CARL's proposed application not to be reasonable or effective.

ISSUE 1: ARE THE 2012 MODIFICATIONS TO THE IFHP UNLAWFUL BECAUSE THE 2012 OIC ITSELF WAS ULTRA VIRES?

35. The applicants submit that ongoing actions taken pursuant to an *ultra vires* statutory instrument are themselves unlawful.

The IFHP is not a scheme of ex gratia payments authorized by crown prerogative:

36. The government describes the IFHP as "a discretionary, *ex gratia* program not based on statutory obligation."[65] This description is incorrect. *Ex gratia* payments typically arise in the context of relationships that are regulated according to the common law of contract, tort, and property, but where the payer expressly disavows any private law obligation to render the payment.

37. The government's definition of an *ex gratia* payment is contained in the Appendix to the Directive on Claims and Ex Gratia Payments. It is:

> …a benevolent payment made by the Crown. The payment is made in the public interest for loss or expenditure incurred where the Crown has no obligation of any kind or has no legal liability or where the claimant has no right of payment or is not entitled to relief in any form. An *ex gratia* payment is used only when there is no other statutory, regulatory or policy vehicle to make the payment[66].

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[64] *Hospitality House Refugee Ministry Inc. v. Canada (Attorney General)*, 2013 FC 543 at paras 24, 25.

[65] OIC Backgrounder (appended to OIC of April 5, 2012)

[66] Available online: http://www.tbs-sct.gc.ca/pol/doc-eng.aspx?id=15782&section=text#Exgratia

38. When the 1957 OIC was promulgated, Canada did not have a nation-wide, provincially administered, publicly funded health care system. Health care was paid for through private contracts. Describing a program of publicly reimbursing health care providers as '*ex gratia*' was consistent with the otherwise private nature of health care. By the 1960s, publicly insured, universal, accessible health care had become the norm, and deviations (based on duration of provincial residency or type of service) became the exception. Describing publicly insured health care in 2012 as '*ex gratia*' is thus anachronistic and inaccurate.

39. Citizenship and Immigration may not lawfully deny coverage to an eligible IFHP applicant, or refuse to reimburse a health provider who has provided services to an IFHP patient by baldly asserting that the payment is merely '*ex gratia*'. The patient or the health provider has a legal entitlement, enforceable not through a private law action (e.g, in debt), but by judicial review. The OIC is a statutory instrument that creates legal obligations and discretion is never unfettered.[67]

40. The fact that the government can modify or terminate the IFHP does not thereby make the IFHP '*ex gratia*' or otherwise distinguish it from any other government program that distributes benefits, such as social assistance or pensions, by way of statute or regulation. None of these schemes arose out of prior legal obligation under contract or tort. The public instrument used to deliver a benefit (statute, regulation, or Order-in-Council) does not determine the character of the benefit, but simply determines how that scheme of public benefits might be altered or abolished.

41. The fact that the IFHP expenditures are not *ex gratia* is evinced by government accounting practices. The Financial Administration Act requires each government department to report its financial activities to the Receiver

[67] Le Bris cross examination, p. 5 lines 14-25.

General, who issues an annual Public Accounts of Canada. The Public Accounts of Canada contains a department-by-department record of the quantum and recipients of ex gratia payments.

42. Citizenship and Immigration Canada has never reported the IFHP as an *ex gratia* payment in the Public Accounts of Canada. Payments in the order of millions of dollars under the Japanese Redress, persons exposed to Agent Orange testing on military bases, and the Chinese Head Tax, are reported as ex gratia payments by the relevant government departments[68]. Neither Citizenship and Immigration Canada, the Receiver General, nor Treasury Board, classify the IFHP as an *ex gratia* scheme

The OIC was ultra vires because there was no remaining executive prerogative in relation to immigration and health care

43. The applicants submit that the executive prerogative in relation to immigration, including access to insured health care for non-citizens in the refugee determination system, has been extinguished by the exercise of federal jurisdiction to legislate in relation to aliens and naturalization (s. 91(25)) and any jurisdiction which it may have over health care.

44. The Ontario Court of Appeal summarized the displacement of executive prerogative by legislative action: "once a statute occupies ground formerly 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"[69].

45. The legislative landscape in 2012 was very different than in 1957. By 2012, the *Immigration and Refugee Protection Act* (IRPA) and the *Immigration and*

[68] Public Accounts of Canada, 1995, 2009, 2012.

[69] *Black v. Canada (Prime Minister)* (2001), 199 D.L.R. (4th) 228, 54 O.R. (3d) 215, 147 O.A.C. 14; at para 27

Refugee Protection Regulations enacted thereunder, along with the *Canada Health Act*, had extinguished expressly or by necessary implication any residual federal prerogative over refugees and refugee claimants, including publicly insured health care[70].

46. Through the *Canada Health Act*, the federal government legislates the categories of persons to whom provinces should extend publicly insured health care in order to obtain federal contributions, and also enumerates classes over whom the federal government assumes direct responsibility (inmates and members of Canadian Forces).

47. The applicants submit that the combined effect of the IRPA and the *Canada Health Act*, situated in the context of a half century of publicly insured health care across Canada, extinguishes any executive prerogative to regulate insured health care for classes of refugees and refugee claimants created under IRPA.

48. Hogg and Monahan authoritatively list the residual spheres of executive prerogative as relating to the legislature, foreign affairs, armed forces, 'emergency', appointments and honours, mercy, creation of Indian reserves, immunities and privileges, and unclaimed property[71]. Refugees, refugee claimants and health care do not appear on this list.

49. Moreover, the structure of the OIC is entirely parasitic on IRPA's classifications of refugees and refugee claimants. This further demonstrates the extent to which IRPA already occupies the field of governing Canada's refugee regime.

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[70] *Khadr v. Canada (Attorney General)* (F.C.), 2006 FC 727, [2007] 2 F.C.R. 218, at para. 89.
[71] Hogg, P.W., Monaghan, P.J., and Wright, W.K., *Liability of the Crown,* ch. 1.5(b) "Crown prerogative" at pp. 23-4

ISSUE 2: LEGITIMATE EXPECTATIONS

If the OIC is intra vires the prerogative power, the government breached a duty of procedural fairness by failing to provide notice and an opportunity to participate prior to its proclamation

50. The doctrine of legitimate expectations does not create substantive rights. It can, however, give rise to procedural obligations that would not exist but for the legitimate expectation created by the administrative actor that a certain procedure would be followed or a certain result would be reached. [72]

51. In the present case, both prior consultation and prior practice gave rise to a legitimate expectations that the IFHP would not be radically altered without a public process of notice and consultation in which provinces, health professionals, refugee organizations, and other affected parties could participate.

Parliamentary Appropriation of Funds is Not a Legislative Act

52. The doctrine of legitimate expectations, and the procedural obligations it entails, does not traditionally apply to legislation, because the making of laws is typically preceded by a democratic process which courts refrain from supplementing with judicially-imposed procedures. For example, had the government dealt with the IFHP by amending the IRPA, "the only procedure due any citizen of Canada is that proposed legislation receive three readings in the Senate and House of Commons and that it receive Royal Assent"[73].

53. However, Parliamentary appropriation of funds is not the democratic equivalent of legislation. Parliament's engagement with the IFHP extends no further than appropriating funds for it. The applicants submit that "the process by which expenditures are authorized is not something which can be

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[72] *Baker v. Canada (Ministry of Citizenship and Immigration)*, [1999] 2 S.C.R. 817, at para. 26.
[73] *Authorson v. Canada (Attorney General),* 2003 SCC 39, [2003] 2 S.C.R. 40, at paras 37, 40..

realistically said to convey Parliamentary endorsement for any specific activity or which can be used to determine the legality of any activity as it occurs"[74]. Appropriating funds for the IFHP is not the equivalent of Parliamentary deliberation on the purpose and content of the IFHP, which is occasioned by Parliamentary reading, referral to committee, debate in the House of Commons, and Senate review. Indeed, the applicant submits that the respondent's insistence that the IFHP is not the product of statutory obligation affirms that appropriation is not tantamount to legislation.

54. The tenuous Parliamentary engagement occasioned by appropriation is exacerbated in the present case, where the appropriation was located in a budget document hundreds of pages long, and shielded from advance disclosure by claims to budget secrecy.

The Doctrine of Legitimate Expectations Applies to Executive Rule Making

55. The applicants submit that the doctrine of legitimate expectation can and should apply to executive rule making, whether authorized by the prerogative or by delegation. The distinction drawn by Evans JA in *Apotex v. Canada (Attorney-General)*[75] between primary legislation and Cabinet regulations enacted under statutorily delegated authority, applies equally to Orders-in-Council untethered to statute. Evans JA noted that delegated legislation is not subject to the "same level of scrutiny as primary legislation that must pass through the full legislative process". He further observed that consultation obligations in relation to Cabinet regulations further "democratic values of accountability, the claim of the governed to attempt to influence the content of the law to which they will be subject, and the belief that a better considered measure is likely to emerge from a consultative process."[76] Indeed, within a

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[74] John Howell, 'What the Crown May Do" (ALBA Summer Conference, delivered at St. John's College, Cambridge, 25 July 2009) at para. 73.
[75] *Apotex Inc. v. Canada (Attorney General) (C.A.),* [2000] 4 FC 264.
[76] Ibid, at 110

month of proclaiming the 2012 OIC, the Governor in Council reconsidered, rescinded it, and proclaimed a 'corrected' version[77].

56. In *Apotex*, Evans JA concluded that the rationale for exempting legislation from the doctrine of legitimate expectations was not apposite to Cabinet regulations. Therefore

> In the absence of binding authority to the contrary, the doctrine of legitimate expectations applies in principle to delegated legislative powers so as to create participatory rights when none would otherwise arise, provided that honouring the expectation would not breach some other legal duty, or unduly delay the enactment of regulations for which there was a demonstrably urgent need[78].

57. The Supreme Court of Canada has taken note of this dictum, and remarked that the "issue remains open for another day"[79].

The Requirements for Legitimate Expectations are Met in the Case at Bar

58. The legitimate expectation that the IFHP would not be radically altered absent a process of notice and an opportunity to participate arises from two sources.

59. First, the applicants submit that the fifty-five year duration of the IFHP created a legitimate expectation that it would not be fundamentally altered to the detriment of beneficiaries, the provinces and health providers suddenly and without warning. Over its history, the scope of coverage varied with changes to the composition of newcomers, the advent of publicly-insured health care at the provincial level, and the particular payment model. However, at no point during those 55 years were groups previously covered suddenly deprived of most or all coverage. Nor were health providers burdened with the task of triaging patients according to complex legal

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[77] *Order Respecting the Interim Federal Health Program*, 2012 SI/2012-26; *Order Amending the Order Respecting the Interim Federal Health Program*, 2012 SI/2012-49 July 18, 2012.

[78] *Apotex Inc. v. Canada (Attorney General)*, 24 Admin. L.R. (3d) 279, [2000] 4 F.C. 264, 188 D.L.R. (4th) 145, 4 F.C. 264 leave to appeal refused [2001] 1 S.C.R. v, [2000] S.C.C.A. No. 379 (S.C.C.)

[79] *Mount Sinai Hospital Center v. Quebec (Minister of Health and Social Services*], [2001] 2 SCR 281 at para. 34.

classifications related to the refugee determination process and completely unrelated to medical factors. Health providers, refugees, and those who represent the interests of refugees had a legitimate expectation, based on 55 years of reliance, that core elements of the IFHP would remain in place unless and until the government provided notice of proposed change, and allowed those affected a reasonable opportunity to express their views.

60. The applicants submit that English courts have moved toward recognizing that reliance on a certain policy will ground a legitimate expectation that the policy will not be fundamentally altered absent notice and an opportunity to participate:

> The court will (subject to the overriding public interest) insist on such a requirement, and enforce such an obligation, where the decision-maker's proposed action would otherwise be so unfair as to amount to an abuse of power, by reason of the way in which it has earlier conducted itself....[t]he impact of the authority's past conduct on potentially affected persons must, again, be pressing and focussed. One would expect at least to find an individual or group who in reason have substantial grounds to expect that the substance of the relevant policy will continue to enure for their particular benefit: not necessarily for ever, but at least for a reasonable period, to provide a cushion against the change. In such a case the change cannot lawfully be made, certainly not made abruptly, unless the authority notify and consult[80].

61. The applicants submit that the impact of the changes to the IFHP were drastic for patients, and very significant for health providers and provinces. The change to the IFHP was abrupt.

62. Secondly, the federal government had a past practice of consultation. When Ontario decided that it no longer wished to cover refugee claimants under OHIP, the federal and Ontario governments entered into negotiations that culminated in a 1995 Memorandum of Understanding (MOU).[81]

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[80] *R (Bhatt Murphy) v Independent Assessor* [2008] EWCA Civ755

[81] Goldberg affidavit, p. 93, Exhibit "C" (Ministry of Health "Bulletin: Eligibility Changes – Refugee Claimants" April 4, 1995).

63. The MOU ensured continuity of coverage so that the health of beneficiaries was not put at risk and compensation to health providers remained uninterrupted. This MOU altered who paid for health care but did not affect entitlement to insured coverage, and so the negotiations did not engender the need to consult with health care providers or recipients of coverage.

64. The 2012 OIC detrimentally affected provinces, health providers, and patients. None were notified or consulted in advance of the 2012 OIC. Respondent's affiant Sonia LeBris expressed the opinion that hospitals and doctors would continue to provide emergency care to uninsured refugees, and to pending, refused, or abandoned/withdrawn refugee claimants. Provinces fund hospitals and health providers. Nevertheless, the federal government did not warn or consult with provincial governments in advance about its intention to transfer to provinces (and provincial taxpayers), and to charitable health providers, the cost of treatment for uninsured patients who were unable to pay their medical and hospital bills.[82]

65. The federal government has long imposed a form of notice and comment requirement on all delegated legislation (Cabinet regulations).[83] This history demonstrates that the potential for the common law doctrine of procedural fairness to generate appropriate and feasible procedures for an Order in Council in the nature of the IFHP.

66. These minimum requirements for procedural fairness were not met in the case at bar.

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[82] Lebris affidavit para 30, LeBris cross examination, p. 43, lines 2-22.

[83] The notice and comment processes already applicable to all proposed federal regulations made under statutory authority, including Immigration and Refugee Protection Regulations, is summarized by Prof. France Houle: 'Regulatory History Material as an Extrinsic Aid to Interpretation: An Empirical Study on the Use of RIAS by the Federal Court of Canada' (2006) 19 CJALP 151 at 157.

67. A breach of procedural fairness results in setting aside the original result, whether or not the same result would have been reached had the process complied with the duty of fairness.[84]

ISSUE 3: SECTION 7 OF THE CHARTER

68. Where the government puts in place a scheme to provide health care, that scheme must comply with the Charter.[85] In order to establish that the changes to the IFHP are inconsistent with s.7, the 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. [86]

69. Privately sponsored refugees, refugee claimants, refused, abandoned and withdrawn refugee claimants are all in Canada, subject to Canadian law, and therefore come within the meaning of 'everyone' under s. 7 of the Charter. As such, the life and security-of-the-person of a refugee or refugee claimant in Canada is *prima facie* equally valuable and worthy of concern, protection and respect as the life and security-of-the-person of others in Canada.

Section 7 is engaged by the facts of the case at bar

70. The evidence before the Court discloses that, because refugees and asylum seeker are generally unable to afford to pay for medical services, the changes to coverage under the IFHP create a situation where individuals will be exposed to a risk of not having access to basic and necessary health care which will affect them both physically and psychologically thus engaging life and security of the person interests guaranteed by s. 7. In *Toussaint* Justice Zinn concluded that it was clear that the denial of IFHP coverage affected a s.7 interest:

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[84] *Cardinal v. Director of Kent Institution* [1985] 2 SCR 643 at para. 23.
[85] *Chaoulli v. Quebec*2005 1 SCR 791 at 104 (opinion of the Chief Justice)
[86] *Gosselin v. Quebec (Attorney General)*, [2002] 4 S.C.R. 429, 2002 SCC 84; at para 75

> (T)he record before the Court establishes 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. [87]

Indeed, this conclusion is consistent with the finding of the Supreme Court of Canada in *Chaoulli v Quebec*[88] and *R v Morgentaler.*[89]

71. It should be noted that the jurisprudence makes it clear that a threat to health is all that is necessary to trigger the engagement of the right to security of the person in s.7; there is no need to demonstrate the realization of the threat. Thus, the fact that the individual applicants and many of the asylum seekers whose situations are described in the affidavit evidence ultimately received or are receiving medical assistance on a philanthropic basis is not determinative of the question of whether there has been a violation of their rights. Furthermore, in this case, there is evidence of a sufficiently serious level of psychological distress suffered by the individual applicants as well as other asylum seekers as a result of difficulties accessing necessary health care after the cuts to IFHP coverage of June 30th 2012.[90]

The s. 7 interest is not an 'economic right'

72. It is submitted that in this case the issue is not an "economic right" which may fall outside the ambit of s.7. As noted in *Chaouilli*, "Limits on access to health care can infringe the right to personal inviolability. The prohibition cannot be characterized as an infringement of an economic right."[91]

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[87] *Toussaint v AG Canada* 2010 FCJ 987. The FCA upheld Justice Zinn on this point para. 59-66
[88] at par 116-119 and 123
[89] *R. v. Morgentaler*, [1988] 1 S.C.R. 30 cited in *Gosselin* supra at 206.
[90] Bradley affidavit, para 5; Cross examination of Dr. Paul Caulford p. 62 lines 23-25; p. 63 lines 1-4; Affidavit of Laura Mansfield, paras 3-7; Affidavit of Manavi Handa, paras 6-7; Cross examination of Manavi Handa, p. 23 lines 17-25, p. 24 lines 1-24.
[91] Chaoulli, paragraph 34, See also *Gosselin* supra at para 311.

The denial or reduction in IFHP coverage constitutes a deprivation by the state

73. The denial or reduction has the effect of leaving in place substantial financial and practical obstacles to obtaining basic medical care that refugees and claimants cannot practically and realistically overcome. As a result, they risk being denied access to basic, essential, urgent and life-saving treatment available to other persons legally present in Canada on a non-transient basis. This jeopardizes both their physical and emotional security of the person.

74. In *Chaoulli* the conduct of the Government that was in play was the prohibition against private health insurance. The Court held that denial of access to private insurance that would allow persons to obtain the treatment they needed was a deprivation by the state: "The evidence here demonstrates that the prohibition on health insurance results in physical and psychological suffering that meets this threshold requirement of seriousness".[92]

75. It is true that, in this case, the government is not prohibiting refugees and asylum seekers from obtaining health care *per se*; however, the government should have known that 1) that the vast majority of these individuals cannot afford to pay for care or private health insurance[93] and 2) that philanthropic access to health care may not be consistently and uniformly available to them.[94] Therefore, reducing IFHP coverage in the face of these facts was tantamount to erecting a barrier to essential health services for refugees and asylum seekers and was therefore a deprivation of their security of the person at least as serious as the prohibition in *Chaoulli.*

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[92] *Chaouilli* supra at para 123

[93] Regarding the economic situation of many refugees Dr. Rashid states, "They come with nothing, they clothe their kids with donations, they often don't have bus fare to come and see us in our clinic" (Rashid cross examination p. 49 lines 21-23). *See also* p. 49 lines19-25, p. 50 lines 1-25, p. 51 lines 1-4 *and* Affidavit of Michael Ornstein paras 12-22.

[94] See footnote 26.

76. The argument that the government has deprived the applicants of security of the person is not dependent on the contention that the government of Canada has a positive duty to provide health care. The issue here is **the withdrawal** of a previously available service. Refugees, refugee claimants, and refused refugee claimants, like applicants Rodriguez and Ayubi, were covered in the past for basic, essential and urgent health care prior to the 2012 IFHP, and it is *the changes in the IFHP that are the subject of this challenge* that exposed or expose them to the risk to their security of the person. Thus, the circumstances in this case are similar to the s. 7 deprivation found by the Supreme Court in *Canada v. PHS* [95] *(Insite)* in connection with the government's decision to close a safe injection facility. In contrast, in *Toussaint,* there was no entitlement to IFHP coverage to begin with.

77. Nor can it seriously be asserted that (as was the case in *Toussaint*) the cause of the deprivation of the section 7 interest in this case was the individual applicants' and other asylum seekers' mere presence in Canada. The applicant in *Toussaint* came to Canada voluntarily. The individual applicants, like refugees and asylum seekers generally, were forced to flee.

78. Characterizing the changes to the IFHP as a "policy choice" also does not insulate them from the ambit of section 7. As stated by the Supreme Court in *Insite*

> I conclude that, whatever form it takes, Canada's assertion that choice rather than state conduct is the cause of the health hazards Insite seeks to address and the claimants' resultant deprivation must be rejected.[96]

79. The Applicants also rely on the dicta of the Ontario Court of Appeal in *Canada v. Bedford* where it held that there was a causal connection between the applicant's security of the person interest and the provisions of the *Criminal Code* dealing with prostitution that prevented the Applicants from

[95] 2011 SCC 44 at paras 97-106
[96] *Insite* supra, para 106, 107

undertaking certain measures. "Where the limitation on security of the person in the nature of an increased risk of serious physical harm or worse, virtually any added risk that is beyond de minimis is sufficient to constitute an infringement on security of person.[97] The same reasoning applies here.

In the alternative, it is submitted that s. 7 imposes a positive duty to extend insured health care for basic, urgent and essential services to the affected populations in the present case

80. The applicants submit that the jurisprudence of the Supreme Court admits to the possibility of a positive duty to provide basic, rights-protective services and that this case is one where the Court should find such a duty. There is no dispute on the evidence that, without IFHP insurance coverage, many if not most of refugees and asylum seekers, being generally impecunious, will be exposed to the risk of not receiving adequate medical treatment.[98]

81. The Supreme Court of Canada has repeatedly recognized circumstances where positive government action may be required to make Charter rights meaningful. In *Vriend v. Alberta*[99] the Court found a positive obligation to add the ground of sexual orientation in provincial human rights legislation. In *R.v Beaulac*, the Court noted that "freedom to choose is meaningless in the absence of a duty of the State to take positive steps to implement language guarantees".[100]Indeed, the Supreme Court of Canada and in particular Justice McLachlin has always been careful not to limit the possibility of a positive claim under s.7—particularly where there is an adequate factual and evidentiary record.[101]

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[97] *Canada v. Bedford* 2012 ONCA 186 at 117-119 The Court did not accept the government's contention that there needs to be a 'strong causal connection" between the legislation and the alleged infringement (at para. 118).

[98] For instance, Applicant Rodriguez' emergency sight-saving operation was cancelled due when it was discovered that his IFHP coverage had been withdrawn and he could not quickly pay the large fee. Applicant Ayubi for many months had no coverage for care for his diabetes and had to rely on philanthropic assistance since he is a low-wage earner; he is still not receiving all the medications he needs. See also Caulford cross examination, p.62, lines14-16.

[99] [1998] 1 SCR 493

[100] *R v. Beaulac* [1999] 1 SCR 768 at para.20

[101] *Gosselin* supra at 82.

82. In *Dunmore v. Ontario (AG)*, the SCC found that that the exclusion of agricultural workers from the *Labour Relations Act* violated their right to freedom of association. In doing so, it recognized a circumstance where positive action was required in order to allow the affected claimants access to a Charter protected right they could not enjoy without government action. The Majority set out three requirements for recognition of such a positive obligation:

    1) The claim must be grounded in a fundamental charter right not only access to a statutory regime.
    2) There must be an evidentiary foundation that the claimants must be incapable of accessing this right on their own.
    3) There must be some level of action to implicate the state.[102]

83. In *Dunmore,* all the requirements were found to be met.[103] The right to organize was found to be included in the s.2(d) right to association, so the claim was not merely about access to the LRA. It was found that the exclusion of agricultural workers from the LRA substantially reinforced the difficulty in exercising their right to association. Finally, there was sufficient state action to implicate the state, as Ontario had legislated in this very area for the purpose of allowing other Ontario workers access to associative right In the words of the Court, " underinclusive state action falls into suspicion not simply to the extent it discriminates against an unprotected class, but to the extent it substantially orchestrates, encourages or sustains the violation of fundamental freedoms"[104]

84. Applying the "Dunmore test" to the case of classes of claimants excluded from IFHP coverage yields analogous results:

    > *The claim is grounded in a charter right.* This claim is to basic, essential, urgent and life-sustaining care which directly implicates life and security of person. As cited above, delays and other barriers to accessing healthcare have been found to engage s.7, and support the grounding of this claim in a fundamental Charter right.

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[102] [2001] 3 SCR 1016 at paras. 24-26
[103] Ibid *at* 34-48.
[104] *Dunmore* at para. 26.

The applicants are substantially incapable of exercising this right on their own. As in *Dunmore,* the affected claimants are a vulnerable group who cannot exercise their charter protected right without government action. The vast majority will not be able to afford care while they await resolution of their claim without IFHP funding. They are not in the position of tourists or other transient visitors to Canada who can arrange for health insurance at private expense when they plan their visit to Canada.

There has been sufficient state action to implicate the state. Again, this is not a claim for health care coverage *ab initio*, but the restoration of health care coverage that began with the 1957 OIC, paralleled the health coverage available to indigent Canadians up to 2012, and was peremptorily curtailed and withdrawn.

85. In these limited circumstances the extensive evidentiary record supports a positive obligation to cover life-sustaining care for individuals seeking protection in Canada. The IFHP was created with the intent to provide temporary health care coverage to persons seeking protection in Canada up until the time when this coverage was no longer necessary. The exclusion of certain classes of refugees and refugee claimants who cannot afford this coverage – coverage necessary for the preservation of life and security of person – deprives these individuals of s.7 protected rights. The affected individuals possess limited practical means to act to preserve their life and security of person if they are excluded from IFHP coverage. As the door to a claim for a positive right under s.7 has never been closed, it is submitted that this is a case where the circumstances merit recognition of such a right.

The deprivation is contrary to the principles of fundamental justice:

86. The principles of fundamental justice can be substantive as well as procedural.[105] The applicants submit that the principles of fundamental justice at play in this case are: equality, and the prohibition against arbitrariness and gross disproportionality.

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[105] *Reference re Section 94(2) of the Motor Vehicles Act*, [1985] 2 SCR 486 at 503

Equality

87. The applicant's submit that substantive equality would readily meet the three-part test in *R v. Malmo-Levine*[106] for recognition as a principle of fundamental justice. The arguments made below that the changes to the IFHP are discriminatory under section 15 could have equal application to the section 7 analysis.[107]

Arbitrariness and Gross Disproportionality

88. In *Chaoulli* the Court held that:

> 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 more serious the impingement on the person's liberty and security, the more clear must be the connection.[108]

Gross disproportionality has been defined as "state actions or legislative responses to a problem that are so extreme as to be disproportionate to any legitimate government interest."[109] It is submitted that the 2012 changes to the IFHP were either arbitrary or grossly disproportionate, or both, in light of the stated objectives of the changes. They are similar to arbitrary and grossly disproportionate health and life-related measures applied to vulnerable populations in *Morgenthaler, Insite, Chaoulli*, *Sfetkopoulos*[110], *A.C. v. Manitoba (Director of Child and Family Services)*[111] and *Bedford.*

89. **"Fairness to Canadians"** was one articulated objective of the changes to the IFHP. Specifically, the respondent asserts that "one of the key underlying

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[106] *R. v. Malmo-Levine; R. v. Caine* 2003 SCC 74 at para 215 . See also: *Reference re Secession of Quebec,* [1998] 2 SCR 217 at para 32; *R. v. Oakes,* [1986] 1 S.C.R. 103 at para 64.See also Patricia Hughes, "Recognizing Substantive Equality as a Foundational Constitutional Principle" (1999) 22 Dal LJ 5

[107] *New Brunswick (Minister of Health and Community Services) v. G.(J.)* [1999] 3 S.C.R. 46

[108] *Chaoulli v Quebec* 2005 1 SCR 791 at para 131

[109] *Canada v. PHS* 2011 SCC 44 (*Insite)* at para 133

[110] *Sfetkopoulos v Canada (AG)* [2008] 3 F.C.R. 399

[111] *A.C. v. Manitoba (Director of Child and Family Services)*, 2009 SCC 30, [2009] 2 SCR 181

principles of the policy reform was to put in place a program that provided coverage that was not more generous than benefits received by Canadians".[112]

90. This objective relies on a principle of fairness as formal equality: like cases should be treated alike, and it is unfair to treat them differently. Measured against this objective, the IFHP is arbitrary in three respects. First, the premise that IFHP recipients systematically benefited from coverage more generous than Canadians is false. Measures adopted to address a situation that does not exist are necessarily arbitrary. Secondly, it is arbitrary to assimilate IFHP candidates to the category of Canadians who are working and able to afford to pay for prescription drugs or drug insurance, without regard to the actual economic circumstances of both groups. Thirdly, the current IFHP does not equalize health care coverage in the name of fairness. Rather, it provides most refugee claimants and refugees with coverage that ranges from somewhat inferior to massively inferior to that of Canadians.

91. As well, the respondent asserts that fairness requires that "a decision to withdraw, abandon or have a refugee claim suspended or rejected, should have consequences in terms of the level of IFHP taxpayer-funded coverage provided by Canada to those recipients".[113] The respondent does not explain the conception of fairness that underlies this assertion. The applicant submits that it is arbitrary to withhold coverage for basic, essential, or urgent health care for purposes of inflicting 'consequences' on these classes of refugee claimants. First, the characterization of an unsuccessful claimant as exercising a 'decision to … have a refugee claim … rejected' is baseless. Secondly, the implication that refugee claimants whose claims are refused are wrongdoers deserving of punitive consequences is arbitrary.[114] Thirdly, to use access to basic, essential, or urgent health care as the "consequence" is

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[112] Le Bris affidavit, para 50.
[113] Ibid, para.60
[114] Goldberg affidavit, paras 35-39; Goldberg cross examination p. 102 lines 23-25, p. 103-104 (all).

arbitrary and grossly disproportionate. Finally, it is arbitrary to withhold health care in the name of saving taxpayer dollars when the respondent simultaneously insists that provincial, taxpayer-funded health care systems will absorb the cost of emergency care provided to individuals denied IFHP coverage.

92. The government asserts that another reason for reforming the IFHP was to **deter abuse of the refugee system**: "the previous IFHP was perceived by some as constituting a reason some foreign nationals came to Canada to assert unfounded claims and also a reason why they sought to remain in Canada for as long as possible after their claims were rejected by the IRB and often the Federal Court."[115] The government provides no evidence in support of who held the perception and whether it had any empirical validity. The applicant submits that it is arbitrary to put the lives of children, women and men at risk on the basis of an unsubstantiated perception of abuse.

93. The government has not produced any evidence to suggest that refugee claimants are motivated to travel to Canada to access the health care system, nor that denying health coverage will discourage frivolous claims. In any case, to withhold health coverage from a sick refugee claimant in Canada in order to deter another person from seeking refugee status in Canada is grossly disproportionate. It is a particularly egregious instance of treating a human being instrumentally as merely a means to an end. To place lives at risk not only to punish individuals for the lawful act of seeking refugee status in Canada, but also to deter others from doing the same, denies the inherent dignity to which 'everyone' under s. 7 is entitled.

94. The government asserts that **cost containment** was an objective driving the IFHP changes. The applicant submits that the fiscal implications of these

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[115] Le Bris affidavit, para 73.

changes expose them as both arbitrary and grossly disproportionate in relation to cost saving.

95. The changes to the IFHP will not create any cost savings for taxpayers (as opposed to the federal government), but only cost transfers. Throughout the Applicants' affidavits it is clear 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. Ultimately, when hospitals cannot recover the cost of health care from refugees and refugee claimants who experience health emergencies because of sudden or accidental events, or lack of timely primary care, these costs are borne by taxpayers in any event.

96. Furthermore, the impact of the IFHP changes on s. 7 interests is grossly disproportionate to the cost saving objective. As noted earlier, the per capita cost of the IFHP was only $552, about 10% of the per capita health cost of Canadians, or about 60 cents per taxpayer per annum. Thus, the IFHP spent little on each recipient, but delivered crucial, life sustaining benefits. The low cost also discredits the alleged perception of IFHP 'abuse', insofar as, overall, IFHP recipients significantly underutilize the healthcare system compared to Canadians.

97. The respondent asserts that '**safeguarding public health and public safety in Canada**'[116] is another objective of the IFHP changes. But in some instances, this objective is actually undermined. The IFHP arbitrarily reduces the scope of public health and public safety coverage by denying it to PRRA-only applicants for no discernible reason. Operational changes can delay the issuance of eligibility certificates to some newly arrived refugees and refugee

[116] Le Bris Affidavit, para 61

claimants who might very well have a communicable disease.[117] Most importantly, the Public Health and Public Safety grids are considered to be impenetrable and, for nearly a year, contained a "catch-22" admitted by the insurer (Blue Cross):[118] namely that if someone presented with symptoms of a contagious condition, there would be no IFH coverage for the investigative consultation unless the patient actually had the condition—which was impossible to determine until the consultation.

Discretionary coverage:

98. The applicants submit that the availability of discretionary provision of insured health services in "exceptional circumstances"[119] does not render the s. 7 violation concordant with the principles of fundamental justice or cure any Charter violations.

99. First, the possibility of discretionary relief cannot compensate for the deprivation of a right.[120] Secondly, essential medications for non-communicable personal health conditions are excluded under this provision in any event. Thirdly, the theoretical availability of healthcare coverage is practically meaningless in a wide range of situations where healthcare is required on an urgent basis. Fourthly it is unrealistic to expect that refugees and refugee claimants can access an opaque, unpublicized, paper-driven, application process. Refugee claimants and refugees who are turned away from health providers because they are not insured, or who have not approached health providers because they are uninsured and unable to pay privately, will be without recourse to the process. Finally, a recent CIC notice

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[117] Affidavit of Dolores de Rico, paras 7-10; Cross Examination of Dolores de Rico p. 19 lines 14-25, p. 20 lines 1-19; Fortin affidavit, para 11; Fortin cross examination p. 8 lines 9-25, p. 9-10 (all), p. 12 lines 3-6.

[118] Cross examination of Christopher Bradley, p.64, lines 14-20; p.66-67; pp. 81-82; Cross examination of Dr.Meb Rashid: pp.65-66 line 6; pp.68-69; p.69 line 23-p.70 line 16; pp.71-72; p.153, lines 7-9: ("Send me Einstein's theory of relativity, it's easier"); p.164-165;p.169.

[119] OIC section 7

[120] *Morgentaler* supra (therapeutic abortion committee process "contains so many potential barriers to its own operation that the defence it creates will in many circumstances be practically unavailable to women" at 72); R. v. Parker, [2000] O.J. No. 2787 at paras. 174-184)

announced that a request for urgent coverage by a refugee claimant may be treated as evidence that the request warrants the adversarial intervention of the Minister to oppose the claim.[121] Thus, a sick refugee claimant who seeks the positive exercise of discretion to obtain health coverage puts her own refugee claim at risk in so doing. As with the hospital committee process for regulating access to abortion in *Morgantaler*, the discretionary availability of health care is illusory and disconnected from the medical needs of the individuals affected.[122]

100. This discretionary mechanism is also illusory in actual practice. There is no formal guidance or application process.[123] The Minister's approval criteria for discretionary coverage is unknown. No one else is privy to this criteria.[124] The protocols for the process have not been publicized.[125] No reasons are required for a decision. Even the most informed health care providers have little working knowledge of it or have never used it.[126] As of September 2013, the government's position was that there was a delay with the Ministry of approximately one month for decisions on these requests.[127] However, anecdotal evidence suggests that the wait time is much longer—during which health deteriorates possibly to extreme levels.[128] The government has admitted that these types of requests are not suited to urgent situations,[129] and this is

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[121] Goldberg Affidavit Exhibit "L"
[122] *Morgentaler* supra at 72 (therapeutic abortion committee)
[123] Fortin cross examination p. 24 lines 6-25, p. 25 lines 20-25, p. 26 lines 1-22.
[124] Fortin Affidavit paragraph 26
[125] The protocol of October 2012 was obtained by request of the CCR (Goldberg affidavit para 30, Exhibit "J"); IR10 of the policy manual was obtained through ATIP and as October 2013 was not available on-line. (Goldberg affidavit, para. 30, Exhibit K). Reference to the existence of discretion was stricken from a media communication, Goldberg Affidavit, page 358, Exhibit P.
[126] Rashid cross examination p. 105 lines 16-25.
[127] Fortin affidavit, para. 27
[128] The applicant, Hanif Ayubi, waited three months for a response (Ayubi affidavit paras 10-11, Ayubi cross examination p. 23-24 (all)). The claimant identified as Patient 2 in the Notice of Application herein applied in November 2012 and apparently received positive discretion in March 2013 but did not realize this. (Affidavit of Victor Wijenaike paras 5-12, Cross examination of Victor Wijenaike, p. 34 lines 2-25). The person identified as Patient 5 in the Notice of Application herein waited several months and never received a reply before she was approved in principle (Affidavit of Richard Goldman, paras 15, 16). Another person waited months and was refused (Goldman affidavt, patient BB, paras 25-26).
[129] Fortin cross examination p. 27 lines 24-25, p. 28 lines 1-5.

supported by evidence.[130] It is not clear why applicant Rodriguez' doctor's letter to Dr. Grondin was not considered an application for discretion when all relevant facts were set out[131] and why CIC would have been content to let this applicant go blind when he was in process for permanent residency.

101. A lack of fundamental justice has been made out on the facts.

ISSUE 4: SECTION 15 OF THE CHARTER

102. The IFHP 2012 creates a health care hierarchy whereby the lives of refugees and refugee claimants, whose presence is anticipated and authorized under Canadian law, and who are a historically disadvantaged group, are deemed less worthy of public protection. This amounts to discrimination under s. 15.

103. In determining whether the legislation in question violates s. 15 of the *Charter,* a two-part test must be applied. It must be determined 1) whether the law creates a distinction that is based on an enumerated or analogous ground and 2) whether the distinction creates a disadvantage by perpetuating prejudice or stereotyping.[132] The key, therefore, is whether a distinction has the effect of perpetuating disadvantage on an individual because of his or her membership in an enumerated or analogous group. If the state conduct perpetuates prejudice, stereotypes or widens the gap between a historically disadvantaged group and the rest of society rather than narrowing it, then it is discriminatory.[133] Both branches of the test are met in the case at bar.

Distinctions Based On Enumerated Or Analogous Ground

104. There are two key distinctions made by the IFHP 2012 in this case. The

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[130] Rashid cross examination p. 132 lines 3-22.
[131] See *Lam v. MCI* 152 F.T.R. 316, [1998]
[132] *Withler v. Canada (Attorney General)* 2011 SCC 12 at para. 30; *R. v. Kapp,* 2008 SCC 41 at para. 17.
[133] *AG of Quebec v. A, 2013* SCC 5

first is on the basis of national or ethnic origin, namely, between refugee claimants from designated countries of origin and refugee claimants that are not from a designated country of origin. The second is based on the claimants' status as individuals legally in Canada for the purpose of seeking protection. In both cases the distinctions are based on enumerated or analogous grounds and in both cases the end result is discriminatory.

Distinction Based on Country of Origin

105. The current IFHP draws a distinction between the health benefits that are received by individuals who are claiming refugee protection from DCO countries and those that are claiming refugee protection from any other country. As noted above, individuals from DCOs have no coverage for medical services or for medications except for contagious diseases and psychotic states involving a risk to others. This severe restriction to potentially life saving treatments is based entirely on the basis of national and ethnic origin and has nothing to do with the medical needs of the individuals excluded from the health benefits.[134] This is consequently a clear distinction based on national or ethnic origin—an enumerated ground under s. 15 of the *Charter.*

Distinction Based On Status as an Individual Lawfully in Canada for the Purpose of Seeking Protection

106. The IFHP also draws a distinction between individuals who are legally in Canada for the purpose of seeking protection and other legal residents who are provided health benefits by the government. Under the new IFHP, individuals like the Applicants who are legally in Canada for the purpose of seeking protection, are now prevented from obtaining the same health benefits as other

[134] Cross Examination of Sonia LeBris, page 34, lines 9-24, page 36, lines 15-24

legal residents in Canada.[135]

107. In Canada, legal residents who are entitled to health care are all entitled to significant health coverage. The extent to which individuals receive additional health benefits from the Government is determined on the basis of income which is used as a proxy for need.[136] Specifically, individuals who fall below a particular income threshold and qualify for social assistance are thought to be unable to pay for certain health benefits or for health insurance that individuals who exceed this threshold are thought to be able to pay for.[137] These individuals consequently receive more health benefits than individuals whose income surpasses that income threshold.[138] In some instances where additional need is demonstrated, even individuals who exceed the income threshold required for social assistance are provided additional support from the Government above and beyond the regular health care coverage they would otherwise receive.[139]

108. In contrast, under the new IFHP, many individuals lawfully in Canada to seek protection do not receive the same baseline benefits that are accorded to individuals who are legally in Canada for the purpose of seeking protection, and additional health benefits are not provided to any individuals, even those who meet the income threshold to obtain social assistance. A clear distinction is consequently drawn between individuals legally in Canada seeking protection and other legal residents of Canada who receive health care. It is submitted that the new IFHP consequently creates a distinction in an individual's entitlement to health benefits based on an analogous ground to

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[135] It should be noted that the Courts have held that there need not be "one" mirror comparator group in order for a distinction to be established. Instead there can be multiple comparator groups used to highlight different elements of distinction being drawn (*Falkiner v. Ontario (Ministry of Community and Social Services, Income Maintenance Branch* 212 D.L.R. (4th) 633 at paras. 70-72.) What must be established is that there is a distinction whereby the claimants are excluded from a benefit that is available to "others" (*Withler v. Canada (Attorney General)* 2011 SCC 12).
[136] Le Bris cross examination, p. 29 lines 9-12, 24-25, p. 30 lines 1-17, p. 31, 32 (all), Exhibit 1".
[137] Ibid; Goldberg affidavit p. 78 lines 3-11, 18-25, p. 79 lines 1-4, 81 lines 22-25.
[138] Le Bris cross examination p. 29 lines 9-12.
[139] Le Bris cross examination p. 29 line 24 to p. 31, line 10

those enumerated in s. 15 of the *Charter.*

109. The Courts have not decided upon the issue of whether the status of individuals legally seeking protection in Canada constitutes an analogous ground. The jurisprudence on immigration status more broadly is mixed and demonstrates that whether or not a person's immigration status constitutes an analogous ground will depend on the nature of that person or group's particular immigration status.[140]

110. For example, this Court in *Jaballah (Re)* found that immigration status was an analogous ground. In *Jaballah,* the accused's specific immigration status was a foreign national detained under a security certificate in Canada. The comparator group was Canadian permanent residents also detained for security reasons. The accused argued that subsection 82(2) of the *Immigration and Refugee Protection Act* discriminated against him on the basis of his immigration status. In the course of its analysis, the Court found that subsection 82(2) did result in discriminatory treatment of a foreign national "solely on the basis of his immigration status," which they found to be an analogous ground. The Court indicated that "the treatment of one foreign national differently from another who has been admitted as a permanent resident, with only a qualified right to remain, cannot be justified as providing equal protection and benefit of the law."[141] In contrast, in *Toussaint v. Canada (Attorney General)* the Court held that an individual who was without legal immigration status because she had overstayed her visitor's visa was not a person whose particular immigration status constituted an analogous ground.

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[140] See e.g. *Jaballah (Re)* [2006] 4 FCR 193 at paras. 80-81*; Church of Scientology,* 33 OR (3d) 65 at para 125; *Pawar v. Canada* [1999] 1 FC 158 at para. 23; *Toussaint v. Canada (Attorney General),* 2011 FCA 213, *Irshad (Litigation Guardian of) v. Ontario (Minister of Health)* (2001), 55 O.R. (3d) 43 (C.A.))

[141] *Jaballah (Re)* [2006] 4 FCR 193 at paras. 80-81

111. The case law indicates that a key factor for determining whether a person's immigration status is considered to be an analogous ground is whether or not the person's immigration status is immutable. A second key factor is whether the group has experienced historic disadvantage.

112. The Applicants' status in this case as individuals in Canada legally seeking protection constitutes an analogous ground because the status of these individuals is constructively immutable and the group is one which has been historically disadvantaged. Individuals who are legally seeking protection in Canada have either fled their countries out of fear of persecution, torture, or cruel and inhumane treatment or punishment or can no longer return to their country of origin because of the persecutory treatment that they will face upon their return. Such is often the case even for individuals who have been excluded or whose claims have been abandoned, as a determination of exclusion or abandonment does not involve an assessment of the risks that the individual faces upon return to their country of origin. This is why such individuals can apply for a Pre-Removal Risk Assessment prior to their removal to ensure that they are not returned to persecution or torture. Even individuals who have had their claims rejected may not have a choice with regard to their status here in Canada. For example some claimants are not able to return to their home countries because of a removals moratorium. These individuals must reside in Canada as a refugee claimant whose claim has been rejected. Therefore, their immigration status is not one that they have the power to change and therefore constitutes an immutable characteristic.[142]

113. In contrast, in the cases where the Courts have found that a particular individual's immigration status does not constitute an analogous ground, the

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[142] While the Government's treatment of individual's within the group of individuals who are legally residing in Canada to claim protection varies according to the subcategory that the Government deems those people to be apart of, Justice Abella in *Quebec (Attorney General) v. A* noted that "heterogeneity within a claimant group does not defeat a claim of discrimination, not all members of a group have to receive the same treatment from an impugned law to be deemed discriminatory" at paras. 354-455. See also: *Brooks v. Canada Safeway Ltd* 59 D.L.R. (4th) 321.

Courts found that the individual's status was not immutable. Indeed, Stratas J.A. for the Federal Court of Appeal in *Toussaint, supra* went as far as to say that the Government of Canada had a legitimate interest in expecting people who were residing illegally in Canada to change that status.

114. Individuals who are in Canada for the purpose of claiming protection also make up a historically disadvantaged group. They are generally individuals who have already been marginalized and are fleeing persecution on the grounds of race, religion, ethnicity, gender, sexual orientation or political opinion. These individuals have been forced to leave their home countries to seek a new home in a country like Canada in spite of many financial, physical and psychological hardships in doing so. These individuals' lack of citizenship in Canada perpetuates their disadvantage. These disadvantages are exacerbated by the invidious portrayal of them as 'bogus' and' fraudulent' which in turn fosters public opinion that they should be regarded with suspicion and disdain[143]. They are the ultimate "discrete and insular minority" whose "needs and wishes elected officials have no apparent interest in attending".[144] As noted by Justice Bastarache in *Lavoie:* "it is settled law that non-citizens suffer from political marginalization, stereotyping and historical disadvantage."[145] Similarly, Justice LaForest held in *Andrews,* that "Non-citizens are a group of person who are relatively powerless politically and whose interests are likely to be compromised by legislative decisions."[146]

115. Given the constructive immutability of the status of individuals legally residing in Canada for the purpose of claiming protection, and the fact that they are individuals who have historically been discriminated against and are at a disadvantage, their particular immigration status constitutes an analogous ground for the purpose of s. 15 of the *Charter.*

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[143] Affidavit of Chris Anderson, paras 5, 7.
[144] *Law Society of British Columbia v. Andrews,* [1989] 1 SCR 143
[145] *Lavoie v. Canada,* [2002] 1 SCR 769 at para. 45
[146] *Law Society of British Columbia v. Andrews,* [1989] 1 SCR 143 at para. 68

116. In *Auton, supra*, the Court held that "it is not open to Parliament…to enact a law whose policy objectives and provisions single out a disadvantaged group for inferior treatment."[147] Yet, both of the distinctions outlined above (country of origin and protection-seeking immigration status) single out a disadvantaged group for inferior treatment by precluding them from health care coverage. These distinctions therefore create a disadvantage by perpetuating prejudice or stereotyping.[148]

The Distinction Creates A Disadvantage By Perpetuating Prejudice Or Stereotyping

117. In the case of claimants from a DCO, the discrimination perpetuates the prejudicial idea that individuals who come from these countries seeking protection are undesirable and unworthy, so that the predictable suffering that they would experience from the lack of basic, essential, urgent or life-saving health care matters less than the suffering of others among us. It also further marginalizes minorities who are known to face significant persecution in DCO countries, such as the Roma from Hungary.[149] As such the distinction is prejudicial and perpetuates discriminatory stereotyping.

118. The distinctions made in the IFHP based on the status of individuals legally residing in Canada for the purpose of claiming protection, widens the gap between historically disadvantaged groups and the rest of society by not providing them with health care coverage that other legal residents receive. In *Eldridge v. British Columbia (Attorney General)*[150] the Supreme Court found that the impact of the impugned law or program would be discriminatory if the law or program restricts access to a fundamental social institution on a

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[147] *Auton (Guardian ad litem of) v. British Columbia (Attorney General),* 2004 SCC 78 at para. 41
[148] *Auton* 2004 SCC 78; *R. v. Kapp,* 2008 SCC 41
[149] Goldberg affidavit, paras 38-39; Goldberg affidavit, Exhibit "Q" (Amnesty International "Human Rights Here - Roma Rights Now, April 2013; US Department of State Country Reports for 2012, Hungary & Mexico; Patterns of Prejudice, "The Exclusion of Roma Refugee Claimants in Canadian Refugee Policy.")
[150] *Eldridge v. British Columbia (AG),* 1997 3 SCR 624

protected ground. Thus, the Court ordered the reinstatement of public funding of translation service for deaf patients after these services had been withdrawn.

119. The deaf patients in *Eldridge* were found not to be seeking more care than what was provided to others; rather the translation services were needed simply in order for them to have the same services as others without disadvantage or discrimination. In the case at bar, the cuts to health services in the IFHP 2012 to individuals who are legally residing in Canada to claim protection creates a risk that these individuals will go without much needed, and potentially life-saving, treatments. Accordingly, the Applicants are asking for health care services at the same level as other persons lawfully in Canada in similar economic circumstances without discrimination. As these services are currently not being provided, a s. 15 breach has been made out.[151]

120. The breach is further evidenced by the fact that the exclusions from health coverage are not in keeping with the overall purpose of the IFHP, which is to provide much needed health benefits to individuals who come to Canada seeking protection. Indeed, the Federal Court of Appeal in *Toussaint, supra,* held that the exclusion of "a particular group in a way that undercuts the overall purpose of the program" would likely be discriminatory as "it amounts to an arbitrary exclusion of a particular group."[152] This is the case even if the program is one that furthers the benefit of the group above others in society.

121. The IFHP, as modified by the 2012 OIC, cannot be shielded as a s.15(2) ameliorative program. The changes do not reflect a "sincere purpose ... to promote equality by ameliorating the conditions of a disadvantaged group".[153]

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[151] In the recent case of *Finch v. The Commonwealth of Massachusetts* 959 NE 2d 970 (2012) the Supreme Judicial Court of Massachusetts ruled that a scheme to exclude certain lawful residents from the state's public health insurance plan constituted impermissible discrimination on the basis of alienage and national origin. See also *Aliessa v. Novello* 96 N.Y.2d 418 (2001).
[152] *Toussaint v. Canada (Attorney General)*, 2011 FCA 213 at para. 107
[153] *R v Kapp,* [2008] 2 SCR 483 at para 47.

122. As noted by the Court in *Service Employees International Union, Local 204 v. Ontario (Attorney General)*[154], "s. 15(2) was placed in the *Charter* to make clear that s. 15(1) does not preclude affirmative action programs in favour of disadvantaged individuals or groups even though such programs inevitably involve some element of reverse discrimination against those not belonging to the disadvantaged groups."[155] The Court further noted that "[s]ection 15(2) does not protect affirmative action legislation from attacks by members of the disadvantaged group it was designed to benefit."[156] The fact that it is members of the disadvantaged group that the Interim Federal Health program was designed to protect that are now excluded from its benefits, is further evidence of the fact that the distinctions drawn by the Government violate s. 15 of the *Charter.*

ISSUE 5: SECTION 12 OF THE CHARTER

123. It is submitted that the right not to be subjected to any cruel and unusual treatment or punishment in s. 12 of the Charter should be considered as the functional equivalent of the international prohibitions against "cruel, inhuman and degrading treatment or punishment" found in the *International Covenant on Civil and Political Rights* (Article 7), and the *European Convention on Human Rights* (Article 3) and should be interpreted in a manner consistent with those provisions as well as with the Eighth Amendment of the Constitution of the United States.

Treatment:

124. According to the Supreme Court, there must be an "active state process in operation, involving an exercise of state control over the individual, in order

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[154] 35 O.R. (3d) 508
[155] *Service Employees International Union, Local 204 v. Ontario (Attorney General),* 35 O.R. (3d) 508 at para. 69
[156] Ibid.

for the state action in question, whether it be positive action, inaction or prohibition, to constitute "treatment" under s. 12."[157]

125. It is submitted that when an affected refugee claimant is deemed eligible by the Canadian government to make a claim for refugee protection or for complementary human rights protection and is awaiting determination of that claim, he/she is effectively under the administrative control of the state. Furthermore, the OIC in question in this case specifically prohibits the Minister from paying the costs of certain medical services or medications for certain categories of refugees or refugee claimants. Accordingly, it is submitted that the denial or withdrawal of interim federal health coverage for certain refugees and asylum seekers constitutes a state process of inaction, prohibition or under-inclusive action.

126. Canadian jurisprudence on what has been found to constitute "treatment" under s. 12 is somewhat sparse. However, internationally, the Judgment of Lord Scott in the landmark case of *R. v. Secretary of State for the Home Department ex parte Adam et al,*[158] provides valuable guidance and explicitly supports the position that the denial or withdrawal of IFHP coverage for certain refugees and asylum seekers constitutes "treatment" under Section 12 of the Charter. The case involved a challenge to a British law that disqualified asylum seekers deemed to have delayed filing their application for asylum from receiving government support in the form of housing etc. The House of Lords unanimously held that the denial of support constituted "treatment" within the meaning of Article 3 of the *European Convention on Human Rights*, and that the treatment was degrading.[159]

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[157] *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 SCR 519 at para 182.
[158] *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
[159] Ibid, paragraph 7, per Lord Bingham

127. Interestingly, Lord Scott concluded, *obiter* and by way of illustration, that a refusal to provide health care services would constitute "treatment" under Article 3 where the government provides such services and determines entitlement to them, even where it is not required to do so:

> The ECHR does not require signatory states to have a national health scheme free at the point of need. In this country we have such a scheme. Asylum seekers are entitled to make use of it whether or not they have applied for asylum as soon as practicable after arrival here. The section 55(1) bar on provision of support does not extend to a ban on medical treatment under the NHS. But suppose that it did. **It could not, in my opinion, sensibly be argued that a statutory bar preventing asylum seekers, or a particular class of asylum seekers, from obtaining NHS treatment would not be treatment of them for article 3 purposes.**[160] (Emphasis added)

128. It is submitted that, based on this jurisprudence, the amendments to the IFHP are "treatment" because, in the words of Lord Scott, they establish a "regime [...] imposed on an individual, or on a class to which the individual belongs, barring that individual from basic social security and other state benefits to which he or she would, were it not for that statutory regime, be entitled."[161] Furthermore, for some asylum seekers, the changes to the IFHP constitute the deliberate imposition of a disadvantage, and this has been acknowledged by the government.[162]

129. An alternative test for the existence of "treatment" can be found in the judgments of Lords Hope and Brown in *ex parte Adam* where both Lords held that in determining whether "treatment" has occurred, the focus should be on whether the government can be held responsible for the applicant's suffering, rather than a focus on positive or negative state action.[163]

130. Based on this formulation, where there is an inability to pay for health services privately, the government's refusal to continue providing interim

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[160] Ibid, para. 69.
[161] Adam, Scott, para 66-67
[162] Affidavit of Sonia Le Bris, paragraph 77, 78
[163] Adam, paragraphs 53, 92. Baroness Hale also commented that availability of philanthropic aid does not change the character of the government's action as imposition of suffering at 77.

federal health and medication coverage to certain categories of refugees and refugee claimants (particularly where no determination has been made as to the possibility of or timing of a return to the country of origin) places a responsibility on the government for the hardship resulting from exposure to the risk of not being able to access health services. This causal link has been admitted by government witnesses.[164]

"Cruel and unusual"

131. The Supreme Court of Canada has ruled that "cruel and unusual" means "so excessive as to outrage [our] standards of decency"[165].

132. The Supreme Court in *R. v. Smith*[166] also approved the usefulness of nine factors that could be considered in determining whether treatment or punishment is "cruel and unusual". These factors were whether the treatment" a) goes beyond what is necessary to achieve a legitimate aim; b)has adequate alternatives; c) is unacceptable to a large segment of population; d)can be applied upon a rational basis in accordance with ascertained or ascertainable standards; e)is arbitrary; f)has no value or social purpose, like reformation, rehabilitation, deterrence or retribution; g)accords with public standards of decency or propriety; h)shocks the general conscience or is intolerable in fundamental fairness; and i) is unusually severe and hence degrading to human dignity and worth.[167]

133. The changes to the IFHP go beyond what is necessary to achieve the government's aims. The evidence indicates that the changes made to the asylum system in 2012 (faster processing times, restrictions on access to the PRRA and H&C process, the DCO list, and other measures taken by the Minister) *by themselves* can be expected to reduce the overall time claimants

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[164] Cross examination of Sonia Le Bris, page 48, lines 9-20.See also: Cross Examination of Teny Dikranian, pp. 60-61, Q's 276-278
[165] *R. v Smith*[1987] 1 S.C.R. 1045
[166] *Ibid,*at 44.
[167] *ibid* at para 92

spend in Canada relying on IFHP insurance coverage and to deter unmeritorious claims, and therefore constituted adequate alternatives.[168]

134. In addition, the changes to the IFHP have no social value. They do not make health care more accessible to Canadians.[169] Nor do they reverse any health care imbalance between Canadians and refugees and asylum seekers because no such imbalance ever existed in the first place. Furthermore, the cuts achieve no real cost savings to taxpayers, only cost transfers.[170]

135. Finally, the cuts to IFHP coverage shock the conscience, are unacceptable to a large segment of the population, do not accord with public standards of decency or propriety and are intolerable in fundamental fairness. Evidence of this is the fact that health care professionals,[171] newspaper editors (some directly in response to the situation of the applicant, Daniel Garcia Rodriquez)[172] and even some provincial politicians[173] have condemned the cuts in the strongest possible terms.

136. Canada's international obligations, as incorporated into Canadian law, affirm Canada's commitment to the notion that asylum seekers are entitled to seek refugee status in Canada.[174] The government has described deterrence as

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[168] IRPA ss. 25(1.2), 100 (4.1), 111(1.2), 112(2)(b.1): IRPR 159.9; Cross Examination of Teny Dikranian, p.33, 43, 47, lines 10-18(fewer remedies, faster processing times);pages 62, 63 (billboards placed in Hungary) .

[169] There was no evidence submitted that the alleged costs savings were going to be applied to improving health insurance benefits for Canadians.

[170] Rachlis affidavit, paras 6(c), 6(f), 25-30, 38; Le Bris cross examination p. 25 lines 6-20, p. 26 lines 4-13, 18-20.

[171] Rashid affidavit, Exhibit "B".

[172] Goldberg affidavit, Exhibit "R", page 560ff (*Neither sound, nor caring*, Winnipeg Free Press June 20, 2012; *Chopping health coverage for refugees is a false saving*, Toronto Star, June 23, 2012; *A Dose of Common Sense,* Calgary Herald July 6, 2012; *A Toronto doctor saves a refugee's eyesight, but what about others?*, The Toronto Star, August 22, 2012; *Amid Kenney's worthy reforms, a misstep on refugees' health*, The Globe and Mail, August 23, 2012.

[173] Affidavit of Mitchell Goldberg, Exhibit "R", page 567 (letter from Ontario Health Minister Deb Matthews to Federal Health Minister Leona Aglukkaq and Federal Immigration Minister Jason Kenney, June 27, 2012); Affidavit of Saleem Akhtar, Exhibit "A", CBC News, "Saskatchewan's Wall slams federal cuts to refugee health"

[174] *Universal Declaration of Human Rights*, GA res. 217A (III), UN Doc A/810 at 71 (1948) art.14.

one of the objectives of the modification of the IFHP. It shocks the conscience to deprive people of insured health care for the express purpose of inflicting predictable and preventable physical and psychological suffering, as a means of deterring people from exercising their entitlement under Canadian law to seek refuge.

137. Aside from applying the factors outline in *Smith*, it is also submitted that s. 12 of the Charter should be interpreted in conformity with the international rights to freedom from "inhuman and degrading treatment" in the ICCPR and the ECHR. As noted by the United States Supreme Court in *Trop v. Dulles*[175], "the basic concept underlying the Eighth Amendment is nothing less than the dignity of man …." Treatment will be degrading if it humiliates a person with disrespect that diminishes their dignity or creates fear, anguish or feelings of inferiority that can damage an individual's physical and moral resistance.[176] Access to health care is recognized to be at the core of the preservation of human dignity. Restriction on access to medical care displays a lack of concern for the victim as a person.

138. For instance, US courts have determined that failure or refusal to provide treatment, when indicating a deliberate indifference to serious medical and psychiatric needs of prisoners, results in unnecessary and wanton infliction of pain prohibited by the Eighth Amendment.[177] This notion has also been extended to exposure of inmates to second-hand smoke, in that exposure to a potential threat to health is sufficient to constitute cruelty.[178] Internationally, in *International Federation of Human Rights Leagues (FIDH) v. France*,[179] the European Committee on Social Rights held that access to health care is a prerequisite for the preservation of human dignity and that legislation or practice which denies entitlement to publically funded medical assistance to

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[175] 78 S.Ct. 590
[176] Pretty v. UK(2002) 35 EHRR 1
[177] Estelle v. Gamble 97 S.Ct. 285; Bowring v. Godwin 551 F.2d 44
[178] Helling v McKinney 113 S.Ct. 2475
[179] COMPLAINT No. 14/2003

impecunious foreign nationals within the territory of a State Party is contrary to the European Social Charter. In *D v UK*[180] the European Court of Human Rights ruled that this principle even prevents a state from deporting someone because they would not receive adequate medical care in their home country. Indeed, s. 97(1)(b)(iv) of IRPA has been interpreted to mean that if a state is able to provide health care but unwilling to do so on discriminatory grounds, this constitutes cruel and unusual treatment and will result in recognition that the person requires protection.[181]

139. Denial of or serious restrictions on access to publically funded health insurance for impecunious refugees and refugee claimants would be an anomaly among health care policies of similarly situated developed countries, supporting a finding of cruel and unusual treatment within the meaning of s. 12.[182] Furthermore, the *Reception Directive of the European Union* mandates

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[180] [1997] 24 EHRR 423

[181] *Covarrubias v. Canada (Minister of Citizenship and Immigration)*, 2006 FCA 365 at para. 39.

[182]In Belgium all asylum seekers are entitled to publically-funded medical care. (Affidavit of Mitchell Goldberg, p. 629, Exhibit "S" Doctors of the World/*Medecins du Monde*, Access to Healthcare in Europe in Times of Crisis and Rising Xenophobia: An Overview of the Situation of People Excluded from Healthcare Systems and Doctors of the World, Update of legislation in 10 European Countries. April 7, 2013) In France they receive the same health insurance as residents.(ibid, p. 634) In Germany, asylum seekers are entitled to coverage for basic health care services including medications for the first 48 months in the country (ibid, p. 637) and their children are entitled to further specialized services.(ibid, p. 638). In Greece, asylum seekers are legally entitled to the same access to publically funded health care as citizens as are all children regardless of status. (ibid, p.642) In the Netherlands, as authorized residents, asylum seekers have the same access to government health insurance as citizens, although rejected asylum seekers can only access care on humanitarian grounds. (ibid, pp.644-645) In Portugal access to publically funded health insurance is income-based and applicable to asylum seekers. Children are given free care regardless of status(ibid, pp.649-650). In Spain asylum seekers are insured for urgent and essential care (ibid, p 654). In Sweden asylum seekers over 18 are entitled to publically funded health insurance for care that cannot be deferred with a small co-payment and asylum-seeker children have the same access to health insurance as citizens even if their claims are rejected(ibid, p.659). In Switzerland, private insurance is mandatory for all citizens but asylum seekers benefit from reduced premiums (ibid, p. 660-661). In the United Kingdom, primary care is available for asylum seekers and undocumented migrants under the National Health Service (ibid, pp. 665-666); In the **United States**, child and pregnant asylum applicants may receive Medicaid or other federal health benefits: Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3 section 214:,42 CFR 435.406. The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) provides assistance for asylum seeker health care that is necessary for the treatment of an emergency medical conditions 8 U.S.C.A. s. 1611(b) and 1621(b).; In **Australia**: All asylum seekers have access to emergency care and ASA recipients who do not have access to full health care can receive assistance with health care costs including

in Article 19 that member states must insure that all asylum applicants and those seeking complementary forms of protection receive at least urgent and essential health care and treatment of illness, and that benefits cannot be withdrawn under any circumstances (Article 20).

140. In determining what is "cruel and unusual" within the meaning of s. 12, courts may consider the effect of the impugned government action in "reasonable hypothetical circumstances"[183] and the Applicants can rely on facts beyond those encountered by an individual applicant. Furthermore, there is no need to wait for catastrophic harm to occur before a violation can be found.

ISSUE 6: CANADA'S INTERNATIONAL LEGAL OBLIGATIONS TOWARDS REFUGEES

141. Canada is a party to the *1951 Convention relating to the Status of Refugees*[184] (hereinafter referred to as "the Refugee Convention"). It applies to refugees and, as we shall see, to refugee claimants, but not to rejected refugee claimants. International human rights law plays an important role in Charter interpretation. The Charter should be presumed to provide at least as great a level of protection as is found in the international human rights instruments which Canada has ratified.[185]

142. Article 3 of the Convention provides that: "The contracting States shall apply the provisions of this Convention to refugees without discrimination as to race, religion or country of origin". This right is a prohibition, not against discrimination as between refugees and nationals, but against discrimination

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pharmaceutical benefits and can also be referred to counseling services *Fact Sheet 62 – Assistance for Asylum Seekers in Australia* http://www.immi.gov.au/media/fact-sheets/62assistance.htm#g

[183] *R v. Goltz* [1991] 3 SCR 485 at para 48.

[184] *Convention relating to the Status of Refugees*, 4 June 1969, 189 UNTS 150

[185] *Health Services and Support-Facilities Subsector Bargaining Assn.* v, *British Columbia* 2007 SCC 27

between and among refugees.[186] It applies to all refugees physically present in the host country's territory.[187]

143. The UNHCR *Handbook on Procedures and Criteria for Determining Refugee Status* states

> A person is a refugee within the meaning of the 1951 Convention as soon as he fulfills the criteria contained in the definition. This would necessarily occur prior to the time at which his refugee status is formally determined. Recognition of his refugee status does not therefore make him a refugee but declares him to be one. He does not become a refugee because of recognition, but is recognized because he is a refugee. [188]

144. Therefore, as Professor James Hathaway points out:

> Convention rights can obviously not be claimed until all the requirements of the Convention refugee definition are satisfied, including departure from one's own state. But since refugee rights are defined to inhere by virtue of refugee status alone, *they must be respected by state parties until and unless a negative determination of the refugee's claim to protection is rendered.* This is because refugee status under the Convention arises from the nature of one's predicament rather than from a formal determination of status…[189] (Emphasis added)

145. Thus, all refugee claimants have treaty rights under the Convention until they are finally determined *not* to be Convention refugees. This is a crucially important point of refugee law.

146. The terms of the 2012 IFHP provide different (and inferior) health care coverage for refugee claimants from DCOs vis-à-vis claimants who are not from such countries of origin. This constitutes discrimination between and among refugees on the basis of country of origin and is prohibited under Article 3 of the Refugee Convention. As admitted by the government, the basis for the differential treatment in terms of access to health care in these

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[186] James Hathaway, *The Rights of Refugees under International Law* (New York: Cambridge University Press, 2005) at 238. .
[187] Hathaway, supra, at 238, 279
[188] UNHCR, *Handbook on Procedures and Criteria for Determining Refugee Status*, paragraph 28
[189] Hathaway, supra, at 278-279.

scenarios is nothing other than country of origin[190], which is contrary to Article 3.

147. Article 7(1) of the Refugee Convention also has application in this case. It provides that "Except where this Convention contains more favorable provisions, a Contracting State shall accord to refugees the same treatment as is accorded to aliens generally." Article 7 of the Convention applies to refugees physically present in the host state and is also applicable to refugee claimants for the reason outlined above. It establishes a general standard of treatment and is the basis on which to get the same treatment as is afforded to aliens generally on any matters regulated by the host state.[191]

148. Canada generally affords aliens access to publically funded universal health care, as long as their presence is authorized and of some foreseeable duration. For instance, permanent residents and, in some cases, students and persons on long-term work visas, are all eligible for provincial Medicare programs. Therefore, in keeping with Article 7(1) standards, resettled refugees and refugees recognized within Canada's determination system have generally had the same health care eligibility. And, prior to June 2012, asylum seekers were receiving essentially the same type of health care via the IFHP. In this way, Canada has traditionally been compliant with the Article 7(1) because all refugee classes, so to speak, have been generally treated the same as other authorized resident aliens.

149. However, with the modifications to the IFHP, there is now a refugee class which is no longer being treated in accordance with Article 7(1). Asylum seekers are no longer receiving the same treatment as authorized aliens generally with regard to access to health care. Specifically, what is happening is that asylum seekers are no longer being assimilated to

[190] Cross Examination of Sonia Le Bris, page 38, line 18-19
[191] Hathaway, supra, p. 192 ff

recognized refugees as is required under standard interpretations of the Refugee Convention, as noted above. They are now being excluded from the promise of universal health care enjoyed by other lawfully present foreign nationals.

150. The denial or withdrawal of health insurance benefits for refugees and asylum seekers is also contrary to international norms and international practice.

151. For instance, both the original and recast EU *Reception Directive*[192] provides as follows in Article 19: "Member States shall 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…" This right cannot be withdrawn (Article 20). The standard of treatment with regard to health care in the *Reception Directive* applies both to those seeking Convention refugee status as well as those who are seeking subsidiary forms of protection.[193] In fact, most countries with a publically funded universal health insurance system ensure that both asylum seekers and failed asylum seekers have access at least to primary health care. This is in contrast to Canada, where DCO claimants and rejected claimants no longer have access to primary health care coverage under the IFHP.

152. As indicated above, treaty rights flowing from the Refugee Convention technically do not adhere in failed asylum seekers. However, the circumstances of this group vary widely;[194] some are applying for subsidiary

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[192] *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 international protection (recast)*

[193] EU *Reception Directive*, supra, preamble, point 13.

[194] Such as the applicant, Daniel Garcia Rodriguez, who was the husband of a recognized Convention refugee and enjoys similar protections under the principle of family unity (see UNHCR *Handbook,* supra, para 181ff).

forms of international protection;[195] some cannot be removed.[196] Failed asylum seekers are furthermore still considered to be under the jurisdiction of the UNHCR and deserve to be treated humanely in the context of their removal.[197] It is submitted that this standard of treatment should apply by extension to the period between non-recognition and removal—at least where removal is delayed through no fault of the failed asylum seeker. In any event failed asylum seekers should not be assimilated to "undocumented migrants". As noted by Baroness Hale in *Ex parte Adam,* even asylum seekers who had delayed filing their claim were considered to be "lawfully" present in the UK.[198]

ISSUE 7: SECTION 1

153. To pass constitutional muster under s. 1, the modifications made to coverage under the IFHP in 2012 must constitute "reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society". This will be the case where the party invoking s. 1 demonstrates (1) that the infringing provisions relate to a pressing and substantial objective, (2) that there is a rational connection between the objective and the infringement of the right, (3) that the chosen means interfere as little as possible with the protected right, and (4) that the salutary effects of the measures outweigh their deleterious effects.[199]

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[195] *See* Wijenaike affidavit (Patient 2 referred to in the Notice of Application herein), at para 3; BradleyAffidavit, para 7 (recounting the situation of a refused child claimant from West Africa who had made a humanitarian application but who had no IFHP coverage for an ear operation).

[196] Affidavit of the applicant, Hanif Ayubi, whose country of origin is subject to a moratorium on removals (para 4); Goldman affidavit paras 7-17; Goldman cross examination p. 11 lines 19-25, pp. 14-15, p. 16 line 1 (recounting the situation of Patient 5 referred to in the Notice of Application herein, a woman who is stateless and cannot be removed).

[197] UN High Commissioner for Refugees, *Conclusion on the return of persons found not to be in need of international protection*,10 October 2003, No. 96 (LIV) – 2003.

[198] *Ex parte Adam,* supra, Baroness Hale, paragraph 77

[199] *Divito v Canada (Public Safety and Emergency Preparedness)* [2013] SCJ No. 47 at para 68 *(cites: R. v. Oakes*, [1986] 1 S.C.R. 103; *Dagenais v. Canadian Broadcasting Corp.*, [1994] 3 S.C.R. 835, at p. 889; Hogg, *Constitutional Law of Canada*, 5 ed. Supp, vol. 2. at pp. 38-17 and 38-18).

154. According to the press release issued on April 25, 2012, the cuts to the Interim Federal Health Program (IFHP) had three objectives. First, according to the Minister of Citizenship and Immigration, the cuts were necessary for cost-saving purposes. Second, the cuts intended to end health care coverage which was allegedly "more generous" than that to which most Canadians were entitled. Finally, the cuts to the IFHP were intended to act as a deterrent against the filing of "unfounded" refugee claims.[200]

Cost containment:

155. Supreme Court of Canada (SCC) jurisprudence is clear that financial constraint generally cannot be a sole justification for limiting rights guaranteed by the *Charter*.[201] The two exceptions to this rule—i.e. that financial constraint can be a pressing and substantial objective that would justify the violation of the rights guaranteed by the *Charter* only in cases of emergencies or crisis [202] or where the cost for upholding the rights is prohibitive[203]-- do not apply to the 2012 modifications to the IFHP. In the 2011-2012 fiscal year, Canada was not in a dire economic situation.[204] Nor were the costs of the IFHP becoming prohibitive: they represented just 0.25% of the deficit in the federal budget over the same fiscal year[205], and only .04% (4/100 of a percent) of total health care expenditures.

156. Even if this were an objective that could justify deprivation of rights, there is no rational connection between the objective and the modifications to the IFHP. The government readily admits that de-insuring refugees and asylum

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[200] Affidavit of Mitchell Goldberg, Exhibit O

[201] *Singh v Minister of Employment and Immigration,* [1985] 1 SCR 177 at para 70; *Reference re Provincial Court Judges*, [1997] 3 S.C.R. 3, at paras 281-284; *Schachter v. Canada*, [1992] 2 S.C.R. 679; *Nova Scotia (Worker's Compensation Board) v Martin*, [2003] 2 SCR 504 at para 109.

[202] *Newfoundland (Treasury Board) v N.A.P.E.,* [2004] 3 SCR 381 at para 59

[203] Singh,supra paragraph 73

[204] Ministry of Finance, "Annual Financial Report – 2011-2012", online: http://www.fin.gc.ca/afr-rfa/2012/afr-rfa-eng.pdf.

[205] The federal deficit is 25.8 billion dollars for 2012-2013;Ministry of Finance: *Budget 2013: the Budget in Brief*, at p. 13. Online: http://www.budget.gc.ca/2013/doc/bb/brief-bref-eng.html

seekers will force them to receive care through provincial emergency rooms or philanthropic enterprises.[206] There is no net savings to taxpayers.[207]

157. Furthermore the means chosen do not minimally impair the protected right. There could have been any number of ways the government could have reduced the costs of the IFHP without withdrawing or denying coverage for basic primary care and putting health at risk. This included reducing the number of claimants present in Canada by speeding up processing times—which in fact, the government admits has already happened pursuant to the wider reforms of Bill-31 and even previous methods such as increasing staffing at the IRB.[208] Indeed, the government admits that the modifications to the IFHP were considered "complementary" to the sweeping reforms in Bill C-31.[209] This suggests that the modifications to the IFHP were, in fact, unnecessary, optional and gratuitous measures.

158. And the alleged cost savings, miniscule as they would be in the grand scheme of things, could not possibly outweigh the pain and suffering inflicted on some refugees and asylum seekers as a result of inadequate or non-existent insurance coverage.

Putting an end to "more generous" coverage/Fairness to Canadians

159. As indicated earlier, The Minister has called the former IFHP coverage "more generous" because it provided for some dental, vision and drug benefits that "most" Canadians do not have access to through universal health coverage. However, in setting this objective, the government fails to compare IFHP recipients with the appropriate comparator group—those who are economically disadvantaged. When viewed through this lens, the objective is not pressing and substantial: the IFHP always provided coverage that was

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[206] Fortin affidavit, paras 94- 98. it p.
[207] Rachlis affidavit, paras 4, 6(c)(f), 25-30, 38.
[208] Cross examination of Teny Dikranian p. 33 lines 10-17.
[209] Dikranian cross examination p. 65, lines 5-6.

similar to (but not better than) what low and no-income Canadians are entitled to and, incidentally, what all 8 million residents of Quebec are entitled to.[210]

160. Thus, there is no health care imbalance that could be a pressing and substantial objective of the modifications to IFHP coverage when the appropriate comparator group is used. It is unclear how granting refugees and asylum seekers insured health care coverage equivalent to that available to Canadians in the same economic circumstances (or those living in Quebec) is unfair to working Canadians who have to pay for pharmaceuticals or drug insurance—given that those working Canadians would have access to this very same coverage if their economic situation deteriorated. There is also no evidence to indicate why granting certain classes of refugee claimant coverage that is *less generous* than what Canadians receive is unfair to Canadians.

161. Furthermore, there is no evidence that denying access to prescription medication to refugee and asylum seekers makes such medication more accessible to Canadians, especially since the federal government plays no role in prescription drug distribution to Canadians. This objective could be achieved without the deprivation of rights. The highly dubious and unsubstantiated definition of "fairness" utilized by the government cannot possible outweigh the effects of precarious access to health care.

Deterrence of abusive claims

162. While this might in theory be a pressing and substantial objective, in practice Canada does not have a problem with abusive claims. Refugee claims are refused for a wide range of reasons, and the mere fact of rejection does not demonstrate that the claimant acted in bad faith. Less than 3% of claims were found to lack a credible basis in 2011[211] and the government has provided no evidence that the availability of IFHP benefits had a causal relation with

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[210] *See* footnote 22.
[211] Goldberg affidavit para 37.

lodging of unmeritorious refugee claims in the past.[212] Claimants from Mexico or EU countries have in fact been misidentified as "fraudulent" or "bogus" in public discourse.[213] Mexico has human rights problems;[214] the vast majority of the EU claims are made by members of the Roma minority who are frequently victimized in several EU countries, such as Hungary or the Czech Republic.[215]

163. In any event, the government has provided no evidence that the IFHP induces foreign nationals to lodge unfounded refugee claims. This contention is admittedly based on "perceptions" and "beliefs".[216] Therefore, there is no evidence that reducing interim federal health benefits would have any effect on the number of unfounded claims in Canada. Denying a basic, fundamental right to a person as a means of preventing others from engaging in unwanted conduct is not rational. In *Sauvé v. Canada (Chief Electoral Officer)*[217], McLachlin C.J., writing for the majority, found that denying inmates the right to vote as a means of deterring Canadians from breaking the law was the wrong type of pedagogy. One might assume that denying inmates insured health care would also not be a Charter-compliant deterrence technique. Violating the Charter rights of asylum seekers is not a means to teach others not to behave in a certain way and is grossly disproportionate.

164. It is unjustifiable to use a prediction of the success of a refugee claim (on the basis of country of origin) to curtail or deny an individual child, woman or man's access to basic, essential or life-saving treatment. The changes to Canada's refugee system made pursuant to Bill C-31 were more than adequate

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[212] Dikranian cross examination, p. 43 lines 19-25, p. 44 lines 1-11.
[213] Goldberg affidavit, Exhibit "Q": Journal of Ethnic and Migration Studies, 2013 "The Discursive Production of a Mexican Refugee Crisis in Canadian media and policy".
[214] Goldberg affidavit, Exhibit "Q": *Department of State Country Reports on Human Rights Practices for 2012*, Mexico.
[215] Goldberg affidavit, Exhibit "Q": *Department of State Country Reports on Human Rights Practices for 2012*, Hungary
[216] Le Bris affidavit, para 74; Dikranian cross examination p. 44 lines 3-4.
[217] [2002] S.C.J. No. 66

to achieve the purported "deterrence" objective, by making the process faster and more streamlined.[218] This renders the modifications to the IFHP and the concomitant rights deprivations entirely unnecessary and grossly disproportionate to the harm caused.

165. The government has put forward no evidence to support its contention that rights violations occasioned by the withdrawal of basic health care coverage for certain refugees and asylum seekers was in any way, shape, or form necessary or justified. Nor did it display the slightest consideration for the life and health of these individuals: not one single study was done to assess the impact of these IFHP coverage cuts or to test the validity of their underpinnings.[219] Instead, the rights of some of the most vulnerable members of society were violated on the basis of "beliefs" and "perceptions", bringing shame to this country.

PART IV: ORDER SOUGHT

166. The applicants seek an order granting the declaratory relief requested herein.

All of which is respectfully submitted this 30th day of October, 2013 at Toronto.

pr LORNE WALDMAN

pr JACQUELINE SWAISLAND

[218] See note 168
[219] Dikranian cross examination, p. 29 lines 1-19 p. 43 lines 19-25, p. 44 lines 1-11; Fortin cross examination p. 32 lines 13-22.

Registry No. T-356-13

FEDERAL COURT

B E T W E E N:

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

Applicants

- and-

THE ATTORNEY GENERAL OF CANADA AND MINISTER OF CITIZENSHIP AND IMMIGRATION

Respondents

MEMORANDUM OF FACT AND LAW OF THE APPLICANTS CANADIAN DOCTORS FOR REFUGEE CARE, THE CANADIAN ASSOCIATION OF REFUGEE LAWYERS, DANIEL GARCIA RODRIGUES and HANIF AYUBI

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