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 APPLICANT JUSTICE FOR CHILDREN AND YOUTH

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OVERVIEW

1. This Application concerns a case of significant importance that has threatened the health of children coming within the jurisdiction of Canada. As a result of two Orders in Council dated April 5, 2013 and June 28, 2013 ("OIC"), the Interim Federal Health Program ("IFHP 2012") healthcare insurance coverage for child refugees and child refugee claimants is no longer universal and uniform. Coverage is now based on a classification system that allocates health care coverage according to a hierarchy of putative merit. The IFHP 2012 has not been made within the context of domestic and international laws, is not in compliance with the *Canadian Charter for Human Rights and Freedoms* ("*Charter*")[1] and the United Nation's *Convention on the Rights of the Child* ("*Convention*"),[2] and fails to meet Canada's obligations to make all decisions in the Best Interests of the Child.

PART I: FACTS

2. JFCY relies on the facts as stated by the Applicants Canadian Doctors for Refugee Care and The Canadian Association of Refugee Lawyers ("CDRC-CARL") as well as the following.

3. The type of IFHP coverage provided to each person depends solely on the person's immigration status. There is no differentiation, exception, or consideration that is made based on age.[3]

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[1] *Canadian Charter of Rights and Freedoms,* Part I of the *Constitution Act, 1982,* being Schedule B to the *Canada Act 1982* (U.K.), 1982, c.11.
[2] *Convention on the Rights of the Child,* 20 November 1989, 3 U.N.T.S. 1577, Can T.S. 1992/3 No. 3.
[3] Cross-Examination of Allison Little Fortin, from line 149 of page 45 to Line 2 of page 46 .

4. Canadian domestic law recognizes the inherent vulnerability of children and their dependence on adults to provide for their care. Examples of this recognition includes: the inherent *parens patriae* power of our courts, child welfare legislation in every province and territory, and recognition of a shared responsibility to address the developmental challenges and needs of young persons in the preamble to *Youth Criminal Justice Act*[4] which also recognizes that Canada is a party to the *Convention*.

5. The United Nations Committee on the Rights of Children ("UN Committee") has defined a child's right to health "as an inclusive right, extending not only to timely and appropriate prevention, health promotion, curative, rehabilitative and palliative services, but also to a right to grow and develop to their full potential and live in conditions that enable them to attain the highest standard of health through the implementation of programmes that address the underlying determinants of health," and that it is necessary to protect children at every state of their development since each stage has an impact on the subsequent phases; as it influences the child's health, potential, risks and opportunities.[5]

6. The expert medical evidence relating to the special needs of children provided by the Applicant CDRC-CARL is uncontested by the Respondent. Dr. Denis Daneman, Paediatrician-in-Chief at the Hospital for Sick Children in the City of Toronto and President of the Paediatric Chairs of Canada states that the IFHP 2012 changes will adversely impact the immediate and long-term health of children and youth. In particular, they express concern that, (i) early treatment for common childhood illnesses

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[4] *Youth Criminal Justice Act,* S.C. 2002, c. 1.
[5] Committee on the Rights of the Child, "The right of the child to the enjoyment of the highest attainable standard of health (art. 24)" General Comment No 15 (2013), Para 2 and 20.

can prevent hospitalizations, whereas delays may result in death; (ii) the inability to diagnose and manage mental health conditions particular to child refugees; (iii) poorer outcomes and long-term consequences due to the failure to diagnose developmental delays, visions and hearing disabilities; (iv) long-term disabilities and morbidity occurring when acute and chronic illnesses in children and youth are not identified and managed; and (v) that there is a proven link between primary health care in the early years and later adult health.[6]

7. Joanna Anneke Rummens, Principal Investigator of research project *"Migratory Status of the Child and Limited Access to Health Care"* (2009-2012) states that uninsured children who presented for paediatric emergency care were found to be more highly represented at more serious triage levels than children with IFHP coverage (there may have been a delay in seeking help) and that uninsured children are also more likely to access paediatric emergency care for bodily injury and trauma, mental health crisis, and chronic health problems compared to children with IFHP coverage.[7]

8. Other Government of Canada reports support the fact that children need specialized healthcare in a timely manner. In response to the United Nations General Assembly Special Session on Children held in May 2002, Canada followed up with a National Plan of Action for Children entitled "A Canada Fit for Children",[8] which was developed by the federal, provincial and territorial governments in consultation with the public. The

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[6] Affidavit of Denis Daneman, para 9.
[7] Affidavit of Joanna Anneke Rummens, para 5 - 7.
[8] A Canada Fit for Children, Canada's plan of action in response to the May 2002 United Nations Special Session on Children, (Ottawa: Her Majesty the Queen in Right of Canada, 2004). This report was referred to in: Government of Canada, "Convention on the Rights of the Child, Third and Fourth Reports of Canada, Covering the period January 1998 – December 2007", submitted to the UN Committee on the Rights of the Child on November 20, 2009, Appendix 5, page 187.

Plan sets out a shared vision to ensure that children in Canada have the best possible start in life and the necessary opportunities to realize their full potential. The shared vision includes four goals, the first of which is for children to be physically and emotionally healthy.[9] While recognizing that most children in Canada are doing well since they have access to universal health and education systems that are among the best in the world, the report notes that not all children in Canada are thriving and that "children of recent immigrants and refugee children are more likely to experience economic disadvantage with its associated risks;" and takes the position that "(n)o child should be excluded on the basis of race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, sexual orientation, birth or other status. Social inclusion is one the primary and most effective vehicles for addressing the rights of children."[10]

9. In a 2007 report prepared for Citizenship and Immigration on the topic of Government Assisted Refugees ("GAR") who are children and youth, the researchers found that refugee and immigrant children are more likely to come from low-income households and thus face economic barriers.[11] The report stated that the one key activity that must be attended to soon after arrival is an in-depth health assessment taking into account the trauma that the child may have experienced as well as the conditions and health issues endemic to their source country; that the exam must pay special attention to normal growth and development milestones, the types of illnesses and conditions that

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[9] Ibid, para 19.
[10] Ibid, para 20 and 59.
[11] Citizenship and Immigration Canada Resettlement Assistance Unit, "A National Approch to Meeting the Needs of GAR Children and Youth within the Resettlement Assistance Program, June 30, 2007, page 76.

GAR children might bring with them so immediate treatment can be initiated; and that access to health care is a primary contributor to health outcomes.[12]

10. The Respondent's affiant Allison Little Fortin, Director of the Interim Federal Health Program in the Health Branch of Citizenship and Immigration Canada has provided Annual Statistics with respect to refugee claims made to the Immigration and Refugee Board and the Interim Federal Health Program 2003 – 2013,[13] but has refused to provide any breakdown of the statistics that may be available as it relates to children.[14]

11. The Respondent's affiant Allison Little Fortin has also provided information on IFHP Beneficiaries by Type of Coverage since the implementation of the IFHP 2012 and by breakdown of Province and Territories,[15] and advises that there has been no breakdown between children and adults.[16]

12. Children are being denied healthcare for a variety of reasons because of the IFHP 2012, including a reduction in coverage, delays in issuing eligibility certificates, doctors not wishing to take patients with IFHP due to complexity, and denial of healthcare treatment due to confusion over changes to IFHP coverage. The affiants for the Applicant CDRC-CARL have provided numerous examples of children adversely impacted by the IFHP 2012, including:

> **a.** A 7 year old with an infected cleft lip and palate being denied care by a doctor because the parent was asked to pay upfront, despite having valid IFHP coverage. The child was provided with some treatment but still has the cleft which puts him at

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[12] Ibid, page 27, 28 and 43.
[13] Affidavit of Allison Little Fortin, Exhibit A, Tab A.
[14] Cross-Examination of Allison Little Fortin, line 15 – 20 of page 44
[15] Affidavit of Allison Little Fortin, Exhibit J, Tab J and Exhibit X, Tab X.
[16] Cross-Examination of Allison Little Fortin, line 21 – 25 of page 44

risk of recurring infections in the ear, nose and throat region which potentially threaten his life.[17]

b. A young child with several ear infections that required surgery was denied the surgery because it was scheduled shortly after the IFHP 2012 cuts and the child, as a refused refugee claimant, was reduced to the PHPS coverage level. Not having the surgery often results in on-going infections, the ear drum not healing and long term effects on the child's ability to hear; in addition antibiotics may be overprescribed, leading to the development of strains of resistant bacteria.[18]

c. A young child with high fever with no IFHP coverage because the family was awaiting their eligibility interview was encouraged to take him to the hospital to rule out malaria, a potentially life threatening illness. The child was seen and asked to return the next day; the mother was given a bill for over $600 and as a result did not follow up.[19]

d. Two young children with previous hospitalizations for asthma could not get access to inhalers leaving them at risk for seeking out care through emergency departments. The children did not have IFHP coverage because the family was awaiting their eligibility interview, which also restricts access to social assistance which can cover medications.[20]

e. A toddler with fever and lethargy was sent to an Emergency Room instead of a walk-in clinic and was found to have pneumonia, the toddler did not have IFHP coverage because the family was awaiting their eligibility interview. The family received a bill for over $700 for the Emergency Room visit, a bill they were not in a position to pay.[21]

f. A 7 year old child with a fever and cough could not obtain a chest x-ray to rule out pneumonia because she only had PHPS health coverage. She eventually got better but the standard of care would have been a chest x-ray.[22]

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[17] Affidavit of Paul Caulford, para 20 and Cross-Examination of Paul Caulford, from line 7 on page 138 to line 16 on page 140

[18] Affidavit of Christopher Bradley, para 7 and Cross-Examination of Christopher Bradley, from line 11 on page 42 to line 14 on page 50

[19] Affidavit of Meb Rashid, para 51(c); and Cross-Examination, from line 25 on page 114 to line 14 on page 115

[20] Affidavit of Meb Rashid, para 51(e); and Cross-Examination of Meb Rashid, from line 18 on page 123 to line 14 on page 125.

[21] Affidavit of Meb Rashid, para 51(j); and Cross-Examination of Meb Rashid, from line 287 on page 137 to line 13 on page 139.

[22] Affidavit of Meb Rashid, para 51(s); and Cross-Examination of Meb Rashid, line 15 on page 148 to line 8 page 151.

g. A teenager with Post Traumatic Stress Disorder and previous suicide attempts who had valid IFHP coverage was cut off from essential psychiatric medications.[23]

h. A mother left Japan with her daughter after the mother discovered the girl attempting suicide after being badly bullied. They can not return to the country they originally fled from. The 14 girl has been taking part of the Royal Canadian Sea Cadets which has been helping her deal with socialization issues, regain confidence and fit into Canadian society. She is a refused claimant and under IFHP 2012 has PHPS coverage only. Based on a lack of healthcare coverage required by the Royal Canadian Sea Cadets, she is being prevented from participating in some of their activities and may be prevented from full participation in the future. [24]

PART II: LEGAL ISSUES

13. JFCY will address the following issues as they pertain to children: (i) ultra vires, (ii) procedural fairness, (iii) best interests of the child, (vi) the *Convention*, (v) the *Charter*, (vi) Refugee Convention, and (vii) Section 1.

PART III: SUBMISSIONS

Preliminary Issue: Standing of JFCY

14. JFCY is a non-profit legal aid clinic with a genuine interest in the legal rights of children and is an appropriate Applicant in these proceedings based on the legal clinic's considerable and specialized expertise on protecting and promoting the legal rights of children and experience working with child refugees.[25] JFCY is the operating name for the Canadian Foundation for Children, Youth and the Law, and was the sole applicant in a constitutional challenge to the corporal punishment sections of the Criminal Code.[26]

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[23] Affidavit of Meb Rashid, para 52(g).
[24] Affidavit of Maria Aylas Marcos de Arroyo, para 2 – 11.
[25] Affidavit of Jeffrey Rosekat, para 3 – 16.
[26] *Canadian Foundation for Children, Youth and the Law v. Canada (Attorney General)*, 2004 SCC 4, [2004] 1 S.C.R. 76.

15. Children are a highly vulnerable group[27] who lack political power, access to resources and disadvantaged in that it is easy to overlook their interests. JFCY is familiar with the extreme difficultly encountered in finding child litigants generally and among the refugee population; and child refugees are in a further disadvantaged position: they generally have no choice in where they are living and if they arrive "unaccompanied" they are exponentially vulnerable, their families are often living in poverty, reluctant to make complaints against the same government from whom they are seeking protection, have significant privacy concerns, continue to fear for their safety and do not want to revisit past experiences in a litigation context.[28]

Issue 1: The OIC is Ultra Vires

16. JFCY supports and relies on the submissions of CDRC-CARL on this issue.

Issue 2: Not in compliance with Procedural Fairness

17. JFCY supports and relies on the submissions of CDRC-CARL and further submits that the failure to act in compliance is a particularly egregious failing given Canada's international obligations towards children. The patient example in paragraph 12a., illustrates just one example of mistaken denial of treatment due to the lack of notice and confusion; and the example in paragraph 12b., illustrates just one example of a child being denied treatment (in this case, surgery) that was scheduled according to the healthcare coverage of the child prior to the change of healthcare coverage, but then not covered when the IFHP 2012 was suddenly announced.

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[27] Ibid, para. 56 and 225.
[28] Affidavit of Jeffrey Rosekat, para 32 - 37.

Issue 3: Contrary to the *Best Interests of the Child* Principle

18. JFCY submits that the best interests of the child principle must be must be applied in assessing the validity of the IFHP 2012. The best interests of children is an established fundamental legal principle in national and domestic law.[29] Children are deserving of heightened protection because of their inherent vulnerability.[30] The "best interests of the child" is the only primary consideration in the *Convention*, and is stated in Article 3(1):

> In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration, (emphasis added).[31]

19. The interests and needs of children including non-citizen children are important factors that must be given substantial weight as they are central humanitarian and compassionate values in Canadian society.[32] There is a positive duty on the state to act on behalf of a child, as well as refrain from taking actions that may harm a child.

20. The UN Committee has provided extensive guidance in how the best interest principle is to be applied[33] and states that the child's right to health (Article 24 of the Convention) and his or her condition are central in assessing the child's best interest.[34] State parties are obliged to (i) ensure that the best interests of the child are appropriately integrated and consistently applied in every action taken by a public institution, and (ii) ensure that all judicial and administrative decisions as well as policies and legislation concerning children demonstrate that the best interests of the child, or particular group of

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[29] *Canadian Foundation, supra*, para 9.
[30] *R. v. Sharpe*, 2001 SCC 2, [2001] 1 S.C.R. 45, para 170.
[31] *Convention, supra* note 2, Article 3(1).
[32] *Baker v. Canada (Minister of Citizenship and Immigration)*, [1999] 2 S.C.R. 817, para 67 and 70.
[33] Committee on the Rights of the Child, "The right of the child to have his or her best interests taken as a primary consideration (art. 3, para.1)" General Comment No 14 (2013).
[34] Ibid, para 77.

children, have been a primary consideration.[35] Further, within the parameters that give full effect to the best interests of the child, short-, medium-, and long-term effects of actions related to the development of the child over time must be borne in mind.[36]

21. JFCY submits that the pre-IFHP 2012 healthcare coverage complies with the best interests of the child principle and that the IFHP 2012 termination of any level of healthcare coverage for selected legal groupings of child refugees is in direct contravention of the best interests of the child.

22. JFCY submits that the Respondent has failed to consider and take measures in the best interests of the child in terminating previous levels of healthcare coverage to refugee claimants and privately sponsored refugees who are children legally within the jurisdiction of Canada. There is no evidence that a full and proper assessment of the special circumstances of child refugees has been undertaken prior to implementing the IFHP 2012. The best interest of the child principle requires consideration of the unique healthcare needs of children and that any denial or delay can result in serious, long-term harm. It is not in the best interests of child refugees and refugee claimants with HCC or PHPS only to go untreated until they become emergencies, with long-term negative health impacts that may be irreversible, and with dire consequences.

23. JFCY further submits that the IFHP 2012 has failed to address the best interests of the child as it relates to the daycare and school context, in that children who have been reduced to a lower level of healthcare coverage will be unable to obtain healthcare for common illnesses (such as conjunctivitis, head lice, scabies, and diarrhea) are not

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[35] Ibid, para 14 and 32.
[36] Ibid, para 16.

covered by PHPS coverage.[37] The affected children could be excluded from school, possibly ostracized or blamed for not getting treatment, and may end up infecting other children.

Issue 4: In Contravention of the *Convention*

24. Canadian laws must be interpreted to comply with Canada's international treaty obligations.[38] Children's rights, and attention to their interests, are central humanitarian and compassionate values in Canadian society.[39] Canada played an instrumental role in drafting and promoting the *Convention* and ratified it in 1991. Canadian courts accept that the values articulated in international human rights law inform the context in which the provisions of the *Charter* must be read.[40]

25. The *Convention* is essential for the interpretation of the rights of children under the *Charter* as the *Charter* does not otherwise directly address their rights as a group who need special consideration and protection. The *Charter* should be presumed to provide at least as great a level of protection as is found in the international human rights documents which Canada has ratified.[41]

26. The *Convention* provides that, "State Parties shall respect and ensure the rights set forth in the present *Convention* to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal

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[37] Affidavit of Christopher Bradley, para 10 – 11.
[38] *Canadian Foundation, supra,* para. 32.
[39] *Baker, supra,* para 67.
[40] *Baker, supra,* para. 70 – 71; *Canadian Foundation, supra,* para. 31; and *Sharpe, supra,* para 171.
[41] *Health Services and Support-Facilities Subsector Bargaining Assn. v. British Columbia,* 2007 SCC 27.

guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status (emphasis added)."[42]

27. The *Convention* requires Canada to act in the best interests of the child and codifies a State's obligation to ensure to the maximum extent possible, the survival and development of the child.[43] As mentioned in paragraph 20 of this memorandum, the UN Committee has stated that the child's right to health and his or her condition are central in assessing the child's best interest.[44] Article 24 provides that:

> 1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.
>
> 2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:
> (a) To diminish infant and child mortality;
> (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care; … (emphasis added).[45]

28. The UN Committee's General Comments include that:

> **a.** Children are entitled to quality health services, including prevention, promotion, treatment, rehabilitation and palliative care services. At the primary level, these services must be available in sufficient quantity and quality, functional, within the physical and financial reach of all sections of the child population, and acceptable to all.

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[42] *Convention, supra,* Article 2(1).
[43] *Convention, supra,* Article 6(2).
[44] Committee on the Rights of the Child, "The right of the child to the enjoyment of the highest attainable standard of health (art. 24)" General Comment No 15 (2013)., para 77.
[45] *Convention, supra,* Article 24(1), 24(2).

b. Barriers to children's access to health services, including financial, institutional and cultural barriers, should be identified and eliminated.

c. Health-seeking behaviour is shaped by the environment in which it takes place, including, inter alia, the availability of services, levels of health knowledge, life skills and values. States should seek to ensure an enabling environment to encourage appropriate health-seeking behaviour by parents and children. [46]

29. Canada has reaffirmed to the Canadian Senate Standing Committee on Human Rights and the UN Committee that it "is maintaining its commitment to the *Convention* and to the obligations it contains."[47] However, in implementing the IFHP 2012, Canada has failed to live up to this commitment. Canada has also contradicted their claim that, "Refugee children, separated children who are determined not to be in need of protection, but remain in Canada, as well as unaccompanied children seeking refugee protection are entitled to <u>essential</u> health services through the (IFHP) (emphasis added)."[48]

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[46] Committee on the Rights of the Child, "The right of the child to the enjoyment of the highest attainable standard of health (art. 24)" General Comment No 15 (2013), para 25, 29 and 30.

[47] Government of Canada Response to: Standing Senate Committee on Human Rights, *Children: the Silence Citizens, Effective Implementation of Canada's International Obligations with Respect to the Rights of Children* (Ottawa: Senate of Canada, 2007). Contained in Government of Canada, "Convention on the Rights of the Child, Third and Fourth Reports of Canada, Covering the period January 1998 – December 2007", submitted to the UN Committee on the Rights of the Child on November 20, 2009, Appendix 5.

[48] Government of Canada, "Convention on the Rights of the Child, Third and Fourth Reports of Canada, Covering the period January 1998 – December 2007", submitted to the UN Committee on the Rights of the Child on November 20, 2009, para 103.

Issue 5: *Charter* violations

a. Section 7 of the *Charter*

30. JFCY supports and relies on the submissions of CDRC-CARL and further submits that the IFHP scheme must be in compliance with the *Charter* and *Convention*, and with due consideration of the best interests of the child, the particular vulnerabilities and disadvantages of children, and the significant risk to physical and psychological health and well-being of children.

b. Section 12 of the *Charter*

31. JFCY supports the submissions of CDRC-CARL and further submits that the IFHP 2012 in as much as they cancel, diminish or deny basic and life-sustaining health care coverage for refugee applicants and privately sponsored refugees who are children is particularly cruel and unusual.

c. Section 15 of the *Charter*

32. JFCY supports and relies on the submissions of CDRC-CARL and further submits that children are under a distinct disability, in that they generally have no choice in where they are living, are excluded and marginalized, and being prevented from receiving a benefit; by conditions not created by the child him or herself.[49]

Issue 6: Refugee Convention

33. JFCY supports and relies on the submissions of CDRC-CARL on this issue.

Issue 7: Not saved under section 1 of the *Charter*

34. JFCY supports and relies on the submissions of CDRC-CARL and further submits that,

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[49] *Granovsky v. Canada (Minister of Employment and Immigration)*, 2000 SCC 28, [2000] 1 S.C.R. 703, para 30.

a. Canada is one of the wealthiest countries and it has appropriate resources to ensure that refugee children, and children seeking refugee status, who are within it's borders are able to attain a level of healthcare that meets their best interests,

b. the discretion available in section 7 of the OIC does not effectively protection children in these circumstances; it is an uncertain process, access is dependent on knowledge and access to resources to assist the child, will result in treatment delays, and does not provide adequate access to all the medications a child may require, and

c. the prevention of abuse by "bogus" refugee claimants and deterrence can not apply to children who generally have no say in their circumstances and where they live.

PART VI: ORDER SOUGHT

35. JFCY seeks the same order as the Applicants CDRC-CARL.

36. In the alternative, JFCY seeks an order declaring a suspension of the IFHP 2012 as it applies to child refugees and child refugee claimants; and restoring IFHP health coverage for child refugees and child refugee claimants to the pre-IFHP 2012 level.

All of which is respectfully submitted this 30th day of October, 2013 by

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per Mary Birdsell
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