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IT IS NOT TO BE CONFUSED WITH THE ONTARIO COURT OF APPEAL'S DECISION OF *CANADIAN DOCTORS FOR REFUGEE CARE v. ATTORNEY GENERAL OF CANADA*. ORIGINAL ONLINE AT: http://canlii.ca/t/g81sg

Date: 20140704

Docket: T-356-13

Citation: 2014 FC 651

Ottawa, Ontario, July 4, 2014

PRESENT: The Honourable Madam Justice Mactavish

BETWEEN:

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 AND MINISTER OF CITIZENSHIP AND IMMIGRATION

Respondents

JUDGMENT AND REASONS

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I. Introduction

[1] For more than 50 years, the Government of Canada has funded comprehensive health insurance coverage for refugee claimants and others who have come to Canada seeking its protection through the Interim Federal Health Program. In 2012, the Governor in Council passed two Orders in Council which significantly reduced the level of health care coverage available to many such individuals, and all but eliminated it for others pursuing risk-based claims.

[2] The effect of these changes is to deny funding for life-saving medications such as insulin and cardiac drugs to impoverished refugee claimants from war-torn countries such as Afghanistan and Iraq.

[3] The effect of these changes is to deny funding for basic pre-natal, obstetrical and paediatric care to women and children seeking the protection of Canada from "Designated Countries of Origin" such as Mexico and Hungary.

[4] The effect of these changes is to deny funding for any medical care whatsoever to individuals seeking refuge in Canada who are only entitled to a Pre-removal Risk Assessment, even if they suffer from a health condition that poses a risk to the public health and safety of Canadians.

[5] The applicants assert that the 2012 modifications to the Interim Federal Health Program are unlawful as the Orders in Council are *ultra vires* the prerogative powers of the Governor in Council. They also say that prior consultations and past practice created a legitimate expectation on the part of stakeholders that substantive changes would not be made to the Interim Federal Health Program without prior notice and consultation with interested parties. According to the applicants, the Governor in Council breached its duty of procedural fairness by making radical changes to the Interim Federal Health Program without any advance notice or consultation.

[6] The applicants further submit that that 2012 changes to the Interim Federal Health Program breach Canada's obligations under the 1951*Convention Relating to the Status of Refugees* and the *Convention on the Rights of the Child*. In addition, the applicants say, the changes violate sections 7,12 and 15 of the *Canadian Charter of Rights and Freedoms* in a manner that cannot be saved under section 1 of the Charter.

[7] For the reasons that follow, I have concluded that the Orders in Council are not *ultra vires* the prerogative powers of the Governor in Council, nor has there been a denial of procedural fairness in this case.

[8] I have also concluded that the applicants' section 7 Charter claim cannot succeed as what they seek is to impose a positive obligation on the Government of Canada to fund health care for individuals seeking the protection of Canada. The current state of the law in Canada is that section 7guarantees to life, liberty and security of the person do not include a positive right to state funding for health care.

[9] I have, however, concluded that while it is open to government to assign priorities and set limits on social benefit plans such as the Interim Federal Health Program, the intentional targeting of an admittedly poor, vulnerable and disadvantaged group for adverse treatment takes this situation beyond the realm of traditional Charter challenges to social benefit programs.

[10] With the 2012 changes to the Interim Federal Health Program, the executive branch of the Canadian government has intentionally set out to make the lives of these disadvantaged individuals even more difficult than they already are in an effort to force those who have sought the protection of this country to leave Canada more quickly, and to deter others from coming here.

[11] I am satisfied that the affected individuals are being subjected to "treatment" as contemplated by section 12 of the Charter, and that this treatment is indeed "cruel and unusual". This is particularly, but not exclusively so as it affects children who have been brought to this country by their parents. The 2012 modifications to the Interim Federal Health Program potentially jeopardize the health, the safety and indeed the very lives, of these innocent and vulnerable children in a manner that shocks the conscience and outrages our standards of decency. They violate section 12 of the Charter.

[12] I have also concluded that the 2012 changes to the Interim Federal Health Program violate section 15 of the Charter inasmuch as the program now provides a lesser level of health insurance coverage to refugee claimants from Designated Countries of Origin in comparison to that provided to refugee claimants from non-Designated Countries of Origin. This distinction is based upon the national origin of the refugee claimants, and does not form part of an ameliorative program.

[13] Moreover, this distinction has an adverse differential effect on refugee claimants from Designated Countries of Origin. It puts their lives at risk and perpetuates the stereotypical view that they are cheats and queue-jumpers, that their refugee claims are "bogus", and that they have come to Canada to abuse the generosity of Canadians. It serves to perpetuate the historical disadvantage suffered by members of an admittedly vulnerable, poor and disadvantaged group.

[14] I have not, however, been persuaded that the Interim Federal Health Program violates subsection 15(1) of the Charter based upon the immigration status of those seeking the protection of Canada, as "immigration status" cannot be considered to be an analogous ground for the purposes of section 15. Consequently, this aspect of the applicants' section 15 claim will be dismissed.

[15] Finally, the respondents have not demonstrated that the 2012 changes to the Interim Federal Health Program are justified under section 1 of theCharter.

[16] Consequently, the applicants' application will be granted.

II. The Parties

A. *Canadian Doctors for Refugee Care*

[17] Canadian Doctors for Refugee Care (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 then-pending changes to the Interim Federal Health Program (IFHP) that had been announced the previous day. CDRC asserts that its members now face difficult moral, ethical and professional dilemmas as to whether to treat or continue to treat patients who no longer have IFHP coverage.

[18] While CDRC's memorandum of fact and law appears to suggest that its members have been directly affected by the changes to the IFHP, it became clear at the hearing that what it seeks is public interest standing to pursue this case. The standing issue will be addressed further on in these reasons.

B. *Canadian Association of Refugee Lawyers*

[19] The Canadian Association of Refugee Lawyers (CARL) is an association of lawyers and academics with an interest in legal issues related to refugees, asylum seekers and the rights of migrants. Its purposes include legal advocacy on behalf of these groups, in part through participation in public interest litigation dealing with issues affecting vulnerable refugees, asylum seekers and migrants.

[20] Since its formation in 2011, CARL has been active in lobbying and public education, and it has intervened in litigation touching on the rights of refugees, asylum seekers and migrants.

C. *Justice for Children and Youth*

[21] Justice for Children and Youth (JFCY) is a non-profit legal aid clinic with a focus on the legal rights of children. It has expertise in protecting and promoting the legal rights of children, and has experience working with child refugees. JFCY is the operating name for the Canadian Foundation for Children, Youth and the Law.

D. *Hanif Ayubi*

[22] Hanif Ayubi is one of the two individual applicants in this proceeding. Mr. Ayubi is a diabetic and a failed refugee claimant from Afghanistan. He has been in Canada since 2001 and has not been removed because Afghanistan is a "moratorium country". That is, the Government of Canada has suspended removals to Afghanistan because the country's general conditions are such as to put the safety of the general population at risk.

[23] Until June 30, 2012, Mr. Ayubi had coverage under the IFHP for his insulin and medical supplies, and for the medical care that he requires to manage his diabetes. After the changes to

the IFHP came into effect, Mr. Ayubi no longer had health insurance coverage for any of his medical care or his medications as he is classified as a rejected refugee.

[24] Mr. Ayubi works as a dishwasher and is a low-income person. He says that he is unable to pay for the medications and the diabetic supplies that he needs to monitor his diabetes and its complications. Mr. Ayubi was eventually granted discretionary IFHP coverage by the Minister which pays for his medical services such as doctors' appointments, but does not pay for his medication and diabetic supplies. Mr. Ayubi is currently being kept alive by free samples of insulin supplied to a Community Health Centre by a pharmaceutical company.

E. *Daniel Garcia Rodrigues*

[25] Daniel Garcia Rodrigues[1] and his wife came to Canada from Colombia in 2007. He claimed refugee protection based upon his fear of paramilitaries belonging to the Fuerzas Armadas Revolucionarias de Colombia (FARC). The Immigration and Refugee Board seems to have accepted that the FARC had attempted to forcibly recruit Mr. Garcia Rodrigues, but it was not persuaded that he would still be of interest to the organization.

[26] While Mr. Garcia Rodrigues' refugee claim was refused, his wife's claim was accepted. She subsequently applied for permanent residence in Canada as a protected person, including Mr. Garcia Rodrigues in her application.

[27] Mr. Garcia Rodrigues had IFHP coverage until the changes to the IFHP came into effect on June 30, 2012. In July of 2012, he suffered a retinal detachment. Mr. Garcia Rodrigues was advised that he needed surgery, and that any delay in operating could put his vision at risk. He was scheduled for surgery in August of 2012, but the surgery was cancelled when it was determined that, as a failed refugee claimant, Mr. Garcia Rodrigues was ineligible for coverage under the IFHP.

[28] Mr. Garcia Rodrigues could not afford to pay the $10,000 cost of the surgery himself. However, his doctor ultimately agreed to operate on him for a fraction of the normal cost, in light of the fact that any further delay could have resulted in the permanent loss of Mr. Garcia Rodrigues' vision.

F. *The Respondents*

[29] The Minister of Citizenship and Immigration is generally responsible for Canada's immigration policy, and is also responsible for the development of strategic and operational policies and guidelines with respect to migration health. The Minister's Department, Citizenship and Immigration Canada (CIC), is responsible for overseeing health screening for newcomers migrating to Canada and for managing the IFHP. CIC was also responsible for the policy review that culminated in the 2012 changes to the IFHP.

[30] The Attorney General of Canada has also been named as a respondent in this matter.

III. Background

[31] I will address the facts giving rise to this application in greater detail as I consider each of the arguments raised by the parties. However, the following summary will serve to provide a context for that discussion.

A. *The Pre-2012 IFHP*

[32] According to the affidavit of Sonia Le Bris, the Acting Manager of Migration Health Policy at CIC, even before Canada signed the 1951*Convention Relating to the Status of Refugees*, it had long recognized that refugees often face more challenges than others in becoming established and self-sufficient in Canada. It had also long been recognized that some such individuals required urgent or essential medical care soon after their arrival in this country and that they would not be able to pay for that care.

[33] As a consequence, the program now known as the IFHP was created shortly after the end of the Second World War as an emergency humanitarian response in order to meet the needs of "refugee-like" individuals. At the time, Canada had a private health care system, and the IFHP was created to fund basic and essential medical and health services for newcomers to Canada who urgently required medical care and lacked the resources to pay for it.

[34] The respondents say that although the IFHP has evolved over time, the purpose of the program has never been to provide health care coverage for*everyone* who comes to Canada, but rather to provide insurance coverage for urgent and essential health care to eligible beneficiaries for a limited and short duration.

[35] The IFHP has always operated pursuant to an Order in Council (OIC) and has never been addressed in immigration legislation. A 1952 OIC authorized the federal government to permit the Immigration Branch "…to pay hospitalization, medical care, dental care and expenses incidental thereto, for immigrants, after being admitted to a port of entry and prior to their arrival at destination, or while receiving care and maintenance pending placement in employment, in cases where the immigrants lack the financial resources to pay these expenses themselves".

[36] In 1957, Order in Council P.C. 1957-11/848 was passed (the 1957 OIC). It revoked the 1952 OIC and provided the authority for the IFHP until the 2012 changes came into effect on June 30, 2012. The 1957 OIC authorized the Department of National Health and Welfare (DNHW) to pay the cost of"medical and dental care, hospitalization, and any expenses incidental thereto" for, amongst others, persons who were at any time:

> 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 of National Health and Welfare.

[37] Persons "subject to Immigration jurisdiction or for whom the Immigration authorities feel responsible" were not specifically identified or defined in the 1957 OIC.

[38] From 1957 to 1993, the DNHW managed what is now known as the IFHP program. With the advent of publicly-funded health care in Canada in the 1950s and 60s, and the subsequent enactment of the *Canada Health Act*, R.S.C., 1985, c. C-6, economic immigrants had access to provincial public health care schemes after a short qualifying residency period and the IFHP stopped funding health care for these individuals.

[39] In 1993, a Memorandum of Understanding was signed between the DNHW and the Canada Employment and Immigration Commission (CEIC, now CIC) to transfer various programs, including the IFHP, from the DNHW to CEIC. CEIC began delivering services under the IFHP in 1995.

[40] Some provinces, notably Ontario and Quebec, had been covering the cost of health care for refugee claimants under their provincial health insurance schemes. However, in the mid-1990s these two provinces announced that they would no longer do so, thereby increasing the cost of the program to the federal government.

[41] By 1996, the focus of the IFHP had shifted away from taking care of the medical needs of newly-arrived indigent immigrants, and the program now applied almost exclusively to refugee claimants, government-assisted refugees and others in humanitarian need. The IFHP was extended to cover members of the "Deferred Removal Orders Class" and persons detained by the newly-created Canada Border Services Agency (CBSA). Later changes extended the IFHP to provide health insurance coverage for applicants for Pre-removal Risk Assessments (PRRAs) and for victims of human trafficking.

[42] Those eligible for IFHP coverage prior to the 2012 changes also included protected persons, government-resettled refugees, privately-sponsored refugees, refugee claimants, and refused refugee claimants whose negative decisions were under judicial review or appeal or who were awaiting removal from Canada. These individuals could receive IFHP benefits until they either became eligible to receive provincial or territorial health care or left the country. No distinction was made in terms of level of coverage based upon the type of claim being advanced or the stage of the proceeding in issue.

[43] Not entitled to coverage under the pre-2012 IFHP were refugee claimants and their dependant children who were not eligible to have their claims determined by the Immigration and Refugee Board, those who were determined under the pre-1993 *Immigration Act* to have "no credible basis" for a claim to refugee status, and those who had withdrawn or abandoned their claims.

[44] Under the pre-2012 IFHP, individuals were also ineligible for coverage if it was ascertained, usually in an interview at the first point of contact with the individual claiming refugee protection, that they had the means to pay for health care or if they were eligible or became eligible for provincial health insurance.

[45] Those who were deemed eligible for the IFHP received an eligibility certificate valid for one year, which was typically renewable for 12-month periods.

[46] For individuals claiming refugee protection at a port of entry, an eligibility certificate was usually issued at the port of entry once it was determined that the individual was eligible to make a refugee claim. In the case of inland refugee claims, if delays were anticipated in processing the claims, inland claimants would be issued a 30-day certificate to provide them with health insurance coverage until their eligibility to make a claim was determined, at which point they would be issued a renewable eligibility certificate that was valid for one year.

[47] An eligibility certificate entitled the individual to federally-funded health insurance coverage for medical care of an urgent or essential nature that was roughly equivalent to the level of health care benefits that is provided to low-income Canadians on social assistance under provincial or territorial health insurance plans.

[48] This included coverage for essential and emergency health services for the treatment and prevention of serious medical conditions and emergency dental conditions. Also covered were immunizations and other forms of preventative medical care, contraception, dental and vision care, essential prescription medications, prenatal and obstetrical care and immigration medical examinations.

B. *The Decision to Reform the IFHP*

[49] Over the years, CIC had carried out several reviews of the IFHP. It made recommendations for the modernization of the program in 1994 and again in 2004, neither of which resulted in substantial changes to the IFHP. However, the cost of the IFHP continued to rise as a result of a general increase in the cost of health care in Canada, and the increasing number of people eligible for IFHP coverage. For example, there were 105,326 people eligible for IFHP benefits in 2003, whereas there were 128,586 people eligible for IFHP benefits in 2012.

[50] The respondents also say that the original intent of the IFHP, namely to provide short term, interim medical care to eligible individuals, had been eroded over time. The cost of the IFHP is directly affected by the length of time that people are eligible for benefits. While the average period of IFHP eligibility was 548 days in 2003, the average eligibility period had climbed to 948 days by 2012.

[51] The combined result of these factors was that the IFHP cost Canadian taxpayers $50,600,000 in 2002/2003 and almost $91,000,000 in 2009/2010. As a consequence, cost containment was a driving principle underlying the decision to reform the IFHP.

[52] Another impetus for reform was this Court's decision in *Toussaint v. Canada (Attorney General)*, 2010 FC 810 (CanLII), 2010 FC 810, [2011] 4 F.C.R. 367 [*Toussaint* FC], aff'd 2011 FCA 213 (CanLII), 2011 FCA 213, [2013] 1 F.C.R. 374, leave to appeal to SCC refused, [2011] S.C.C.A. No. 412. This decision traced the evolution and expansion of the IFHP since its inception, with this Court noting that the actual operation and beneficiaries of the IFHP in 2010

bore little resemblance to the terms of the 1957 OIC. The Court further observed that the current operation of the IFHP was based largely upon CIC's own internal policies, and took little heed of the 1957 OIC. As a result of this decision, CIC decided that a new IFHP policy had to be grounded in a new OIC.

[53] As a consequence of these and other considerations, CIC decided that the IFHP was in need of reform, and that five key principles should guide that reform. The respondents identify these principles as including the need to:

i. Modernize, clarify and reaffirm the original intent of the IFHP as a temporary, interim, short term *ex gratia* program;

ii. Change the IFHP to ensure "fairness to Canadians";

iii. Protect public health and public safety in Canada;

iv. Defend the integrity of Canada's refugee determination system and deter its abuse; and

v. Contain the financial cost of the IFHP.

[54] In September of 2010, the Minister announced that CIC would undertake a complete policy review of the IFHP. The result of this review was the April 25, 2012 announcement of major changes to the IFHP as part of the federal budget. That same day, Order in Council P.C. 2012-433, the "*Order Respecting the Interim Federal Health Program, 2012*" (the April 2012 OIC), was published in the Canada Gazette. The April 2012 OIC, together with the amendments made on June 28, 2012 by Order in Council P.C. 2012-945 (the amending OIC), replaced the 1957 OIC, effective June 30, 2012. These two OICs will be referred to jointly in these reasons as the "2012 OICs".

[55] The respondents say that abuse of the IFHP was "not the issue which guided or motivated the reform". Rather, the changes were intended to support the overall objective of refugee reform, and were "but one way in which the government could deter unfounded claims and possibly discourage failed refugee claimants from remaining in Canada when they ought to be leaving": Transcript, Vol. 3, p. 38.

[56] A statement made on behalf of the then-Minister of Citizenship and Immigration shortly after the 2012 changes to the IFHP came into force provides further insight into the rationale for the modifications made to the program. The Minister's spokesperson explained the changes in the following terms:

> Canadians have been clear that they do not want illegal immigrants and bogus refugee claimants receiving gold-plated health care benefits that are better than those Canadian taxpayers receive. Our Government has listened and acted. We have taken steps to ensure that protected persons and asylum seekers from non-safe countries

> receive health care coverage that is on the same level as Canadian taxpayers receive through their provincial health coverage, no better. Bogus claimants from safe countries, and failed asylum seekers, will not receive access to health care coverage unless it is to protect public health and safety. Shamefully, the NDP and the Liberals support bogus and rejected asylum seekers receiving gold-plated health care benefits. We disagree. Those who have been through our fair system and [are] rejected should respect Canada's laws and leave the country.

C. *The 2012 IFHP*

[57] The pre-2012 IFHP provided the same level of insurance coverage to all individuals eligible for benefits, whether they were refugees, refugee claimants, failed refugee claimants, individuals only entitled to a PRRA, victims of human trafficking or immigration detainees. Coverage was available to these individuals until they either became eligible to receive provincial or territorial health insurance, or left the country.

[58] The 2012 IFHP continues to provide limited, temporary health insurance coverage to:

i. Protected persons, including resettled refugees, successful refugee claimants and positive PRRA recipients;

ii. Refugee claimants and rejected refugee claimants;

iii. Victims of human trafficking with temporary resident permits;

iv. Persons granted permanent residency as part of a public policy or for humanitarian and compassionate reasons by the Minister, and who receive income support through the resettlement assistance program or the equivalent in Quebec; and

v. Foreign nationals and permanent residents detained under the *Immigration and Refugee Protection Act*, S.C. 2001, c. 27.

[59] However, unlike the situation under the pre-2012 IFHP, individuals who are only entitled to make a PRRA application and not a refugee claim are no longer entitled to any form of IFHP coverage whatsoever. This includes people who not admissible to Canada on security grounds, or because of criminal activity or human rights violations. It also includes those who fail to file their refugee claims in a timely manner and those who have previously made an unsuccessful refugee claim.

[60] For the purpose of these reasons, I will refer to the various classes of individuals described in the two preceding paragraphs collectively as individuals "seeking the protection of Canada".

[61] In contrast to the pre-2012 IFHP, which provided the same level of coverage to all those eligible for the program, the 2012 IFHP regime now provides for three tiers of coverage:

i. Expanded Health Care Coverage (EHCC);

ii. Health Care Coverage (HCC); and

iii. Public Health or Public Safety Health Care Coverage (PHPS).

[62] Which tier of IFHP coverage a person will be entitled to receive under the 2012 IFHP depends upon a number of factors including:

i. Where the individual is in the refugee determination process (e.g. refugee claimant, successful claimant or rejected claimant);

ii. whether the individual is a national of a Designated Country of Origin (DCO)[2];

iii. if the individual is not a refugee claimant, the person's status in Canada (e.g: permanent resident, resettled refugee, victim of human trafficking, person with a positive PRRA decision, etc.);

iv. whether the individual receives federally-funded resettlement assistance; and

v. whether the individual is being detained.

[63] Under the 2012 IFHP it is now therefore possible for an individual to receive different levels of IFHP coverage at different times. By way of example, a refugee claimant from a non-DCO country would receive HCC while their claim is outstanding, but their coverage would be reduced to the PHPS level if the claim is rejected. This is the case even where, as with Mr. Ayubi, the Government of Canada has placed a moratorium on returning rejected refugees to their country of origin.

[64] Similarly, a refugee claimant from a DCO country would be limited to PHPS coverage while his or her refugee claim is pending before the Immigration and Refugee Board, but if the claim is ultimately accepted, the individual's level of insurance coverage would then increase to the HCC level.

[65] Also noteworthy is the fact that the 2012 changes to the IFHP eliminated the means test, with the result that everyone in a particular category of claimants is entitled to health insurance coverage at the relevant level, regardless of their ability to pay for their own health care.

[66] The scope of the coverage provided under each tier of the IFHP will be discussed next.

(1) Expanded Health Care Coverage

[67] Expanded Health Care Coverage is substantially equivalent to the level of IFHP benefits provided under the pre-2012 program, and is essentially the same level of publicly-funded health care insurance coverage as is available to low-income Canadians under provincial or territorial benefit plans. EHCC pays for the services of hospitals, physicians, nurses, and other health care professionals. Coverage is also provided for laboratory, diagnostic and ambulance services, translation services for health purposes, and supplemental services and products such as prescription medications, emergency dental services, vision benefits and assistive devices.

[68] Those entitled to EHCC benefits include most government-assisted refugees and some privately-sponsored refugees, as well as victims of human trafficking and some individuals admitted under a public policy or on humanitarian and compassionate grounds. According to the respondents, 14% of all IFHP beneficiaries now receive EHCC benefits.

(2) Health Care Coverage

[69] The second tier of coverage is Health Care Coverage. The respondents submit that HCC provides health insurance coverage that is similar to the level of coverage received by working Canadians through their provincial or territorial health insurance plans. In addition, HCC provides coverage for medications and immunizations that are required to prevent or treat a disease posing a risk to public health or treat a condition that is a public safety concern. Other medications are not covered under HCC, even if they are required for life-threatening conditions.

[70] While not a change from the pre-2012 IFHP, it is factually incorrect to say that HCC provides health insurance coverage that is similar to the level of coverage received by working Canadians. There is a limitation on HCC coverage that does *not* apply to the coverage provided to working Canadians under provincial or territorial health insurance plans. That is, while HCC beneficiaries recieve coverage for services and products such as hospital in-patient and out-patient services, physicians, nurses, and other health care professionals and laboratory, diagnostic and ambulance services, the 2012 OIC makes it clear that these services and products are only covered "*if they are of an urgent or essential nature*" as defined in the IFHP itself.

[71] The IFHP defines services and products of an *urgent* nature as "those provided in response to a medical emergency – an injury or illness that poses an immediate threat to a person's life, limb or a function". There is a further qualifier imposed by the IFHP with respect to the availability of services and products of an urgent nature which is that they are not to be "more than what is required to respond to the medical emergency …".

[72] Services of an *essential* nature are defined by the IFHP as being services provided to an IFHP beneficiary for the "assessment and follow-up of a specific illness, symptom, complaint or injury". Essential services also include "prenatal, labour and delivery, and postpartum care" and services provided"for the diagnosis, prevention, or treatment of a disease posing a risk to public health or for the diagnosis or treatment of a condition of public safety concern".

[73] Thus, routine primary health care services such as annual check-ups, preventative health care and standard screening tests (other than those for communicable diseases or conditions of concern to public safety) are not available to recipients of HCC benefits, although these types of services are generally available to working Canadians under provincial or territorial health insurance plans.

[74] Those entitled to HCC benefits include refugee claimants from non-DCO countries, refugees, successful PRRA applicants, most privately-sponsored refugees, and all refugee claimants whose claims were filed before December 15, 2012, regardless of the claimant's country of origin. The respondents indicate that 62% of all IFHP beneficiaries receive HCC benefits.

(3) Public Health or Public Safety Health Care Coverage

[75] Public Health or Public Safety Health Care Coverage only insures those health care services and products that are necessary or required to diagnose, prevent or treat a disease posing a risk to public health, or to diagnose or treat a condition of public safety concern.

[76] According to the April, 2012 OIC, a "disease posing a risk to public health" is defined as a communicable disease that is either identified in the*Interim Federal Health Program Policy* or is on the list of national notifiable diseases maintained by the Public Health Agency of Canada. These include diseases such as tuberculosis, HIV, malaria, measles, chicken pox, and other contagious diseases. A "condition posing a risk to public safety" includes mental health conditions where a person is likely to cause harm to others. Mental health conditions where the individual only poses a risk to him or herself are not covered under PHPS coverage.

[77] Those entitled to PHPS-level coverage include refugee claimants from DCO countries whose claims were filed after December 15, 2012, refugee claimants whose claims have been suspended while they are under investigation for possible inadmissibility, and failed refugee claimants. The respondents say that 24% of all IFHP beneficiaries receive PHPS benefits.

[78] Beyond these services, the IFHP covers the cost of immigration medical examinations for those individuals eligible for any of the three aforementioned tiers of coverage.

(4) PRRA-only Claimants

[79] There is, however, a fourth class of individuals who had health insurance coverage under the pre-2012 IFHP who now receive no health insurance coverage whatsoever, even if they suffer from a health condition that poses a risk to public health or safety. This class is made up of individuals who are only entitled to a Pre-removal Risk Assessment (PRRA-only claimants).

(5) Ministerial Discretion

[80] Under section 7 of each of the 2012 OICs, the Minister retains the discretion to pay the cost of HCC, PHPS coverage or immigration medical examinations "in exceptional and

compelling circumstances". It will be recalled that Mr. Ayubi was ultimately granted discretionary IFHP coverage by the Minister for his diabetes-related medical services, but not for his medication.

[81] Indeed, the amending OIC makes it clear that the Minister's discretion does not extend to cover the payment of medications or immunizations, unless they are required to treat a condition that involves a threat to public health or safety.

[82] The respondents further acknowledge that the existence of Ministerial discretion under section 7 of the 2012 OICs is not designed to address emergency medical situations.

[83] It also appears that a request for section 7 discretionary relief may potentially have consequences for the way in which an individual's refugee claim is processed.

[84] CIC's Operational Bulletin 440-G provides guidance with respect to the processing of refugee claims in accordance with amendments to *IRPA*made under the *Balanced Refugee Reform Act*, S.C. 2010, c. 8 (which received Royal Assent on June 29, 2010) and the *Protecting Canada's Immigration System Act*, S.C. 2012, c. 17, which came into force on December 15, 2012.

[85] Section 8 of the Operational Bulletin deals with Ministerial interventions and identifies criteria for use by CIC and CBSA in identifying refugee cases that may warrant Ministerial intervention. One such criteria is that the "claimant appears to be making a claim in order to access benefits". The Bulletin goes on to cite the example of where "urgent IFH[P] coverage [is] requested during or before the eligibility interview". The applicants submits that this could serve as a disincentive for refugee claimants to apply for section 7 relief, raising the fear that such a request could negatively affect their claims.

[86] I do not accept the respondents' contention that section 8 of Operational Bulletin 440-G has no application in the case of requests for section 7Ministerial relief. The respondents' argument is predicated on the assumption that concerns that a claimant may be making a refugee claim in order to access benefits will *only* arise where the individual requests urgent IFHP coverage during or before his or her eligibility interview. Indeed, the respondents suggest that the Operational Bulletin should actually have referred to an "urgent request for an eligibility interview" rather than an "urgent request for IFH[P]."

[87] I am not prepared to interpret the Operation Bulletin in the way suggested by the respondents. It is clear on the face of section 8 of the Operational Bulletin that a request for IFHP coverage during or before an eligibility interview is cited as only one example of circumstances that could trigger a Ministerial intervention. This does not, however, preclude the possibility that a request for section 7 Ministerial relief at any point in the processing of a refugee claim could also potentially give rise to concerns that a claimant is making a refugee claim in order to access health care benefits, thus prompting Ministerial involvement in the claim.

D. *The Impact of the 2012 Changes to the IFHP*

[88] The 2012 changes to the IFHP have provoked a strong public reaction and have had a significant impact on individual patients, health care providers and the health care system. Before turning to consider these issues, however, it is first necessary to address the respondents' objection to some of the evidence adduced by the applicants.

…

(2) The Public Reaction

[126] The 2012 changes to the IFHP were condemned by many involved in providing health care and other forms of assistance to those seeking the protection of Canada, as well as by newspaper editorial writers and provincial governments. I will deal with the public outcry that followed the creation of the 2012 IFHP in greater detail in the context of my section 12 *Charter* analysis, but will briefly identify the nature of the concerns that were expressed in order to provide a context for the discussion that follows.

[127] Some 21 national medical organizations, including the Canadian Medical Association, the Royal College of Physicians and Surgeons, the College of Family Physicians of Canada, the Canadian Association of Midwives, the Canadian Psychiatric Association, the Canadian Paediatric Society, the Public Health Physicians of Canada and the Canadian Association of Emergency Physicians offered statements expressing concerns with respect to the cuts to the IFHP.

[128] A group of these organizations wrote to the Minister of Citizenship and Immigration on May 18, 2012, decrying the pending changes to the IFHP. Amongst other things, the organizations observed that the cost of providing care to vulnerable individuals would be downloaded to provincial social support programs, community-based health programs, the charitable sector and others.

[129] The organizations further note that the failure to provide "upfront health services" created the risk that undiagnosed and untreated medical conditions would result in increased medical complications, as well as future health care costs. In addition, the failure to address medical concerns would make it more difficult for newcomers to Canada to learn new languages, attend school or enter the job market.

[130] Dr. Meb Rashid is a family physician in Toronto and a founding member of CDRC. He states in his affidavit that despite requests from these medical associations for a meeting with the Minister of Citizenship and Immigration to discuss the pending changes to IFHP, no such meeting ever took place.

[131] Provincial governments also expressed serious concerns with respect to the changes to the IFHP. For example, shortly before the 2012 IFHP came into effect, the Ontario Minister of

Health and Long Term Care wrote to the federal Ministers of Health and Immigration calling on the federal government to reinstate the pre-2012 IFHP.

[132] The Ontario Health Minister's letter accused the Government of Canada of having "abdicat[ed] its responsibility towards some of the most vulnerable in our society". The Minister stated that if denied coverage for early health care interventions and medication, people would not seek medical care until they were in need of emergency treatment. In addition to causing "needless pain and suffering", the failure to treat conditions "will exacerbate the future health care needs [of affected individuals]" and has "effectively downloaded federal costs onto the provincial health care system".

(3) Confusion in the Health Care Profession

[133] It will be recalled that the changes to the IFHP were first announced on April 25, 2012, and came into effect on June 30, 2012. CIC carried out a number of briefings during this time, explaining the changes to the provinces and territories, national health organizations, service provider organizations, the Canadian Council of Refugees and other national organizations representing refugees and refugee claimants. Information Bulletins were also published on the CIC website and on the website of the claims administrator, Medavie Blue Cross.

[134] There was, nevertheless, considerable confusion on the part of health care providers in processing the health care claims of refugee claimants in the wake of the 2012 changes to the IFHP. The applicants' affiants state that surgeries have been cancelled due to uncertainties surrounding patients' IFHP insurance coverage. Incorrect information has also been provided with respect to other patients' IFHP status, with the result that health care has been denied to patients who were in fact eligible for coverage for the care in question.

[135] In others cases, doctors have demanded that patients pay the cost of medical treatment "up front", even though patients might actually have IFHP coverage for the services or treatment in question.

[136] Some doctors have found the new system too confusing, and are now simply refusing to see any IFHP patients. According to the affidavit of Dr. Rashid, this is a particular problem with specialists.

[137] Manavi Handa is a midwife working with refugee claimants in Ontario. She describes in her affidavit how two of her clients, IFHP beneficiaries receiving obstetrical care in hospitals were asked to pay hospital fees upfront following the 2012 changes to the IFHP, even though the status of their health care coverage had in fact remained unchanged.

[138] Dr. Paul Caulford, a family physician and co-founder and Medical Director of the Community Volunteer Clinic for the Medically Uninsured, outlines numerous difficulties that his clinic has encountered since June 30, 2012, asserting that the IFHP system has "become a confusing administrative nightmare": at para. 23.

[139] This confusion on the part of health care providers is hardly surprising. Indeed, the chapter in the CIC manual dealing with the IFHP is some 52 pages in length, complete with flow-charts and eligibility tables explaining which class of claimant is entitled to what level of care at which stage in the proceedings. Dr. Rashid testified that a colleague of his with an interest in refugee health told him "[s]end me Einstein's theory of relativity. It's easier":Rashid cross-examination at question 337.

[140] While not denying that problems have occurred since the changes to the IFHP came into effect on June 30, 2012, Allison Little Fortin, the Director of the IFHP in the Health Branch of CIC, describes in her affidavit the efforts that CIC has made to address the concerns that have arisen in the wake of the changes to the IFHP, particularly with respect to ensuring that information regarding a patient's entitlement to IFHP coverage is accessible and accurate.

[141] The respondents note that the claims administration process is substantially the same as it was before the 2012 changes were made to the IFHP. The respondents further argue that cross-examination of some of the affiant health practitioners reveals that some of this confusion was due "in large part" to their failure to "inform themselves of the changes": see Transcript, Vol. 2 at p. 72. The record also reveals, however, that some doctors such as Dr. Caulford did make efforts to learn about the 2012 changes to the IFHP and to understand how it works.

(4) The Systemic Consequences of the 2012 Changes to the IFHP

[142] In addition to the confusion in the health care profession discussed in the preceding section, the 2012 changes to the IFHP have had a number of other consequences for the health care system as a whole.

[143] As was noted earlier, an individual's entitlement to IFHP coverage, and the level of that coverage can change over time. As a consequence, patient eligibility for coverage now has to be updated on a regular basis, creating an additional administrative burden for health care providers.

[144] Difficulties confirming the status of a patient's IFHP coverage have been encountered when the patient presents for treatment outside of the office hours of the IFHP claims administrator - Medavie Blue Cross. Problems have also been encountered when the Medavie Blue Cross website is down, which has evidently occurred from time to time.

[145] Delays in issuing eligibility certificates for inland refugee claimants have also created difficulties when these refugee claimants have developed health problems prior to receiving their certificates. In contrast to the pre-2012 system where most refugee claimants were granted temporary coverage upon entry into Canada pending determination of their eligibility, under the 2012 IFHP, refugee claimants are not granted any health care coverage until their eligibility is determined. Although some of these delays have been addressed by the respondents, it appears that difficulties may still be encountered in emergency situations.

[146] Ms. Handa, the midwife mentioned earlier, identified a particular concern that arises in the case of pregnant women. Ms. Handa notes that obstetricians commit to take on the care of

pregnant women for a defined period of time, generally nine months. A patient's entitlement to IFHP can change over time as individuals move through the refugee determination process. Patient entitlement to health insurance coverage can also change over time as the program continues to evolve, for example, as new countries are added to the DCO list. As a result, obstetricians cannot be certain that a woman taken into care at one stage in her pregnancy will still have IFHP coverage for obstetrical care later in her pregnancy.

[147] The result of this, Ms. Handa says, is that "more and more obstetricians are reluctant to take on any women who now have IFHP regardless of what category they fall into": Handa affidavit at para. 12.

[148] Concerns have also been expressed by doctors with respect to the ethical issues that are created for them as a result of the 2012 changes to the IFHP. As Dr. Rashid explained in his cross-examination "…once you see somebody who has pneumonia, and you've ruled out TB, what if they're still sick?" Are we supposed to then just say, I'm sorry, your coverage is finished, please move on? Once you assume care for an individual I think ethically it's highly problematic to say two visits, three visits, sorry, you don't have TB. We don't care what you have, please move on": Rashid cross-examination at question 357.

[149] Evidence has also been provided with respect to the impact of the 2012 changes to the IFHP on overall health care spending. While the respondents have pointed to a decrease in spending on health care for IFHP beneficiaries as a result of the changes to the program, the applicants' witnesses suggest that it is not at all clear that the changes will actually result in any net savings to Canadian taxpayers, once the costs that have simply been downloaded to others are factored into the equation. The changes will, moreover, most certainly have negative health consequences for the affected individuals.

[150] Dr. Rachlis has analyzed the 2012 changes to the IFHP and has provided an expert opinion on health care utilization and costs. He asserts that study after study has confirmed that poor individuals without health insurance are less likely to seek medical care, which can increase the risk of adverse health effects. These individuals "use fewer primary health care services (e.g. family doctors, nurse practitioners, midwives), taking less needed prescribed medication, and therefore only seek health care if/when they have a health crisis …": Rachlis affidavit at para. 5. This results in "poorer overall health and higher use of hospital services, both emergency rooms and acute care beds": at para. 6.

[151] There is, moreover, a cost to reducing access to primary health care. According to Dr. Rachlis, any cost savings achieved by cutting insurance for primary health care "may be outweighed by higher subsequent costs for other health care services, especially hospital services".

[152] Dr. Rachlis has identified what he says is the proper methodology that should be followed in order to determine whether the 2012 changes to the IFHP have actually resulted in any net public sector cost savings. To the best of Dr. Rachlis' knowledge, the Government of Canada has not carried out such an analysis.

[153] Evidence was also provided by Dr. Rummens with respect to the impact of health care insurance coverage or a lack thereof on access to medical care and health outcomes for immigrant, refugee claimant and other migrant children. It will be recalled that Dr. Rummens is a Principal Investigator in a research project entitled "*Migratory Status of the Child and Limited Access to Health Care*". Dr. Rummens' evidence essentially mirrors that of Dr. Rachlis, except that it specifically addresses the health consequences of a lack of health insurance for children.

[154] Based upon an analysis of paediatric emergency records, Dr. Rummens says that the preliminary findings of her research are that "children without health care insurance access emergency care less often and with more serious health concerns compared to children who were covered under the former … IFHP": Rummens affidavit at para. 6.

[155] These children "are also found to be more highly represented at more serious triage levels than children with [pre-2012] IFHP coverage": at para. 5. According to Dr. Rummens, this suggests that there may have been a delay in seeking help for some of the children – a phenomenon that has been identified in research regarding uninsured adult populations.

[156] It can be anticipated, says Dr. Rummens, that the health status outcomes of children who have had their health care insurance coverage reduced by the 2012 changes to the IFHP "will likely come to mirror" the health status outcomes for the uninsured children in her study: at para. 8.

(5) The Impact on Individual Claimants

[157] A significant body of evidence was adduced by the applicants with respect to the impact that the 2012 changes to the IFHP have had on individuals requiring health care. Before turning to consider this evidence, however, it is first necessary to address the respondents' objections to some of the applicants' evidence on this issue.

(a) *The Frailties in the Applicants' Non-expert Evidence*

[158] The respondents take issue with much of the evidence adduced by the applicants with respect to the impact of the 2012 changes to the IFHP on individuals other than Messrs. Ayubi and Garcia Rodrigues, submitting that the applicants have failed to place sufficient direct, specific and detailed evidence before the Court to support their Charter claims.

[159] The respondents note that although the applicants have provided evidence regarding the experiences of many individuals under the 2012 IFHP, only a few of these individuals have been identified by name. According to the respondents, much of this evidence is hearsay, or is anecdotal, unreliable, general and non-specific, and thus of little value.

[160] Furthermore, the respondents say that cross-examination on a number of the applicants' affidavits revealed uncertainty as to critical facts, including the IFHP eligibility of the patient in question, as well as the tier of IFHP coverage to which the patient may have been entitled at the relevant time.

[161] As will be discussed in greater detail in relation to the issue of standing, the applicants say that they have encountered "considerable practical difficulties" in having individuals come forward with information in this case. For example, Dr. Rashid explains that, beyond their physical and mental illnesses and their psychological frailties, his patients have been reluctant to share their stories publicly because of their lack of secure immigration status, and the fact that they would be criticizing the very government from which they are seeking protection.

[162] While acknowledging that doctors and other health care providers who have provided affidavits in this case were, in some cases, referring to information that they had received from others, the applicants nevertheless say that the vast majority of the evidence provided by these affiants was evidence regarding cases in which the deponents were personally and directly involved.

[163] The applicants also note that the respondents do not dispute that the 2012 modifications to the IFHP have probably had an adverse effect on the health of some of those affected by the changes. According to the applicants, "there is no better evidence than that of a doctor who is called upon to treat an individual and can't provide the treatment that is required because the individual doesn't have the necessary health care coverage": see Transcript, Vol. 2 at p. 226.

[164] The applicants further observe that the respondents were unable to produce evidence to dispute any of the information provided by the affiants demonstrating that the changes to the IFHP are having adverse effects, with the result that the evidence of harm is uncontradicted.

[165] The Supreme Court has been clear that "Charter decisions should not and must not be made in a factual vacuum" and that "Charter decisions cannot be based upon the unsupported hypotheses of enthusiastic counsel": *MacKay v. Manitoba*, 1989 CanLII 26 (SCC), [1989] 2 S.C.R. 357 at para. 9, [1989] S.C.J. No. 88.

[166] Similarly, in *Danson v. Ontario (Attorney General)*, 1990 CanLII 93 (SCC), [1990] 2 S.C.R. 1086, [1990] S.C.J. No. 92, the Court observed that it had "been vigilant to ensure that a proper factual foundation exists before measuring legislation against the provisions of the Charter, particularly where the effects of impugned legislation are the subject of the attack": at para. 26. See also *Canada v. Stanley J. Tessmer Law Corp*., 2013 FCA 290 (CanLII), 2013 FCA 290 at para. 9, [2013] F.C.J. No. 1360.

[167] A distinction is drawn in Charter litigation between "adjudicative facts" and "legislative facts": see *Danson*, above at para. 27 for an explanation of the distinction between the two. More recently, however, the Supreme Court has recognized that social and legislative facts may in fact be intertwined with adjudicative facts: *Canada (Attorney General) v. Bedford*, 2013 SCC 72 (CanLII), 2013 SCC 72 at para. 52, [2013] S.C.J. No. 72 [*Bedford*].

[168] Although they are not parties to the litigation, the evidence regarding the experiences of unnamed individuals is closer to evidence regarding"adjudicative facts" rather than to "legislative facts". According to the Supreme Court in *Danson*, "[s]uch facts are specific, and must be proved by admissible evidence": at para. 27.

[169] That said, as will be discussed further on in these reasons, there is some room in Charter litigation for the use of reasonable hypotheticals which are neither "far-fetched" nor "only marginally imaginable as a live possibility": see, for example, *R. v. Goltz*, 1991 CanLII 51 (SCC), [1991] 3 S.C.R. 485 at paras. 68-69, [1991] S.C.J. No. 90.

[170] I agree with the respondents that there are frailties in some of the applicants' evidence regarding the experiences of individuals under the 2012 IFHP. There are, for example, material gaps in the information regarding the immigration status of certain individuals or the level of IFHP coverage to which the individual was entitled at the time in question. These gaps significantly undermine the probative value of the evidence.

[171] There are, however, several affidavits provided by individuals other than Mr. Ayubi and Mr. Garcia Rodrigues who – people who have themselves been directly affected by the 2012 changes to the IFHP. This evidence is specific, and deals with matters coming within the direct knowledge of the deponents. As a consequence, I am prepared to ascribe probative value to this evidence, which will be discussed further on in this section.

[172] A number of community workers, health care providers and lawyers have also provided affidavit evidence about the cases of unnamed individuals in which the deponents have been directly involved. I am satisfied that in the cases discussed below, enough reliable detail has been provided to warrant consideration of the evidence in question as being illustrative of some of the ways in which the 2012 changes to the IFHP can affect program beneficiaries.

[173] Before turning to consider the evidence regarding non-parties, however, I will first address the evidence with respect to the two individual applicants.

(b) *Mr. Ayubi's Experience*

[174] As was noted earlier in these reasons, Mr. Ayubi is a failed refugee claimant from Afghanistan who first came to Canada in April 2001. Mr. Ayubi says that he developed "juvenile" or "Type 1" diabetes when he was 10 years old, and that since then he has been dependent on regular injections of insulin for his survival.

[175] Mr. Ayubi deposes that he left Afghanistan in part because of his fear of the human rights violations committed by the Taliban, and also because the war in Afghanistan prevented him from getting adequate medical care for his diabetes. He confirmed in his cross-examination on his affidavit that part of the reason that he came to Canada was because he could not always get the medication that he needed in Afghanistan.

[176] Mr. Ayubi's refugee claim was rejected by the Immigration and Refugee Board in 2001. In light of Mr. Ayubi's "overall lack of credibility", the Board did not believe that he had encountered any problems with the Taliban as a result of his opposition to the war in his country. Nor did the Board accept that Mr. Ayubi would have any problems with governmental authorities, based upon his alleged opposition to the war. The Board noted that Mr. Ayubi's "fragile health" made him unfit for military service, and that he had not provided

credible and trustworthy evidence to demonstrate that he had a well-founded fear of being recruited by the Taliban.

[177] The rejection of Mr. Ayubi's refugee claim does not, however, mean that he is not at risk in Afghanistan.

[178] As was noted earlier, Mr. Ayubi was not removed from Canada after the rejection of his refugee claim because Afghanistan is a "moratorium country". That is, the Government of Canada has determined that the conditions in Afghanistan are simply too dangerous to allow for the repatriation of Afghan nationals, including failed refugee claimants.

[179] While Mr. Ayubi has briefly accessed social assistance benefits, he has worked "fairly steadily" since his arrival in Canada, primarily in minimum wage jobs in restaurants and gas stations. Throughout his time in this country, Mr. Ayubi has filed his tax returns and paid his taxes. He was working as a dishwasher at the time that he swore his affidavit, but continues to be a low-income person making approximately $10,000 a year.

[180] In accordance with the provisions of the pre-2012 IFHP, Mr. Ayubi had health care coverage from the time of his arrival in Canada until the changes to the IFHP came into effect on June 30, 2012. As a result, Mr. Ayubi's insulin and diabetic supplies, as well as the medical tests and care that he required to manage his diabetes were all paid for by the federal government. Mr. Ayubi was unable to confirm in his cross-examination how much the Government of Canada has paid for his medical expenses over time.

[181] After June 30, 2012, Mr. Ayubi only had Public Health or Public Safety Health Care Coverage. This only covered those health care services and products necessary or required to diagnose, prevent or treat a disease posing a risk to public health, or to diagnose or treat a condition of public safety concern.

[182] Mr. Ayubi's diabetes is complicated by retinopathy, nephropathy and neuropathy. According to Dr. Stephen Feder, who has been Mr. Ayubi's family physician at the Pinecrest-Queensway Community Health Centre since 2007, "this places him at significant risk for major morbidity such as blindness, renal failure requiring dialysis or transplant, peripheral arterial disease requiring surgical intervention, coronary artery disease and of course premature mortality": Ayubi affidavit, Exhibit A.

[183] Dr. Feder explains that the only way for Mr. Ayubi to avoid these problems "is by taking good care of himself". To do this, "he requires numerous medications to lessen the burden of illness", including "insulin, antihypertensives, renal protection, lipid lowering agents to name but a few". Dr. Feder also explains that Mr. Ayubi "benefits from an antidepressant to help him maintain his morale and his courage going forward".

[184] After the changes to the IFHP came into effect, Mr. Ayubi no longer had insurance coverage for his medications or his medical treatments and tests as he is classified as a rejected

refugee. Mr. Ayubi is unaware of the cost of his various medications and his diabetic supplies such as lancets and testing strips, but is certain that he would not be able to afford them.

[185] A request for discretionary relief was made on behalf of Mr. Ayubi in January of 2013. In May of 2013, he was granted discretionary IFHP coverage by the Minister. This pays for his medical services, but not for his medication and diabetic supplies.

[186] Mr. Ayubi is currently being kept alive by free samples of insulin which are provided to his Community Health Centre by a pharmaceutical company on compassionate grounds. There is, however, no guarantee that these samples will continue to be available to Mr. Ayubi in the future. Mr. Ayubi indicated that samples of the specific medications prescribed to him are not always available, and that he sometimes takes "different kind[s]" of medication: Ayubi cross-examination, at question 215.

[187] Mr. Ayubi is not currently able to access some of his other medications at all. According to Dr. Feder, "not having access to these essential medications will undoubtedly be disastrous for [Mr. Ayubi] … and will ultimately … be far more expensive to the health care system when he inevitably presents with complications placing him in a life and death situation".

[188] In his affidavit Mr. Ayubi describes the "constant and severe psychological stress" that he is suffering as a result of his lack of health insurance and the uncertainty surrounding his continued access to life-saving medication. . He adds that the situation is "taking a serious toll" on his health: para. 14.

[189] Mr. Ayubi is a resident of Ontario. He has never applied for coverage under the Ontario Health Insurance Plan (OHIP), although it is by no means clear that he would qualify for OHIP coverage in light of the tenuous and transitory nature of his employment. In any event, OHIP would not cover the cost of Mr. Ayubi's medication and diabetic supplies. Mr. Ayubi has also stated that he cannot afford to purchase private health insurance.

[190] Evidence was also provided regarding Mr. Ayubi's case by Christopher Bradley, a nurse practitioner at the Pinecrest-Queensway Community Health Centre.

[191] Mr. Bradley describes the efforts that he made to find a new endocrinologist for Mr. Ayubi after his long-time endocrinologist refused to keep treating him when he lost his pre-2012 IFHP health insurance coverage.

[192] Mr. Bradley's affidavit also discusses the time that he spent trying to locate other specialists willing to see Mr. Ayubi. He describes his efforts to negotiate lower prices at a local hospital so that Mr. Ayubi could receive certain tests, something Mr. Bradley says that he never had to do before June 30, 2012. While Mr. Bradley was successful in negotiating a lower price for the tests, the Community Health Centre nevertheless paid some $2,700 on Mr. Ayubi's behalf for tests that would previously have been covered under the pre-2012 IFHP.

[193] Mr. Bradley also notes that all of the time that he has spent advocating on Mr. Ayubi's behalf is time that could otherwise have been spent attending to the health care needs of other patients.

[194] Mr. Bradley confirmed on his cross-examination that free samples of Mr. Ayubi's medications are not always available, and that Mr. Ayubi has not been able to obtain certain of his medications. In other cases it has been necessary to substitute one medication for another. According to Mr. Bradley, a substitution in Mr. Ayubi's anti-hypertensive medication led to him suffering a hypotensive crisis. This required the administration of intravenous fluids to restore Mr. Ayubi's blood pressure.

[195] Mr. Bradley says that the Pinecrest-Queensway Community Health Centre has been unable to provide Mr. Ayubi with enough test strips to allow him to test his blood sugar levels as often as they should be checked, thereby creating an unsafe situation.

[196] Finally, Mr. Bradley stated in his cross-examination that he understood that Mr. Ayubi was working part-time, observing that before he received discretionary medical coverage in May of 2013, Mr. Ayubi would likely have been better off if he quit his job and went on social assistance.

[197] Mr. Ayubi is not directly challenging any specific decision with respect to his own IFHP coverage, nor is he seeking compensation from the government. Rather he is asking for the reinstatement of his IFHP coverage retroactive to June 30, 2012.

(c) *Mr. Garcia Rodrigues' Experience*

[198] As noted earlier, Mr. Garcia Rodrigues is a failed refugee claimant from Colombia who arrived in Canada in October 2007. After his refugee claim was rejected in January of 2012, he sought permanent residence in Canada as the husband of a protected person, as his Venezuelan-born wife had been granted Convention refugee status. At the time of the events in issue in this proceeding, Mr. Garcia Rodrigues was awaiting the outcome of his wife's sponsorship application. He is also the father of a Canadian-born child.

[199] Mr. Garcia Rodrigues had been employed for three years at the time of his cross-examination in September of 2013, and he had been paying his taxes. He was employed as a security equipment specialist earning $19 an hour, giving him an annual income of somewhere between $39,000 and $41,000. This is approximately $4,000 to $6,000 above the low income cut-off for a family of three.

[200] Mr. Garcia Rodrigues' employment did not provide him with any health insurance benefits. Mr. Garcia Rodrigues' wife worked part-time in the cosmetics department at Target, and she also did not have access to any health insurance benefits through her employment.

[201] Mr. Garcia Rodrigues had IFHP coverage for urgent and essential medical care and medications from October 2007 until the changes to the IFHP came into effect in June of 2012.

Over that five year period, Mr. Garcia Rodrigues did not take any medications on a regular basis and he had no serious health issues.

[202] As a failed refugee claimant, Mr. Garcia Rodrigues only had health insurance coverage after June 30, 2012, for conditions that threatened public health or public safety.

[203] In July of 2012, Mr. Garcia Rodrigues began suffering from vision problems in his right eye. He was referred to Dr. David Wong, an eye surgeon in Toronto, and on August 8, 2012, Mr. Garcia Rodrigues was diagnosed as having suffered a retinal detachment. He was told that he needed to have surgery as quickly as possible, or he risked the permanent loss of his vision.

[204] Mr. Garcia Rodrigues was initially scheduled for surgery on August 13, 2012. However, the surgery was cancelled when it was determined that he did not have any IFHP coverage for the procedure. It appears that Mr. Garcia Rodrigues' PHPS coverage had expired on August 12, 2012, and he had not renewed it.

[205] Mr. Garcia Rodrigues explained in his cross-examination that when he made inquiries to immigration authorities about renewing his IFHP coverage on August 8, 2012, he was told that there was not point in renewing his insurance certificate as his immigration status meant that he was not entitled to coverage for any of his current medical needs.

[206] Mr. Garcia Rodrigues says in his affidavit that the cancellation of his surgery caused him "severe emotional distress", as he feared losing his vision, and he could not see how he would be able to provide for his family if he lost his sight: at para. 12.

[207] Efforts were nevertheless made to reinstate Mr. Garcia Rodrigues' IFHP coverage, and the surgery was re-scheduled for August 20, 2012. In particular, Dr. Wong contacted the CIC Health Branch on two occasions to explain the urgency of Mr. Garcia Rodrigues' health situation.

[208] On August 17, 2012, CIC advised Mr. Garcia Rodrigues' ophthalmologist that he was not entitled to coverage for the surgery. According to a CIC representative, Mr. Garcia Rodrigues was "an illegal migrant in Canada and [was] expected to leave the country". The CIC representative further noted that Mr. Garcia Rodrigues was only entitled to public health or safety coverage, and that this would not cover the cost of the eye surgery: Garcia Rodrigues affidavit, Exhibit B.

[209] Although the respondents have suggested that Mr. Garcia Rodrigues was eligible for OHIP benefits, he states in his affidavit that he made inquiries during the period at issue and was told that he did not qualify for OHIP. He further states that he was unable to raise the estimated $10,000 cost of the surgery on such short notice. Indeed, the respondents acknowledged during the hearing that it was "not realistic" to think that he would be able to do so: Transcript, Vol. 2, at p. 130.

[210] Dr. Wong ultimately agreed to operate on Mr. Garcia Rodrigues, given that any further delay in the surgery could cause the permanent loss of his vision. Dr. Wong also provided Mr. Garcia Rodrigues with post-operative care, seeing him every couple of weeks for two and a half months after the surgery, waiving his fees for the follow-up care.

[211] Ultimately the only cost incurred by Mr. Garcia Rodrigues in connection with his retinal detachment was the $130 fee that he paid to see an optometrist when he first began experiencing vision problems in July of 2012.

[212] Mr. Garcia Rodrigues and his wife's applications for permanent residence were subsequently approved in principle, and he became eligible for OHIP coverage. On September 16, 2013, Mr. Garcia Rodrigues and his wife were both landed as permanent residents of Canada.

[213] Like Mr. Ayubi, Mr. Garcia Rodrigues is not directly challenging any specific decision relating to his own IFHP coverage and is not seeking compensation from the government. Rather he is asking for reinstatement of his IFHP coverage retroactive to June 30, 2012.

[214] As noted earlier, the applicants have also provided affidavits from a number of other individuals who have been detrimentally affected by the 2012 changes to the IFHP, individuals who are not parties to these proceedings. This evidence will be reviewed next.

(d) *Saleem Akhtar*

[215] Saleem Akhtar is a Pakistani national who sought refugee protection in Canada after unsuccessfully seeking refugee protection in the United States. Mr. Akhtar's refugee claim was based upon his alleged fear of persecution in Pakistan because of his Christian faith. His refugee claim had not been heard at the time that Mr. Akhtar signed his affidavit. Mr. Akhtar is identified in the Notice of Application as "Patient 1".

[216] Shortly after his arrival in Canada in June of 2012, Mr. Akhtar began feeling ill and he was subsequently diagnosed with an aggressive form of lymphoma which required urgent treatment. Mr. Akhtar went to a hospital on July 14, 2012 for his first round of chemotherapy. As a refugee claimant, his IFHP insurance covered his hospital services, but not the cost of his chemotherapy or anti-nausea drugs. Mr. Akhtar had to sell some of his possessions to cover his first round of chemotherapy, after which he says that he was destitute.

[217] The Royal University Hospital in Saskatoon ultimately agreed to pay for the cost of Mr. Akhtar's second round of chemotherapy treatments, which included one treatment a week for 15 weeks. As of August 2012, he received outpatient chemotherapy treatments through the Saskatoon Cancer Centre.

[218] In November of 2012, the provincial government announced that it would cover the cost of the medication provided to Mr. Akhtar. The Premier of Saskatchewan was quoted in a newspaper article about Mr. Akhtar's case as saying "It's unbelievable … [t]he decisions that

have been taken federally have been having this impact on people who are clearly the most vulnerable": Akhtar affidavit, Exhibit A.

[219] A nun who had been assisting Mr. Akhtar was also quoted in the same article as stating that "[t]his gentleman's life was on the line and the amount of anxiety and stress that has been added to his situation was awful".

[220] Mr. Akhtar confirmed in his affidavit that it was stressful enough to receive a cancer diagnosis when he was alone in Canada seeking refugee protection, and that the lack of health insurance for his chemotherapy treatments added greatly to his stress.

(e) *Victor Pathiyage Wijenaike*

[221] Victor Pathiyage Wijenaike is a failed refugee claimant from Sri Lanka who was 76 years at the time he swore his affidavit in this proceeding. He is identified in the applicants' Notice of Application as "Patient 2".

[222] The Immigration and Refugee Board found Mr. Wijenaike's allegations of past persecution to be credible, but concluded that conditions within Sri Lanka had changed enough in the months since Mr. Wijenaike had left the country that he was not currently in need of protection in Canada. Leave was denied by this Court to judicially review the Board's decision. At the time that he swore his affidavit, Mr. Wijenaike had outstanding applications for permanent residence on humanitarian and compassionate grounds and for a Pre-removal Risk Assessment. These applications were subsequently refused.

[223] Mr. Wijenaike lives in Calgary in subsidized seniors' housing. As a failed refugee claimant, he is only entitled to Public Health and Public Safety coverage under the IFHP, and he is no longer entitled to benefits under the Alberta Works program. Mr. Wijenaike testified that he never inquired about his entitlement to provincial health insurance coverage, nor did he look into the cost of private health insurance.

[224] Mr. Wijenaike suffers from a number of life-threatening health conditions including bladder cancer, diabetes, hypertension, aortic valve endocarditis and anaemia. His urologist has agreed to cover the cost of his chemotherapy treatments, but he deposes in his affidavit that his other medications cost approximately $600 a month.

[225] On his cross-examination, Mr. Wijenaike clarified that he gets free samples of some medications from his family doctor, and some from the Calgary Urban Project Society. Nevertheless, each month Mr. Wijenaike has to beg family members for money to pay for his other drugs. He asserts that this is only a short-term solution, as he does not expect that his family will continue to be able to assist him in the future.

[226] Mr. Wijenaike has also incurred significant medical expenses as a result of emergency room visits related to his failing health. He has been unable to pay for these services, and is being

pressed for payment by a collection agency. According to Mr. Wijenaike, all of this has caused him to be "burdened daily with immense psychological stress": at para. 10.

[227] A lawyer acting on Mr. Wijenaike's behalf applied to CIC for discretionary relief for Mr. Wijenaike on November 26, 2012. In his May, 2013 affidavit, Mr. Wijenaike indicated that to date there had been no answer to this request. The respondents suggested to Mr. Wijenaike in his cross-examination that he had in fact been granted discretionary IFHP HCC benefits in February of 2013, which were in effect retroactively from January 9, 2013 to January of 2014, although the evidence on this point is unclear. In any event, as was noted earlier, discretionary IFHP benefits would not cover the cost of Mr. Wijenaike's medication.

[228] Mr. Wijenaike was unable to confirm information put to him by the respondents as to the amount of money for medical expenses that had been paid on his behalf under IFHP to June 30, 2013, although he did express his appreciation for whatever money had been expended on his behalf.

(f) *Rosa Maria Aylas Marcos de Arroyo*

[229] The story of Rosa Maria Aylas Marcos de Arroyo and her 14 year old daughter, Naomi, reveals a different aspect of the impact that the 2012 changes to the IFHP has had on beneficiaries of the program.

[230] Ms. Marcos de Arroyo and Naomi are citizens of Peru, and both are failed refugee claimants. As such, they are only entitled to PHPS-level IFHP coverage. At the time that Ms. Marcos de Arroyo swore her affidavit, the family had an outstanding application for permanent residence in Canada on humanitarian and compassionate grounds.

[231] In October of 2012, Naomi joined the Royal Canadian Sea Cadets, where she has been involved in community service, as well as fitness and leadership training. Naomi has greatly enjoyed her involvement in the Sea Cadets and has received awards for her participation in the organization. According to her mother's affidavit, Naomi's involvement in the Sea Cadets "has been an important part of [her] integration into Canadian society and has helped her, a traditionally shy girl, to gain confidence": at para. 9.

[232] In February of 2013, Naomi's Sea Cadets group went on a camping trip. In order to go on the trip, cadets had to provide proof that they had health insurance. Because Naomi's health insurance coverage was limited to conditions involving public health and safety, she was the only member of her Sea Cadet group who was not permitted to go on the trip.

[233] In April of 2013, Ms. Marcos de Arroyo was advised by the Sea Cadets administration that Naomi would have to provide proof of a new health card, as her previous card had expired. Discussions ensued, and as of the date of Ms. Marcos De Arroyo's affidavit, it was unclear whether Naomi would be permitted to remain in the Sea Cadets, given the restrictions on her health insurance.

(g) *"Sarah"*

[234] Laura Mansfield is a social worker in British Columbia, who works for a non-profit settlement organization assisting refugee claimants. One of Ms. Mansfield's clients is an Iranian woman she calls "Sarah".

[235] Ms. Mansfield has seen Sarah's immigration papers and confirms that she is a refugee claimant from a non-DCO country whose refugee claim is currently outstanding. As a consequence, Sarah is entitled to HCC-level IFHP coverage, which covers her for medical services and products of an urgent or essential nature, but does not cover the cost of her medications.

[236] Sarah suffers from angioedema, asthma and severe allergies. She requires a number of medications to manage her conditions. Her Canadian doctor has provided a letter stating that Sarah may die if she does not take her medications regularly: Mansfield affidavit, Exhibit A.

[237] Sarah's family of three has had to use some of their $401 monthly support budget from provincial income assistance to pay for medications, which has threatened their basic food needs. The family simply could not afford to pay for some of Sarah's medications, as well as the diagnostic testing and follow-up visits that are not covered under the IFHP.

[238] Ms. Mansfield states in her affidavit that she and her colleagues have devoted "countless hours looking for resources to help with Sarah's medication needs". Ms. Mansfield's organization has also expended some of its own limited resources to purchase medication for Sarah from time to time, although this is not something that the organization can continue to do over the long term, or on a regular basis: para. 4.

[239] By the time that Ms. Mansfield swore her affidavit, Sarah had received a work permit and had thus become eligible for provincial "MSP" [Medical Services Plan] benefits, subject to a three-month waiting period. Once Sarah received MSP benefits, her medications would evidently be paid for, as is the case with other low-income people in British Columbia. However, Ms. Mansfield points out that the time Sarah has spent without access to her medications has led to great uncertainty, anxiety and stress for her and her family: Mansfield affidavit at para. 7.

[240] I would note that the respondents have not identified any frailties in Ms. Mansfield's evidence, nor did they choose to cross-examine her on her affidavit.

(h) *"BB"*

[241] Richard Goldman is a lawyer, and is the sole staff member of the Committee to Aid Refugees in Montreal. In that capacity Mr. Goldman has represented two HIV positive individuals who he identifies in his affidavit as "AA" and "BB".

[242] AA is identified as "Patient 5" in the applicants' Notice of Application. Based upon allegedly poor advice, AA withdrew her refugee claim before it could be heard. The applicants

have confirmed that they are not pursuing their challenge to the 2012 changes to the IFHP inasmuch as they apply to individuals who have withdrawn or abandoned their refugee claims, as health insurance coverage was not provided to these individuals under the pre-2012 IFHP. Consequently I will not consider this aspect of Mr. Goldman's evidence.

[243] Mr. Goldman explains that BB is not entitled to make a refugee claim, although the evidence as to why this is so is not entirely clear. In any case, there is no dispute about the fact that BB is in the "PRRA-only" category. As such, BB is not entitled to any health care coverage *whatsoever* under the IFHP, despite the fact that he is HIV positive and thus has a communicable disease that could potentially pose a threat to public health or the safety of Canadians. According to Mr. Goldman, the Quebec government has also not assumed any responsibility for BB's medical care.

[244] Mr. Goldman's affidavit includes a letter from BB's doctor at the McGill University Health Centre. The doctor states that after BB lost his IFHP coverage, the Centre was forced to find "compassionate access" so as to allow BB to continue with his anti-retroviral therapy. BB is receiving treatment through the generosity of a pharmaceutical company, but his doctor describes his situation as "precarious", noting that it requires renewal and reassessment on a monthly basis. According to the doctor, this has caused extra work on the part of the Centre's pharmacy team, and considerable anxiety for BB: Goldman affidavit, Exhibit A.

[245] BB's doctor further explains that an interruption in his drug therapy "could have dire health consequences" for BB, putting him at immediate risk of developing the serious opportunistic infections associated with full-blown AIDS.

[246] Mr. Goldman assisted BB in applying for discretionary IFHP coverage under section 7 of the 2012 OIC. The application was filed in October of 2012 and was refused in April of 2013. No reasons were provided for this decision, and when Mr. Goldman requested reasons he was advised by CIC that"reasons are not provided in the context of a s.7 discretionary decision".

(i) *Manavi Handa's "Second Case"*

[247] It will be recalled that Manavi Handa is a midwife working with refugee claimants in Toronto. She describes the case of one of her patients, a refugee claimant from Mexico.

[248] This patient's refugee claim was outstanding at the time that Mexico was added to the DCO list. The patient was in the late stages of pregnancy, and was planning a hospital delivery. When she went to pre-register at the hospital, the patient was advised that she would have to pay an up-front hospital fee of $2,600 a day. Concerned about this situation, and unable to pay this fee, the woman decided to plan a home birth instead, since midwifery services are covered by the province at no charge to the patient, although she was "very afraid" about this option. It turned out that the patient was in fact entitled to HCC-level IFHP coverage, as it appears that her refugee claim was filed prior to December 15, 2012.

[249] Although the patient's situation was eventually sorted out and the patient safely delivered her baby at home, this example is nevertheless illustrative of the difficulties that may be encountered by female IFHP beneficiaries from DCO countries who seek obstetrical care.

(j) *Conclusion as to the Impact of the 2012 Changes to the IFHP on Individual Claimants*

[250] As illustrated by the above examples, it is apparent that the 2012 changes to the IFHP have had a serious impact on the physical health and psychological well-being of numerous individuals. The respondents say that even though individuals may no longer have health insurance coverage for the treatment of their medical conditions under the IFHP, there are numerous other avenues of access to medical care available to these individuals. This issue will be addressed next.

E. *Alternative Sources of Health Care*

[251] The respondents submit that the cuts to the IFHP have to be considered in light of what they call the "whole panoply of options" that are available to people who would otherwise have had comprehensive health care insurance coverage under the pre-2012 IFHP.

[252] According to the respondents, there are any number of alternatives available to individuals who find themselves in a situation where their particular level of IFHP coverage is not sufficient for their medical needs. These include provincial health insurance coverage that has been instituted to "fill the gaps" created by the 2012 changes to the IFHP, as well as regular provincial or territorial health insurance, private insurance and the goodwill of others.

[253] Indeed, the respondents note that the record is replete with examples of people benefiting from the goodwill of pharmaceutical companies, and from medical clinics for the uninsured.

[254] Each of the alternatives identified by the respondents will be discussed below.

(1) Provincial and Territorial Health Insurance

[255] At the time that the changes to the IFHP came into effect on June 30, 2012, no province or territory was providing health care coverage for individuals who had previously received comprehensive coverage under the pre-2012 IFHP.

[256] As was noted earlier, several provinces vociferously criticized the federal government's change in policy, calling it "unbelievable" in the case of Premier Wall of Saskatchewan, and an "abdication of responsibility towards some of the most vulnerable in our society", by the Ontario Minister of Health. The Manitoba Health Minister stated that the changes were "hurting families and [would] lead to longer-term and more expensive problems".

[257] Since June 30, 2012, a number of provinces have stepped in to provide some level of health insurance for those who would previously have had comprehensive health care insurance

coverage under the pre-2012 IFHP. The respondents rely on this to show that health care is in fact still being provided to individuals who have lost their health insurance coverage under the 2012 changes to the IFHP.

[258] In August of 2012, the Québec government announced that it would provide refugee claimants with insurance coverage for urgent and essential services, as well as coverage for the treatment of conditions that pose a risk to public health and safety. A newspaper report from September of 2012 stated that Manitoba would pay for medical benefits that had been cut by the federal government, although it is not clear from the article who would be eligible for these benefits, or what level of benefits would be provided.

[259] On December 9, 2013, the Ontario government announced the creation of a new program funding health care services for refugees living in Ontario called the *Ontario Temporary Health Program* (OTHP) which would come into effect on January 1, 2014. As of that date, refugee claimants (whether from a DCO country or not) and failed refugee claimants would have funded access to basic medical care, including coverage for medications, subject to an income test. Privately-sponsored refugees (who are currently entitled to OHIP benefits) would also be covered for the cost of their medications under the OTHP.

[260] No such programs appear to have been implemented as yet by the provinces of Alberta, Nova Scotia, or Saskatchewan, although the Alberta Health Minister was quoted as saying that the province was considering setting up a temporary health care program for refugee claimants. Saskatchewan does provide coverage for individuals in need on a case-by-case basis, as it did for Mr. Akhtar, and some health care is evidently being provided to affected individuals on an *ad hoc* basis in Nova Scotia. No information has been provided as to the situation in the remaining provinces and territories.

[261] I am thus satisfied that there are still parts of Canada where provincial governments have not "filled the gap" created by the 2012 changes to the IFHP. In addition, the fact that the situation may now have been remedied in some provinces such as Québec and Ontario does not address the concerns that may have arisen prior to the creation of provincial health insurance plans for IFHP beneficiaries who were "falling through the cracks".

[262] Moreover, while it is commendable that provinces such as Saskatchewan are "filling the gap" on a case-by-case basis, I am not persuaded that *ad hoc* provincial largesse constitutes a reasonable alternative to funded health insurance coverage. We need only look at the case of Mr. Akhtar to see the flaw in the respondents' position.

[263] Indeed, the respondents' argument takes no account of the extreme human cost incurred as individuals search for sources of potentially life-saving medical care. One can only imagine the psychological distress that someone like Mr. Akhtar would feel, being alone in a strange country, having just been diagnosed with an aggressive cancer, and not knowing whether or not he would be able to get the chemotherapy treatments on which his life depended.

[264] The respondents also note that most provinces have schemes in place whereby refugee claimants with valid work permits are eligible for health coverage under provincial and territorial plans. I accept that there is at least a possibility that some people who would have had comprehensive health care coverage under the pre-2012 IFHP could eventually qualify for provincial health insurance in some provinces, but there are a number of reasons why this will not be a viable option for many people.

[265] First of all, refugee claimants from DCO countries are not entitled to receive a work permit for the first 180 days that they are in Canada.

[266] Secondly, many refugee claimants will speak neither of Canada's official languages. They may have limited education, and no familiarity with Canadian culture. There is no assurance that they will come to this country with the language, education or skills to allow them to immediately begin work in Canada. Indeed, the respondents accept that full-time employment is not something that refugee claimants can "walk into immediately": Transcript, Vol. 2 at p. 132.

[267] Thirdly, to qualify for provincial health insurance, at least in Ontario, a claimant has to have an agreement in place to work full-time for an employer and they must be working under that agreement for six months or longer. Many refugee claimants are only able to access part-time or transitory work that would not allow them to qualify for OHIP benefits.

[268] Finally, the majority of provincial and territorial health insurance plans have a waiting period before coverage will take effect, typically three months, leaving applicants uninsured or under-insured in the interim.

(2) Self-funding

[269] The respondents also identify self-funding as an option for those requiring medical services or medications not covered by the IFHP. That is, they say that affected individuals can pay for their own medical care, either directly, or by purchasing private health insurance. Once again, however, this will not be a realistic option for many of those affected by the 2012 changes to the IFHP.

[270] Working as a dishwasher making $10,000 a year, it is inconceivable that Mr. Ayubi could ever pay the $2,700 reduced cost of the medical tests that he needed. Nor could Mr. Garcia Rodrigues, supporting a family of three on a job paying $19 an hour, ever have hoped to raise $10,000 in time to pay for the emergency eye surgery that would preserve his sight and allow him to keep on working and supporting his family.

[271] It will be recalled that Dr. Rashid is a family physician in Toronto who works with refugees. He noted that "we are seeing people who have often been fleeing war; they left with nothing but the clothes on their back; many of them just don't have a change of clothing when they arrive. So the notion of accessing private health insurance, for the refugees I see, and the refugee claimants I see it's not on the radar. So it's out there and I would hope that people know

that, it's not really something that's attainable for most people": Rashid cross-examination at question 289.

[272] Indeed, the respondents accept that the beneficiaries of the IFHP program are generally vulnerable, poor and disadvantaged. Paying for doctors' visits, diagnostic testing, medications and hospitalizations or private health care insurance will be simply out of the question for many, if not most of the affected individuals.

(3) Community Health Centres and Refugee Shelters

[273] Assistance may be available for some of those seeking the protection of Canada through community health centres and refugee shelters. While Richard Goldman has testified that there are no clinics in Québec that offer medical services to the uninsured, community health centres serving the uninsured do exist, at least in Ontario. However, access to medical assistance at these centres is severely restricted.

[274] This is explained by Dr. Rashid, who has worked in a dozen or so community health centres over a fourteen year period. He states that over the last 10 years, the patient rosters for most community health centres have been closed. Moreover, most centres do not operate on a "walk-in" basis so that, for example, a mother would not be able to access medical care for her feverish child at a community health centre.

[275] Dr. Caulford, the Medical Director of the Community Volunteer Clinic for the Medically Uninsured, stated that "what I have seen in my practice since June 30, 2012 is without precedent". He goes on to describe "[r]efugee patients not able to access the care they need, patients arriving needing urgent care for otherwise treatable illnesses because they lacked or thought they lacked coverage, medical services being denied due to confusion around eligibility, and the downloading of costs onto health care providers, clinics, and provincial hospitals". He notes that clinics that were previously scheduled to last four hours now sometimes last 6 hours. He concludes by expressing his concern that "this pace is not sustainable over the long term, as we rely so heavily on volunteers." All quotes from Caulford affidavit at para. 27.

(4) Midwifery Services

[276] The respondents point out that midwifery services are available to anyone in Ontario, free of charge. This may be true, but it obviously does not assist pregnant women in other provinces. Nor does it assist the pregnant woman in Ontario whose high-risk pregnancy requires that her baby be delivered in a hospital setting.

(5) Hospital Emergency Rooms

[277] Hospital emergency rooms are also identified by the respondents as a source of medical care for IFHP beneficiaries. While they may indeed provide care in emergency situations, emergency rooms are a costly way in which to deliver health care. Moreover, as we saw in the

case of Mr. Wijenaike, at least some provinces will attempt to recover the cost of medical services provided to uninsured patients.

[278] Hospital emergency rooms also do not provide primary health care, nor do they provide the kind of preventative health care (such as diabetic monitoring or treatment for mental health conditions, for example) that would allow patients to avoid the hospital in the first place. Finally, patients still have to pay to fill prescriptions that they receive through hospital emergency rooms.

(6) Social Assistance

[279] The respondents also suggest that going on social assistance is another way that IFHP beneficiaries can access health insurance. Indeed, Mr. Bradley observed that Mr. Ayubi would likely have been better off in terms of his ability to access health care had he simply quit his job and gone on social assistance.

[280] At the same time, the respondents acknowledge that privately-sponsored refugees are banned from going on social assistance for their first year in Canada, with the result that this is not a viable option for these individuals.

[281] Moreover, provincial social assistance programs do not provide comprehensive medical benefits to recipients. Where health benefits are provided, they only cover things like medication and supplementary services, but do not ordinarily extend to cover the cost of doctor's visits, pre-natal care, diagnostic testing etc.

[282] To the extent that cost containment was identified as an objective of the 2012 changes to the IFHP, it must also be recognized that there are costs associated with forcing people to go onto social assistance in order to access potentially life-saving medications and medical treatment. These include, of course, the direct financial cost of the social assistance benefits themselves.

[283] There is, however, also an intangible cost to human dignity that comes with forcing people to quit their jobs and go on welfare in order to access medical care. Not only does forcing people to withdraw from the workforce inhibit their ability to integrate into Canadian society, as the Supreme Court of Canada observed in *Reference re Public Sector Employee Relations Act (Alberta)* 1987 CanLII 88 (SCC), [1987] 1 S.C.R. 313, [1987] S.C.J. No. 10:

> Work is one of the most fundamental aspects in a person's life, providing the individual with a means of financial support and, as importantly, a contributory role in society. A person's employment is an essential component of his or her sense of identity, self-worth and emotional well-being. [at para. 91]

(7) Charity

[284] The respondents also point to charitable donations as an alternate source of health care for those affected by the cuts to the IFHP.

[285] It is true that a number of the individuals identified in the record have benefited from the charity of health care providers, medical institutions and pharmaceutical companies. However, the evidence also shows that the availability of the charity of others is uncertain, and that the uncertainty as to whether or not medical care will ultimately be available puts tremendous psychological strain on those in need of medical care.

[286] The respondents' argument that charity is an appropriate alternate source of medical care for the affected individuals also does not take into account the cost to human dignity incurred by requiring sick individuals to have to rely on the goodwill of others. Supreme Court of Canada Charter jurisprudence is replete with references to the importance of human dignity. It is simply demeaning to require desperately ill people to go begging for essential medical treatment.

(8) Section 7 Discretionary IFHP Coverage

[287] The last alternate source of medical insurance coverage identified by the respondents is section 7 discretionary IFHP coverage.

[288] It will be recalled that in accordance with the provisions of section 7 of the 2012 OIC, the Minister retains the discretion to pay the cost of health care coverage, public health or public safety health care coverage or immigration medical examinations "in exceptional and compelling circumstances". Mr. Ayubi was ultimately the beneficiary of such discretionary IFHP coverage for his diabetes-related medical services, but not for his medication.

[289] Once again, this may be a satisfactory source of alternate medical insurance coverage for some individuals, but it does not come close to compensating for the loss of health care benefits resulting from the 2012 changes to the IFHP.

[290] First, the Minister's discretion under section 7 of the OIC does not extend to cover the cost of medications or immunizations, unless they are required to treat a condition that involves a threat to public health or safety.

[291] Second, it is conceded by the respondents that the existence of Ministerial discretion under section 7 of the OIC is not designed to address emergency medical situations. The concession that the exercise of this discretion is not a viable option in emergencies is supported by the evidence regarding Mr. Ayubi's request for discretionary relief, which was outstanding for five months before it was approved. Indeed, Ms. Fortin admitted on her cross-examination that many requests for section 7 relief had been outstanding for several months.

[292] Moreover, although the 2012 OICs are publicly available documents, as is CIC's 2013 policy manual dealing with the IFHP, it appears that the existence of section 7 Ministerial discretion is not widely known. This is demonstrated by the fact that, as of the date of the record, only 23 requests for discretionary relief had been received by CIC.

[293] Finally, section 7 relief is discretionary, and thus, by definition, uncertain.

(9) Conclusion Regarding the Alternatives to IFHP Funded Health Care

[294] The respondents repeatedly emphasized that in every case cited by the applicants, the individuals in question were ultimately able to obtain the medical care that they required. According to the respondents, this is proof that there are satisfactory alternatives to federally-funded health care insurance benefits for those involved in the refugee process.

[295] There are a number of reasons why I do not accept this submission.

[296] The first is that it is factually incorrect. We know that Mr. Ayubi has *not* been able to obtain all of the medical care that he requires. He has been unable to get some of his medications, which his doctor says "will undoubtedly be disastrous for him … and will ultimately … be far more expensive to the health care system when he inevitably presents with complications placing him in a life and death situation": Ayubi affidavit, Exhibit A.

[297] We also know that Mr. Ayubi's inability to access prescribed medication has in fact already caused him physical harm. That is, when one of Mr. Ayubi's anti-hypertensive drugs was not available though his community health centre, an alternative medication had to be substituted. This caused him to suffer a hypotensive crisis, requiring the administration of intravenous fluids at a community health centre to restore his blood pressure.

[298] There are, moreover, numerous short-comings in all of the alternate sources of health care identified by the respondents. These other sources of health care are not always timely. We know that it was only through the goodwill of Mr. Garcia Rodrigues' ophthalmologist, who agreed to perform his surgery for a fraction of the usual price, that he did not lose the vision in his eye, which could have impaired his ability to support his family.

[299] The respondents' proposed alternatives are also uncertain, and do not take into account the psychological harm inflicted on people like Mr. Akhtar, who, on top of receiving a cancer diagnosis, was left wondering whether or not he would be able to receive life-saving chemotherapy treatments.

[300] Nor do the respondents' proposed alternatives take into account the negative impact on human dignity that flows from forcing people to have to rely on the charity of others for life-saving medical treatments.

[301] The respondents concede that people have probably been harmed by the 2012 changes to the IFHP: Transcript, Vol. 2 at p. 119. Given the number of people affected by the changes, and the uncertain and unsatisfactory nature of the alternative avenues of care, this is undoubtedly true. Indeed, I accept the evidence of Dr. Rachlis, to the extent that he asserts that the changes to the IFHP are most certainly causing illness and disability. I further agree with Dr. Caulford that sooner or later, "a refugee claimant will eventually die as a result of inadequate access to health care" caused by these changes: Caulfordaffidavit at para. 28.

IV. Issues

[302] The applicants identify the subject of their challenge as being the decision of the Governor in Council to cancel the pre-2012 IFHP and replace it with a new IFHP that provides lesser care to most program beneficiaries, and eliminates health care insurance coverage altogether for others.

[303] The following issues have been raised by the parties:

1. Whether CDRC, CARL and JFCY should be granted public interest standing in this matter;

2. Whether the 2012 modifications to the IFHP are unlawful because the 2012 OICs are *ultra vires* the executive branch of government;

3. Whether Governor in Council breached its duty of procedural fairness by failing to provide notice and an opportunity to participate prior to the proclamation of the 2012 OICs;

4. Whether the 2012 changes to the IFHP violate section 7 of the Charter;

5. Whether the 2012 changes to the IFHP violate section 12 of the Charter;

6. Whether the 2012 changes to the IFHP violate section 15 of the Charter;

7. Whether any breaches of Charter rights can be saved under section 1 of the Charter; and

8. What, if any, remedy is appropriate in this case.

…

IX. Introduction to the Charter Issues

[476] The applicants identify the subject matter of this proceeding as being the decision implemented by the 2012 OICs to cancel the pre-2012 IFHP and replace it with a modified IFHP which limits access to health care insurance for the majority of program beneficiaries, and eliminates it altogether for certain individuals who had previously received coverage under the pre-2012 IFHP.

[477] The applicants have served a Notice of Constitutional Question in which they assert that the changes to the IFHP reflected in the 2012 OICs violatesections 7, 12 and 15 of the *Canadian Charter of Rights and Freedoms*, s. 7, Part I of the *Constitution Act, 1982*, Schedule B to the *Canada Act 1982*(U.K.), 1982, c. 11 (the Charter), in a manner that cannot be saved under section 1 of the Charter.

[478] In order to provide a context for these arguments, consideration must first be given to the role of the Courts when reviewing actions taken by the executive branch of government.

[479] The respondents identify three main changes that were made to the previous IFHP. These include the abolition of the means test, and the institution of tiered coverage tied to the immigration status of the individual. The third change has been described by the respondents as the institution of a different "comparator group".

[480] That is, the respondents say that there has been a "shift in focus of the program". Rather than continue to tie the level of insurance coverage available to IFHP beneficiaries to that available to low-income Canadians on social assistance, the goal is now to "try and make most of the recipients receive what working Canadians not collecting social assistance, but having provincial healthcare get": Transcript, Vol. 2 at p. 136

[481] According to the respondents, each of these changes reflects a governmental policy choice.

[482] The respondents concede that "probably some Interim Federal Health plan beneficiaries have been harmed in some way, to some degree by the changes in the Order in Council": Transcript, Vol. 2 at p. 119. Nevertheless, they say that the Courts have recognized that "sometimes hard choices need to be made": *Li v. Canada (Minister of Citizenship and Immigration)*, 2011 FCA 110 (CanLII), 2011 FCA 110 at para. 37, [2012] 4 F.C.R. 479.

[483] Indeed, the respondents say that the making of, and acting on policy choices is at the heart of the role of both the executive and the legislative branches of government, and that considerable deference has to be paid to these choices by the Courts.

[484] In support of this contention, the respondents cite the decision of Justice Hugessen in *A.O. Farms Inc. v. Canada*, 2000 CanLII 17045 (FC), [2000] F.C.J. No. 1771, 28 Admin. L.R. (3d) 315, where he observed that "[a]ny, perhaps most, government actions are likely to cause harm to some members of the public. That is why government is not an easy matter. Of course, the government owes a duty to the public, but it is a duty owed to the public collectively, not individually. The remedy for those who think that duty has not been fulfilled is at the polls and not before the Courts": at para. 11.

[485] That said, the respondents do acknowledge that in exercising its powers, the executive branch of government is not exempt from constitutional scrutiny: *Operation Dismantle*, above, *Khadr* above at para. 36. As the Supreme Court observed in *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44 (CanLII), 2011 SCC 44, [2011] 3 S.C.R. 134 [*Insite*], once a government policy choice has been translated into state action, it becomes reviewable under the Charter: at para. 105.

[486] Indeed, this Court has already found that the exclusion of individuals from coverage under the IFHP constitutes government action to which theCharter applies: *Toussaint* (FC), above at para. 87.

[487] As Justice Zinn also noted in *Toussaint* (FC), the Supreme Court held in *Singh v. Minister of Employment and Immigration*, 1985 CanLII 65 (SCC), [1985] 1 S.C.R. 177, [1985] S.C.J. No. 11, that "the word 'Everyone' in s. 7 of the Charter … includes every human being who is physically present in Canada...": at p. 202. He went on to observe that "[s]uch a broad conception of s. 7 is consistent with the notion that all human beings, regardless of their immigration status, are entitled to dignity and the protection of their fundamental right to life, liberty and security of the person": *Toussaint* (FC) above at para. 87.

[488] A number of factors favour a high degree of deference being paid to governmental policy choices. The Supreme Court has identified a non-exhaustive list of these factors as including "the prospective nature of the decision, the impact on public finances, the multiplicity of competing interests, the difficulty of presenting scientific evidence and the limited time available to the state": *Chaoulli*, above at para. 95.

[489] At the same time, however, as [now Chief] Justice McLachlin stated in *RJR-MacDonald Inc. v. Canada (Attorney General)*, 1994 CanLII 117 (SCC), [1994] 1 S.C.R. 311, [1995] S.C.J. No. 68, "... care must be taken not to extend the notion of deference too far". Indeed, she went on to observe that"[d]eference must not be carried to the point of relieving the government of the burden which the Charter places upon it of demonstrating that the limits it has imposed on guaranteed rights are reasonable and justifiable": at para. 136.

[490] Even though a matter may be "complex, contentious or laden with social values", this "does not mean that the courts can abdicate the responsibility vested in them by our Constitution to review legislation for Charter compliance when citizens challenge it": *Chaoulli* above, at para. 107. Indeed, it is the duty of the Courts to ensure that governments "do not transgress the limits of their constitutional mandate and engage in the illegal exercise of power": *Re B.C. Motor Vehicle Act*, 1985 CanLII 81 (SCC), [1985] 2 S.C.R. 486 at p. 497, [1985] S.C.J. No. 73, citing *Amax Potash Ltd. v. Government of Saskatchewan*, 1976 CanLII 15 (SCC), [1977] 2 S.C.R. 576 at p. 590, 11 N.R. 222.

[491] Finally, the Supreme Court has not hesitated to intervene in cases where it finds that government policy choices in relation to the provision of health services violate the Charter rights of affected individuals: see, for example, *Chaoulli* and *Insite*.[3]

[492] With this understanding of the role of the Courts in reviewing actions taken by the executive branch of government, I turn now to consider theCharter arguments advanced by the parties, starting with their section 7 arguments.

X. Do the 2012 Changes to the IFHP Violate Section 7 of the Charter?

[493] Section 7 of the Charter provides that "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice".

[494] I understand the parties to agree that the onus is on the applicants to prove the violation of constitutional rights: *Chaoulli*, above at para. 30. This violation must be proved on a balance of probabilities: *Khadr*, above at para. 21.

[495] I also understand it to be common ground that the test to be applied in determining whether or not there has been a violation of section 7 of theCharter is the two-part test established by the Supreme Court of Canada in cases such as *Gosselin v. Quebec (Attorney General)*, 2002 SCC 84 (CanLII), 2002 SCC 84 at para. 75, 2002 SCC 84 (CanLII), [2002] 4 S.C.R. 429; *Chaoulli*, above at paras. 29 and 109, *Insite*, above at para. 84, and *R. v. Malmo-Levine*, 2003 SCC 74 (CanLII), 2003 SCC 74 at para. 83, 2003 SCC 74 (CanLII), [2003] 3 S.C.R. 571.

[496] That is, the applicants must demonstrate:

1. That the government action in issue deprives individuals of their right to life, liberty, security of the person;

2. If so, that this deprivation was not carried out in accordance with the principles of fundamental justice.

[497] The first question, then, is whether the modifications to the IFHP implemented through the 2012 OICs deprive persons seeking the protection of Canada of their right to life, liberty or security of the person. In addressing this question, I note that the Supreme Court has held that government action that interferes with any of these rights will "engage" this provision of the Charter or constitute a "deprivation" under section 7: *Insite*, above at para. 85.

[498] The applicants say that the 2012 modifications to the IFHP have affected individuals' section 7 rights to life and to security of the person. Because those seeking the protection of Canada are generally unable to afford to pay for medical services, the changes to the IFHP will expose them to a risk of not having access to basic and necessary health care, which will in turn put lives and the security of these persons at risk.

[499] The right to security of the person is also implicated in this case, the applicants say, because of the severe psychological distress caused by being denied the health insurance coverage that had previously been made available to those seeking the protection of Canada.

[500] The applicants acknowledge that although the government may not be prohibiting refugees and asylum seekers from obtaining health care *per se*, the government is nevertheless creating a situation of deprivation in which the lives and the security of the person of vulnerable individuals are being jeopardized.

[501] According to the applicants, the government should have known that the vast majority of affected individuals would be unable to pay for health care or private health insurance. It should, moreover, have also been aware that philanthropic access to health care for these individuals might not be consistently and uniformly available to them.

[502] By reducing IFHP health insurance coverage for individuals who cannot afford to pay for their own health care or for private health insurance, and for whom alternative avenues of access to health care may be neither consistent nor satisfactory, the applicants say that the Governor in Council has effectively erected a barrier to essential health services for refugees and asylum seekers.

[503] According to the applicants, this constitutes a deprivation of section 7 rights that is at least as serious as the bar to accessing private health insurance that was found to constitute a section 7 deprivation in *Chaoulli*.

[504] The applicants further submit that their argument does not require a finding by this Court that the Government of Canada has a positive duty to provide state-funded health care to those seeking its protection. Rather, what they challenge is the withdrawal of a previously available service, which exposes vulnerable individuals to risks to their lives and to the security of their persons.

[505] The respondents say that what the applicants are asserting is a right to state-funded health care under section 7 of the Charter, and that there is no positive obligation on the Government of Canada to provide health insurance coverage to those seeking its protection. In support of this contention, the respondents note that Canadian law to date has overwhelmingly held that section 7 of the Charter does not create or impose a positive obligation on the state to provide any necessities to maintain life and the security of the person.

[506] The respondents recognize that in *Chaoulli*, the Supreme Court held that while the Charter does not confer a free-standing constitutional right to health care, if the government does choose to put a health insurance scheme in place, it must comply with the Charter.

[507] However, the respondents say that the 2012 OICs do not cause a deprivation of medical care, nor do they prevent or prohibit access to it. According to the respondents, it remains open to any refugee, refugee claimant or failed refugee claimant who is not otherwise eligible for IFHP coverage or specific services or products under the IFHP to obtain such care, services or products by other means.

[508] This distinguishes this case from the situation in *Chaoulli*, where the question was whether residents of the Province of Québec who were prepared to spend their own money to get speedier access to health care could be prevented from doing so by the state. As a result, the respondents say that the rights at issue in this case are economic in nature, and are not protected by section 7 of the Charter.

[509] Finally, the respondents say that even if there is a deprivation of section 7 Charter rights in this case, the 2012 OICs are not the operative cause of that deprivation.

[510] As will be explained in the next section of these reasons, after giving their arguments careful consideration, I have concluded that the applicants' section 7 claim must be dismissed as what they seek is to impose a positive obligation on the Government of Canada to fund health

care for those seeking the protection of Canada. As sympathetic as the applicants' arguments may be, the law does not currently recognize a section 7 Charter right to state-funded health care.

A. *Positive Rights and Section 7 of the Charter*

[511] As noted above, a major focus of the respondents' section 7 argument is their contention that the applicants are essentially seeking to impose a positive obligation on the Government of Canada to provide state-funded health care for those seeking the protection of Canada. According to the respondents, the applicants' section 7 claim cannot succeed as it is well-established in Canadian jurisprudence that the Charter does not impose positive obligations on governments to provide social benefits programs such as health insurance in order to secure their life, liberty or security of persons.

[512] The question of whether the Charter imposes positive obligations on governments to provide social benefits programs is one that has generated an enormous amount of discussion, both in the jurisprudence[4] and in academic circles[5]. Different Courts have, however, addressed this question at different stages in the section 7 analysis.

[513] For example, it was at the outset of its section 7 analysis that the Supreme Court held in *Chaoulli* that there is no "free-standing" constitutional right to health care: at para. 104.

[514] In contrast, in *Bedford*, above, the Supreme Court addressed the question of whether the case involved the assertion of a positive right in the context of its discussion of whether section 7 rights were engaged and whether there had been a deprivation of those rights: at paras. 88 and 89. A similar approach was taken by the Supreme Court in *Gosselin*, above at para. 81 and by the Ontario Court of Appeal in *Wynberg v. Ontario,* 2006 CanLII 22919 (ON CA), [2006] O.J. No. 2732 at paras. 218-225, 82 O.R. (3d) 561.

[515] In contrast, the question of whether the case involved the assertion of a positive right under section 7 of the Charter was discussed in the context of the Federal Court of Appeal's "fundamental justice" analysis in *Toussaint* (FCA), above at paras. 76 to 80.

[516] Finally, in *New Brunswick (Minister of Health and Community Services) v. G. (J.)*, 1999 CanLII 653 (SCC), [1999] 3 S.C.R. 46, [1999] S.C.J. No. 47 [*J.G.*], the Supreme Court addressed the issue of positive rights in the context of its section 1 analysis, and again in relation to the question of remedy.

[517] The respondents' assertion that the applicants were seeking to assert a positive section 7 right was a major focus of their section 7 argument. Moreover, the question of whether a claim involves the assertion of a positive right permeates the entire section 7 analysis, starting with the question of whether section 7 rights have been engaged. As a consequence, I will deal with this issue at the outset of my analysis, keeping in mind the teachings of the jurisprudence mentioned above.

[518] In *Baier v. Alberta*, 2007 SCC 31 (CanLII), 2007 SCC 31, [2007] 2 S.C.R. 673, the Supreme Court discussed the difference between positive and negative rights, albeit in the context of a freedom of expression claim under subsection 2(b) of the Charter. The Court explained that in order "[t]o determine whether a right claimed is a positive right, the question is whether the appellants claim the government must legislate or otherwise act to support or enable an expressive activity". In contrast, "a negative right would require the appellants to seek freedom from government legislation or action suppressing an expressive activity in which people would otherwise be free to engage, without any need for any government support or enablement": at para. 35.

[519] A number of academics have observed that the line between positive and negative rights is not always a bright one: see, for example, Wilkie & Zisman Gary, above at p. 38. Professor Jamie Cameron argues that "the distinction between the two is not persuasive": at p. 71. Indeed, one commentator has gone so far as to describe the distinction between positive and negative rights as "highly artificial": Cousins, above at p. 725.

[520] Indeed, as Professor Cameron has observed, it can be difficult to characterize an entitlement as either exclusively positive or exclusively negative. She cites the example of an accused's negative right not to be denied a trial within a reasonable time under subsection 11(b) of the Charter. She observes that the practical consequence of the Supreme Court's decision in *R. v. Askov*, 1990 CanLII 45 (SCC), [1990] 2 S.C.R. 1199, [1990] S.C.J. No. 106, vindicating a negative subsection 11(b) right not to be deprived of a trial within a reasonable time, was nevertheless to compel the government to inject significant sums of money into the justice system in order to ensure that timely trials could be provided: at pp. 70-71.

[521] I recognize that *Askov* was not a section 7 claim. I note, however, that the Supreme Court's section 7 decision in *Singh*, above, had similar consequences for the refugee determination process.

[522] Indeed, the section 7 jurisprudence has demonstrated that the fact that a particular claim may involve a request that the government spend money in a particular way is not necessarily fatal to the claim. For example, in *J.G.*, the Supreme Court ordered that state-funded legal counsel be provided in a child welfare case in light of, amongst other things, the seriousness of the interests at stake and the limited capacity of J.G. to represent herself: at paras. 75-81.

[523] Similarly, in *Inglis v. British Columbia (Minister of Public Safety)*, 2013 BCSC 2309 (CanLII), 2013 BCSC 2309, [2013] B.C.J. No. 2708, the British Columbia Supreme Court recently observed that "the fact that the state might be required to expend some resources does not transform the claim into one alleging a positive obligation": at para. 393.

[524] The respondents rely on a line of cases (cited at para. 103 of their memorandum of fact and law) which have culminated in the recent decision of the Ontario Superior Court in *Tanudjaja v. Canada (Attorney General)*, 2013 ONSC 5410 (CanLII), 2013 ONSC 5410, [2013] O.J. No. 4078[6], as authority for the proposition that there is no positive obligation on the Government of Canada to fund social programs such as comprehensive health care insurance

for all IFHP beneficiaries. In the absence of such an obligation, the respondents say that there can be no violation of section 7 of the Charter.

[525] The question raised in the *Tanudjaja* case was whether section 7 of the Charter imposed a positive obligation on governments to provide affordable, adequate, accessible housing for vulnerable individuals or to take steps to reduce homelessness.

[526] Unlike the present case, however, *Tanudjaja* did not involve a single, discrete decision taken by a government with respect to access to a particular social program. Rather what was in issue were a series of changes to legislative policies, programs and services taken over a number of decades, at both the federal and provincial levels, which allegedly eroded access to affordable housing. According to the applicants in *Tanudjaja*, the combined effect of these changes over the years was to increase homelessness and violate the section 7 rights of vulnerable individuals.

[527] The Court struck out the application in *Tanudjaja* as disclosing no reasonable cause of action and as having no reasonable prospect of success. In concluding that the application should be struck, the Court noted that there was no positive obligation on governments under section 7 to provide affordable, adequate, accessible housing for vulnerable individuals, nor was it obliged to take steps to reduce homelessness. The Court further held that the government action at issue in *Tanudjaja* did not constitute a "decision" that engaged section 7 of the Charter.

[528] The Court was, however, careful to distinguish the Supreme Court's decision in *Chaoulli*. The Court observed in *Tanudjaja* that in *Chaoulli*, the Government of Québec had made "a self contained decision to disallow the purchase of private insurance": at para. 33. It was as a result of this decision that access to timely health care was limited, thereby breaching section 7 of the Charter.

[529] Like *Tanudjaja*, a number of the other cases cited by the respondents involve the sort of broad, values-based social policy questions that might be better addressed through a Royal Commission than a Charter challenge.

[530] For example, in *Grant v. Canada*, 2005 CanLII 50882 (ON SC), [2005] O.J. No. 3796, 77 OR (3d) 481, the Ontario Superior Court held thatsection 7 of the Charter did not impose a positive duty on governments to provide housing. In *Lacey v. British Columbia*, [1999] B.C.J. No. 3168, the Supreme Court of British Columbia held that section 7 did not guarantee a minimum standard of living and welfare benefits.

[531] In contrast, this case raises a focused question with respect to a discrete government action, namely the decision of the Governor in Council reflected in the 2012 OICs to reduce IFHP health care insurance coverage for the majority of those previously entitled to benefits under the program, and to eliminate it altogether for those only entitled to apply for a PRRA. As a consequence, the issue in this case is closer to that in *Chaoulli* than the issues that confronted the Courts in *Tanudjaja* and its predecessors.

[532] Does it necessarily follow from this that the decision of the Governor in Council engages section 7 Charter rights? A review of the jurisprudence confirms that it does not.

[533] In *Chaoulli*, the applicants succeeded in their section 7 challenge to provincial health care legislation in Québec. However, it is important to note that the Supreme Court was not asked in *Chaoulli* to *require* that the Province of Québec fund specific health services for the applicants. Rather, what was at issue was a provincial law that *limited* access to private health services by prohibiting the individuals from purchasing private health insurance for those services covered by provincial public insurance. What the applicants sought was "a ruling that because delays in the public system place their health and security at risk, they should be allowed to take out insurance to permit them to access private services": para. 103.

[534] In other words, the applicants in *Chaoulli* were not asking the Court to order that the government pay for their private health care. As the Ontario Court of Appeal observed in *Wynberg v. Ontario*, "on the contrary, they sought the right to spend their own money to obtain insurance to pay for private health care services": above, at para. 222.

[535] In their dissenting opinion in *Chaoulli*, Justices Binnie and LeBel warned that basing a positive right to health care on section 7 of the Charterwould require the Courts to weigh in and determine the appropriate scope of health services and the acceptable length of wait times reasonably required under the Charter. This would be a very uncomfortable role for the Courts, as it has long been recognized that decisions as to the setting of priorities and the allocation of scarce resources are matters not for the Courts, but for governments.

[536] In *Insite*, a governmental decision was made not to renew an exemption from the application of the *Controlled Drugs and Substances Act*, S.C. 1996, c. 19 that had previously allowed for the operation of safe injection sites for drug addicts. Once again, the Supreme Court did *not* find that there was a positive obligation on the government to fund safe injection sites. Rather, the Court was satisfied that the Ministerial decision not to renew an exemption from the application of drug legislation created a risk to health by preventing access to health care. Consequently, it was the decision to deny the exemption that led to the deprivation of the right to security of the person in that case.

[537] It can be argued that in *Chaoulli*, the Supreme Court ordered the government not to do something, whereas in *Insite*, the government was ordered to do something, namely grant the exemption. Indeed, it has been suggested that portions of the Supreme Court's decision in *Insite* can arguably be interpreted"as holding that where a government action will decrease the risk of death and disease, (i.e., ensure access to health care) and there are no compelling reasons to do otherwise, the government should take that action, and that the failure to do so may amount to a breach of the Charter": Voell, above at p. 12.

[538] There is, however, a world of difference between requiring the state to grant an exemption that would allow a health care provider to provide medical services funded by others and requiring the state itself to fund medical care.

[539] Indeed, the respondents have cited a line of cases dealing with access to health care services as authority for the proposition that there is no obligation on governments to fund specific health care services: see, for example, *Flora v. Ontario (Health Insurance Plan, General Manager)*, 2008 ONCA 538 (CanLII), 2008 ONCA 538, [2008] O.J. No. 2627; *C-W(C) v. Ontario Health Insurance Plan (General Manager)*, 2009 CanLII 712 (ON SCDC), [2009] O.J. No. 140, 95 O.R. (3d) 48; and *Wynberg*, above. These cases are instructive as to the scope of the health-related rights that have been found to exist based upon section 7 of the Charter.

[540] At issue in *Flora* was a decision of the Health Services Appeal and Review Board which upheld OHIP's refusal to reimburse the appellant for the $450,000 cost of a liver transplant on the basis that it was not an "insured service" within the meaning of the provincial *Health Insurance Act*. The appellant had been diagnosed with liver cancer and had been told that he was not a suitable candidate for a liver transplant by Ontario standards. He subsequently underwent transplant surgery in the United Kingdom, surgery which saved his life.

[541] The Ontario Court of Appeal had to address the appellant's claim that his rights to life and security of the person under section 7 of the *Charter* had been violated by the statutory definition of "insured services", which limited coverage to services that were "generally accepted in Ontario as appropriate for a person in the same medical circumstances as the insured person".

[542] That is, the appellant in *Flora* contended that the denial of his OHIP claim deprived him of access to a life-saving medical treatment, thus violating his section 7 rights to life and security of the person. Amongst other things, the appellant argued that section 7 of the Charter imposed a positive obligation on the government to provide life-saving medical treatment: at para. 93.

[543] The Ontario Court of Appeal concluded in *Flora* that the appellant had failed to demonstrate that the law in question constituted a "deprivation" by the state of his right to life or to the security of his person, and that this was fatal to his section 7 claim: above at para. 95.

[544] In coming to this conclusion, the Ontario Court of Appeal distinguished the Supreme Court's decisions in *Chaoulli*, *R. v. Morgentaler*, 1988 CanLII 90 (SCC), [1988] 1 S.C.R. 30, 44 D.L.R. (4th) 385, and *Rodriguez v. British* Columbia, 1993 CanLII 75 (SCC), [1993] 3 S.C.R. 519, 107 D.L.R. (4th) 342, on the basis that, in contrast to the legislative provisions at issue in those cases, the legislation at issue in the case before it did "not prohibit or impede anyone from seeking medical treatment": *Flora*, above at para. 101.

[545] Rather, the legislation provided "a defined benefit for out-of-country medical treatment that is not otherwise available to Ontarians". It identified this as "the right to obtain public funding for certain specific out-of-country medical treatments". The Court held that "[b]y not providing funding for all out-of-country medical treatments, it does not deprive an individual of the rights protected by s. 7 of the Charter": *Flora*, above at para. 101. See also *C-W(C) v. Ontario Health Insurance Plan*, above at para. 100.

[546] The Ontario Court of Appeal expressly addressed the question of whether the protections afforded by section 7 of the Charter could extend to require the provision of a minimum level of health care: *Flora*, above at paras. 105-109. Noting that this question had specifically been left open by the Supreme Court in *Gosselin*, the Court also observed that thus far, the protection afforded by the Charter had not been extended to cases involving what the Court in *Flora* characterized as "solely economic rights": above at para. 106.

[547] The Ontario Court of Appeal further observed in *Flora* that there was no law limiting the appellant's ability to spend his own money to obtain a liver transplant at a private hospital in England, which was, of course, precisely what he had chosen to do: above at para. 107.

[548] The Court concluded that "where - as here - the government elects to provide a financial benefit that is not otherwise required by law, legislative limitations on the scope of the financial benefit provided do not violate s. 7". The Court went on to observe that "[o]n the law at present, the reach of s. 7does not extend to the imposition of a positive constitutional obligation on the Ontario government to fund out-of-country medical treatments even where the treatment in question proves to be life-saving in nature": at para. 108. Consequently, the Court found that the appellant had failed to establish a deprivation of his right to life or security of his person under section 7 of the Charter: at para. 109.

[549] Similarly, in *Toussaint* (FCA), the Federal Court of Appeal observed that claims under section 7 of the Charter seeking to obtain state funding or financial assistance for necessary medical care had all been rejected by the Courts, referring specifically to *Flora* and *Wynberg*, above, as well as to the Supreme Court's decision in *Auton (Guardian ad litem of) v. British Columbia (Attorney General)*, 2004 SCC 78 (CanLII), 2004 SCC 78, at para. 78, 2004 SCC 78 (CanLII), [2004] 3 S.C.R. 657.

[550] Likewise, in *Covarrubias v. Canada (Minister of Citizenship and Immigration)*, 2006 FCA 365 (CanLII), 2006 FCA 365, 354 N.R. 367, an applicant was seeking a positive Pre-removal Risk Assessment on the basis that he would be unable to access life-sustaining medical treatment in his country of origin. In rejecting his appeal, the Federal Court of Appeal found that the appellant was essentially seeking to expand the law so as to create a new human right to a minimum level of health care for the purposes of section 97 of *IRPA*.

[551] The Court observed in *Covarrubias* that "[w]hile their efforts are noble, the law in Canada has not extended that far": at para. 36, citing *Chaoulli* for the proposition that there is no freestanding constitutional right to health care. That being the case, the Federal Court of Appeal observed that the Supreme Court would be unlikely to contemplate "a freestanding right to health care for all of the people of the world who happen to be subject to a removal order in Canada".

[552] The applicants in this case say that they are not asking the Governor in Council to implement a social benefit program where none previously existed. They note that the executive branch has, for more than half a century, chosen to provide health care insurance to those seeking the protection of Canada. It is the decision made by the Governor in Council in 2012 to reduce the level of benefits available to most IFHP beneficiaries and to eliminate benefits altogether for

others who had previously been entitled to benefits under the pre-2012 regime that the applicants say is the subject of the section 7Charter challenge in this case.

[553] Indeed, the applicants concede that there may have been no obligation on the executive branch to provide health insurance coverage to those seeking the protection of Canada. However, they say that once it chooses to do so, it must do so in a manner that complies with the Charter, citing *Chaoulli*, above at para. 104.

[554] In support of this contention, the applicants rely on the statement by the Supreme Court in *Eldridge* that even though the state may be under no obligation to provide a benefit, once it elects to do so, the benefit must be provided "in a non-discriminatory manner", and in some circumstances, "this will require governments to take positive action": above, at para. 73. See also *Auton*, above at para. 41 to the same effect.

[555] I accept that this is so, but this does not mean that the Charter necessarily imposes an ongoing positive right to a particular level of health insurance.

[556] It should be noted that the statements in *Eldridge* and *Auton* relied upon by the applicants were made in the context of claims made under section 15of the Charter, and not under section 7. As will be discussed further on in these reasons, Courts have been far less reluctant to impose positive obligations on governments in order to ensure substantive equality.

[557] As previously noted, the applicants assert that what is in issue in this case is the decision to cut or eliminate the IFHP benefits available to affected individuals. According to the applicants, it is this change to the program that makes their claim reviewable under section 7 of the Charter.

[558] The difficulty with this argument is that it has already been rejected in a number of cases. For example, in *Flora*, the appellant argued that the Ontario Legislature's decision to amend the former version of the legislation so as to modify the test for OHIP funding for out-of-country medical services constituted a deprivation of his rights under section 7 of the Charter. However, the Ontario Court of Appeal held that "a Charter violation cannot be grounded on a mere change in the law": *Flora*, above at para. 104, citing *Ferrel v. Ontario (Attorney General)* 1998 CanLII 6274 (ON CA), [1998] O.J. No. 5074, 42 O.R. (3d) 97 (Ont. C.A.).

[559] In *Ferrel*, Associate Chief Justice Morden observed that "[i]f there is no constitutional obligation to enact [the legislation at issue] in the first place, I think that it is implicit, as far as the requirements of the constitution are concerned, that the legislature is free to return the state of the statute book to what it was before [the impugned legislation]": at p. 110.

[560] The Ontario Court of Appeal came to a similar conclusion in *Lalonde v. Ontario* 2001 CanLII 21164 (ON CA), [2001] O.J. No. 4767, 56 O.R. (3d) 505, where the Court held that "in the absence of a constitutional right that requires the government to act in the first place, there can be no constitutional right to the continuation of measures voluntarily taken, even where those measures accord with or enhance Charter values": at para. 94.

[561] Similarly, in *Masse v. Ontario (Ministry of Community and Social Services)*, reflex, [1996] O.J. No. 363, 134 D.L.R. (4th) 20, the Ontario Divisional Court held that no section 7 Charter violation was established where the provincial government cut welfare benefits by 21.6%: see also*Tanudjaja*, above at paras. 38 and 107.

[562] Indeed, *Gosselin*, above, involved a change made by the Government of Québec to the provincial social assistance scheme. In an effort to encourage young people to obtain job training and enter the work force, the Province decided that the base amount of welfare benefits payable to recipients under the age of 30 should be lower than those payable to welfare recipients over the age of 30, unless the younger recipients agreed to participate in a designated work activity or educational program. In rejecting a Charter challenge to the legislation, the Supreme Court held that the change effected by the new legislation did not affect an interest protected by the right to life, liberty and security of the person guaranteed by section 7 of the Charter, in the absence of a positive right to an adequate standard of living.

[563] Consequently, I cannot accept the applicants' argument that the exercise of the discretionary power of the Governor in Council in enacting the IFHP becomes reviewable under the Charter by virtue of the changes that were made to the Program in 2012.

[564] Like the legislation that confronted the Ontario Court of Appeal in *Flora*, there is nothing in the 2012 IFHP that limits the ability of those seeking the protection of Canada to spend their own money to obtain health care. I fully recognize that the right of those affected to pay for their own medical treatment will be a largely illusory one, given the fact that most of those affected by the 2012 modifications to the IFHP will be economically disadvantaged individuals.

[565] I would, however, note that in *Wynberg*, the Ontario Court of Appeal upheld a limitation on access to publicly-funded treatment for autistic children through the public school system, even though the Court recognized that alternative avenues of access to the treatment at issue were likely to be out of reach for most families.

[566] In so doing, the Court observed that there was no constitutional obligation on governments to ensure that every school-age autistic child had access to particular educational services. As a result, the failure of the Province to provide a particular type of treatment to children over a certain age, did not amount to depriving those children of a constitutionally-protected right: see also *Sagharian (Litigation guardian of) v. Ontario (Minister of Education)*,2008 ONCA 411 (CanLII), 2008 ONCA 411, [2008] O.J. No. 2009.[7]

[567] As the Court observed in *Wynberg*, there was no mandatory requirement that school-age children attend public school. Parents were free to seek treatment elsewhere, and there was no

legal impediment to parents educating their children at home or in private schools. The Court expressly recognized that the financial realties were such that this may not be a viable option for "many if not most parents". This financial reality did not, however, engage section 7 rights

that were not otherwise engaged, nor did it convert a non-section 7 deprivation into a deprivation of section 7 rights: at para. 231.

[568] Finally, the applicants rely on the Supreme Court's decision in *Dunmore v. Ontario (Attorney General)*, 2001 SCC 94 (CanLII), 2001 SCC 94 at paras. 24-26, 207 D.L.R. (4th) 193 as authority for the proposition that there are circumstances where positive action on the part of the state may be required in order to allow vulnerable claimants access to a Charter-protected right that they could not otherwise enjoy.

[569] As the applicants note, in *Dunmore*, the majority decision in Supreme Court identified three requirements for recognition of such a positive obligation:

1. The claim must be grounded in a fundamental Charter right, not just 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; and

3. It must be possible to hold the state accountable for any inability to exercise a fundamental freedom.

[570] The difficulty for the applicants is, of course, with the first element of the *Dunmore* test. That is, they have not established that there is indeed a right to state-funded health care under section 7 of the Charter.

B. *Conclusion with respect to the Applicants' Section 7 Claim*

[571] For these reasons I have concluded that the current state of the law in Canada is that section 7 of the Charter's guarantees of life, liberty and security of the person do not include the positive right to state funding for health care. Consequently, the applicants' section 7 claim must be dismissed.

XI. Do the 2012 Changes to the IFHP Violate Section 12 of the Charter?

[572] Section 12 of the Charter provides that "[e]veryone has the right not to be subjected to any cruel and unusual treatment or punishment".

[573] The applicants accept that the 2012 changes to the IFHP do not constitute "punishment" as contemplated by section 12 of the Charter. They do, however, assert that the changes to the IFHP constitute cruel and unusual treatment of a poor, vulnerable and disadvantaged group by the executive branch of the Canadian government.

[574] The respondents say that the IFHP funds health care "treatment" at the expense of the state, but that no one in Canada is "subjected" to the IFHP. The respondents contend that section 12 of the Charter is concerned with mandatory matters imposed by the state and is in

no way analogous to an IFHP beneficiary's acceptance of medical "treatment". The IFHP does not prevent anyone from obtaining medical care: rather it offers and funds some health care services for eligible beneficiaries, who can access them if they choose, at state expense.

[575] As the respondents point out, the threshold for establishing a breach of section 12 is high: *Charkaoui v. Canada (Minister of Citizenship and Immigration)*, 2007 SCC 9 (CanLII), 2007 SCC 9 at para. 95, 2007 SCC 9 (CanLII), [2007] 1 S.C.R. 350. Moreover, as the Ontario Superior Court held at paragraph 24 of *McNeill v. Ontario (Ministry of Solicitor General and Correctional Services)*, 1998 CanLII 14947 (ON SC), [1998] O.J. No. 2288, 126 C.C.C. (3d) 466, "[a] program introduced to comply with a well motivated and properly passed law designed to meet an entirely worthy social goal, public health, can hardly be found to be cruel and unusual".

[576] With this in mind, there are two questions that must be resolved in determining whether a breach of section 12 of the Charter has been made out. The first is whether those seeking the protection of Canada are being subjected to "treatment" within the meaning of section 12. The second is whether any such treatment is "cruel and unusual".

A. *Do the 2012 Changes to the IFHP Constitute "Treatment" within the Meaning of Section 12 of the Charter?*

[577] The vast majority of the section 12 jurisprudence arises out of the criminal law, and involves "punishment" rather than "treatment". As a consequence, there has been limited judicial consideration of the meaning of "treatment" for the purposes of section 12 of the Charter.

[578] None of the parties have identified a successful section 12 claim made outside of the penal or quasi-penal context. While there has in fact been at least one such case, it was an early Charter decision and is of limited assistance here: see *Alvero-Rautert v. Canada (Minister of Employment and Immigration)*, reflex, [1988] F.C.J. No. 8, [1988] 3 F.C. 163 (F.C.T.D.).

[579] The Supreme Court has, however, expressly left open the possibility that "treatment" may include "that imposed by the state in contexts other than that of a penal or quasi-penal nature": *Rodriguez*, above at para. 182.

[580] In *Chiarelli v. Canada (Minister of Employment & Immigration)*, 1992 CanLII 87 (SCC), [1992] 1 S.C.R. 711, 2 Admin. L.R. (2d) 125, the Supreme Court observed that the *Concise Oxford Dictionary* (1990) defined 'treatment' as "a process or manner of behaving towards or dealing with a person or thing...". According to the Supreme Court, deportation may "come within the scope of a 'treatment' in s. 12": at para. 29.

[581] In *Rodriguez*, the Supreme Court considered what could constitute "treatment" for the purposes of section 12 of the Charter in the context of aCharter challenge to the provision of the *Criminal Code* that prohibited assisting in a suicide. After referring to its earlier comments in *Chiarelli*, the Court observed that "a mere prohibition by the state on certain action, without more, cannot constitute 'treatment' under s. 12". However, the Court went on to state that by this

it "should not be taken as deciding that only positive state actions can be considered to be treatment under s. 12; there may well be situations in which a prohibition on certain types of actions may be 'treatment'…": both quotes at para. 182, citations omitted.

[582] The Court went on in *Rodriguez* to explain that in cases where a prohibition on certain types of actions may constitute "treatment", claimants will be"in some way within the special administrative control of the state": at para. 182. It was not enough that Ms. Rodriguez, like all other Canadians, was subject to the prohibition on assisted suicide contained in the *Criminal Code*. Similarly, the fact that the prohibition created particular suffering for her as a result of her illness did not mean that she had been subjected to "treatment" by the state.

[583] Indeed the Court was clear in *Rodriguez* that "[t]here must be some more active state process in operation, involving an exercise of state control over the individual, in order for the state action in question, whether it be positive action, inaction or prohibition, to constitute 'treatment' under s. 12".: at para. 182.

[584] I agree with the applicants that the situation of those seeking the protection of Canada may be readily distinguished from that of Ms. Rodriguez.

[585] In this case, those seeking the protection of Canada are under immigration jurisdiction, and as such are effectively under the administrative control of the state. Some claimants may be detained, and obligations such as reporting requirements may be imposed upon others. In addition, their rights and opportunities (such as their right to work or their ability to receive social assistance benefits) may be limited in a number of different ways by the state. Indeed, their entitlement to a range of benefits is wholly dependent upon decisions made by various branches of the Government of Canada as to their right to seek protection, and the ultimate success of their claims for protection.

[586] Furthermore, Ms. Rodriguez was subject to a law of general application, albeit one that had an adverse differential impact on her because of her compromised physical condition.

[587] In contrast, in the present case, the decision to change the IFHP was not a neutral decision taken by the Governor in Council that has only incidentally had a negative impact on historically marginalized individuals who were covered under the former IFHP. Rather, the executive branch of government has in this case *intentionally targeted* an admittedly vulnerable, poor and disadvantaged group for adverse treatment, making the 2012 changes to the IFHP for the express purpose of inflicting predictable and preventable physical and psychological suffering on many of those seeking the protection of Canada.

[588] The respondents explain that "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…": Le Bris affidavit, at para. 73. Indeed, one of the articulated objectives of the 2012 OIC was to deter this supposed abuse of the refugee system.

[589] Thus, through the introduction of the 2012 changes to the IFHP, the Governor in Council is intentionally trying to make life harder for vulnerable, poor and disadvantaged individuals who have lawfully come to Canada seeking the protection of this country. It has done this in order to encourage these individuals to leave the country more quickly once their refugee claims have been rejected: see Transcript, Vol. 3, p. 38. In addition, as the then-Minster of Immigration himself noted, the 2012 changes to the IFHP were also intended to discourage "bogus" refugees from coming to Canada and abusing the generosity of Canadians.

[590] Whether or not this action can be justified by the government in furtherance of its policy goals is a matter for consideration under section 1 of theCharter. For the purpose of my section 12 analysis, however, this intentional targeting of a vulnerable, poor and disadvantaged group distinguishes this case from the usual situation involving the assigning of priorities and the drawing of lines by government in relation to the availability of social benefit programs. In the unusual circumstances of this case, I am thus satisfied that the actions of the executive branch of government at issue here constitute "treatment" for the purposes of section 12 of the Charter.

[591] While recognizing that foreign jurisprudence is not binding on me, I would nevertheless note that my conclusion on this point is consistent with the international jurisprudence. Of particular relevance is the decision of the British House of Lords in *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, (2006) 1 AC 396 ["*ex parte Adam*"].

[592] Before addressing the ruling in *ex parte Adam*, it must first be recognized that it was a case decided under the *European Convention for the Projection of Human Rights and Fundamental Freedoms, as amended by Protocols Nos. 11 and 14*, 4 November 1950, ETS 5, 213 U.N.T.S. 222 ["*European Convention*"]. Article 3 of the *European Convention* prohibits member states from subjecting persons within their jurisdiction "to torture or inhuman or degrading treatment or punishment".

[593] The wording of article 3 of the *European Convention* is somewhat different to that of section 12 of the Canadian Charter. However, when invited to do so, counsel for the respondents was unable to explain how "torture or inhuman or degrading treatment or punishment" is materially different from "cruel or unusual treatment or punishment".

[594] Indeed, in *R. v. Smith*, 1987 CanLII 64 (SCC), [1987] 1 S.C.R. 1045, [1987] 1 S.C.J. No. 36, the Supreme Court of Canada observed that article 3 of the *European Convention* provides protection against cruel or inhuman punishment that is "similar" to that provided under section 12 of the Charter. The Court further noted that this, and other international instruments with comparable provisions, "may on occasion be of assistance in attempting to give meaning to relevant provisions of the Charter": at paras. 25 and 26. See also *United States of America v. Burns*, 2001 SCC 7 (CanLII), 2001 SCC 7 at para. 5, 2001 SCC 7 (CanLII), [2001] 1 S.C.R. 283.

[595] *Ex parte Adam* involved a challenge to a British law that disqualified asylum seekers who were deemed to have delayed in filing their applications for asylum from receiving government support in most cases. According to Lord Bingham, the legislation at issue prohibited the Secretary of State "from providing or arranging for the provision of accommodation and even the barest necessities of life for such an applicant": at para. 6.

[596] The question for determination by the House of Lords was whether the regime imposed on late claimants amounted to "treatment" within the meaning of article 3 of the *European Convention*.

[597] In concluding that it did, the House of Lords started its analysis by identifying the concerns that had given rise to the legislative change in issue. These concerns bear a striking resemblance to those identified by the respondents' affiants in this case as motivating the 2012 changes to the IFHP.

[598] In his reasons, Lord Bingham explained that there had been a sharp rise in the number of applications for asylum that had been made in the United Kingdom over the last decade, and that this had "given rise to a number of administrative and other problems": at para. 2. He went on to observe that:

> The legislative response of successive governments has been founded on two premises in particular: that while some of the applications are made by genuine refugees, having a well-founded fear of persecution in their home countries, a majority are not but are made by so-called economic migrants, applicants seeking a higher standard of living than is available in their home countries; and that the UK is an attractive destination for such migrants because it treats, or is widely believed to treat, such applicants more generously than other countries: at para. 2.

[599] In order to address this latter concern, legislation had been enacted to limit the access of asylum claimants to public funds in order to "reduce the burden on the public purse; to restrict public support, so far as possible, to those who both need and deserve it; to mitigate the resentment widely felt towards unmeritorious applicants perceived as battening on the British taxpayer": at para. 2.

[600] As in this case, a further objective of the legislation at issue in *ex parte Adam* was "to discourage the arrival here of economic migrants by dispelling the international belief that applicants for asylum are generously treated". Lord Bingham noted, however, that the legislative policy choices underlying the statutory provision in question were not at issue before the Court: at para. 2.

[601] While there may be no general public duty to provide for the destitute under article 3 of the *European Convention*, Lord Bingham stated that he had"no doubt that the threshold [for establishing a section 3 claim] may be crossed if a late applicant with no means and no

alternative sources of support, unable to support himself, is, *by the deliberate action of the state*, denied shelter, food or the most basic necessities of life": at para. 7 [my emphasis].

[602] 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 Law Lords held that in determining whether "treatment" has occurred, the focus should be on whether the government could be held responsible for the applicant's suffering, rather than on whether the conduct in issue constituted positive or negative state action.

[603] In concluding that the regime imposed on refugee claimants who filed their claims late amounted to "treatment" within the meaning of Article 3 of the *European Convention*, Lord Hope noted that "[t]he imposition by the legislature of a regime which prohibits asylum seekers from working and further prohibits the grant to them, when they are destitute, of support amounts to positive action directed against asylum-seekers and not to mere inaction. This constitutes 'treatment' within the meaning of the article": at para. 56.

[604] Lord Scott noted in *ex parte Adam*, albeit in *obiter* and by way of illustration, that a bar from receiving health care services under the national health care service 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. He noted that "[i]t 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": at para. 69.

[605] I recognize that there is no express statutory bar contained in the IFHP preventing asylum seekers, or a particular class of asylum seekers, from obtaining medical treatment. The Governor in Council has, however, deliberately cut access to health insurance coverage in order to achieve a similar goal to that of the legislation at issue in *ex parte Adam*, namely to deter "bogus" refugee claimants from seeking the protection of Canada.

[606] Moreover, as was discussed earlier in these reasons, the practical effect of the 2012 cuts to the coverage provided by the IFHP is to limit or prevent access to a range of health care to those seeking the protection of Canada as a result of the combined effect of the impecuniosity of the majority of IFHP beneficiaries and the uncertain and unsatisfactory nature of the alternative sources of health care that were identified by the respondents.

[607] Furthermore, as was the case in *ex parte Adam*, at least some of those seeking the protection of Canada are statutorily prohibited from working. In this regard it will be recalled that refugee claimants from DCO countries are not entitled to receive a work permit for the first 180 days that they are in Canada. Others, such as privately-sponsored refugees, are banned from going on social assistance for their first year in Canada. These statutory bars further inhibit the ability of affected individuals to access health care, through provincial or private health insurance schemes or by self-funding, thereby exacerbating the impact of the 2012 changes to the IFHP.

[608] There has, moreover, been express government action limiting the health care coverage to some classes of individuals affected by the 2012 changes to the IFHP, and eliminating it altogether for others. For instance, subsection 4(3) of the April 2012 OIC states that the "Minister is not authorized to pay the cost of health care coverage incurred for refugee claimants who are nationals of a country that is, when services or products are provided, [a] designated [country of origin]". This has been done, to quote Lord Brown, "by the deliberate action of the state", in order to make the lives of a vulnerable, poor and disadvantaged group even more difficult.

[609] This is precisely the kind of "more active state process" contemplated by the Supreme Court of Canada in *Rodriguez* that constitutes "treatment" under section 12 of the Charter.

[610] As a result, in the unusual circumstances of this case, I am prepared to find that the decision of the Governor in Council to limit or eliminate a benefit previously provided to a discrete minority of poor, vulnerable and disadvantaged individuals coming within the administrative control of the Government of Canada subjects these individuals to "treatment" for the purposes of section 12 of the Charter.

[611] The next question, then, is whether this treatment is "cruel and unusual".

B. *Are the 2012 Changes to the IFHP "Cruel and Unusual" within the meaning of Section 12 of the Charter?*

[612] In *R. v. Smith*, above, the Supreme Court established the test to be applied in determining when a treatment or punishment will be found to have violated section 12 of the Charter. The Court held that "in its modern application, the meaning of 'cruel and unusual treatment or punishment' must be drawn 'from the evolving standards of decency that mark the progress of a maturing society'": at para. 83, citing *Trop v. Dulles* (1958), 356 U.S. 86 at p. 101, 78 S. Ct. 590.

[613] The Court concluded in *R. v. Smith* that "cruel and unusual" treatment or punishment is that which is "so excessive as to outrage [our] standards of decency": above at para. 83.

[614] In determining whether treatment or punishment is "cruel and unusual", Canadian courts have looked at a number of factors as part of a kind of 'cost/benefit' analysis. These factors include whether the treatment goes beyond what is necessary to achieve a legitimate aim, whether there are adequate alternatives, whether the treatment is arbitrary and whether it has a value or social purpose. Other considerations include whether the treatment in question is unacceptable to a large segment of the population, whether it accords with public standards of decency or propriety, whether it shocks the general conscience, and whether it is unusually severe and hence degrading to human dignity and worth: *R. v. Smith*, above at para. 44.

[615] With respect to the question of whether the treatment goes beyond what is necessary to achieve a legitimate aim, as will be discussed in greater detail in the context of my section 1 analysis, while deterring abuse of the refugee system is a legitimate goal, it has not been shown that the 2012 changes to the IFHP are necessary to achieve the government's aims.

[616] The modifications to the IFHP are part of a comprehensive package of changes that have been made to the Canadian refugee process over the last several years. These changes include faster processing times and removals, temporal restrictions on access to the PRRA and H&C processes, the introduction of the DCO list and a summary claims process for claimants from DCO countries, as well as other measures that have been taken by the Government of Canada. Early evidence indicates that these changes have reduced the overall amount of time that refugee claimants spend in Canada relying on IFHP insurance coverage, thereby reducing the overall cost of the program.

[617] There is, however, no persuasive evidence to show that the changes to the eligibility and coverage provisions of the IFHP have served to deter unmeritorious claims, thereby reducing the cost of the program. While the respondents have provided information regarding the overall reduction in refugee claims following the recent changes to the refugee process, there has been no attempt to identify how much of a reduction in refugee claims, if any, is actually attributable to the cuts to the IFHP, as opposed to the other changes that have been made to the refugee determination process. As a consequence, it cannot be said that the 2012 changes to the IFHP were necessary to achieve a legitimate aim.

[618] The cuts to the IFHP are also somewhat arbitrary. Funding for medical care is being allocated in accordance with factors that are completely unrelated to the health needs of those seeking the protection of Canada. While the respondents initially asserted that the program had been "tailored to meet the [needs of] specific subgroups of beneficiaries who get benefits under the IFH[P]", when asked to explain how this was, it was conceded that the program does not in fact respond to the health needs of the various classes of individuals covered under the program: Transcript, Vol. 2, pp. 187-190.

[619] Moreover, as counsel for the applicants pointed out by way of illustration, under the 2012 IFHP, a government-assisted refugee from Burma will have insurance coverage for asthma medication, but a refugee claimant from Burma would not. A pregnant refugee claimant from Iran will have insurance coverage for pre-natal and obstetrical care, but a pregnant refugee claimant from Mexico will not. A psychotic refugee claimant from Hungary will have insurance coverage for medications and doctors' visits, while a suicidal refugee claimant from Hungary will not.

[620] The changes to the IFHP have limited social value. While cutting the level of benefits provided may result in a cost savings to taxpayers (at least at the federal level), they do not make health care any more accessible to Canadians. Nor do they address an inequity in the health care system between Canadians and refugees and asylum seekers - one of the stated objectives of the changes - because no such unfairness existed in the first place.

[621] Again, as will be explained in greater detail in the context of my section 1 analysis, there was nothing inherently unfair about providing those seeking the protection of Canada (who are admittedly predominately low-income individuals) with a comparable level of health insurance coverage to that provided to low-income Canadians. It is, moreover, difficult to see how it is any

fairer to Canadians to provide low-income refugees and asylum seekers with a comparable level of health care to that available to working Canadians who are not on social assistance.

[622] Similarly, it is difficult to see how it is any fairer to Canadians to only provide PHPS coverage to refugee claimants from DCO countries. Nor is it apparent how it is any fairer to Canadians to deny any health care insurance coverage whatsoever to those only entitled to a PRRA. Indeed, one has to ask how fair it is to Canadians to deny insurance coverage to PRRA-only claimants for the diagnosis and treatment of infectious diseases that potentially present a risk to the health and safety of the Canadian public.

[623] While I have insufficient evidence before me to make a finding in this regard, I would also note that there is a real question as to whether the cuts to the IFHP will in fact achieve any real cost savings to taxpayers - another stated objective of the changes - or whether the costs of providing medical care to those seeking the protection of Canada are simply being downloaded to the provinces and others.

[624] The next question is whether the 2012 changes to the IFHP are unacceptable to a large segment of the population. As was noted earlier, the cuts to the IFHP were met with considerable consternation on the part of provincial governments, groups involved in providing health care and other forms of assistance to those seeking the protection of Canada, and newspaper editorial writers.

[625] Some 21 national medical organizations, including the Canadian Medical Association, the Royal College of Physicians and Surgeons, the College of Family Physicians of Canada, the Canadian Association of Midwives, the Canadian Psychiatric Association, the Canadian Paediatric Society, the Public Health Physicians of Canada and the Canadian Association of Emergency Physicians offered statements expressing concerns with respect to the cuts to the IFHP. As an editorial in the Calgary Herald observed, “it’s rare that doctors are so outspoken on political matters”.

[626] A group of these organizations also wrote to the Minister of Citizenship and Immigration on May 18, 2012 decrying the pending changes to the IFHP. Amongst other things, the organizations observed that by failing to provide “upfront health services” there was a risk that undiagnosed and untreated medical conditions would result in increased medical complications, as well as future health care costs. In addition, the failure to address medical concerns would make it more difficult for newcomers to Canada to learn new languages, attend school or enter the job market.

[627] In a June 6, 2012 letter to the Minister of Citizenship and Immigration, the Canadian Psychiatric Association asked “[h]ow are we to tell a woman with PTSD that she can no longer receive an anti-depressant or an anxiolytic to help her cope with the effects of trauma?” The letter goes on to ask “[h]ow should we tell a recently arrived mother fleeing from danger and suffering from depression that neither she nor her child are eligible for care, simply because of their country of origin?”

[628] A group of health professionals at the McGill University Department of Psychiatry noted their concerns with the changes, observing that, "for example, a rape victim from a Designated Country of Origin suffering from severe depression would not be entitled to either health care or anti-depressant medication unless she is viewed as a threat to others".

[629] The City of Toronto's Medical Officer of Health observed that "[r]efugees are an already marginalized group, facing health risks, barriers to access, and difficult and traumatic pre-migration experiences". Similar concerns were also expressed by the Ontario Medical Association, University of Toronto Department of Psychiatry, the Canadian Healthcare Association, the Catholic Health Alliance of Canada, the Public Health Association of British Columbia, and the Wellesley Institute.

[630] Provincial governments also expressed serious concerns with respect to the changes to the IFHP. For example, as was mentioned earlier, shortly before the 2012 IFHP came into effect the Ontario Minister of Health and Long Term Care wrote to the federal Ministers of Health and Immigration, accusing the Government of Canada of having "abdicat[ed] its responsibility towards some of the most vulnerable in our society".

[631] The Ontario Health Minister stated that by denying coverage for medications and early health care interventions, people would not seek medical care until they were in need of emergency treatment. She added that in addition to causing "needless pain and suffering", the failure to treat conditions "will exacerbate the future health care needs [of affected individuals]" and has "effectively downloaded federal costs onto the provincial health care system".

[632] It will also be recalled that Premier Brad Wall of Saskatchewan was quoted in the newspaper in relation to Mr. Akhtar's case, stating that "[i]t's unbelievable … [t]he decisions that have been taken federally have been having this impact on people who are clearly the most vulnerable".

[633] Premier Wall went on to say that he did not understand the government's decision, observing that "it is very much part of Canadian values and Saskatchewan values to want to make sure that these people, who are obviously very vulnerable, especially if they have a medical issue that they developed either before or after they came here, that we help them".

[634] Newspaper editorials from across the country also decried the changes to the IFHP. A number of these editorials questioned whether any real saving to the taxpayer would be realized as a result, or whether costs would simply be downloaded to the provinces. More importantly for our purposes, they questioned the humanity of subjecting already disadvantaged and vulnerable individuals to this kind of treatment, describing it in one case as "needlessly punitive": Applicants' Compendium, at p. 838.

[635] There is, thus, substantial evidence before me, not just of philosophical differences with a government policy choice, but of real outrage on the part of informed, affected individuals and groups at what has been done through the 2012 changes to the IFHP. While this is by no means

determinative, it is a strong indication that the cuts to the IFHP are unacceptable to at least a segment of the Canadian population and do not, in the view of these individuals and organizations, accord with public standards of decency or propriety.

[636] I am, moreover, satisfied that the effects of the 2012 changes to the IFHP are indeed "cruel and unusual" in terms of their impact on affected individuals.

[637] While the negative impact of the 2012 changes to the IFHP is by no means felt exclusively by the children of those seeking the protection of Canada, the cruelty of the changes to the IFHP is especially evident insofar as they affect children.

[638] To the extent that the 2012 changes to the IFHP were intended to act as a deterrent to so-called "bogus" claims, it must be recognized that children ordinarily have no choice in where they live: this is a matter that will be determined by the adults in their lives. Children are thus the innocent victims of world events and family choices.

[639] Nevertheless, the ability of these children to access health care has been severely curtailed by the Governor in Council in its attempt to deter their parents and others from coming to Canada and seeking the protection of this country.

[640] Indeed, the effect of the 2012 changes to the IFHP is to take away insurance coverage for pediatric health care for certain children who are in Canada seeking the protection of this country. Some children will only have insurance coverage for conditions that endanger the public health and safety of Canadians, and others will have no insurance coverage whatsoever for *any* form of health care.

[641] The applicants' witnesses have provided evidence with respect to the impact of the 2012 changes to the IFHP on children seeking the protection of Canada. While I have found that the evidence surrounding certain of these cases to be lacking, I note that section 12 jurisprudence permits the use of reasonable hypothetical examples to demonstrate constitutional deficiencies: see, for example, *R. v. Goltz*, 1991 CanLII 51 (SCC), [1991] 3 S.C.R. 485 at para. 69, [1991] S.C.J. No. 90. See also *R. v. Wiles*, 2005 SCC 84 (CanLII), 2005 SCC 84 at para. 5, 2005 SCC 84 (CanLII), [2005] 3 S.C.R. 895, *R. v. Mills*, 1999 CanLII 637 (SCC), [1999] 3 S.C.R. 668 at para. 41, [1999] S.C.J. No. 68.

[642] A "reasonable hypothetical example" is one which is "not far-fetched or only marginally imaginable as a live possibility". It must not involve"remote or extreme examples", but must instead "focus on imaginable circumstances which could commonly arise in day-to-day life": *Goltz*, above. See also *R. v. Wiles*, above, *R. v. Mills*, above.

[643] With this in mind, the following examples serve to illustrate the cruelty of the government's policy choice insofar as it relates to children.

[644] It will be recalled that the recipients of HCC benefits include refugee claimants from non-DCO countries, refugees, successful PRRA applicants, most privately-sponsored refugees,

and all refugee claimants whose claims were filed before December 15, 2012, regardless of the claimant's country of origin.

[645] HCC provides health insurance coverage for medical services of an urgent or essential nature. It does not, however, cover the cost of medications, even if they are required for life-threatening conditions, unless they are required to prevent or treat a disease posing a risk to public health or to treat a condition that is a public safety concern.

[646] As a result, a refugee-claimant child with asthma may be able to access emergency room treatment for an acute asthma attack, but could later be left gasping for breath if his impoverished refugee claimant parents could not afford the cost of the child's asthma medication.

[647] A child with difficulties hearing might receive coverage for a hearing assessment, but may be left hearing impaired if his parents could not afford the cost of a hearing aid. This could impact on the child's ability to attend school, and have long-term consequences for the child's development.

[648] The situation is far worse for children brought to Canada by their parents from Designated Countries of Origin whose refugee claims were filed after December 15, 2012. It will be recalled that these children are only entitled to Public Health or Public Safety Health Care Coverage. PHPS coverage only insures those health care services and products that are necessary or required to diagnose, prevent or treat a disease posing a risk to public health, or to diagnose or treat a condition of public safety concern.

[649] As a consequence, a child screaming in pain because of an ear infection would not be entitled to funding for any medical care whatsoever, because an ear infection is not a condition that poses a risk to public health or safety. While the child's parent's might be able to have the child seen by a doctor through a hospital emergency room, no health insurance coverage would be available to assist with the cost of the antibiotics that would be required to treat the infection.

[650] In his affidavit, Dr. Rashid described the case of a young child with a fever and cough who was unable to get a chest x-ray to rule out pneumonia - a potentially life-threatening illness - because the child only had PHPS coverage.

[651] Dr. Caulford described the case of an asthmatic 8 year old from Africa who began coughing and wheezing more severely because his mother could no longer afford medical care and asthma medications after his IFHP coverage was reduced to the PHPS level following the rejection of the family's refugee claim: Caulford affidavit at para. 17.

[652] Similarly, the young girl from a DCO country who has been traumatized by sexual or gang violence in her country of origin would not be entitled to health insurance coverage for any kind of mental health care if she becomes suicidal, as medical care is not available to the child whose mental health condition only poses a risk to the child herself. Once again, emergency hospital care might be available to deal with a suicide attempt, but no insurance coverage would

be available for the ongoing psychiatric treatment and medications that could assist in allowing the traumatized child to recover.

[653] Finally, it will be recalled that children who are only entitled to a PRRA are not entitled to any medical care whatsoever, even if they have a health condition that poses a risk to the public health and safety of Canadians.

[654] Thus a young child infected at birth with HIV would have no right to insurance coverage for any kind of medical treatment, effectively condemning the child to an early death.

[655] Not only would a child with active tuberculosis be ineligible for insurance coverage to cover the cost of his or her diagnosis and treatment, the child could also potentially expose family members, friends, teachers and classmates to the disease.

[656] I recognize that many of the situations that could result in claimants only being entitled to a PRRA, such as past involvement in war crimes, are unlikely to arise in the case of children. However, children could find themselves in this position if their parents fail to file their refugee claims in a timely manner, whether it be as a result of ignorance or bad advice: see *IRPA* subsection 99(3).

[657] A child could also find him or herself in this position if the child's parent has previously made an unsuccessful refugee claim on behalf of the family: see, for example, *Canada (Minister of Citizenship and Immigration) v. Toledo*, 2013 FCA 226, 454 N.R. 139.

[658] As the Federal Court of Appeal observed in *Toledo*, children do sometimes have to live with the consequences of their parents' actions: at para. 67. It is, however, one thing to say that a child has to live with the procedural consequences of his parents' choices, insofar as they relate to access to the refugee determination process. It is quite another thing to say that children should be exposed to unnecessary pain and suffering, potentially putting their very lives at risk, because of choices made by their parents.

[659] As was noted earlier in discussing Canada's international obligations, Canada has recognized its obligations with respect to children, most particularly in the *Convention on the Rights of the Child*. While this Convention has not been incorporated into Canadian law, the respondents accept that it is nevertheless a valuable interpretive aid in determining whether there has been a breach of the Charter.

[660] It will also be recalled that Article 6(2) of the *Convention on the Rights of the Child* requires Canada to act in the best interests of children, and codifies its obligation as a signatory to ensure to the maximum extent possible, the survival and development of children. The treatment of children described in the preceding paragraphs does not, in my view, conform to this standard.

[661] Moreover, Canada's own domestic law recognizes that the best interests of children should always be taken into account, and contemplates the exercise of *parens patriae* jurisdiction

where necessary to ensure that the interests of children are protected. In *Baker*, above, the Supreme Court of Canada recognized that 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: at paras. 67 and 70.

[662] I have not, however, been directed by the respondents to *any* evidence that would show that *any* consideration was given by the Governor in Council as to the impact that the 2012 cuts to the IFHP would have on the lives of children affected by the changes.

[663] I fully accept that amongst those who arrive here ostensibly seeking the protection of Canada there will inevitably be some who are not refugees at all, but economic migrants who are attempting to use the refugee system as a back door into this country. There will be others who file refugee claims in an attempt to achieve family reunification in Canada.

[664] Be that as it may, it is surely antithetical to the values of our Canadian society to visit the sins of parents on their innocent children.

[665] While recognizing that it is not binding on me, the words of the Supreme Court of the United States in *Plyler v. Doe*, 457 U.S. 202, 102 S. Ct. 2382 (1982) on this point are nevertheless apposite.

[666] In *Plyler v. Doe*, the United States' Supreme Court struck down a state statute denying funding for the education of the children of illegal immigrants. In so doing, the Court stated that the children in question were "special members" of the underclass of illegal immigrants. The Court went on to observe that while "[p]ersuasive arguments support the view that a State may withhold its beneficence from those whose very presence within the United States is the product of their own unlawful conduct. These arguments do not apply with the same force to classifications imposing disabilities on the minor children of such illegal entrants": at pp. 219-20.

[667] While recognizing that those who elect to enter the United States illegally should be prepared to bear the consequences of their actions, the Court held that the children of illegal immigrants are not comparably situated. It went on to observe that "[e]ven if the State found it expedient to control the conduct of adults by acting against their children, legislation directing the onus of a parent's misconduct against his children does not comport with fundamental conceptions of justice": at p. 220.

[668] Citing its earlier decision in *Weber v. Aetna Casualty & Surety Co*., 406 U.S. 164, 175 (1972), the Court stated that "visiting … condemnation on the head of an infant is illogical and unjust. Moreover, imposing disabilities on the … child is contrary to the basic concept of our system that legal burdens should bear some relationship to individual responsibility or wrongdoing. Obviously, no child is responsible for his birth *and penalizing the … child is an ineffectual - as well as unjust - way of deterring the parent*": at p. 220, my emphasis.

[669] There is an important distinction between the children in *Plyler v. Doe* and the children affected by the 2012 changes to the IFHP: the children in this case are generally *not* in this

country illegally. With that caveat, the same point may be made in this case. Denying health care insurance coverage to innocent children as a means of affecting the behaviour of their parents and others is illogical and unjust. It constitutes cruel and unusual treatment.

[670] The cruelty of the 2012 changes to the IFHP is not, however, limited to children. Because pregnancy is not a condition that poses a risk to public health or public safety, the pregnant victim of sexual violence from a DCO country will have no coverage for prenatal or obstetrical care, potentially putting the lives of both mother and baby at risk: see CIC's "*Interim Federal Health Program Reform: Examples of Coverage for Selected Conditions*", at p. 5.

[671] Similarly, no health insurance coverage will be available for a refugee claimant from a DCO country who is having a heart attack: CIC's "*Interim Federal Health Program Reform: Examples of Coverage for Selected Conditions*", at p. 6.

[672] It is no answer to say, as the respondents suggest, that claimants from DCO countries can simply get health care in their countries of origin. If that is indeed the case, one has to wonder how the availability of health insurance coverage in Canada under the pre-2012 IFHP would have operated as a "pull factor" in the first place.

[673] More fundamentally, however, for some claimants from DCO countries, returning home is simply not an option. The respondents have conceded that not every refugee claimant from a DCO country will be making an unfounded claim. At the hearing, the respondents expressly accepted that there can and will be *bona fide* refugee claims from all of the countries that have been identified as Designated Countries of Origin: Transcript, Vol. 2, at pp. 170-171.

[674] Recognizing that this is the case, the respondents' argument actually demonstrates that it is the DCO claimants who cannot return home - those who really are genuine refugees - who are the ones most severely hurt by the cuts to their insurance coverage resulting from the 2012 changes to the IFHP.

[675] Nor is it an answer to say that alternative sources of health care are available to those seeking the protection of Canada, including claimants from DCO countries. As I previously found, it is theoretically possible that such individuals may purchase such care, services or products themselves, or may purchase private medical insurance to cover this type of expenses. However, as a practical matter, this will be beyond the reach of most of those affected by the 2012 changes to the IFHP, given their extreme economic deprivation.

[676] Indeed, the observations of the trial judge in *Chaoulli* that, in light of the costs involved, the economic barriers in that case were so closely related to the possibility of gaining access to healthcare that access to private care was illusory, have similar application here.

[677] Moreover, as was explained earlier in these reasons, there are numerous shortcomings in all of the alternate sources of health care identified by the respondents. They are uncertain and not always timely. Indeed, in some cases, the treatment prescribed by doctors has simply been unavailable to patients.

[678] I have also concluded that forcing individuals to rely on the charity of others is not a reliable or appropriate alternate source of medical care for affected individuals, and that it is demeaning to require desperately ill people to go begging for essential medical treatment.

[679] Nor do the respondents' proposed alternatives take into account the psychological harm inflicted on individuals with serious health conditions as a result of their uncertain or limited access to medical treatment.

[680] Refugee claimants from non-DCO countries also face potentially devastating consequences as a result of the 2012 cuts to the IFHP.

[681] It will be recalled that Mr. Akhtar came to Canada from Pakistan, a non-DCO country, and was waiting for his refugee hearing when he was diagnosed with an aggressive form of lymphoma. Mr. Akhtar and others described "awful" psychological distress that he felt being alone in a strange country, having just been diagnosed with an aggressive cancer, and not knowing whether or not he would be able to get the chemotherapy treatments on which his life depended.

[682] The cruelty of the 2012 changes to the IFHP is also evident as it relates to Mr. Ayubi. As a failed refugee claimant, Mr. Ayubi only had Public Health or Public Safety coverage after June 30, 2012 until May of 2013, when the Minister exercised his discretion under section 7 of the 2012 IFHP to provide him with discretionary IFHP coverage. Mr. Ayubi still does not, however, have insurance coverage for the cost of his medications.

[683] Mr. Ayubi is, however, effectively trapped in this country as he cannot safely return to Afghanistan. Indeed, through the imposition of a moratorium on removals to Afghanistan, the Government of Canada has itself recognized that it is simply too dangerous to allow for the repatriation of Afghan citizens.

[684] As a diabetic, Mr. Ayubi has a life-threatening illness. He is trying to work. He pays his taxes. Nevertheless, he never knows from one day to the next whether he will be able to get the insulin upon which his survival depends. He has already suffered at least one health crisis as a result of his lack of access to necessary medications, and he is now dependent on the charity of others.

[685] Mr. Garcia Rodrigues also suffered great stress and came very close to losing the vision in his eye, because of his lack of insurance coverage. Indeed, it was only as a result of the kindness of Dr. Wong that Mr. Garcia Rodrigues' vision was saved.

[686] In *Smith,* the Supreme Court of Canada identified the question of whether state action is degrading to human dignity and worth as being another factor to consider in determining whether a treatment is cruel and unusual: above at para. 44.

[687] Access to health care is recognized as being at the core of the preservation of human dignity: see, for example, *Chaoulli*, above at para. 241.

[688] As I have already found, putting individuals affected by the 2012 cuts to the IFHP such as Mr. Ayubi, Mr. Garcia Rodrigues and Mr. Akhtar in the position where they have to beg for life-saving medical treatment is demeaning. It sends the message that their lives are worth less than the lives of others. It is cruel and unusual treatment that violates section 12 of the Charter.

C. *Conclusion with Respect to Section 12 of the Charter*

[689] For these reasons, I have concluded that while is it open to government to assign priorities and set limits on social benefit plans such as the IFHP, the intentional targeting of an admittedly poor, vulnerable and disadvantaged group takes this situation outside the realm of ordinary Charter challenges to social benefit programs.

[690] With the 2012 changes to the IFHP, the executive branch of the Canadian government has set out to make the lives of disadvantaged individuals even more difficult than they already are in an effort to force those who have sought the protection of this country to leave Canada more quickly, and to deter others from coming here. In light of the unusual circumstances of this case, I am satisfied that the affected individuals are being subjected to "treatment" as contemplated by section 12 of the Charter.

[691] I am also satisfied that this treatment is "cruel and unusual", particularly, but not exclusively, as it affects children who have been brought to this country by their parents. The cuts to health insurance coverage effected through the 2012 modifications to the IFHP potentially jeopardize the health, and indeed the very lives, of these innocent and vulnerable children in a manner that shocks the conscience and outrages our standards of decency. They violatesection 12 of the Charter.

XII. Do the 2012 Changes to the IFHP Violate Section 15 of the Charter?

[692] Subsection 15(1) of the Charter provides that "[e]very individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability".

[693] Subsection 15(1) is, however, qualified by subsection 15(2), which provides that "[s]ubsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability".

[694] The applicants assert that the 2012 changes to the IFHP create a health care hierarchy whereby the lives of some refugees and refugee claimants - a historically disadvantaged group whose presence is anticipated and authorized by Canadian law - are deemed less worthy of public protection. This, the applicants say, amounts to discrimination under section 15 of the Charter.

[695] The applicants assert that the 2012 changes to the IFHP violate section 15 of the Charter in two ways. First, the 2012 OICs draw a distinction between classes of refugee claimants based upon their country of origin. They provide a lower level of health insurance coverage to individuals coming from DCO countries than is provided to refugee claimants coming from non-DCO countries. According to the applicants, this constitutes discrimination on the basis of national or ethnic origin.

[696] The applicants also submit that the 2012 IFHP draws a distinction between individuals who are lawfully in Canada for the purpose of seeking protection, and other legal residents in Canada who are provided with health insurance benefits by the government. Under the 2012 IFHP, individuals legally in Canada such as Mr. Ayubi and Mr. Garcia Rodrigues are now prevented from obtaining the same level of health benefits as other legal residents in Canada.

[697] According to the applicants, this distinction in entitlement to health benefits is based upon the analogous ground of immigration status.

[698] The respondents deny that there has been any violation of section 15 of the Charter on the basis of either the national or ethnic origin or the immigration status of IFHP beneficiaries.

[699] According to the respondents, the 2012 changes to the IFHP do not create a distinction on the basis of the national origin of IFHP beneficiaries because any distinction that may be made arises out of the provisions of the *Immigration and Refugee Protection Act*. The respondents further note that a multitude of countries have been designated as Designated Countries of Origin, arguing that any distinction that may be made between foreign nationals of diverse origins does not constitute discrimination on the basis of "national or ethnic origin".

[700] If there is any unequal treatment in treating refugee claimants from DCO countries differently from others seeking the protection of Canada, the respondents say that the distinction creates an *advantage* in that it provides access to state-funded health insurance, and not a disadvantage.

[701] Further, by granting DCO claimants a level of state-funded health care benefits, the respondents submit that the Governor in Council is not"perpetuating prejudice or stereotyping". Rather, the executive branch is recognizing that even though refugee claimants from these countries are generally coming from safe, "non-refugee producing" nations with health care systems that are comparable to that of Canada, they are deserving of a minimum level of state-funded health care while they are in Canada making a refugee claim.

[702] Insofar as the applicants' arguments regarding alleged discrimination on the basis of immigration status are concerned, the respondents submit that"immigration status" has clearly been rejected by the Courts as an analogous ground for the purposes of section 15 of the Charter. As a consequence, the applicants have failed to establish that there is a "distinction" resulting from 2012 changes to the IFHP that would engage the provisions of subsection 15(1)of the Charter.

[703] The respondents also submit that the nature of the interest asserted by the applicants is a right to state-funded health care, which is a right that not even Canadian citizens possess. There are, moreover, shortcomings in the Canadian health care system, and not every Canadian can receive the health care that he or she needs in a timely fashion.

[704] In the alternative to the above arguments, the respondents submit that the 2012 IFHP is an "ameliorative program", with the result that any potential distinction it creates is thus protected by subsection 15(2) of the Charter. According to the respondents, it is unavoidable that in seeking to help one group, ameliorative programs necessarily exclude others.

[705] Finally, if there is any distinction in the 2012 IFHP that is not saved by subsection 15(2) of the Charter, the respondents submit that the applicants have failed to demonstrate that the distinction constitutes substantive discrimination, with the result that their section 15 arguments must fail.

A. *Legal Principles Governing Section 15 Claims*

[706] In *Law Society British Columbia v. Andrews*, 1989 CanLII 2 (SCC), [1989] 1 S.C.R. 143, [1989] S.C.J. No. 6 [*Andrews*], the Supreme Court described the subsection 15(1) guarantee of equality as "the broadest of all guarantees", noting that it "applies to and supports all other rights guaranteed by the Charter": at para. 52.

[707] Subsection 15(1) of the Charter is aimed at preventing the drawing of discriminatory distinctions that impact adversely on members of groups identified by reference to the grounds enumerated in section 15 or to analogous grounds: *R. v. Kapp*, 2008 SCC 41 (CanLII), 2008 SCC 41, [2008] 2 S.C.R. 483 [*Kapp*].

[708] The focus of subsection 15(1) of the Charter is on "*preventing* governments from making distinctions based on the enumerated or analogous grounds that: have the effect of perpetuating group disadvantage and prejudice; or impose disadvantage on the basis of stereotyping": *Kapp*, above at para. 25, emphasis in the original.

[709] The law governing section 15 claims is complex, and has undergone a number of iterations since the Supreme Court's seminal decision in *Andrews*"set the template" for the Court's approach to claims under section 15 of the Charter: see *Kapp*, above at para. 14.

[710] The majority in *Andrews* defined "discrimination" as "a distinction, whether intentional or not but based on grounds relating to personal characteristics of the individual or group, which has the effect of imposing burdens, obligations, or disadvantages on such individual or group not imposed upon others, or which withholds or limits access to opportunities, benefits, and advantages available to other members of society": above at para. 37.

[711] It was also in *Andrews* that the Supreme Court first articulated its commitment to the principle of substantive, rather than formal, equality.

[712] "Formal equality" requires that everyone, regardless of their individual circumstances, be treated in an identical fashion. In contrast, "substantive equality" recognizes that in some circumstances it is necessary to treat different individuals differently, in order that true equality may be realized. In this regard, "substantive equality" is based upon the concept that "[t]he promotion of equality entails the promotion of a society in which all are secure in the knowledge that they are recognized at law as human beings equally deserving of concern, respect and consideration": *Andrews*, above at para. 34, per McIntyre J.

[713] As William Black and Lynn Smith explained in "The Equality Rights", in Gérald Beaudoin & Errol Mendes, eds., *Canadian Charter of Rights and Freedoms*, 4th ed. (Markham, Ontario: LexisNexis Butterworths, 2005), at p. 969:

> The term "substantive equality" indicates that one must take account of the outcomes of a challenged law or activity and of the social and economic context in which the claim of inequality arises. Assessing that context requires looking beyond the law that is being challenged and identifying external conditions of inequality that affect those outcomes. Substantive equality requires attention to the "harm" caused by unequal treatment.

[714] In 1999, the Supreme Court of Canada rendered its decision in *Law v. Canada (Minister of Employment and Immigration)*, 1999 CanLII 675 (SCC), [1999] 1 S.C.R. 497, [1999] S.C.J. No. 12 [*Law*]. In *Law*, the Supreme Court observed that "[a] purposive and contextual approach to discrimination analysis is to be preferred, in order to permit the realization of the strong remedial purpose of the equality guarantee, and to avoid the pitfalls of a formalistic or mechanical approach": at para. 88.

[715] As the Court subsequently observed in *Gosselin*, above, the central lesson of *Law* was the need for a contextual inquiry in order to establish whether a governmental distinction conflicts with the purpose of subsection 15(1) of the Charter, such that "a reasonable person in circumstances similar to those of the claimant would find that the legislation which imposes differential treatment has the effect of demeaning his or her dignity": see *Gosselin*, above at para. 25, citing *Law* above at para. 60.

[716] In *Kapp*, the Supreme Court recognized that difficulties had arisen in using human dignity as a legal test. The Court observed that although human dignity is an essential value underlying the subsection 15(1) equality guarantee, "human dignity is an abstract and subjective notion that […] cannot only become confusing and difficult to apply; it has also proven to be an *additional* burden on equality claimants, rather than the philosophical enhancement it was intended to be": *Kapp*, above at para. 22, emphasis in the original.

[717] The Supreme Court observed that the analysis "more usefully focusses on the factors that identify impact amounting to discrimination", recognizing that the "perpetuation of disadvantage and stereotyping" are the "primary indicators of discrimination": *Kapp*, above at para. 23. Thus the "central concern"of section 15 is "combatting discrimination, defined in terms of perpetuating disadvantage and stereotyping": at para. 24.

[718] For the purposes of a section 15 Charter analysis, "disadvantage … connotes vulnerability, prejudice and negative social characterization": *Kapp*, above at para. 55. In determining whether a government action imposes disadvantage on the basis of "stereotyping", regard should be had to, amongst other things, "the degree of correspondence between the differential treatment and the claimant group's reality": *Kapp*, above at paras. 19 and 23.

[719] Since *Kapp*, the Supreme Court has reminded us of the importance of looking beyond the impugned government action in a section 15 Charteranalysis, and of the need to examine the larger social, political and legal context of the legislative distinction in issue: see *Ermineskin Indian Band and Nation v. Canada*, 2009 SCC 9 (CanLII), 2009 SCC 9 at paras. 193-194, 2009 SCC 9 (CanLII), [2009] 1 S.C.R. 222.

[720] Indeed, in *Withler v. Canada (Attorney General)*, 2011 SCC 12 (CanLII), 2011 SCC 12, [2011] 1 S.C.R. 396 [*Withler*], the Supreme Court stated that "[a]t the end of the day there is only one question: Does the challenged law violate the norm of substantive equality in s. 15(1) of the Charter?": above at para. 2.

[721] Most recently, in *Quebec (Attorney General) v. A.*, 2013 SCC 5 (CanLII), 2013 SCC 5, [2013] 1 S.C.R. 61 [*A.G. v. A.*], Justice Abella noted that"the main consideration must be *the impact* of the law on the individual or the group concerned". She also observed that the purpose of section 15 was "to eliminate the exclusionary barriers faced by individuals in the enumerated or analogous groups in gaining meaningful access to what is generally available": at para. 319, citing *Andrews*, emphasis in the original.

[722] Thus the test to be used in identifying whether there has been a section 15 violation is whether an applicant can show that the government has made a distinction based on an enumerated or analogous ground and that the distinction's impact on the individual or group creates a disadvantage by perpetuating prejudice or stereotyping: *A.G. v. A.*, above at para. 324. If the applicant discharges his or her burden in this regard, then the burden shifts to the government to justify the distinction under section 1 of the Charter.

[723] According to *A.G. v. A.*, while prejudice and stereotyping are *indicia* that may help identify discrimination, "they are not discrete elements of the test which the claimant is obliged to demonstrate": above at para. 325.

[724] 'Prejudice' has been described by the Supreme Court as "the holding of pejorative attitudes based on strongly held views about the appropriate capacities or limits of individuals or the groups of which they are a member". While 'stereotyping', like prejudice, "is a disadvantaging attitude", it is an attitude "that attributes characteristics to members of a group regardless of their actual capacities": both quotes from *A.G. v. A.*, above at para. 326.

[725] Citing its earlier decision in *Withler*, the Supreme Court held in *A.G. v. A.* that "where the discriminatory effect is said to be the perpetuation of disadvantage or prejudice, evidence that goes to establishing a claimant's historical position of disadvantage or to demonstrating existing

prejudice against the claimant group, as well as the nature of the interest that is affected, will be considered": above at para. 327.

[726] Caution must, however, be exercised so as to avoid improperly focusing on whether a discriminatory *attitude or conduct* exists, rather than on whether the impugned government action has a discriminatory *impact*. As a consequence, it is not necessary that claimants prove that a distinction perpetuates negative attitudes about them: *A.G. v. A.*, above at paras. 327-330.

[727] Ultimately, the question is whether "a distinction has the effect of perpetuating arbitrary disadvantage on the claimant because of his or her membership in an enumerated or analogous group": *A.G. v. A.*, above at para. 331. As a consequence, "[i]f the state conduct widens the gap between the historically disadvantaged group and the rest of society rather than narrowing it, then it is discriminatory": at para. 332.

[728] With this understanding of the relevant legal principles, I turn now to consider whether the applicants have demonstrated that the 2012 changes to the IFHP create a distinction between refugee claimants from DCO countries and refugee claimants from non-DCO countries in a way that violatessection 15 of the Charter.

B. *Does the 2012 IFHP Draw a "Distinction" Between Refugee Claimants from DCO Countries and Non-DCO Countries on the Basis of an Enumerated or Analogous Ground?*

[729] As noted above, the first question that must be addressed is whether the government action in issue, in this case, the changes to the IFHP brought about by the 2012 OICs, creates a "distinction" based on an enumerated or analogous ground under subsection 15(1) of the Charter.

[730] As the Supreme Court observed in *Withler*, above, "inherent in the word 'distinction' is the idea that the claimant is treated differently than others": at para. 62.

[731] It will be recalled that unlike the pre-2012 IFHP (which provided the same level of coverage to all those eligible for benefits), the 2012 IFHP regime provides for different tiers of coverage: Expanded Health Care Coverage (EHCC), Health Care Coverage (HCC) and Public Health or Public Safety Health Care Coverage (PHPS).

[732] The tier of IFHP coverage that a person is entitled to receive under the 2012 IFHP depends upon a number of factors. Amongst others, these include where the individual is in the refugee determination process; *whether the individual is a national of a Designated Country of Origin*; if the individual is not a refugee claimant, the person's status in Canada; whether the individual receives federally-funded resettlement assistance; and whether the individual is being detained.

[733] EHCC is the highest level of health insurance benefits available under the 2012 IFHP. It is roughly equivalent to the level of IFHP benefits provided under the pre-2012 IFHP program, and is similar to the level of health insurance coverage available to low-income Canadians.

Those entitled to EHCC benefits include most government-assisted refugees and some privately-sponsored refugees, as well as victims of human trafficking and some individuals admitted under a public policy or on humanitarian and compassionate grounds.

[734] HCC benefits are similar to the health insurance benefits received by working Canadians through their provincial or territorial health insurance plans, with the proviso that services and products are only covered "if they are of an urgent or essential nature" as defined in the IFHP. Those entitled to HCC benefits include *refugee claimants from non-DCO countries*, recognized refugees, successful PRRA applicants, most privately-sponsored refugees, and all refugee claimants whose claims were filed before December 15, 2012, regardless of the claimant's country of origin.

[735] Refugee claimants *from DCO countries* and failed refugee claimants are only entitled to Public Health or Public Safety (PHPS) benefits. It will be recalled that PHPS coverage only insures those health care services and products that are necessary or required to diagnose, prevent or treat a disease posing a risk to public health, or to diagnose or treat a condition of public safety concern.

[736] With respect to refugee claimants from DCO countries, subsection 4(3) of the April 2012 OIC specifically provides that the Minister is not authorized to pay "the cost of health care coverage incurred for refugee claimants who are *nationals of a country* that is, when services or products are provided, designated under subsection 109.1(1) of the Act" [my emphasis].

[737] Thus, as a result of the changes brought about by the Governor in Council through the promulgation of the 2012 OICs, the 2012 IFHP now draws a distinction, on its face, as to the level of health insurance coverage that will be provided to those seeking the protection of Canada based, in part, on the nation from which the claimant comes.

[738] The 2012 IFHP provides a lesser level of health insurance coverage to refugee claimants from DCO countries than is afforded to refugee claimants from non-DCO countries, thereby singling out refugee claimants from DCO countries for adverse differential treatment. This situation is thus readily distinguishable from that which confronted the Federal Court of Appeal in *Toussaint*: above at paras. 104-105.

[739] It is also important to keep in mind that what is at issue in this case is not access to extraordinary or experimental treatment, or what the Supreme Court described in *Auton* as "recent and emergent" treatment: above at para. 56. The effect of the 2012 changes to the IFHP is to deny insurance coverage for basic, "core" medical care that is available to refugee claimants from non-DCO countries under the IFHP and to Canadians under provincial or territorial health insurance programs.

[740] The respondents say that the nature of the interest asserted by the applicants on behalf of refugee claimants from DCO countries is a right to state-funded healthcare - a right that not even Canadian citizens possess: *Chaoulli*, above.

[741] While I have already concluded in the context of my section 7 analysis that there is no free-standing constitutional right to state-funded health care, that does not provide the respondents with a defence to the applicants' section 15 claim.

[742] Although there may be no obligation on the Governor in Council to provide health insurance coverage to those seeking the protection of Canada, once it chooses to provide such a benefit, "it is obliged to do so in a non-discriminatory manner": *Eldridge*, above. The Supreme Court went on in *Eldridge*to observe that "[i]n many circumstances, this will require governments to take positive action, for example by extending the scope of a benefit to a previously excluded class of persons": both quotes at para. 73, citations omitted.

[743] It is, moreover, not open to government to enact a law whose policy objectives and provisions single out a disadvantaged group for inferior treatment: *Auton*, above at para. 41, citing *Corbière v. Canada (Minister of Indian and Northern Affairs)*, 1999 CanLII 687 (SCC), [1999] 2 S.C.R. 203, [1999] S.C.J. No. 24 [*Corbière*].

[744] The respondents say that if there is any distinction in treating claimants from DCO countries differently from others seeking the protection of Canada, this distinction creates the *advantage* of providing access to state-funded health care to refugee claimants from DCO countries, and not a disadvantage. I do not agree.

[745] In this case, we have a government program that provides health insurance coverage to IFHP beneficiaries. However, the eligibility requirements established by the 2012 OICs result in unequal access to that benefit, providing an inferior level of benefits to some IFHP beneficiaries based on the claimant's nation of origin.

[746] The question, then, is whether this unequal access constitutes discrimination on the basis of the "national origin" of the claimants.

[747] The respondents say that there is no such discrimination, as numerous countries have been identified as "Designated Countries of Origin". According to the respondents, distinctions made between foreign nationals of diverse origins do not constitute discrimination on the basis of "national or ethnic origin".

[748] I do not accept this argument. The fact that a program may explicitly exclude Asians, Hispanics and Blacks does not make it any less discriminatory than a program that only excludes Asians.

[749] The respondents also argue that "national or ethnic origin is not the same as citizenship": Transcript, Vol. 2, at p. 175. In support of this contention, the respondents submit that one can be a citizen of one country, while having a national or ethnic origin that is quite different. The difficulty with this argument is that it equates national origin with ethnic origin, and fails to consider the distinction between the two.

[750] Subsection 15(1) of the Charter prohibits discrimination on the basis of national *or* ethnic origin. The use of the disjunctive "or" suggests that the two terms are not synonymous. It is, moreover, clear that an individual can have one national origin while having a different, or even several different ethnic origins.

[751] The 2012 OICs explicitly state that a lower level of health care benefits will be provided to refugee claimants from certain designated countries of origin. This is clearly discrimination on the basis of the nation that the claimant comes from: that is, their national origin.

[752] The respondents have cited several cases to support their claim that the IFHP does not draw a distinction on the basis of national origin. However, each of these cases is readily distinguishable from the situation that confronts the Court in this case.

[753] *Pawar v. Canada* (1999), 247 N.R. 271, [1999] FCJ No 1421 involved a challenge to the residency requirement of the *Old Age Security Act*, R.S.C. 1985, c. O-8 brought by individuals who were born abroad. In dismissing the action, the Federal Court of Appeal held that "being born abroad" was not embraced in the concept of "national and ethnic origin" and was neither an enumerated nor an analogous ground under section 15 of the Charter.

[754] The Court in *Pawar* also held that a distinction based upon prior residency in countries without reciprocal pension agreements with Canada had nothing directly to do with the plaintiffs' "national or ethnic origin". In other words, the distinction at issue in *Pawar* was not based on the particular country where the individual had previously resided, but rather on whether that country had entered into a reciprocal pension agreement with Canada: para. 2.

[755] In contrast, in this case, the distinction drawn by the 2012 OICs is based entirely on the country that the refugee claimant comes from.

[756] In *Tabingo v. Canada (Minister of Citizenship and Immigration)*, 2013 FC 377 (CanLII), 2013 FC 377, 431 F.T.R. 118, Justice Rennie had to consider whether the cancellation of applications for Federal Skilled Workers based on the date of application under subsection 87.4(1) of the *Immigration and Refugee Protection Act* resulted in a section 15 violation based upon the applicants' national origin.

[757] Although Justice Rennie observed at paragraph 120 of *Tabingo* that "the applicants were a diverse group, sharing no commonality of [...] national origin …", that was *not* the basis for his finding that there had been no section 15 violation.

[758] Justice Rennie accepted that the impact of the decision to cancel visa applications had a differential impact, depending on the location of the visa office to which an applicant had applied as a result of variances in processing rates at different visa offices. However, in concluding that this did not constitute a distinction based on an enumerated or analogous ground for the purposes of section 15 of the Charter, he noted that visa applications were transferred between visa posts, with files from high demand posts being transferred to lower demand posts in order to facilitate timelier processing. Consequently, the differences in clearance rates at various posts did not

directly correspond to the applicants' countries of origin. As a consequence, there was no discrimination on the basis of national origin.

[759] It does not, however, follow from the decision in *Tabingo* that there could be no discrimination on the basis of national origin in the hypothetical event that the Government of Canada decided to process visa applications emanating from Great Britain at twice the rate of visa applications from, say, Cameroon, Pakistan and Vietnam (assuming for the sake of argument that visa applicants outside of Canada do in fact have rights under section 15 of theCharter).

[760] The last two cases relied upon by the respondents involved human rights complaints brought under two different human rights statutes, rather than under section 15 of the Charter. Both cases involved complaints with respect to higher tuition fees charged to foreign students in comparison to those charged to Canadians students: *Nova Scotia Confederation of University Faculty Assns. v. Nova Scotia (Human Rights Commission)* 1995 CanLII 4556 (NS SC), (1995), 143 N.S.R. (2d) 86, [1995] N.S.J. No. 296 [*Nova Scotia*] and *Simon Fraser University International Students v. Simon Fraser University*, [1996] B.C.C.H.R.D. No. 13 [*Simon Fraser*].

[761] The complaints alleged that the differential fee structures constituted discrimination on the basis of the students' race and national or ethnic origin in the *Nova Scotia* case, and on the basis of race and/or place of origin in the *Simon Fraser* case. Both complaints were dismissed.

[762] In *Nova Scotia*, the Court observed that the higher fee did not apply to Canadian citizens and landed immigrants, who may come from many different racial backgrounds and national/ethnic origins. The extra fee was based on the students' citizenship or place of residence, and not on their race or national or ethnic origin. Neither citizenship nor place of residence was a proscribed ground of discrimination under the applicable human rights legislation, with the result that the complaint had to be dismissed.

[763] Similarly, in *Simon Fraser*, international students were charged much higher tuition fees than were charged to Canadians students. In rejecting the complaint, the British Columbia Council of Human Rights observed that the affected students came "from over fifty different countries" and could not "be characterized by race or place of origin". The Tribunal further observed that Canadian students may also come from a variety of other countries: at para. 17.

[764] As a result, the Tribunal in *Simon Fraser* concluded that the University's fee policy was based on the citizenship or place of residence of the affected students and their legal status in Canada, and not their race or place of origin. Given that these were not statutorily prohibited grounds of discrimination, it followed that this complaint was also dismissed.

[765] These decisions do not, however, lead to the conclusion that there would be no discrimination on the basis of national origin if higher tuition fees were only charged to students coming from, for example, Hungary, Mexico and the United States, which would be the more apt analogy to the current case.

[766] As was noted earlier, the April 2012 OIC specifically provides that the Minister is not authorized to pay "the cost of health care coverage incurred for refugee claimants who are *nationals of a country* that is, when services or products are provided, *designated under subsection 109.1(1) of the Act*" [my emphasis]. The ordinary meaning of this phrase is to deny a benefit to individuals seeking the protection of Canada from specified countries based upon their national origin, thereby creating a distinction for the purposes of subsection 15(1) of the *Charter*.

[767] The plain meaning of the term "national origin" is broad enough to include people who are not only born in a particular country, but who come from that country. Indeed, such an interpretation is consistent with the term used in *IRPA*, namely "Designated *Country of Origin*" [my emphasis].

[768] Before leaving this issue, I would also note that my interpretation of "national origin" for the purposes of subsection 15(1) of the Charter as encompassing a prohibition on discrimination between classes of non-citizens based upon their country of origin is one that is also consistent with the provisions of the *Refugee Convention*, article 3 of which prohibits discrimination against refugees based upon their country of origin.

[769] Although not raised in their memorandum of fact and law, the respondents argued at the hearing that the distinction drawn in the 2012 OICs between refugee claimants from DCO countries and non-DCO countries is one based upon *citizenship*, rather than national origin. As a result, they say there can be no section 15 violation.

[770] As I have already explained, I am satisfied that the 2012 IFHP does indeed make a distinction based upon the national origin of claimants. As a consequence, it is not strictly necessary to address the respondents' citizenship argument, and I will do so only briefly, particularly given that citizenship was not identified as a basis for the applicants' constitutional challenge in their Notice of Constitutional Question.

[771] I would simply note that to the extent that the respondents submit that any distinction contained in the 2012 OICs was based upon citizenship rather than national origin, it would still be discriminatory, as citizenship has expressly been recognized as an analogous ground for the purposes of section 15 of the Charter: see *Andrews*, above, and *Lavoie v. Canada*, 2002 SCC 23 (CanLII), 2002 SCC 23, [2002] 1 S.C.R. 769.

[772] Indeed, as Justice La Forest observed in *Andrews*, "[d]iscrimination on the basis of nationality has from early times been an inseparable companion of discrimination on the basis of race and national or ethnic origin, which are listed in s. 15": at para. 68.

[773] While I recognize that both *Andrews* and *Lavoie* involved distinctions being drawn between Canadian citizens and non-Canadians, as the Supreme Court observed in *Lavoie*, "[o]nce identified, an analogous ground stands as 'a constant marker of potential legislative discrimination' and need not be established again in subsequent cases": at para. 41, citing *Corbière*, above at paras. 7-10, and *Little Sisters Book and Art Emporium v. Canada (Minister of Justice)*, 2000 SCC 69 (CanLII), [2000] 2 S.C.R. 1120 at para. 119, 2000 SCC 69.

[774] Finally, the respondents submit that the distinction in the 2012 OIC is not discriminatory, as the distinction between DCO and non-DCO countries arises out of the provisions of the *Immigration and Refugee Protection Act*, noting that the applicants have not challenged the statutory DCO designation process in this proceeding.

[775] It is true that the concept of a "Designated Country of Origin" is one that is created by subsection 109.1(1) of *IRPA*, which allows the Minister of Citizenship and Immigration to designate countries for certain purposes under the Act. That does not, however, serve to insulate the 2012 changes to the IFHP from scrutiny under section 15 of the Charter.

[776] What is at issue in this case is not the inclusion of subsection 109.1(1) in *IRPA*, but rather the decision of the Governor in Council to import the concept of "Designated Countries of Origin" into the 2012 OICs, using it as a criterion for determining who will be eligible for health insurance coverage, and at what level. This decision is clearly reviewable under section 15 of the Charter.

[777] Having concluded that the 2012 OICs create a distinction based on the enumerated ground of national origin, the next issue that must be addressed is the respondents' assertion that the IFHP is an ameliorative program and that this distinction is thus saved by subsection 15(2) of the Charter.

C. *Is the Subsection 15(1) Breach Saved on the Basis that the IFHP is an Ameliorative Program?*

[778] Subsection 15(2) of the Charter provides that subsection 15(1) of the Charter "does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability".

[779] In the event that this Court were to find that the distinction drawn with respect to the level of IFHP benefits that are made available to refugee claimants from DCO countries relative to those available to refugee claimants from non-DCO countries constitutes a violation of subsection 15(1) of theCharter, the respondents assert that the IFHP is an ameliorative program directed at improving the situation of groups that are in need of assistance in order to enhance substantive equality, as contemplated by subsection 15(2) of the Charter.

[780] That is, the respondents say that the IFHP is a government program that has as its object the amelioration of the health conditions of refugee claimants, refugees and failed claimants in particular circumstances of need in Canada: respondents' memorandum of fact and law, at para. 122. They submit that the distinction between the benefits provided to refugee claimants from DCO countries and others serves that purpose in allocating funds to persons from countries whose claims take longer to process, with the result that they are in Canada for a longer period of time.

[781] In *Alberta (Aboriginal Affairs and Northern Development) v. Cunningham*, 2011 SCC 37 (CanLII), 2011 SCC 37, [2011] 2 S.C.R. 670 [*Cunningham*], the Supreme Court explained that the purpose of subsection 15(2) of the Charter is to save ameliorative programs from claims of "reverse discrimination": at para. 41. It allows governments to implement programs or laws that are designed to improve the situation of members of historically disadvantaged groups to assist in the move towards substantive equality.

[782] The Supreme Court observed in *Cunningham* that subsection 15(2) achieves its purpose by "affirming the validity of ameliorative programs that target particular disadvantaged groups, which might otherwise run afoul of subsection 15(1) by excluding other groups". The Court further observed that in so doing, "[i]t is unavoidable that ameliorative programs, in seeking to help one group, necessarily exclude others": above at para. 40.

[783] Underlying subsection 15(2) is the notion that "governments should be permitted to target subsets of disadvantaged people on the basis of personal characteristics, while excluding others". The Court recognized that governments may have particular goals in relation to advancing or improving the situation of particular groups, and that they may not be in a position to help all of the members of a disadvantaged group at the same time. As a consequence, governments should be permitted to establish priorities, failing which "they may be precluded from using targeted programs to achieve specific goals relating to specific groups": both quotes from *Cunningham*, above at para. 41.

[784] The first detailed consideration of the scope of the subsection 15(2) exception appears in the Supreme Court's decision in *Kapp*, above. There, the Court explained that subsections 15(1) and 15(2) of the Charter "work together to promote the vision of substantive equality that underlies s. 15 as a whole". The Court stated that "subsection 15(1) is aimed at preventing discriminatory distinctions that impact adversely on members of groups identified by the grounds enumerated in s. 15 and analogous grounds", which was "one way of combating discrimination": *Kapp*, above at para. 16.

[785] That is not, however, the only way to combat discrimination. Governments may also attempt to address discrimination by developing measures that pro-actively combat discrimination through programs aimed at helping disadvantaged groups improve their situation: *Kapp*, at para. 25. Subsection 15(2) of the Charter preserves the right of governments to do so, without the program being struck down under subsection 15(1).

[786] In order to establish that a government program constitutes an ameliorative program for the purposes of subsection 15(2) of the Charter, the government must show "that the program is a genuinely ameliorative program directed at improving the situation of a group that is in need of ameliorative assistance in order to enhance substantive equality": *Kapp*, above at para. 41. A "naked declaration" that a program has an ameliorative purpose is not sufficient to attract the protection of subsection 15(2) against a claim of discrimination: *Kapp*, above at para. 46.

[787] There must also be a correlation between the program in question and the disadvantage suffered by the group that the program is intended to benefit: *Kapp*, above at para. 49.

[788] According to *Cunningham*, if the above conditions are met, subsection 15(2) of the Charter will protect "all distinctions drawn on enumerated or analogous grounds that 'serve and are necessary to' the ameliorative purpose". To show that a distinction is 'necessary' to this ameliorative purpose, it must be shown that "the impugned distinction in a general sense serves or advances the object of the program, thus supporting the overall s. 15 goal of substantive equality". That is, "distinctions that might otherwise be claimed to be discriminatory are permitted, *to the extent that they go no further than is justified by the object of the ameliorative program*", my emphasis. To come within the exception created by subsection 15(2) of the Charter, the distinction"must in a real sense serve or advance the ameliorative goal, consistent with s. 15's purpose of promoting substantive equality": all quotes from*Cunningham*, above at para. 45.

[789] The Supreme Court identified the "fundamental question" in subsection 15(2) cases as being "up to what point does s. 15(2) protect against a claim of discrimination?", noting that "[t]he tentative answer suggested by *Kapp* […] is that the distinction must serve or advance the ameliorative goal":*Cunningham*, at para. 46.

[790] The Court went on in *Cunningham* to note that "[a]meliorative programs, by their nature, confer benefits on one group that are not conferred on others". Such distinctions will generally be protected "if they serve or advance the object of the program, thus promoting substantive equality", even if, for example, "the included and excluded groups are aboriginals who share a similar history of disadvantage and marginalization": above at para. 53, citing*Lovelace v. Ontario* 1997 CanLII 2265 (ON CA), (1997), 33 O.R. (3d) 735 (Ont. C.A.) [*Lovelace – O.C.A.*], aff'd 2000 SCC 37 (CanLII), 2000 SCC 37, [2000] 1 S.C.R. 950 [*Lovelace*].

[791] Ameliorative programs are often challenged by those *outside* the group that the program is designed to assist. By way of example, in *Kapp*, a program that provided for the issuance of communal fishing licenses to three aboriginal bands was challenged by commercial fishers, most of whom were non-aboriginal.

[792] That is not the situation here: in this case, the changes to the IFHP brought about through the 2012 OICs are being challenged on behalf of some of the very individuals that the program was purportedly designed to benefit, namely refugee claimants from DCO countries and failed refugee claimants.

[793] As the Ontario Court of Appeal observed in *Lovelace – O.C.A.*, "[a] s. 15(2) program that excludes from its reach disadvantaged individuals or groups that the program is designed to benefit likely infringes s. 15(1)": at para. 67. The Supreme Court of Canada affirmed the Court of Appeal's decision without specific comment on this point.

[794] This also distinguishes this case from the situation that confronted the Federal Court of Appeal in *Toussaint*. There, the Court was faced with a challenge to the exclusion of illegal immigrants from coverage under the IFHP: that is, a claim of under-inclusiveness brought by someone *outside* the group that the program was designed to assist. It was in this context that the Federal Court of Appeal observed that if Ms. Toussaint had succeeded in establishing

a "distinction" under subsection 15(1), "subsection 15(2) of the Charter might become live": at para. 102.

[795] In contrast to the situation in *Toussaint*, the 2012 IFHP provides health insurance coverage for those seeking the protection of Canada, but specifically singles out certain refugee claimants for lesser treatment, based upon their country of origin, thus discriminating against refugee claimants from DCO countries, in both purpose and effect.

[796] The respondents say that the IFHP has as its object the amelioration of the health conditions of refugee claimants, refugees and failed claimants in particular circumstances of need in Canada. Given that this is the goal of the program, it is unclear how the exclusion of refugee claimants from DCO countries from eligibility for basic, "core" health care benefits serves or is necessary to the ameliorative object of the program or how it advances a goal of enhancing substantive equality.

[797] Indeed, as the Supreme Court observed in *A.G. v. A*, above, "if the state conduct widens the gap between the historically disadvantaged group and the rest of society, rather than narrowing it, then it is discriminatory": at para. 332.

[798] It also bears recalling that the government action at issue in this case is the decision of the Governor in Council to modify the IFHP to *take away* the health insurance coverage that was previously available to refugee claimants from DCO countries. Indeed, it is difficult to understand how the DCO/non-DCO distinction in the IFHP can be characterized as ameliorative when one of the stated goals of the 2012 modifications to the program was to make things harder for refugees from DCO countries in order to deter other so-called "bogus" claimants from coming to Canada and abusing the generosity of Canadians.

[799] In determining whether the IFHP qualifies as an "ameliorative program" for the purposes of subsection 15(2) of the Charter, regard must also be had to whether it was "rational for the state to conclude that the means chosen to reach its ameliorative goal would contribute to that purpose". The Supreme Court explained that for a distinction to be rational, "there must be a correlation between the program and the disadvantage suffered by the target group". While this standard "permits significant deference to the legislature", it allows for judicial review "where a program nominally seeks to serve the disadvantaged but in practice serves other non-remedial objectives": all quotes from *Kapp*, above at para. 49.

[800] As was noted earlier, distinctions that might otherwise be claimed to be discriminatory are permitted under subsection 15(2) of the Charter, but only"to the extent that they go no further than is justified by the object of the ameliorative program": *Cunningham*, at para. 45.

[801] The respondents have described the object of the IFHP as being "the amelioration of the health conditions of refugee claimants, refugees and failed claimants in particular circumstances of need in Canada". They say that "[t]he distinction between DCOs and others serves that purpose in allocating funds to persons from countries whose claims take longer to process such

that they are in Canada for a longer period of time": both quotes from respondents' memorandum of fact and law at para. 122.

[802] The question is thus whether there is a correlation between the provisions of the IFHP and the disadvantage suffered by the target group.

[803] The respondents argued at the hearing that any distinctions were tailored to meet the specific needs of subgroups of beneficiaries who get benefits under the IFHP. These "needs" were initially identified by the respondents as being health needs: Transcript, Vol. 2, p. 188, see also the respondents' memorandum of fact and law at para. 122.

[804] However, the fact that some refugee claimants from DCO countries may be in Canada for less time than claimants from non-DCO countries does not mean that their health conditions and health care needs will be any less acute while they are here than the needs of non-DCO claimants. It does not follow that a refugee claimant from Mexico (a DCO country) who arrives in Canada about to give birth necessarily requires less health care than does a pregnant refugee claimant who has come to Canada from Sri Lanka (a non-DCO country).

[805] Indeed, Ms. Le Bris acknowledged in her cross-examination that the respondents have no data that would suggest that the health needs of refugee claimants from DCO countries are any less than those of refugee claimants from non-DCO countries, nor do they have any evidence to suggest refugee claimants from DCO countries are any more able to pay for their health care than are refugee claimants from non-DCO countries: Transcript, questions 105-106.

[806] There is thus no evidence to show that the tiered coverage structure of the IFHP corresponds to the reality of refugee claimants from DCO countries, or to use the language from *Kapp*, that there is a correlation between the distinction drawn in the IFHP and the disadvantage suffered by refugee claimants from DCO countries.

[807] As a consequence, it cannot be said that the distinction between refugee claimants from DCO countries and refugee claimants from non-DCO countries contributes to the stated purpose of "amelioration of the health conditions of refugee claimants, refugees and failed claimants in particular circumstances of need in Canada".

[808] Having failed to demonstrate that the 2012 changes to the IFHP can be saved as an ameliorative program under subsection 15(2) of the Charterinsofar as refugee claimants from DCO countries are concerned, the focus of the analysis returns to subsection 15(1).

[809] The next question for consideration is thus whether the distinction drawn in the IFHP as to the health insurance benefits that are available to refugee claimants from DCO countries relative to those provided to refugee claimants from non-DCO countries creates a disadvantage by perpetuating prejudice or stereotyping, thus violating subsection 15(1) of the Charter.

D. *Do the 2012 OICs Create a Disadvantage by Perpetuating Prejudice or Stereotyping?*

[810] The respondents say that by granting refugee claimants from DCO countries a level of state-funded health insurance coverage, the Governor in Council is not "perpetuating prejudice or stereotyping." Rather, it is simply recognizing that even though these refugee claimants are from countries that are generally safe, "non-refugee producing" nations with health care systems that are comparable to Canada's own, they are deserving of a minimum level of state-funded health care while they are in Canada making a refugee claim.

[811] There are several problems with this argument.

[812] The first problem is with the respondents' starting premise that DCO countries have health care systems that are comparable to that in Canada. The quality or availability of health care is *not* a criterion that is used in designating countries as "Designated Countries of Origin" under *IRPA*, and I have not been directed to any evidence that would demonstrate that the level of health care that is available in, say, Mexico, is comparable to that which is available in Canada.

[813] The second problem with the respondents' argument is that it assumes that a refugee claimant in Canada from a DCO country who develops a serious health condition can simply return home and get the health care that he or she needs in his or her country of origin.

[814] Implicit in this argument is the assumption that there is no merit to the individual's refugee claim and that they are indeed "bogus" refugees (to quote the Minister's spokesperson), with the result that they can safely return home to access the health care that they need.

[815] While this may be true of some claimants from DCO countries, the respondents themselves concede that it is not true of all of them. As was mentioned earlier, the respondents have expressly acknowledged that some claimants from DCO countries do indeed face real persecution in their countries of origin and are in fact genuine refugees.

[816] Indeed, as I have previously noted, the irony of the respondents' argument is that it demonstrates that it is the DCO claimants who cannot return home - those who really are genuine refugees - who are the ones most severely hurt by the cuts to their insurance coverage resulting from the 2012 changes to the IFHP.

[817] The Supreme Court of Canada held in *Auton*, above, that in considering whether a benefit has been conferred in a discriminatory manner where stereotyping of members of the group is at issue, regard must be had to "the purpose of the legislative scheme which confers the benefit and the overall needs it seeks to meet": at para. 42.

[818] The Court observed that "[i]f a benefit program excludes a particular group in a way that undercuts the overall purpose of the program, then it is likely to be discriminatory: it amounts to an arbitrary exclusion of a particular group". On the other hand, if "the exclusion is consistent

with the overarching purpose and scheme of the legislation, it is unlikely to be discriminatory": *Auton*, above at para. 42.

[819] More recently, *Kapp* taught us that in considering the issue of stereotyping, regard had to be had to the degree of correspondence between the differential treatment and the claimant group's reality: above at para. 23.

[820] Finally, as the Supreme Court observed in *Gosselin*, government action that is "closely tailored to the reality of the affected group" is unlikely to discriminate within the meaning of subsection 15(1): above at para. 37.

[821] As was noted earlier, the respondents described the object of the IFHP as being "the amelioration of the health conditions of refugee claimants, refugees and failed claimants in particular circumstances of need in Canada": respondents' memorandum of fact and law at para. 122.

[822] However, the respondents have also conceded that the 2012 IFHP program does not in fact respond to the health needs of the affected individuals. Thus it cannot be said that the changes to the IFHP brought about by the 2012 OICs were "closely tailored to the reality of the affected group". Indeed, the changes to the program *limit* access to core health care services to genuine refugee claimants from DCO countries in a manner that undercuts the stated objective of the program.

[823] The respondents also say that abuse of the IFHP was not the issue, in and of itself, that guided or motivated the 2012 reforms to the program. The changes to the IFHP were, however, made to support the government's overall goal of reforming the refugee process and curtailing abuse of the system. According to the respondents, making changes to the IFHP was but one way in which the government could deter unfounded claims and possibly discourage failed refugee claimants from remaining in Canada when they ought to be leaving the country: Transcript, Vol. 3, at p. 38.

[824] As Ms. Le Bris explained in her affidavit, "the previous IFHP *was perceived by some* as constituting a reason why 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": at para. 73 [my emphasis].

[825] There does not, however, appear to have been any attempt by the government to determine whether the subjective perception on the part of certain unidentified individuals referred to by Ms. Le Bris was in fact justified. Nor has there been any attempt to determine the extent to which, if at all, the availability of state-funded health care operates as a "pull factor" for non-meritorious refugee claimants.

[826] Indeed, it is hard to reconcile the respondents' argument that the availability of health care in Canada operates as a "pull factor" for refugee claimants from DCO countries with their

claim that refugee claimants from DCO countries do not need health insurance coverage while they are in Canada because they can get comparable health care back home.

[827] As was noted earlier, and as will be explained in greater detail in the context of my section 1 analysis, there is also no persuasive evidence before me to show that the changes to the IFHP have themselves served to deter unmeritorious claims, or encouraged anyone to leave Canada more quickly.

[828] What is apparent, however, is that the decision was made by the executive branch of the Canadian government to reduce the level of IFHP benefits for refugee claimants from DCO countries relative to those available to refugee claimants from non-DCO claimants as a result of a belief that refugee claimants from DCO countries are not real refugees at all, but are simply in Canada seeking to "game the system" and abuse the generosity of Canadians.

[829] This was made very clear by the statement made on behalf of the then-Minister of Citizenship and Immigration at the time that the changes to the IFHP were introduced. It will be recalled that the Minister's spokesperson explained the changes in the following terms:

> Canadians have been clear that they do not want *illegal immigrants and bogus refugee claimants* receiving gold-plated health care benefits that are better than those Canadian taxpayers receive. Our Government has listened and acted. We have taken steps to ensure that protected persons and asylum seekers from non-safe countries receive health care coverage that is on the same level as Canadian taxpayers receive through their provincial health coverage, no better. *Bogus claimants from safe countries, and failed asylum seekers, will not receive access to health care coverage unless it is to protect public health and safety…* [my emphasis]

[830] As was noted earlier in my review of the legal principles applicable to section 15 claims, the Court's focus should be on whether the impugned government action has a discriminatory impact. It is not necessary that claimants prove that a distinction perpetuates negative attitudes about them.

[831] That said, both have been established in this case.

[832] Insofar as the discriminatory impact of the 2012 changes to the IFHP are concerned, funding for potentially life-saving medical treatments is made available to refugee claimants from non-DCO countries but is denied to refugee claimants from DCO countries. The 2012 changes to the IFHP have erected additional barriers to accessing basic health care for refugee claimants from DCO countries, clearly perpetuating the hardship suffered by what the respondents have accepted are a vulnerable, poor and disadvantaged group.

[833] Indeed, even though refugee claimants from DCO countries may come from wealthier countries, I do not understand the respondents to dispute that most individual refugee claimants from these countries will nevertheless themselves be vulnerable, poor and disadvantaged. Indeed,

as was previously noted, Ms. Le Bris acknowledged in her cross-examination that the respondents have no evidence suggesting that refugee claimants from DCO countries are any more able to pay for their health care than are refugee claimants from non-DCO countries.

[834] The disadvantage suffered by refugee claimants from DCO countries is, moreover, exacerbated by the fact that recent changes to the *Immigration and Refugee Protection Act* and *Regulations* prohibit them from working for the first 180 days that they are in Canada, further limiting their ability to pay for their own medical treatment: *Immigration and Refugee Protection Regulations*, subsection 206(2).

[835] The interests at stake in this case are significant. I have found as a fact that the distinction drawn between the health insurance benefits available to refugee claimants from non-DCO countries and to refugee claimants from DCO countries puts the lives of claimants in this latter group at risk. Moreover, it sends the clear message that refugee claimants from DCO countries are undesirable, and that their well-being, and indeed their very lives, are worth less than those of refugee claimants from non-DCO countries.

[836] The respondents have acknowledged that in cutting the health insurance benefits for refugee claimants from DCO countries, it is trying to use the hardship that will be suffered by claimants in Canada as a means to an end in deterring others from coming to Canada. Indeed, this is one of the stated objectives of the 2012 changes to the IFHP. This demonstrates a lack of regard for the inherent dignity of these claimants.

[837] The distinction drawn between the health insurance benefits accorded to refugee claimants from DCO and non-DCO countries also serves to further marginalize, prejudice, and stereotype refugee claimants from DCO countries. In particular, it perpetuates the stereotype that refugee claimants from DCO countries are queue-jumpers, "bogus" claimants and cheats who are only here to take advantage of Canada's social benefits and its generosity.

[838] As described by Dr. Anderson in his affidavit, this attitude reflects historical stereotypes that have been ascribed to groups of immigrants identified as "undesirable": stereotypes that have their origins in racism, fear of "others", fear of economic competition, and more recently, fear of criminality and terrorism. By limiting the health insurance benefits that are provided to refugee claimants from DCO countries, the executive branch of the Canadian government is perpetuating the stereotypical view that refugee claimants from these countries are undesirable, thereby reinforcing existing prejudice and disadvantage.

[839] As was noted earlier, the fact is that some refugee claimants from DCO countries are indeed genuine refugees. By way of example, in 2011, the Immigration and Refugee Board accepted 155 refugee claims from Hungary. In 2013, the Board accepted 183 such claims. Having been accepted by the Board as being legitimately in need of refugee protection, these claimants were clearly not queue-jumpers, bogus claimants or cheats.

[840] It is also true that a substantial percentage of refugee claims from DCO countries do not succeed. Does it necessarily follow that these claims were all "bogus", brought by queue jumpers

and cheats seeking to abuse the generosity of Canadians? To suggest that this is the case is to have a grossly simplistic understanding of the refugee process.

[841] Amongst all of the people who come to Canada each year seeking refugee protection there will undoubtedly be some who are in reality economic migrants and those who are using the refugee process in an effort to achieve family reunification. It is, however, both unfair and inaccurate to characterize all failed refugee claimants from DCO countries as "bogus" refugees.

[842] Refugee claims are often brought on the basis of real hardship and genuine suffering. Amongst those whose claims do not succeed will be individuals who may well have come to Canada because of a real fear of persecution in their country of origin, but who were unable to meet the strict legal requirements of the refugee definition.

[843] By way of example, a Roma from Hungary may have experienced a lifetime of discrimination, abuse and marginalization in her country. She may truly dread returning home as a result of her past experiences. The Immigration and Refugee Board may well accept the claimant's story as true, but may conclude that the treatment experienced by the claimant, while discriminatory, did not rise to the level of "persecution". Alternatively, the Board may accept that the claimant had experienced "persecution", but may also find that adequate state protection is available to her in Hungary. Under either scenario, the fact that the refugee claim did not ultimately succeed does not mean that there was anything "bogus" about it.

[844] Similarly, a family targeted for kidnapping and extortion by a drug cartel in Mexico may flee their country, seeking to put as much distance between themselves and their persecutors as possible. The Immigration and Refugee Board may well believe that the family had been targeted by a powerful cartel, and that their terror is indeed genuine. The Board may nevertheless conclude, however, that by the time of the hearing, the family had been away from Mexico for long enough that their persecutors may have lost interest in them, or that the family could live safely in another part of Mexico.

[845] While our hypothetical family's refugee claim may not have succeeded, it does not follow that the claim was necessarily "bogus", that it was made in bad faith, or that it had been brought for an ulterior motive such as a desire to access so-called "gold-plated" health care in Canada.

[846] There are other reasons why a refugee claim may not succeed that have nothing to do with the *bona fides* of the claimant. Using a hypothetical example from a non-DCO country to illustrate the point, a young Tamil man from northern Sri Lanka may have fled his country in 2009, at the height of the civil war, and come to Canada in order to make a refugee claim.

[847] In 2009, a person with the profile of our hypothetical claimant was presumptively a genuine refugee. However, by the time that the refugee claim is heard a couple of years later, the Immigration and Refugee Board could conclude that conditions in Sri Lanka had changed enough that it would now be safe for our claimant to return home. As a result, the claimant

would no longer have a well-founded forward-looking fear of persecution, and his refugee claim would fail. [8]

[848] Once again, the fact that such a refugee claim does not succeed would not mean that it was necessarily a "bogus" claim. Indeed, some failed refugee claimants do in fact go on to gain status in Canada through other processes such as Pre-removal Risk Assessments, or they may be granted humanitarian relief because of the unusual, undeserved and disproportionate hardships that they would face if returned to their countries of origin.

E. *Conclusion on the Subsection 15(1) Issue Relating to DCO Claimants*

[849] For these reasons, I have concluded that the changes made to the IFHP through the promulgation of the 2012 OICs violate subsection 15(1) of theCharter, both in their purpose and in their effect.

[850] The 2012 IFHP draws a distinction between refugee claimants from DCO-countries and those from non-DCO countries, providing a lesser level of health insurance coverage to refugee claimants from DCO countries based upon the national original of these claimants. This distinction cannot be saved as an "ameliorative program" contemplated by subsection 15(2) of the Charter.

[851] The DCO/non-DCO distinction drawn in the IFHP has an adverse differential effect on refugee claimants from DCO countries. It puts their lives at risk and perpetuates the stereotypical view that they are cheats, that their refugee claims are "bogus", and that they have come to Canada to abuse the generosity of Canadians. This aspect of the applicants' section 15 claim thus succeeds.

F. *Does the 2012 IFHP also Violate Subsection 15(1) of the Charter on the Basis of Immigration Status?*

[852] The applicants further submit that the 2012 IFHP also discriminates between asylum seekers generally and other similarly-situated individuals accessing health care in Canada, specifically low-income Canadians. Under the 2012 IFHP, individuals who are legally in Canada for the purpose of seeking protection are now prevented from obtaining the same level of health benefits as are provided to other lawful residents of Canada.

[853] The applicants point out that the extent to which lawful residents who are not seeking the protection of Canada receive state-funded health insurance coverage is determined on the basis of income, which is used as a proxy for need. Low-income residents thus receive a higher level of health insurance benefits than ordinary working Canadians.

[854] In some instances, where additional need is demonstrated, individuals who exceed the income threshold required for social assistance may also be provided with additional support, above and beyond the regular health insurance coverage they would otherwise receive.

[855] In contrast, under the 2012 IFHP, most low-income individuals who are lawfully in Canada seeking its protection no longer receive the same base level of health insurance benefits that are accorded to other low-income legal residents of Canada. According to the applicants, a clear distinction is drawn between individuals legally in Canada seeking its protection and other legal residents of Canada who receive health care. The applicants submit that the 2012 IFHP thus creates a distinction in an individual's entitlement to health insurance coverage based upon their immigration status, which should be recognized as an analogous ground for the purpose of subsection 15(1) of the Charter.

[856] The applicants acknowledge that the jurisprudence relating to immigration status as an analogous ground for the purpose of subsection 15(1) of theCharter is "mixed", but submit that whether or not a person's immigration status constitutes an analogous ground should depend on the nature of the particular immigration status in issue. According to the applicants, being an asylum seeker is not a situation that is marked by choice. As a result, the status of being an asylum seeker should be considered to be an immutable characteristic that qualifies as an analogous ground.

[857] In support of their argument the applicants point out that immigration status was treated as an analogous ground in *Jaballah (Re)*, 2006 FC 115 (CanLII), 2006 FC 115, [2006] F.C.J. No. 110. In that case, this Court concluded that a provision of the *Immigration and Refugee Protection Act* infringed Mr. Jaballah's rights under subsection 15(1) of the Charter on the basis of his immigration status.

[858] The legislation at issue provided that foreign nationals detained under the provisions of a security certificate had no right to a detention review until a determination was made as to the reasonableness of the certificate, whereas permanent residents detained under security certificates had the right to a detention review every six months. As a consequence, the Court ordered that Mr. Jaballah be provided with a detention review on the same basis as a permanent resident similarly detained.

[859] While recognizing that there are other decisions that have rejected immigration status as an analogous ground, the applicants suggest that the issue should be approached on a case-by-case basis, having regard to the particular immigration status at issue. They point out that the Courts have not yet decided whether the status of "individuals legally seeking protection in Canada" constitutes an analogous ground for the purposes of section 15 of theCharter. As will be explained below, I cannot accept the applicants' argument.

[860] First of all, the individuals described collectively in these reasons as "those seeking the protection of Canada" are not merely refugee claimants, but have a range of different immigration statuses. These include protected persons, (including resettled refugees, recognized refugees and positive PRRA recipients), refugee claimants, rejected refugee claimants, victims of human trafficking with temporary resident permits, persons granted permanent residency as part of a public policy or for humanitarian and compassionate reasons by the Minister, and who receive income support through the resettlement assistance program or the equivalent in Québec,

foreign nationals and permanent residents detained under the provisions of the *Immigration and Refugee Protection Act*.

[861] Moreover, the Federal Court of Appeal held in *Toussaint* that "immigration status" does not qualify as an analogous ground under section 15 of theCharter on the basis that it "is not a '[characteristic] that we cannot change'. It is not 'immutable or changeable only at unacceptable cost to personal identity": at para. 99, citing *Corbière*, above at para. 13. See also *Forrest v. Canada (Attorney General)*, 2006 FCA 400 (CanLII), 2006 FCA 400 at para. 16, 357 N.R. 168.

[862] It is true that the Court then went on in *Toussaint* to consider the specific context of the claim being advanced, noting that the "immigration status"at issue in that case - presence in Canada illegally - was "a characteristic that the government has a 'legitimate interest in expecting [the person] to change'": at para. 99.

[863] As I read the decision, however, this statement appears to be a *further* reason for the Court's overall conclusion that "immigration status" does not constitute an analogous ground for the purposes of section 15 of the Charter, and not a basis for limiting the Court's finding to cases where the immigration status in question was illegal presence in Canada.

[864] The Ontario Court of Appeal came to a similar conclusion with respect to immigration status as an analogous ground in *Irshad (Litigation guardian of) v. Ontario (Minister of Health)*, 2001 CanLII 24155 (ON CA), [2001] O.J. No. 648 at paras. 133-136, 55 O.R. (3d) 43 [*Irshad*].

[865] In *Irshad*, the Court was called upon to consider changes made to the *Ontario Health Insurance Plan* which tied the eligibility of some claimants to their status under the *Immigration Act*, R.S.C. 1985, c. I-2.

[866] In concluding that status as a permanent or non-permanent resident of a province was not an analogous ground for the purposes of section 15 of theCharter, the Court observed that "[a] person's status as a non-permanent resident for the purposes of OHIP eligibility is not immutable". In support of this conclusion, the Court noted that "[i]n the course of this litigation, four of the five appellants who were non-permanent residents for the purposes of OHIP eligibility became permanent residents by virtue of changes in their immigration status": *Irshad*, above at para. 136.

[867] For the Ontario Court of Appeal, the fact that an individual's immigration status may be beyond the individual's effective control and may require the intervention of another party before it could be changed did not render that status immutable. The Court noted that the residency status of one appellant would change "if his immigration status changes, *either because he is reclassified or because the Minister grants him landed immigrant status*": *Irshad*, above at para. 136 [my emphasis]. That need for the intervention of a government actor did not, however, serve to render the individual's immigration status immutable.

[868] As was noted earlier, in *Lavoie*, the Supreme Court rejected a context-dependent approach to the identification of analogous grounds. It held that"[o]nce identified, an analogous ground stands as 'a constant marker of potential legislative discrimination' and need not be established again in subsequent cases": above at para. 2, citing *Corbière*, above at paras. 7-10.

[869] If the recognition of an analogous ground stands for all situations and does not have to be re-litigated in every case, it follows that the *refusal* to recognize a particular ground as an analogous ground for the purpose of section 15 of the Charter should also stand for all cases and should not be judicially revisited whenever the issue arises in a different context.

[870] The Federal Court of Appeal has already held that "immigration status" does not qualify as an analogous ground under section 15 of the Charter. That finding is binding on me, and is dispositive of the applicants' argument. Consequently, this aspect of the applicants' section 15 claim will be dismissed.

G. *Conclusions on the Section 15 Issues*

[871] For these reasons, I have concluded that the 2012 IFHP violates section 15 of the Charter inasmuch as it provides a lesser level of health insurance coverage to refugee claimants from DCO countries in comparison to that provided to refugee claimants from non-DCO countries. This distinction is based upon the national origin of the refugee claimants and does not form part of an ameliorative program. It is, moreover, based upon stereotyping, and serves to perpetuate the disadvantage suffered by members of an admittedly vulnerable, poor and disadvantaged group.

[872] I have not, however, been persuaded that the 2012 IFHP violates subsection 15(1) of the Charter based upon the immigration status of those seeking the protection of Canada. Consequently, this aspect of the applicants' section 15 claim will be dismissed.

XIII. Have the Breaches of Sections 12 and 15 been Justified by the Respondents under Section 1 of the Charter?

[873] Section 1 of the Charter provides that "[t]he Canadian Charter of Rights and Freedoms guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society".

[874] Unlike the other provisions of the Charter, where the onus is on Charter claimants to establish a breach of the right in issue, the onus is on the respondents to establish a justification for the breaches of sections 12 and 15 that have been established by the applicants: *Bedford*, above at para. 126.

[875] The respondents say that the changes to the IFHP created pursuant to the 2012 OICs are reasonable limits prescribed by law which are demonstrably justified in Canada's free and democratic society. In support of this contention, the respondents cite the Supreme Court's decision in *Chaoulli*, where it observed that "[a]s we enter the 21st century, health care is a

constant concern…[t]he demand for health care is constantly increasing…no one questions the need to preserve a sound public health system": above at paras. 2, 14 and 104.

[876] The respondents further note that governments have finite resources to spend on health care for everyone present in Canada, including Canadian citizens, permanent residents, refugee claimants, refugees, failed claimants and those with no legal status or claims whatsoever. It is "impractical", they say, for governments to fund all of the health services that everyone in Canada may seek. As a consequence, "difficult and potentially unpopular choices" have to be made.

[877] The respondents submit that the Supreme Court has told Canadians they must accept such choices, even though they have Charter rights: citing*Auton*, above at paras. 35 and 41. According to the respondents, the applicants must similarly accept the choices made in the IFHP that affect them: respondents' memorandum of fact and law, at paras. 128-29.

A. *Legal Principles Governing Section 1 of the Charter*

[878] According to the Supreme Court, "[t]he question of justification on the basis of an overarching public goal is at the heart of s. 1" of the Charter. This section addresses "whether the negative impact of a law on the rights of individuals is proportionate to the pressing and substantial goal of the law in furthering the public interest": both quotes from *Bedford*, above at para 125.

[879] Moreover, as the Supreme Court observed in *A.G. v. A.*, the public policy basis for government action in issue is "central to the s. 1 inquiry": above at para. 421; see also *Andrews*, above at pp. 177-78.

[880] I understand the parties to agree that the test to be applied by this Court in determining whether the 2012 changes to the IFHP are saved by section 1of the Charter is that first articulated by the Supreme Court of Canada in *R. v. Oakes*, 1986 CanLII 46 (SCC), [1986] 1 S.C.R. 103, [1986] S.C.J. No. 7.

[881] That is, in order to establish a section 1 justification, the respondents must demonstrate that:

1) the objectives of the 2012 changes to the IFHP are pressing and substantial; and that

2) the impairment of the rights at issue is proportional to the importance of those objectives in that

   a) the means chosen are rationally connected to the objectives of the program;

b) the means chosen impair the Charter rights minimally or "as little as possible"; and

c) there is a proportionality between any deleterious effects of the program and its salutary objectives, so that the attainment of the goal of the program is not outweighed by the abridgment of the rights in question.

See *Oakes* at paras. 69 and 70. See also *R. v. Edwards Books & Art Ltd*., 1986 CanLII 12 (SCC), [1986] 2 S.C.R. 713, [1986] S.C.J. No. 70; *RJR-MacDonald Inc.*, above; and *Divito*, above at para. 68.

[882] As the Supreme Court observed in *Eldridge*, "where the legislation [or in this case, the program] under consideration involves the balancing of competing interests and matters of social policy, the *Oakes* test should be applied flexibly, and not formally or mechanistically": above at para. 85.

[883] With these principles in mind, I will next identify the objectives of the 2012 OICs, and consider whether these objectives are pressing and substantial.

B. *What were the Objectives of the Changes to the IFHP Brought About by the 2012 OICs?*

[884] In order to identify the objectives of the government action in issue, the Court must examine the nature of the social problem addressed by the 2012 OICs. The context of the impugned government action "is also important in order to determine the type of proof which a court can demand of the legislator to justify its measures under s. 1": see *Thomson Newspapers Co. v. Canada (Attorney General)*, 1998 CanLII 829 (SCC), [1998] 1 S.C.R. 877 at paras. 87and 88, [1998] S.C.J. No. 44.

[885] Relevant contextual factors may include the nature of the harm addressed, the vulnerability of the group protected, subjective fear and apprehension of harm, and the nature and importance of the infringed activity: see *R. v. Bryan*, 2007 SCC 12 (CanLII), 2007 SCC 12, at para. 10, 2007 SCC 12 (CanLII), [2007] 1 S.C.R. 527. See also *Thomson Newspapers Co.*, above, and *Harper v. Canada (Attorney General)*, 2004 SCC 33 (CanLII), 2004 SCC 33, [2004] 1 S.C.R. 827.

[886] It will be recalled that in the context of their subsection 15(2) argument, the respondents argued that the IFHP is a government program that has as its object the amelioration of the health conditions of refugee claimants, refugees and failed claimants in particular circumstances of need in Canada: respondents' memorandum of fact and law, at para. 122.

[887] However, the respondents also contend that the 2012 IFHP "is *not* a program that has *as its focus* the treatment of people's illnesses and conditions"[my emphasis]. While recognizing that it provides funded access to health care, the respondents say that this is not the sole purpose of the modified IFHP. According to the respondents, "you have to look at the IFHP in the

context of refugee law and the reality of refugee claims and processing deportations and removals and what the government was trying to do in a broad sense". As a consequence, changes made to the IFHP may have nothing to do with the health of the people who benefit from the program, but may relate instead "to the government's broader goals in the area of immigration and refugee law":Transcript, Vol. 2, pp. 189-191.

[888] The respondents submit that the federal government has reformed Canadian immigration and refugee legislation with several broad public policy goals in mind. These include reducing the time taken to decide refugee claims, and reducing the strains on the Immigration and Refugee Board, in part by addressing its significant backlog.

[889] Other policy goals include reducing the multiple forms of recourse available to failed refugee claimants, facilitating timely removals of those with no right to be or remain in Canada, and deterring possible abuse of the refugee determination system by individuals from "safe, non-refugee producing"countries.

[890] According to the respondents, abuse of the IFHP, in and of itself, was not the predominant issue which guided or motivated the reform. Rather, the IFHP was reformed in 2012 in order to complement and accord with the government's broad public policy goals and accompanying legislative changes in the areas of immigration and refugee protection.

[891] The respondents say that the 2012 changes to the IFHP are consistent with, and complementary to Parliament's goals of accelerating the processing of refugees, removing failed refugees from Canada faster, and dissuading migration to Canada for the purpose of making unfounded claims: Dikranian affidavit at paras. 55-56.

[892] The press release accompanying the announcement of the April 2012 OIC identifies several parallel goals underlying the changes to the IFHP. These include cost containment, fairness to Canadian taxpayers, and the protection of public health and safety. Defending the integrity of Canada's immigration system was also identified as a further objective of the changes.

[893] Thus, the 2012 changes to the IFHP must be viewed in context as forming part of a larger government program of reform to the immigration and refugee system. Within that broader context, the specific objectives of the 2012 OICs may be summarized as being:

1. Cost containment;

2. Fairness to Canadians;

3. The protection of public health and safety; and

4. The protection of the integrity of Canada's immigration system.

[894] The next question to be addressed is whether these goals are "pressing and substantial".

C. *Are the Objectives of the 2012 changes to the IFHP "Pressing and Substantial"?*

[895] As Chief Justice McLachlin observed in *A.G. v. A*, in order to satisfy the section 1 test, the onus is on the respondent to demonstrate "a sufficiently important objective to justify an infringement of a Charter right": above at para. 434. Indeed, "[b]ecause the question is whether the broader public interest justifies the infringement of individual rights, the law's goal must be pressing and substantial": *Bedford*, above at para. 126.

[896] As will be explained below, I am satisfied that some, but not all of the objectives of the 2012 changes to the IFHP do qualify as "pressing and substantial" objectives.

(1) Cost Containment

[897] The first question is whether the goal of "cost containment" can be said to be a "pressing and substantial" government objective.

[898] The respondents' submissions on this point were very brief. Reference was made to evidence contained in Ms. Le Bris' affidavit indicating that the cost of providing health care in Canada generally increased by about 25% between 2005 and 2010, during which period, the number of IFHP beneficiaries continued to rise. The categories of individuals covered under the IFHP also expanded.

[899] The respondents further note that the average period of IFHP eligibility rose over time. In 2003, it was 548 days, on average. By 2012, that number had almost doubled.

[900] According to an explanatory note accompanying the publication of the April 2012 OIC in the *Canada Gazette*, the government anticipated saving $70 million in the first three years of the new program, and $15 million in each fiscal year thereafter.

[901] The respondents submit that "this is not insignificant for CIC and for the federal government", and that "cost containment is a sufficiently important objective [to be considered pressing and substantial], particularly in times of fiscal constraint": Transcript, Vol. 3, p. 137.

[902] Controlling costs is clearly a central responsibility of governments as guardians of the public purse. Does it follow that a policy objective of containing costs within a given government department is necessarily a pressing and substantial one for the purposes of a section 1 Charter analysis?

[903] The Supreme Court has on several occasions considered the extent to which the issue of cost can be considered to be a "pressing and substantial"objective in the context of a section 1 Charter analysis.

[904] In *Nova Scotia (Workers' Compensation Board) v. Martin*, 2003 SCC 54 (CanLII), [2003] 2 S.C.R. 504, 2003 SCC 54, the Court observed that"[b]udgetary considerations in and of

themselves cannot normally be invoked as a free-standing pressing and substantial objective for the purposes of s. 1of the Charter": at para. 109.

[905] The Court did, however, find that budgetary considerations were a "pressing and substantial" objective in *Newfoundland (Treasury Board) v. N.A.P.E.*, 2004 SCC 66 (CanLII), 2004 SCC 66, [2004] 3 S.C.R. 381 [*N.A.P.E.*]. In that case, the Court had to determine whether a legislative provision that had the effect of extinguishing a pay equity settlement, thereby breaching the section 15 Charter rights of the beneficiaries of the settlement, could be justified under section 1 of the Charter.

[906] In concluding that a section 1 justification had been established by the Government of Newfoundland, the Supreme Court had regard to its comment in *Martin* that budgetary considerations cannot *normally* be invoked as a free-standing pressing and substantial objective for the purposes of section 1 of theCharter. The Court went on, however, to note that the evidence before it demonstrated that "[t]he spring of 1991 was not a 'normal' time in the finances of the provincial government". Indeed, the Court was satisfied that at the time that the legislation in issue was enacted, the province was facing a financial crisis: *N.A.P.E.*, above at paras. 59-62.

[907] The Supreme Court went on to observe that "[a]t some point, a financial crisis can attain a dimension that elected governments must be accorded significant scope to take remedial measures, even if the measures taken have an adverse effect on a Charter right, subject, of course, to the measures being proportional both to the fiscal crisis and to their impact on the affected Charter interests": *N.A.P.E.*, above at para. 64.

[908] In contrast, while the respondents in this case made passing reference to these being "times of fiscal constraint", there was no suggestion that Canada is currently in a state of financial crisis as was the case in *N.A.P.E.*

[909] That said, the Court went on in *N.A.P.E.* to state that while financial cost alone will not ordinarily create a pressing and substantial objective for the purposes of section 1 of the Charter, "financial considerations wrapped up with other public policy considerations *could* qualify as sufficiently important objectives under s. 1": at para. 69, emphasis in the original.

[910] Thus it appears that where cost is the only objective of the government action in issue, cost containment will only be considered to constitute a pressing and substantial government objective in extreme situations.

[911] Given that cost containment is only one of several goals of the 2012 changes to the IFHP, and was accompanied by other policy objectives, I am prepared to accept that it is a pressing and substantial government objective. I will, however, return to consider the respondents' financial arguments under both the "minimal impairment" and "proportionality" components of the section 1 analysis.

(2) Fairness to Canadians

[912] Insofar as the "fairness to Canadians" argument is concerned, I accept that ensuring that Canadians are treated fairly in comparison to how non-Canadians are treated could, in some cases, constitute a pressing and substantial governmental objective. I am not, however, persuaded that seeking"fairness for Canadians" constitutes a "pressing and substantial" government objective in this case, simply because it has not been established that there was anything unfair to Canadians about the pre-2012 IFHP.

[913] The respondents say that to be fair to Canadians, most IFHP beneficiaries should receive health care benefits that are equal to government-funded provincial or territorial health insurance plans available to working Canadians who are not receiving social assistance. Fairness to Canadians further requires that the level of taxpayer-funded coverage provided by Canada to IFHP recipients should diminish if a refugee claim is withdrawn, abandoned, suspended or rejected.

[914] Finally, the respondents say that in order to be fair to Canadians, some IFHP beneficiaries receiving government assistance should receive enhanced benefits, equal to what Canadians receiving certain forms of government assistance receive.

[915] Dealing with the respondents' first "fairness" argument, Ms. Le Bris' affidavit explains that "[o]ne of the key underlying 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": at para. 50.

[916] Similarly, the April 25, 2012 press release accompanying the announcement of the April 2012 OIC quotes the then-Minister of Citizenship and Immigration explaining that "we do not want to ask Canadians to pay for benefits for protected persons, refugee claimants and others that are more generous than what they are entitled to themselves".

[917] It will be recalled that the statement made on behalf of the then-Minister shortly after the 2012 changes to the IFHP came into effect also addressed this "fairness to Canadians" issue, stating that "Canadians have been clear that they do not want illegal immigrants and bogus refugee claimants receiving gold-plated health care benefits that are better than those Canadian taxpayers receive".

[918] The respondents elaborated on this at the hearing, explaining that under the pre-2012 IFHP, all program beneficiaries received more publicly funded health care insurance benefits than were received by Canadians under their provincial or territorial plans. This included insurance benefits for virtually all their health care needs, including optometry, dental, prescription medication, nursing visits, long term care, rehabilitative care, and ambulatory services - benefits that are not ordinarily available to working Canadians through provincial and territorial health-insurance plans.

[919] As was noted earlier, there is no dispute about the fact that those seeking the protection of Canada are generally economically disadvantaged. Under the pre-2012 IFHP, individuals who were able to satisfy a means test were entitled to a level of health insurance coverage that provided them with health care benefits that were roughly equivalent to those afforded to low-income Canadians through provincial or territorial health insurance plans.

[920] The pre-2012 IFHP thus provided low-income individuals seeking the protection of Canada with a level of health insurance coverage that was comparable to that provided to similarly-situated Canadians. There was nothing unfair about this.

[921] This aspect of the respondents' "fairness to Canadians" argument is thus based upon a flawed premise: namely, that there was something "unfair to Canadians" about the pre-2012 IFHP. In the absence of any demonstrated unfairness to Canadians resulting from the provisions of the pre-2012 IFHP, there was no question of "fairness to Canadians" that could constitute a "pressing and substantial" objective of the government action in issue.

[922] The respondents contend that the objective of "fairness to Canadians" also took into account that individuals who have abandoned or withdrawn their refugee claims should not be entitled to publicly funded health insurance benefits under the IFHP. I do not need to address this argument as the applicants are not challenging this aspect of the 2012 changes to the IFHP.

[923] The respondents also say that the objective of "fairness to Canadians" means that persons not in need of Canada's protection - those who have been determined not to be refugees - should not be the beneficiaries of publicly funded health insurance benefits under the IFHP.

[924] Ms. Le Bris explains this policy objective in her affidavit, stating that "[a]nother important element of this 'fairness' requirement supporting the IFHP reforms was that persons found not to be in need of protection by Canada should not be granted the same level of health coverage as those who could be refugees (refugee claimants) or have been found to be refugees by the IRB": at para. 56.

[925] To the extent that this is really an argument that Canadians should not be expected to *pay* for health insurance coverage for failed refugee claimants, the argument is better addressed in the context of the objective of cost containment. Suffice it to say in the present context, that it is not readily apparent how it is *unfair* to Canadians that those individuals seeking the protection of Canada receive health insurance coverage for core health care services and products for as long as they are in compliance with Canadian immigration and refugee laws.

[926] This is especially so when one considers that some failed refugee claimants will ultimately succeed in obtaining the protection of Canada through the Pre-removal Risk Assessment process. Other failed claimants may be unable to leave Canada until such time as travel documents are obtained from their country of origin. Still others, like Mr. Ayubi, may come from moratorium countries, where the Government of Canada has determined that the conditions are simply too dangerous to allow them to return home.

[927] Finally, the respondents assert that in order to be fair to Canadians, some IFHP beneficiaries receiving government assistance should receive enhanced benefits equal to what Canadians receiving certain forms of government assistance receive. It is not, however, clear how it is any *fairer* to Canadians that most government-assisted refugees and some privately-sponsored refugees receive Expanded Health Care Coverage, while other privately-sponsored refugees and refugee claimants only receive Health Care Coverage or Public Health and Public Safety Coverage.

[928] As a consequence, I have not been persuaded that seeking "fairness for Canadians" constitutes a "pressing and substantial" government objective in this case

(3) Protecting Public Health and Public Safety

[929] I accept the respondents' contention that safeguarding public health and public safety is a pressing and substantial government objective. Whether the changes to the IFHP actually have this effect is a question that I will address under the "rational connection" component of the analysis.

(4) Protecting the Integrity of Canada's Immigration System

[930] Finally, the applicants accept that there is abuse in the refugee system and have expressly conceded that preserving the integrity of Canada's immigration system is a pressing and substantial objective.

[931] The respondents have, moreover, provided evidence of the significant number of refugee claims that are rejected each year by the Immigration and Refugee Board, particularly those emanating from countries that have been identified as Designated Countries of Origin.

[932] I am thus satisfied that the protection of the integrity of Canada's immigration system is a pressing and substantial governmental objective.

D. *Is the Impairment of the Charter Rights at Issue Proportional to the Importance of the Objectives of the 2012 OICs?*

[933] Having identified the objectives of the 2012 changes to the IFHP, and having determined that at least some of these objectives are pressing and substantial, the analysis then moves on to the second phase of the *Oakes* test. At this stage the question is whether the impairment of the section 12 andsection 15 rights at issue in this case is proportional to the importance of the government's objectives: that is, whether the means chosen by the Governor in Council to achieve its objectives are proportional or appropriate to the ends.

[934] Put another way, the task for the Court at this stage of the inquiry is to determine whether impugned legislation is "carefully designed, or rationally connected, to the objective". Legislation "must impair the right in issue as little as possible", and the effect of the legislation "must not so severely trench on individual or group rights that the legislative

objective, albeit important, is nevertheless outweighed by the abridgment of rights": *R. v. Edwards Books*, above at para.117.

[935] The three branches of the proportionality component of the *Oakes* test have been usefully described as concerning the *logical* (rational connection), the *careful* (minimal impairment) and the *just* (balancing/proportionality): Guy Davidov, "*Separating Minimal Impairment from Balancing: A Comment on R. v. Sharpe* (B.C.C.A.)" (2000) 5 Rev. Const. Stud. 195.

[936] Context infuses every aspect of this component of the *Oakes* test: *Health Services and Support - Facilities Subsector Bargaining Assn. v. British Columbia*, above at para. 195.

[937] In assessing whether the impairment of the sections 12 and 15 Charter rights at issue in this proceeding is proportional to the importance of the objectives of the 2012 changes to the IFHP, the first question is whether there is a rational connection between the policy objectives of the Governor in Council and the means that were chosen to attain those objectives. This issue will be considered next.

(1) Are the 2012 Changes to the IFHP Rationally Connected to the Objectives of the Governor in Council?

[938] As the Supreme Court observed in *Bedford*, "[t]he 'rational connection' branch of the s. 1 analysis asks whether the law was a rational means for the legislature to pursue its objective": above at para. 126.

[939] That is, the respondents must show that reducing the level of health insurance coverage for some classes of individuals seeking the protection of Canada and eliminating it altogether for others is rationally connected to the four identified goals of the Governor in Council in modifying the IFHP. The burden on the respondents to show a rational connection between its means and its ends is "is not a heavy one": *A.G. v. A.*, above at para. 359.

[940] To establish the existence of such a rational connection, the party invoking section 1 of the *Charter* must demonstrate "a causal connection between the infringement and the benefit sought on the basis of reason or logic": *RJR-MacDonald Inc.*, above at para. 153.

[941] As the Supreme Court explained in *Alberta v. Hutterian Brethren of Wilson Colony*, 2009 SCC 37 (CanLII), 2009 SCC 37, [2009] 2 S.C.R. 567 [*Hutterian Brethren*], "[t]he rational connection requirement is aimed at preventing limits being imposed on rights arbitrarily. The government must show that it is *reasonable to suppose* that the limit may further the goal, not that it will do so": at para. 48, my emphasis.

[942] As Chief Justice Dickson observed in *Canada (Human Rights Commission) v. Taylor*, 1990 CanLII 26 (SCC), [1990] 3 S.C.R. 892, [1990] S.C.J. No. 129, "... as long as the challenged provision can be said to further *in a general way* an important government aim it cannot be seen as irrational": at para. 56, my emphasis.

[943] With this understanding of the relevant legal principles, I turn now to consider the 2012 changes to the IFHP in light of each of the Governor in Council's four underlying objectives.

(a) *Cost Containment*

[944] Dealing first with the objective of "cost containment", as will be discussed further on in these reasons, there are significant problems with the evidence adduced by the respondents as to the cost savings that will allegedly be achieved as a result of the 2012 changes to the IFHP. Suffice it to say at this juncture that to the extent that one of the objectives of the changes to the IFHP was cost containment, it has not be demonstrated that the 2012 changes to the IFHP will in fact result in any real savings to Canadian taxpayers.

[945] That said, the effect of the 2012 changes to the IFHP has been to reduce the number of people eligible for benefits under the IFHP. The 2012 OICs also cut the level of health insurance coverage provided by the federal government to the vast majority of those seeking the protection of Canada, and eliminated it altogether for individuals who are only entitled to a PRRA. To that extent, it is reasonable to suppose that the cuts may result in a reduction of costs *to the program*, and the changes to the IFHP are thus rationally connected to the goal of cost containment.

(b) *Fairness to Canadians*

[946] The second objective of the 2012 changes to the IFHP identified by the respondents is "fairness to Canadians". In other words, the intention of the Governor in Council was to put in place a program that did not provide more generous benefits than those that are received by working Canadians.

[947] I have already explained why this argument is based upon a faulty premise inasmuch as there was no unfairness to Canadians arising out of the pre-2012 IFHP. However, even if I had accepted that such unfairness existed, I have also not been persuaded that the changes made to the IFHP in 2012 could rationally be seen to address that unfairness.

[948] That is, it is no fairer to Canadians to now provide vulnerable, poor and disadvantaged asylum seekers with a level of health insurance coverage that is comparable to that available to working Canadians.

[949] Canadians are also not treated any more fairly because refugee claimants from DCO countries, and failed refugee claimants who are still in compliance with Canadian immigration and refugee laws, are now denied any health insurance coverage whatsoever, unless it is for a condition that endangers public health or public safety.

[950] Nor is it somehow fairer to Canadians that those only entitled to a PRRA receive no health insurance coverage whatsoever, even if they suffer from a health condition that puts the health and safety of those same Canadians at risk. This is not a hypothetical concern: for example, the respondents' own witness acknowledged the high incidence of tuberculosis in the refugee population: see Le Bris affidavit at para. 67.

[951] Moreover, a City of Toronto study entitled "*Health Impacts of Reduced Federal Health Services for Refugees*", states that Canadian research has shown that "refugees face increased health risks as a result of infectious and communicable diseases, including mortality form infectious and parasitic diseases and hepatitis": at p. 6.

[952] The government may well have an interest in seeing that Canadians are treated fairly. However, given the absence of any evidence that the pre-2012 IFHP was unfair to Canadians or that the 2012 IFHP is any fairer to Canadians, the respondents have failed to establish that the 2012 changes to the IFHP are rationally connected to the goal of achieving fairness for Canadians.

(c) *Protecting Public Health and Safety*

[953] To the extent that the 2012 IFHP continues to provide health insurance coverage to those involved in the refugee determination process for conditions that pose a risk to public health or public safety, it could be said that it is rationally connected in a general way to the objective of protecting public health and safety.

[954] However, I agree with the applicants that concerns about the extent of their health insurance coverage may well deter some IFHP beneficiaries, particularly those from DCO countries, from seeking medical treatment for health conditions that may turn out to be communicable diseases, thereby potentially jeopardizing public health.

[955] Indeed, as Dr. Rachlis observed, denial of coverage for routine primary health care service will inevitably lead to reduced contact with health care services: affidavit at para. 35.

[956] The result of this is that if, for example, impecunious failed refugee claimants or refugee claimant parents from a DCO country have a child with a cough, they may be reluctant to take the child to see a doctor because of the restricted nature of the family's health insurance coverage and their limited financial resources. If it subsequently turns out that the cause of the child's cough was tuberculosis, the child's classmates, friends and teachers may have already been infected by the child, thereby jeopardizing the public health and safety of Canadians.

[957] Moreover, as Mr. Bradley pointed out, there are other communicable health conditions such as conjunctivitis, head lice, scabies and diarrhoea, all of which can jeopardize the health of school children, in particular. These conditions are *not* on the list of communicable diseases for which treatment will be available under the Public Health and Public Safety component of the 2012 IFHP: Bradley affidavit at para. 11.

[958] This means that children affected with these ailments may be banned from school under school board policies, thus perpetuating their disadvantage. It also means that they may infect other children as a result of their untreated conditions, thereby jeopardizing the public health and safety of Canadian children.

[959] While the problem appears to have now been resolved, I would also note that the 2012 IFHP originally limited coverage for doctors' visits and diagnostic testing in a way that impeded the ability of doctors to determine whether a patient did, in fact, suffer from a condition that posed a risk to public health or public safety and was covered by the IFHP.

[960] Moreover, as was noted earlier, one of the 2012 changes to the IFHP was to *take away* every form of previously-offered health insurance coverage for those only entitled to a PRRA, including coverage for the diagnosis and treatment of health conditions such as tuberculosis or HIV – conditions that can pose a risk to public health or public safety.

[961] The respondents explain that the IFHP was not intended to provide benefits to everyone seeking protection in Canada. According to the respondents, a policy decision was made to link IFHP eligibility to the refugee determination process. Because PRRA-only applicants do not go before the Immigration and Refugee Board, they are no longer eligible for IFHP benefits.

[962] That may be so, but what is at issue at this stage of the analysis is whether the means chosen by the Governor in Council in making the 2012 changes to the IFHP are rationally connected to their objectives. Inasmuch as the decision was made to take health insurance coverage for the diagnosis and treatment of health conditions that pose a risk to public health or public safety *away* from those individuals who are only entitled to a PRRA, that decision cannot be said to be rationally connected to the objective of protecting public health and safety.

(d) *Protecting the Integrity of Canada's Immigration System*

[963] The final objective of the 2012 changes to the IFHP is the protection of the integrity of Canada's immigration system.

[964] According to the respondents, the 2012 changes to the IFHP limit or take away an incentive for individuals, particularly those from Designated Countries of Origin, to come to Canada and make refugee claims, and may encourage unsuccessful refugee claimants to leave the country more rapidly.

[965] The evidentiary foundation for this argument is found in paragraph 73 of the affidavit of Sonia Le Bris. It will be recalled that Ms. Le Bris has been the Acting Director of Migration Health Policy and Partnerships within CIC's Health Branch since June 2011.

[966] As noted earlier, Ms. Le Bris explained that "the previous IFHP *was perceived by some* as constituting a reason why 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" [my emphasis].

[967] I find it troubling that the respondents seek to justify actions that I have found to be cruel, inhumane and discriminatory by relying on the subjective perceptions of unidentified individuals.

[968] As I have already noted, no attempt appears to have been made by the government to determine whether this subjective perception is in fact objectively justified. Ms. Dikranian (the Manager of Asylum Policy in the Refugee Affairs Branch of Citizenship and Immigration Canada during the relevant period) confirmed that she was not aware of any studies having been carried out by the federal government in an effort to determine if there was*any* objective validity to this perception: Dikranian cross-examination, question 210.

[969] Not only have I not been provided with any empirical evidence on this point, I have also not been provided with any evidence as to why such empirical evidence could not be obtained by the respondents.

[970] The respondents argued at the hearing that evidence of this nature would not be available as no one was going to admit that they came to Canada in order to access state-funded health care. Instead, the respondents urge me to simply rely on "reason and logic" in this regard.

[971] In support of this contention, the respondents point to the Supreme Court's decisions in cases such as *Libman v. Quebec (Attorney General)*, 1997 CanLII 326 (SCC), [1997] 3 S.C.R. 569 at para. 39, [1997] S.C.J. No. 85, and *RJR-MacDonald Inc.*, above, where the Supreme Court observed that scientific proof is not always required in order for a government to establish a section 1 justification on a balance of probabilities. The Court observed in*RJR-MacDonald Inc.* that "the balance of probabilities may be established by the application of common sense to what is known, even though what is known may be deficient from a scientific point of view": at p. 333.

[972] The respondents have not, however, established that asking those seeking the protection of Canada whether access to state-funded health care operated as a "pull" factor in their case would be the only way to measure the extent to which access to state-funded health care operates as an incentive for people to come to Canada in order to advance unmeritorious refugee claims or to remain in this country for longer than they would otherwise have done, once those claims have been rejected.

[973] As was discussed in the course of the hearing, one potential way to determine whether this perception is objectively supported would be to look at epidemiological research as to the incidence of chronic illnesses such as diabetes in the refugee population in Canada as compared to the incidence of the same illnesses within the equivalent population in the claimants' countries of origin.

[974] Evidence showing that a disproportionate number of those seeking the protection of Canada suffer from chronic diseases could provide at least *some*objective circumstantial evidence regarding the extent to which the availability of state-funded health care operates as an incentive for people to come to or remain in Canada.

[975] The respondents' arguments as to the incentive provided by state-funded health insurance coverage are also inconsistent with other arguments that they have made in this case.

[976] I have already noted that the respondents' claim that the availability of health care in Canada operates as a "pull factor" for refugee claimants from DCO countries is difficult to reconcile with their argument that refugee claimants from DCO countries do not need health insurance coverage while they are in Canada because they can get comparable health care back home.

[977] The respondents also argued that the cuts to the IFHP are defensible as there are numerous alternative ways that those seeking the protection of Canada can access medical care, such as community health clinics and hospital emergency rooms. I did not accept this argument. However, if it were true that there are indeed satisfactory alternatives readily available to those seeking the protection of Canada, it is difficult to see how changing the IFHP would deter anyone from coming to Canada.

[978] I will return to my concerns with respect to the frailties in the respondents' evidence on this point when I examine the issues of minimal impairment and proportionality.

[979] However, we know from the Supreme Court's decision in *Hutterian Brethren* that all that is required at the "rational connection" stage is that it be"reasonable to suppose" that the changes to the IFHP may further the government's goal of preventing abuse of the immigration system, "not that it will do so", above at para. 48.

[980] We know from reading the Immigration and Refugee Board's decision in Mr. Ayubi's case that one of the reasons he left Afghanistan and came to Canada was his fear about his continued ability to access medication for his diabetes in Afghanistan. While that may not have been the only reason that Mr. Ayubi came to Canada, the availability of medical care in this country does appear to have played a role in his decision.

[981] It is also reasonable to assume that Mr. Ayubi is not alone, and that the availability of state-funded health care may provide something of an incentive for at least some individuals to come to Canada, although we have no evidence as to the extent to which this may be a consideration.

[982] We also know that the unavailability of medical care in other countries can and has provided an incentive for some individuals to seek to stay in Canada after their refugee claims have failed: see, for example, *Covarrubias*, above.

[983] As a consequence, I am satisfied that the 2012 changes to the IFHP are rationally connected to the objective of protecting the integrity of Canada's refugee determination system and deterring its abuse.

(2) Do the 2012 Changes to the IFHP Impair Charter Rights Minimally or "As Little as Possible?

[984] The next stage of the *Oakes* analysis requires the Court to examine whether the changes made to the IFHP through the 2012 OICs impair the*Charter* rights of those seeking the

protection of Canada minimally or "as little as reasonably possible in order to achieve the legislative objective": *RJR-MacDonald Inc.*, above at para. 160. See also *A.G. v. A.*, above at para. 360, *R. v. Edwards Books*, above at para. 117.

[985] In *Hutterian Brethren*, the Supreme Court observed that the question at this stage of the analysis is "whether the limit on the right is reasonably tailored to the pressing and substantial goal put forward to justify the limit". That is, the Court must consider "whether there are less harmful means of achieving the legislative goal": above at para. 53.

[986] Courts must, however, accord governments "a measure of deference, particularly on complex social issues where the legislature may be better positioned than the courts to choose among a range of alternatives": *Hutterian Brethren*, above at para. 53.

[987] Indeed, in *A.G. v. A.*, Chief Justice McLachlin observed that "the state must have a margin of appreciation in selecting the means to achieve its objective": at para. 439. That said, this deference "is not blind or absolute": para. 63.

[988] In *RJR-MacDonald Inc.*, the Supreme Court held that in order for an impairment to be "minimal", the legislative or policy choice of the government"must be carefully tailored so that rights are impaired no more than necessary". The Court acknowledged that the tailoring process may not be perfect, but that if the government action "falls within a range of reasonable alternatives, the courts will not find it overbroad merely because they can conceive of an alternative which might better tailor objective to infringement": above at para. 160.

[989] Where, however, "the government fails to explain why a significantly less intrusive and equally effective measure was not chosen, the law may fail": *RJR-MacDonald Inc.*, above at para. 160.

[990] The Court further explained in *Hutterian Brethren* that there is an "internal limitation" within the minimal impairment test, given that the test"requires only that the government choose the least drastic means of achieving its objective", whereas other, less drastic means that do *not* achieve the stated objectives are not considered at this stage: above at para. 54, emphasis in the original.

[991] In conducting a 'minimal impairment' analysis, a Court "need not be satisfied that the alternative would satisfy the objective to *exactly* the same extent or degree as the impugned measure": *Hutterian Brethren*, above at para. 55, emphasis in the original.

[992] The Supreme Court went on in the same paragraph in *Hutterian Brethren*, however, to state that Courts "should not accept an unrealistically exacting or precise formulation of the government's objective which would effectively immunize the law from scrutiny at the minimal impairment stage".The Court further noted that "[t]he requirement for an 'equally effective' alternative measure … should not be taken to an impractical extreme", and"includes alternative measures that give sufficient protection, in all the circumstances, to the government's

goals", citing *Charkaoui v. Canada (Citizenship and Immigration)*, 2007 SCC 9 (CanLII), 2007 SCC 9, [2007] 1 S.C.R. 350.

[993] The Court concluded in *Hutterian Brethren* by noting that "[t]he test at the minimum impairment stage is whether there is an alternative, less drastic means of achieving the objective in a real and substantial manner": above at para. 55.

[993] The Court concluded in *Hutterian Brethren* by noting that "[t]he test at the minimum impairment stage is whether there is an alternative, less drastic means of achieving the objective in a real and substantial manner": above at para. 55.

[994] Given my earlier conclusions with respect to the objectives of "fairness to Canadians" and the protection of public health and safety, it is clear that the impairment of the rights at issue is not responsive to, and goes well beyond what could be justifiably necessary to advance these two goals.

[995] The question for the Court is thus whether the means chosen by the Governor in Council to achieve its remaining goals of cost containment and the protection of the integrity of Canada's immigration system were reasonably tailored to address the problems of escalating costs and abuse of the immigration system: *Hutterian Brethren*, above at para. 56.

[996] Can it be said that the 2012 changes to the IFHP impair the section 12 and 15 *Charter* rights of those seeking the protection of Canada minimally or"or as little as is reasonably possible" in order to achieve the objectives of the Governor in Council? In other words, could the Governor in Council achieve its objectives in a less infringing manner?

(a) *Cost Containment*

[997] Insofar as the issue of cost containment is concerned, the jurisprudence has made it clear that although purely financial considerations are insufficient to justify an infringement of Charter rights, the issue of cost can be taken into consideration at the minimal impairment stage in determining the standard of deference owed to government policy choices: *N.A.P.E.*, above, at para. 79, citing *Reference re Remuneration of Judges of the Provincial Court of Prince Edward Island; Reference re Independence and Impartiality of Judges of the Provincial Court of Prince Edward Island*, 1997 CanLII 317 (SCC), [1997] 3 S.C.R. 3 at para. 283, [1997] S.C.J. No. 75.

[998] As previously noted, the explanatory note accompanying the publication of the April 2012 OIC in the *Canada Gazette* stated that the government anticipated saving $70 million in the first three years of the new IFHP program, and $15 million in each fiscal year thereafter.

[999] While these amounts are substantial, it does not necessarily follow that the anticipated reduction in program spending is entirely, or even primarily, attributable to the 2012 changes to the IFHP.

[1000] First of all, it was not clear from the cross-examination of Ms. Le Bris how these estimates were arrived at, or the extent to which a reduction in the number of refugee claims, particularly those filed by claimants from DCO countries, factored into the equation. Ms. Le Bris did, however, confirm that the estimated $70 million saving over three years "was a global saving", and she was unable to recall how much of that amount would have been attributable to IFHP savings: Le Bris cross-examination, questions 63-80.

[1001] Indeed, as was emphasized by the respondents throughout the hearing, the 2012 changes to the IFHP cannot be considered in isolation as they were but one part of a comprehensive package of changes that have been made to the refugee determination system in recent years.

[1002] Entitlement to IFHP benefits was previously closely tied to the length of time that a program beneficiary remained in Canada, and the average period of IFHP eligibility continued to rise over time. According to Ms. Le Bris' affidavit, in 2003, the average period of program eligibility was 548 days. By 2012, that number had almost doubled to 948 days: at para. 83.

[1003] This was due, in part, to the fact that the previous refugee determination process was slow. According to Ms. Dikranian's evidence, before the changes were made to the IFHP in 2012, it took some 20 months from the time that a refugee claim was filed for the case to proceed to a hearing before the Immigration and Refugee Board.

[1004] Ms. Dikranian further explained that it took on average some four-and-a-half years from the date a refugee claim was filed to the date that the individual was removed from Canada following the rejection of that claim. That number has been greatly reduced as a result of the changes to the system, and the government is currently aiming to have failed refugee claimants removed from Canada within approximately 14 months of the rejection of their claims.

[1005] However, as the respondents have pointed out, the speeding up of the refugee determination process and the deterrence of abuse was not a goal that was unique to the reform of the IFHP. Through the enactment of the *Balanced Refugee Reform Act*, the *Protecting Canada's Immigration System Act,* and the *Faster Removal of Foreign Criminals Act*, S.C. 2013, c. 16, Parliament has implemented other measures designed to achieve the same goal.

[1006] The changes to the refugee determination process included the creation of "Designated Countries of Origin", and the introduction of an expedited claims process for claimants from DCO countries. According to the respondents, the number of refugee claims made by individuals coming from DCO countries since January of 2013 has dropped significantly.

[1007] Ms. Dikranian also confirmed in her cross-examination that the imposition of a visa requirement for visitors coming from Mexico likely had an impact on the number of refugee claims from that DCO country.

[1008] Moreover, certain classes of individuals are no longer entitled to a statutory stay of removal pending an application for leave and for judicial review to this Court, permitting the government to remove individuals in these groups from Canada more quickly.

[1009] Other changes designed to expedite the process included time bars on alternate avenues of recourse for failed refugee claimants, such as Pre-removal Risk Assessments and applications for permanent residence on humanitarian and compassionate grounds. In addition, the government has implemented an "Assisted Voluntary Returns and Reintegration" pilot program, which provides financial support to those willing to voluntarily return to their countries of origin.

[1010] Ms. Dikranian also confirmed in cross-examination that the Refugee Protection Division of the Immigration and Refugee Board was able to reduce its backlog by approximately 50%, once the government appointed a full complement of members to the Board after having left many positions vacant for long periods of time. This has greatly assisted in speeding up the refugee determination process.

[1011] Spending on the IFHP may well decrease substantially over the next few years. However, no attempt appears to have been made to determine how much of the anticipated cost savings will actually be attributable to the cuts to the level of benefits provided under the program and the restriction on the classes of people that are eligible for benefits, as opposed to the fact that fewer individuals are coming to Canada to make refugee claims and many claimants who do come are now in Canada for much shorter periods of time.

[1012] There is, thus, no reliable evidence before this Court of the extent to which the 2012 changes to the IFHP will, on their own, result in cost savings at the federal level. Moreover, as will be discussed in the next section of these reasons, it appears that some of the cost of medical services that was previously covered under the IFHP has now simply been downloaded to the provinces.

[1013] Assuming, however, that the 2012 changes to the IFHP have indeed resulted in some measure of cost savings at the federal level, are there ways that this cost savings could be achieved in a less infringing manner, keeping in mind that this alternative measure does not have to satisfy the objective of cost containment to exactly the same extent or degree?: *Hutterian Brethren*, above at para. 55.

[1014] The applicants point out that by simply bringing the complement of adjudicators on the Immigration and Refugee Board up to full strength, the government was able to greatly reduce the length of time that cases languished before the Immigration and Refugee Board. This has, in turn, helped to shorten the time that unsuccessful claimants remain in Canada, reducing the period for which they are eligible for IFHP benefits, with a commensurate cost savings. Adding even more members to the Board would presumably further improve processing times.

[1015] The government is also ensuring that removals are carried out more quickly after refugee claims are rejected, again reducing the time that claimants are eligible for IFHP benefits, reducing program costs accordingly. One can assume that speeding up the removals process even more would result in further cost savings to the IFHP, without requiring a reduction in the level of benefits provided by the program.

[1016] There would, of course, be costs associated with adding more members to the Immigration and Refugee Board or expediting the removal of failed refugee claimants, and I have no evidence as to what these costs would be.

[1017] However, I also do not have any reliable evidence as to the cost savings that are or will likely be directly attributable to the 2012 changes to the IFHP. In the circumstances, the respondents have not persuaded me that there are no alternatives to cutting the benefits to the IFHP that could reasonably achieve the government's goal of cost containment "in a real and substantial manner": *Hutterian Brethren*, above at para. 55.

(b) *Protecting the Integrity of Canada's Immigration System*

[1018] Insofar as the protection of the integrity of Canada's immigration system is concerned, the respondents' evidence is that the 2012 changes to the IFHP were intended to take away an incentive for individuals, particularly those from Designated Countries of Origin, to come to Canada and make unmeritorious refugee claims.

[1019] As was noted earlier, the respondents' deterrence argument is founded to a large extent on a subjective perception held by unidentified individuals that the provision of state-funded health insurance coverage to those seeking the protection of Canada constituted a reason why some foreign nationals came to Canada to assert unfounded refugee claims.

[1020] As the applicants have noted, there is no evidence that any other developed country uses the denial of publicly-funded primary health care as a means of deterring unfounded refugee claims.

[1021] Moreover, the Government of Canada has conceded that it has not carried out any research in order to determine whether denying health care as a means of deterrence has any empirical validity or chance of success. Indeed, the respondents' witnesses confirmed in their cross-examinations that the means chosen were based on "perceptions" and "beliefs", and they were not aware of *any* evidence that would support limiting access to state-funded health insurance coverage as an effective means of deterring unmeritorious refugee claims.

[1022] It is true that the respondents have adduced evidence that shows that the number of refugee claims from DCO countries have dropped significantly since the implementation of the changes to the IFHP. According to the affidavit of Ms. Dikranian, 6,718 refugee claims were filed by individuals from DCO countries in 2011, which represented 26% of all claims filed that year, and 4,298 such claims were filed in 2012, representing 21% of all claims filed. In the first half of 2013, after the implementation of the changes to the IFHP, only 323 refugee claims had been filed by individuals from DCO countries, constituting only 7% of the total number of claims filed in the same period. It does not, however, follow from this that the 2012 changes to the IFHP are necessarily having their intended deterrent effect.

[1023] This is because the promulgation of the 2012 OICs was accompanied by the numerous other measures that have been previously identified, all of which were intended to speed up the

refugee determination process and curtail the abuse of the system. No attempt has, however, been made to segregate out the extent to which the various deterrent measures implemented by the Government of Canada are having their desired effect.

[1024] Indeed, the respondents conceded at the hearing that "one can only speculate" that the drop in refugee claims from DCO countries is attributable, at least in part, to the 2012 changes to the IFHP since "the government does not have any numbers or any sort of study on why this is the case". The respondents did suggest that "one possible and very plausible explanation" for the drop in numbers of claims from DCO countries is the changes that were made to the IFHP: Transcript, Vol. 3 at p. 39.

[1025] I have already indicated that I am prepared to accept that the availability of state-funded medical care in Canada may provide something of an incentive for some individuals to come to Canada to seek medical care. I have not, however, been provided with any reliable evidence as to the extent to which this is the case, or whether it is a material factor in the choices made by a significant number of refugee claimants. Nor have I been provided with any reliable evidence to show whether the 2012 cuts to the IFHP will in fact serve the objective of deterring these individuals from coming to Canada.

[1026] The respondents also assert that the changes to the IFHP were intended to encourage people to leave Canada more quickly after their claims are dismissed. While I have accepted that some failed refugee claimants may indeed seek to remain in Canada in order to access potentially life-saving medical care, I have not been persuaded that there is no less infringing way to achieve the government's objective of faster departures.

[1027] Indeed, as I have already noted in relation to the issue of cost containment, by devoting additional resources to the timely removal of failed refugee claimants, the Government of Canada can achieve its objective of faster departures without compromising the health and safety of those who have come to Canada seeking its protection.

(c) *Other Minimal Impairment Arguments*

[1028] The respondents also submit that the 2012 IFHP minimally impairs the Charter rights of those seeking the protection of Canada because it provides 76% of those currently entitled to IFHP benefits with health insurance coverage that is comparable to, or better than the level of health insurance coverage that is provided to working Canadians under provincial or territorial health insurance plans.

[1029] However, as was noted earlier, 62% of IFHP beneficiaries only receive HCC-level benefits, the class of benefits that are roughly comparable to those available to working Canadians not on social assistance. Given that these individuals are predominately poor, their position cannot reasonably be equated to the position of working Canadians. As a result, it cannot be said that the availability of HCC benefits means that the affected individuals' section 12 and 15 Charter rights have been minimally impaired.

[1030] A further 24% of IFHP beneficiaries admittedly now only have health insurance coverage for conditions that pose a threat to public health or public safety. This group is made up of refugee claimants from DCO countries and claimants who have exhausted all their remedies in Canada. Meanwhile, those who are only entitled to make PRRA claims receive no health insurance coverage whatsoever. Once again, it cannot be said that these individuals' section 12 and 15 Charter rights have been minimally impaired.

[1031] The respondents further contend that the 2012 IFHP minimally impairs the Charter rights of those seeking the protection of Canada because it is carefully "tailored to their needs as an immigrant group": Transcript, Vol. 3, at p. 65.

[1032] As was noted earlier, the respondents initially identified these "needs" as being "health needs": Transcript, Vol. 2, p. 188.

[1033] The respondents explain that government-assisted refugees and certain privately-sponsored refugees are eligible for Extended Health Care Coverage under the 2012 IFHP because CIC had identified that government-assisted refugees and certain privately-sponsored refugees who are receiving government income support would be unable to pay for supplemental health care services. A CIC Operational Manual appended to Ms. Le Bris' affidavit also suggests that there was a recognition on the part of CIC that these classes of refugees cannot access social services for a year after their arrival in Canada.

[1034] There is, however, no evidence to suggest that other classes of refugee claimants are any more economically advantaged than government-assisted refugees and privately-sponsored refugees receiving income assistance. It also bears recalling that refugee claimants from DCO countries are barred from working for the first six months that they are in Canada, greatly inhibiting their ability to pay for their own health care.

[1035] Indeed, Ms. Le Bris confirmed that the government has no data that would suggest that refugee claimants from DCO countries are any more able to pay for their health care needs than those from non-DCO countries: Le Bris cross-examination, question 106.

[1036] The respondents have also not explained how the health needs of the immigrant group of government-sponsored refugees are different from those of the immigrant group of privately-sponsored refugees not receiving income support, or how the needs of the immigrant group of inland refugee claimants from non-DCO countries are different from those of the immigrant group of inland refugee claimants from DCO countries. Nor has it been suggested that the health needs of those seeking the protection of Canada change in a way that accords with the changes to their level of health insurance coverage as they move through the refugee determination process.

[1037] When pressed on this point at the hearing, counsel for the respondents indicated that the only response that she could offer was that government-assisted refugees, resettled refugees and privately-sponsored refugees have already been determined to be refugees prior to their arrival in Canada.

[1038] That may be so, but it does not address the question of how the *needs* of these "immigrant groups" are different from the needs of individuals making their refugee claims from within Canada. Indeed, the respondents ultimately conceded that the changes to the IFHP do not, in fact respond to the health needs of the various classes of individuals covered under the program: Transcript, Vol. 2, pp. 187-191.

[1039] The respondents also note that in assessing whether government action minimally impairs Charter rights, regard may be had to the fact that alternative measures were considered and reasonably rejected by the government. They point to changes that were made to the April 2012 OIC through the amending OIC, as well as CIC's efforts to address the confusion that followed the 2012 changes to the IFHP as evidence of "responsiveness and consultation": Transcript, Vol. 3, p. 143.

[1040] Not only are these steps not evidence that alternative measures were considered and reasonably rejected by the government, it is noteworthy that all of them *post-dated* the fundamental changes to the IFHP that were effected by the promulgation of the first OIC in April of 2012.

[1041] Finally, the respondents submit that the changes to the IFHP minimally impair the rights of those seeking the protection of Canada because of the possibility of an exemption being granted by the Minister under section 7 of the IFHP in "exceptional and compelling circumstances".

[1042] However, as I have previously explained, the respondents have conceded that section 7 does not assist in cases where urgent medical care is required. Moreover, the Minister cannot provide discretionary coverage for medications and medical products such as the insulin and diabetic supplies on which Mr. Ayubi's survival depends.

[1043] As a consequence, the respondents have not demonstrated that the changes made to the IFHP through the promulgation of the 2012 OICs minimally impair the Charter rights of those seeking the protection of Canada.

(3) Are the 2012 Changes to the IFHP Proportionate in their Effect?

[1044] The final stage of the *Oakes* test requires the Court to consider whether there is proportionality between the deleterious effects of the program and its salutary objectives, such that the attainment of the goals of the program is not outweighed by the abridgment of the rights in question.

[1045] As the Supreme Court observed in *Hutterian Brotherhood*, "the first three stages of *Oakes* are anchored in an assessment of the law's purpose. Only the fourth branch takes full account of the 'severity of the deleterious effects of a measure on individuals or groups'": above at para. 76.

[1046] In *Bedford*, the Court further explained that at this stage of the analysis, the Court is required to "weigh the negative impact of the law on people's rights against the beneficial impact of the law in terms of achieving its goal for the greater public good". In so doing, the Court is to have regard to the impact of the impugned government action, "judged both qualitatively and quantitatively": above at para 126.

[1047] In addressing the issue of proportionality, it is important to start by recalling the fundamental nature of the rights at stake in this case: namely the right to be free from cruel and unusual treatment and the right to equal treatment without discrimination on the basis of national origin.

[1048] Also important to the analysis is the devastating impact that the 2012 changes to the IFHP have had on those seeking the protection of Canada. As discussed earlier, I have concluded that the changes brought about by the 2012 OICs are causing significant suffering to an already vulnerable, poor and disadvantaged population.

[1049] Indeed, I have found as a fact that the 2012 changes to the IFHP are causing illness, disability, and death.

[1050] I am therefore satisfied that the deleterious effects of the government action at issue in this case are serious in terms of their quality. Quantitatively, I am satisfied that these deleterious effects will be felt by a significant number of individuals, given the thousands of people who come to this country each year, seeking its protection.

[1051] The question, then, is whether the respondents have met their onus and shown that the salutary objectives of the 2012 changes to the IFHP outweigh its significant deleterious effects. On the evidence before me, I have no hesitation in concluding that they have failed to do so.

[1052] While the protection of public health and public safety is a salutary objective of the IFHP, *taking away* health insurance coverage for conditions that pose a risk to public health or public safety from those seeking the protection of Canada who are only entitled to a PRRA does nothing to advance that objective. Indeed, it is actually detrimental to its achievement.

[1053] I have, moreover, concluded that there was nothing unfair to Canadians about the pre-2012 IFHP, and that Canadians are not treated any more fairly as a result of the changes brought about by the 2012 OICs. Consequently, this objective cannot be said to outweigh the negative impact that the 2012 changes to the IFHP has had on those seeking the protection of Canada.

[1054] To the extent that the respondents' "fairness to Canadians" arguments are really about the *cost* of the IFHP program for Canadian taxpayers, cost is certainly a factor that may be considered in connection with the question of proportionality.

[1055] Indeed, in *N.A.P.E.*, the Supreme Court observed that governments "have a large 'margin of appreciation' within which to make choices".However, the Court went on to note that "the scope of that 'margin' will be influenced, amongst other things, by the scale of the financial

challenge confronting a government and the size of the expenditure required to avoid a Charter infringement in relation to that financial challenge": above, at para. 84.

[1056] It has not been suggested by the respondents that Canada is currently facing a financial crisis of the sort that faced the Government of Newfoundland in *N.A.P.E.* Nor is it evident from the record before me that there have, in reality, been any significant net savings for the taxpayers of Canada that are clearly attributable to the 2012 changes to the IFHP.

[1057] First of all, as was noted in the previous section of these reasons, we do not have any reliable data that would indicate precisely how much money will actually be saved directly as a result of the 2012 changes to the IFHP. While estimates of cost savings have been provided by the respondents, it is not clear to what extent these program savings are actually attributable to the fact that refugee claims are now being processed faster and failed refugee claimants are being removed more quickly after their claims have been dismissed, rather than the cuts to the IFHP.

[1058] I have accepted that the decreased level of coverage and limitations on the classes of individuals who are eligible to IFHP benefits will likely result in *some* degree of cost savings at the federal level. However, there does not appear to have been any attempt by the respondents to quantify the extent to which the health care costs for those seeking the protection of Canada that were previously borne by the federal government through the IFHP have now simply been downloaded to provincial and territorial governments, or are being absorbed by others involved in the health care sector.

[1059] It will be recalled that the respondents have argued that there are any number of alternatives that are available to individuals who find themselves in a situation where their particular level of IFHP coverage is not sufficient for their medical needs. They pointed to the provincial health insurance coverage that has been instituted in certain provinces in order to "fill the gaps" created by the 2012 changes to the IFHP as one such example.

[1060] The respondents further submitted that assistance will be available for some individuals through community health centres and refugee shelters. Others may benefit from provincially-funded midwifery services, at least in Ontario. Hospital emergency rooms are another source of medical care for IFHP beneficiaries. The respondents also suggested that going on social assistance is another way that IFHP beneficiaries can access health care.

[1061] I have previously found as a fact that there are numerous shortcomings in all of the alternate sources of health care identified by the respondents. More important for our present purposes, however, is the fact that *there is a real cost to Canadian taxpayers* in providing these alternate forms of health care.

[1062] I have not, however, been provided with any reliable data to show the extent to which these cost savings have simply been downloaded to others, including provincial and territorial governments.

[1063] We do know, however, that a community health centre paid some $2,700 on Mr. Ayubi's behalf for tests that would previously have been covered under the pre-2012 IFHP, and that the Ottawa Hospital absorbed $1,500 of the cost. Similarly, the cost of Mr. Akhtar's chemotherapy treatment was absorbed by the Saskatoon Cancer Centre.

[1064] Mr. Wijenaike's urologist has kindly agreed to cover the cost of his chemotherapy, but he has had to seek medical care through hospital emergency rooms on a number of occasions. The hospitals have billed Mr. Wijenaike for their services, but he has been unable to pay the cost of the medical services that he has received, leaving the hospitals with approximately $5,000 in unpaid receivables.

[1065] Mr. Bradley, a community health centre employee, also described the hours that he spent negotiating and advocating on Mr. Ayubi's behalf – time that could otherwise have been spent attending to the health care needs of other patients. Other health care providers have provided similar evidence with respect to the additional time that they have had to spend on behalf of patients as a result of the 2012 changes to the IFHP. There is, of course, an administrative cost to all of this that is borne by publicly-funded health care institutions.

[1066] Dr. Rachlis has suggested that the reduced expenditures for primary health care services under the IFHP may actually be outweighed by higher subsequent costs for other health care services, particularly hospital costs and emergency room visits. He has identified what he calls the "optimal method" that should be used to estimate the true costs of providing care for refugees and refugee claimants who have lost their health insurance coverage. He further explains that, in the absence of such an analysis having been conducted, "there is significant doubt that there will be reduced public sector costs as a result of this new policy": Rachlis affidavit at para. 6.

[1067] Ms. Le Bris confirmed in her cross-examination that when the respondents calculated the savings that would be achieved through the 2012 changes to the IFHP, regard was only had to the cost savings that would be realized by CIC. No consideration was given to the impact that the changes might have on provincial or territorial health care costs.

[1068] According to Ms. Le Bris, this was because "it's such a small percentage of the overall health expenditure in Canada that our opinion was that the impact would be very, very minimal because it was like $83 million versus, like, you know, billions that it cost. So we looked into it from that perspective but we didn't do a detailed cost analysis": Le Bris cross-examination, question 84.

[1069] Ms. Le Bris was then asked: "So if I understand you, the total impact was so small that it wasn't really worth trying to figure out how much it would cost when it shifted to the provinces?" Her response was "Exactly because we continued to pay a significant amount of the services we were used [*sic*] to pay for": Le Bris cross-examination, question 85.

[1070] The respondents say that the federal government is interested in containing spending at the federal level, and that it is not obliged to look at provincial costs. That may be so, but one of the stated goals of the 2012 changes to the IFHP was to "ensure fairness to *Canadian*

taxpayers": see the April 25, 2012 press release. It is not at all clear that *Canadian taxpayers* are realizing any savings at the end of the day as a result of the 2012 changes to the IFHP.

[1071] As a result, it has not been shown that the beneficial impact of the 2012 changes to the IFHP in terms of cost containment and fairness to Canadian taxpayers outweighs the negative impact of the 2012 changes to the IFHP on the constitutional rights of those seeking the protection of Canada.

[1072] Finally, I have accepted that the protection of the integrity of Canada's refugee determination process is undoubtedly a pressing and substantial government objective. However, I have also noted that that the respondents have provided no evidence as to the extent to which access to taxpayer-funded health care plays a material role in the abuse of the Canadian refugee system. Nor have the respondents demonstrated that denying health insurance coverage for primary health care for those seeking the protection of Canada will have a material deterrent effect on the bringing of unmeritorious refugee claims.

[1073] Consequently it cannot be said that the beneficial impact of the 2012 changes to the IFHP in terms of protecting the integrity of Canada's refugee determination process outweighs the negative impact of the 2012 changes to the IFHP on the constitutional rights of those seeking the protection of Canada.

[1074] In summary, I am satisfied that the profoundly deleterious effects of the 2012 changes to the IFHP greatly outweigh the salutary goals of the Governor in Council in making these changes. This is especially so in light of the fact that it has not been established that the changes will in fact contribute in a material way to the realization of *any* of these goals.

(4) Conclusion with Respect to the Section 1 Justification

[1075] For these reasons I have concluded that the respondents have not satisfied their onus of demonstrating that the rights violations resulting from the 2012 changes to the IFHP are justified under section 1 of the Charter as a reasonable limit prescribed in a free and democratic society.

XIV. Final Conclusion

[1076] I have thus concluded that the 2012 OICs are not *ultra vires* the prerogative powers of the Governor in Council, nor has there been a denial of procedural fairness in this case.

[1077] I have also concluded that the applicants' section 7 Charter claim cannot succeed as what they seek is to impose a positive obligation on the Government of Canada to fund health care for individuals seeking the protection of Canada. The current state of the law in Canada is that section 7guarantees to life, liberty and security of the person do not include a positive right to state funding for health care.

[1078] I have, however, concluded that while it is open to governments to assign priorities and set limits on social benefit plans such as the IFHP, the intentional targeting of those seeking the

protection of Canada - an admittedly poor, vulnerable and disadvantaged group - takes this situation beyond the realm of traditional Charter challenges to social benefit programs.

[1079] With the 2012 changes to the IFHP, the executive branch of the Canadian government has intentionally set out to make the lives of these disadvantaged individuals even more difficult than they already are. It has done this in an effort to force those who have sought the protection of this country to leave Canada more quickly, and to deter others from coming here to seek protection.

[1080] I have found that the affected individuals are being subjected to "treatment" as contemplated by section 12 of the Charter, and that this treatment is indeed "cruel and unusual". This is particularly, but not exclusively, so with respect to children who have been brought to this country by their parents. The 2012 modifications to the IFHP potentially jeopardize the health, and indeed the very lives, of these innocent and vulnerable children in a manner that shocks the conscience and outrages our standards of decency. They violate section 12 of the Charter.

[1081] I have also concluded that the 2012 changes to the IFHP violate section 15 of the Charter inasmuch as it now provides a lesser level of health insurance coverage to refugee claimants from DCO countries in comparison to that provided to refugee claimants from non-DCO countries. This distinction is based entirely upon the national origin of the refugee claimants, and does not form part of an ameliorative program.

[1082] Moreover, this distinction has an adverse differential effect on refugee claimants from DCO countries. It puts their lives at risk, and perpetuates the stereotypical view that they are cheats, that their refugee claims are "bogus", and that they have come to Canada to abuse the generosity of Canadians. It undermines their dignity and serves to perpetuate the disadvantage suffered by members of an admittedly vulnerable, poor and disadvantaged group.

[1083] I have not, however, been persuaded that the IFHP violates subsection 15(1) of the Charter based upon the immigration status of those seeking the protection of Canada, as "immigration status" cannot be considered to be an analogous ground for the purposes of subsection 15(1). Consequently, this aspect of the applicants' section 15 claim will be dismissed.

[1084] Finally, the respondents have not demonstrated that the 2012 changes to the IFHP are justified under section 1 of the Charter.

[1085] Consequently, the application is granted. What remains to be determined is the appropriate remedy. This issue will be considered next.

XV. Remedy

[1086] The applicants have challenged the constitutional validity, applicability and effect of the 2012 Orders in Council that created the 2012 IFHP.

[1087] I do not understand the respondents to dispute that Orders in Council constitute "law" for the purposes of subsection 52(1) of the Charter, which provides that "any law that is inconsistent with the provisions of the Constitution is, to the extent of the inconsistency, of no force or effect".

[1088] I am mindful of the admonitions of the Supreme Court in cases such as *Schachter v. Canada*, 1992 CanLII 74 (SCC), [1992] 2 S.C.R. 679, [1992] S.C.J. No. 68 [*Schachter*], where the Court observed that Courts should only strike down laws "to the extent of the inconsistency" by using the doctrine of severance or 'reading down': at para. 26. However, none of the parties have suggested that the offending portions of the Orders in Council are severable in this case, and a review of the Orders in Council confirms that this is so.

[1089] Consequently, a declaration will issue declaring that the Orders in Council that created the 2012 IFHP are inconsistent with sections 12 and 15 of the *Canadian Charter of Rights and Freedoms* and are of no force or effect.

[1090] The applicants further seek a declaration that the denial of health insurance coverage to those seeking the protection of Canada is inconsistent with Canada's obligations under Articles 3 and 7 of the 1951 *Convention Relating to the Status of Refugees* and its obligations under the *Convention on the Rights of the Child*.

[1091] As mentioned earlier in these reasons, while it is a valuable interpretative aid, international law, whether binding or not, is *not* a source of domestic rights or remedies. Consequently I decline to grant declaratory relief in this regard.

[1092] In the event that I were to grant the declaratory relief sought by the applicants, the respondents ask that I suspend the operation of that declaration for a period of one year in order to permit the Governor in Council to act. The respondents submit that a suspension is appropriate in this case, as a legislative void created by my order would jeopardize public safety and deprive deserving people of important benefits.

[1093] Given that the 2012 OICs had the effect of repealing the pre-2012 IFHP, the respondents were asked if the effect of a general declaration of invalidity would not be to simply reinvigorate the pre-2012 IFHP, rendering a temporary suspension unnecessary. The respondents replied that a general declaration of invalidity would create a policy vacuum, and that new government appropriations would be required to create the policy.

[1094] The applicants point out that there is no evidence before the Court that the necessary appropriations no longer exist. As a consequence, they say that there is no need for a temporary suspension of my declaratory order.

[1095] While it is true that I have no evidence with respect to the administrative and policy consequences that would flow from a general declaration of invalidity, I am prepared to accept as a matter of common sense that it is inevitable that a certain degree of administrative disruption will result from my decision. I am also concerned that this disruption could potentially

exacerbate the harm suffered by those seeking the protection of Canada. It is thus appropriate to give the Governor in Council a period of time in which to act in response to this decision.

[1096] At the same time, I am also mindful of the fact that the changes to the IFHP that were effected through the 2012 OICs are having a devastating impact on those seeking the protection of Canada. Indeed, I have found as a fact that lives are being put at risk.

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

[1098] This leaves the question of individual remedies for Mr. Ayubi and Mr. Garcia Rodrigues.

[1099] Several personal claims for relief are asserted on behalf of the individual applicants under subsection 24(1) of the Charter. Subsection 24(1)provides that "[a]nyone whose rights or freedoms, as guaranteed by this Charter, have been infringed or denied may apply to a court of competent jurisdiction to obtain such remedy as the court considers appropriate and just in the circumstances".

[1100] The applicants seek a declaration that what Mr. Ayubi and Mr. Garcia Rodrigues each experienced in relation to their treatment under the 2012 IFHP constituted a violation of their constitutional rights. In my view, this is implicit in the general declaration of invalidity that I have already granted, and no further order is required in this regard.

[1101] In their Notice of Application, the applicants (other than JFCY) also sought orders of *mandamus* directing the Minister of Citizenship and Immigration to forthwith issue health insurance coverage at the pre-2012 level to Mr. Ayubi and Mr. Garcia Rodrigues, both on a going-forward basis and retroactively to June 30, 2012.

[1102] The respondents note that a section 24 remedy is generally not available at the same time as a section 52(1) declaration of invalidity, citing *Canada(Attorney General) v. Hislop*, 2007 SCC 10 (CanLII), 2007 SCC 10 at para. 102, 2007 SCC 10 (CanLII), [2007] 1 S.C.R. 429 [*Hislop*]. They submit, moreover, that such remedies are not appropriate on the facts of this case.

[1103] The respondents note that Mr. Garcia Rodrigues is now a permanent resident of Canada with the result that he is entitled to health insurance coverage under the Ontario Health Insurance Plan. As a consequence, he is no longer eligible for IFHP benefits.

[1104] Because Mr. Garcia Rodrigues is now a permanent resident of Canada, he is no longer a person seeking the protection of Canada. He would no longer have been entitled to health insurance coverage under the pre-2012 IFHP, and I agree with the respondents that he is not entitled to such coverage on a prospective basis. Indeed, I do not understand the applicants to still be pressing this claim.

[1105] Insofar as his claim for *past* benefits is concerned, while Mr. Garcia Rodrigues was undoubtedly subjected to unnecessary distress, no claim for damages has been asserted in this

regard. Moreover, Mr. Garcia Rodrigues did ultimately receive the health care that he required at no cost to himself, other than the minimal fee that he paid to see an optometrist when his eye problem first surfaced. A mandatory order that he be provided with health insurance coverage on a retrospective basis would not provide any real benefit to Mr. Garcia Rodrigues, but could only benefit non-parties. In these circumstances, I decline to make a mandatory order in favor of Mr. Garcia Rodrigues.

[1106] Mr. Ayubi has also been subjected to considerable psychological distress as a result of his lack of health insurance coverage and his uncertain access to life-saving medical treatment and medications. Once again, however, no claim for damages has been asserted in this regard. He has, moreover, ultimately received the health care that he required at no financial cost to himself. Any order that Mr. Ayubi be provided with health insurance coverage on a retrospective basis would thus not provide any actual benefit to him, and could only benefit non-parties.

[1107] Mr. Ayubi has been granted discretionary relief under section 7 of the 2012 IFHP since May of 2013. This covers the costs of his doctors' appointments and medical tests. While I have concluded that the 2012 OICs creating the 2012 IFHP are constitutionally invalid, I have suspended the operation of my order for a period of four months, with the result that Mr. Ayubi's discretionary coverage will likely continue for at least that period. It is, however, not clear what will happen thereafter.

[1108] Moreover, Mr. Ayubi does not currently have any insurance coverage for the cost of his medications and diabetic supplies, and his access to these medications and supplies remains uncertain. As a consequence, an order reinstating his coverage in this regard could result in a potentially life-saving benefit for him.

[1109] That said, the Supreme Court has held that a section 24(1) remedy cannot operate during a period in which a declaratory order is under suspension: see, for example, *R v. Demers*, 2004 SCC 46 (CanLII), 2004 SCC 46 at paras. 56-64, 2004 SCC 46 (CanLII), [2004] 2 S.C.R. 489.

[1110] The question, then, is whether I should order that Mr. Ayubi be provided with health insurance coverage for the cost of doctors' appointments and medical tests, as well as his medications and diabetic supplies on a prospective basis, with such order taking effect only after the expiry of the four month period during which my declaratory order is suspended.

[1111] The rationale for limiting the availability of a subsection 24(1) remedy in cases where there has been a subsection 52(1) declaration of invalidity was addressed in *Hislop*. There, the Supreme Court explained that it "is a general rule of public law that 'absent conduct that is clearly wrong, in bad faith or an abuse of power, the courts will not award damages for the harm suffered as a result of the mere enactment or application of a law that is subsequently declared to be unconstitutional'": above at para. 102, citing *Mackin v. New Brunswick (Minister of Finance); Rice v. New Brunswick*, 2002 SCC 13 (CanLII), 2002 SCC 13 at para. 78, 2002 SCC 13 (CanLII), [2002] 1 S.C.R. 405.

[1112] As previously noted, I have concluded that in this case, the Governor in Council purposefully targeted a vulnerable, poor, and disadvantaged group, intentionally setting out to make their lives even more difficult than they already are in an effort to force those who have sought the protection of this country to leave Canada more quickly, and to deter others from coming here.

[1113] Mr. Ayubi is himself vulnerable, poor, and disadvantaged. He is stuck in this country, as the Government of Canada has itself recognized that it is simply too dangerous to return him to Afghanistan. He is seriously ill, but tries to work to support himself. The respondents have themselves conceded that"[n]obody expects him to make enough money to purchase his own health care": Transcript, Vol. 2, at p. 129.

[1114] In my view, the circumstances of this case come within the exceptional situation that was identified by the Supreme Court in *Hislop* where a section 24 remedy is appropriate, notwithstanding that I have also granted a declaratory remedy under section 52 of the Charter.

[1115] I will therefore order that commencing four months from the date of my decision, Mr. Ayubi is to be provided with health insurance coverage that is equivalent to that to which he was entitled under the provisions of the pre-2012 IFHP so that he may continue to receive the medical care on which his life depends.

[1116] Finally, none of the parties seek an order of costs, and none are awarded.

JUDGMENT

THIS COURT:

1. Declares that Orders in Council P.C. 2012-433 and P.C. 2012-945 are inconsistent with sections 12 and 15 of the *Canadian Charter of Rights and Freedoms* and are of no force or effect;

2. Orders that the effect of this declaratory order is suspended for a period of four months; and

3. Orders that commencing four months from the date of this decision, the respondents are to provide Hanif Ayubi with health insurance coverage that is equivalent to that to which he was entitled under the provisions of the pre-2012 IFHP.

"Anne L. Mactavish"

Judge

FEDERAL COURT

SOLICITORS OF RECORD

DOCKET:	T-356-13
STYLE OF CAUSE:	CANADIAN DOCTORS FOR REFUGEE CARE, THE CANADIAN ASSOCIATION OF REFUGEE LAWYERS, DANIEL GARCIA RODRIGUES, HANIF AYUBI AND JUSTICE FOR CHILDREN AND YOUTH v. ATTORNEY GENERAL OF CANADA AND MINISTER OF CITIZENSHIP AND IMMIGRATION
PLACE OF HEARING:	TORONTO, ONTARIO
DATE OF HEARING:	DECEMBER 17, 2013, DECEMBER 18, 2013 AND JANUARY 30, 2014
JUDGMENT AND REASONS:	MACTAVISH J.
DATED:	JULY 4, 2014

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[1] There is some confusion in the record as to the correct spelling of Mr. Garcia Rodrigues' name. I have adopted the spelling used in the applicants' Notice of Application.
[2] Section 109.1(1) of the *Immigration and Refugee Protection Act* allows the Minister to designate countries for certain purposes under the Act. Refugee claimants from Designated Countries of Origin are provided with an expedited process for the determination of their refugee claims, and do not have the right to appeal negative decisions to the Refugee Appeal Division of the Immigration and Refugee Board. The Act provides criteria for inclusion on the DCO list. As of August 13, 2013, there were 27 countries on the list, which are primarily, but not exclusively, countries that are members of the European Union
[3] Indeed, some academic commentators have suggested that the Supreme Court's decisions in *Chaoulli* and *Insite* make it "clear that the Charter has become ... an important tool for policy change in the health care field": Matthew Rottier Voell, "*PHS Community Services Society v. Canada (Attorney General): Positive Health Rights, Health Care Policy, and Section 7 of the Charter*" (January, 2012) 31 W.R.L.S.I. 41 at p. 16 citing Christopher P. Manfredi & Antonia Maioni, "Judicializing Health Policy: Unexpected Lessons and an Inconvenient Truth" in James B. Kelly & Christopher P. Manfredi, eds,*Contested Constitutionalism: Reflections on the Canadian Charter of Rights and Freedoms* (Vancouver: UBC Press, 2009) 129 at 137.

[4] See, for example, the discussion in the various opinions in *Gosselin*, above, where the majority of the Supreme Court accepted the possibility that section 7 could be read as encompassing economic rights, and that "one day s. 7 may be interpreted to include positive obligations": at para. 82.
[5] See, forexample, Colleen Flood and Brandon Chen, "Charter Rights & Health Care Funding: A Typology of Canadian Health Rights Litigation" (2010) 19 Annals Health L 479; Voell, "PHS Community Services Society v. Canada (Attorney General): Positive Health Rights, Health Care Policy, and Section 7 of the Charter", above; Mel Cousins, "Health Care and Human Rights after Auton and Chaoulli", (2009) 54 McGill L. J. 717; Martha Jackman, "Charter Review as a Health Care Accountability Mechanism in Canada" (2010) 18 Health L. J. 1 – 29; Cara Wilkie & Meryl Zisman Gary, "Positive and Negative Rights under the Charter: Closing the Divide to Advance Equality", (2011) 30 W.R.L.S.I 37; Jamie Cameron, "Positive Obligations under Sections 15 and 7 of the Charter: A Comment on Gosselin v. Québec" (2003) 20 S.C.L.R. (2d) 65.
[6] The appeal of this decision has been argued and has been taken under reserve by the Ontario Court of Appeal.
[7] It bears noting that a different approach to access to treatment for learning disabilities has been taken under provincial human rights legislation. That is, in *Moore v. British Columbia (Education)*, 2012 SCC 61 (CanLII), 2012 SCC 61, [2012] S.C.J. No. 61,

the Supreme Court of Canada held that if education services are ordinarily provided to the public, they must be made available in a way that does not arbitrarily or unjustifiably exclude individuals by virtue of their membership in a protected group.
[8] This is not a far-fetched example. It will be recalled that the Immigration and Refugee Board found Mr. Wijenaike's allegations of past persecution to be credible but concluded that conditions within Sri Lanka had changed enough in the months since Mr. Wijenaike had left the country that he was not currently in need of protection in Canada