Registry No. T-

FEDERAL COURT

B E T W E E N:

CANADIAN DOCTORS FOR REFUGEE CARE,
THE CANADIAN ASSOCIATION OF REFUGEE LAWYERS,
DANIEL GARCIA RODRIGUES, AHMAD AWATT and
HANIF AYUBI

Applicants

and

ATTORNEY GENERAL OF CANADA
MINISTER OF CITIZENSHIP AND IMMIGRATION

Respondents

APPLICATION UNDER section 18.1 of the *Federal Courts Act*, R.S.C. 1985, c. F-7

NOTICE OF APPLICATION

TO THE RESPONDENT:

A PROCEEDING HAS BEEN COMMENCED by the applicant. The relief claimed by the applicant appears on the following page.

THIS APPLICATION will be heard by the Court at a time and place to be fixed by the Judicial Administrator. Unless the Court orders otherwise, the place of hearing will be as requested by the applicant. The applicant requests that this application be heard at the Federal Court in Toronto.

IF YOU WISH TO OPPOSE THIS APPLICATION, to receive notice of any step in the application or to be served with any documents in the application, you or a solicitor acting for you must prepare a notice of appearance in Form 305 prescribed by the Federal Court Rule and serve it on the applicant's solicitor, or where the applicant is self-represented, on the applicant WITHIN 10 DAYS after being served with this notice of application

Copies of the relevant Rules of Court, information on the local office of the Court and other necessary information may be obtained from any local office of the Federal Court or the Registry of the Trial Division in Ottawa, telephone: (613) 992-4238.

IF YOU FAIL TO OPPOSE THIS APPLICATION, JUDGEMENT MAY BE GIVEN IN YOUR ABSENCE AND WITHOUT FURTHER NOTICE TO YOU.

February 25, 2013

Issued by;_____
(Registry Officer)

Registrar Federal Court
180, Queen Street West
Suite 200
Toronto, Ontario
M5V 3L6

TO: Respondent, The Department of Justice
The Exchange Tower
130, King Street West
Suite 3400, Box 36
Toronto, Ontario
M5X 1K6

APPLICATION

This is an application for judicial review in respect of

> The Minister of Citizenship and Immigration and the Interim Federal Health Program as modified.

The applicants make application for:

a. An order in the nature of a declaration, declaring that the denial of Interim Federal Health Insurance coverage to refugee claimants and privately sponsored refugees and in particular the denial of Interim Federal Health Insurance coverage to the Applicants Daniel Garcia Rodrigues, Ahmad Awatt and Hanif Ayubi is inconsistent with the provisions of section 7, 12 and 15 of the Charter of Rights and Freedoms.

b. An order in the nature of a declaration, declaring that the denial of Interim Federal Health Insurance coverage to refugee claimants and privately sponsored refugees 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*;

c. An order in the nature of a declaration declaring that the denial of Interim Federal Health Insurance to refugee claimants and privately sponsored refugees and in particular to the Applicants Daniel Garcia Rodrigues, Ahmad Awatt and Hanif Ayubi was effected and carried out in a manner inconsistent with the administrative law principles of fairness, in an arbitrary manner inconsistent with the principles of natural and fundamental justice and in violation of the Bill of Rights and the Charter of Rights and Freedoms;

d. An order in the nature of mandamus directing the Minister of Citizenship and Immigration to forthwith issue Interim Federal Health Insurance to the Applicants Daniel Garcia Rodrigues, Ahmad Awatt and Hanif Ayubi both going forward and retroactively to June 30, 2012.

e. An order in the nature of a declaration declaring that the Order in Council creating the Interim Health Program 2012 is ultra vires.

f. Such further and other relief as counsel may advise and this Honourable Court may allow.

The grounds for the application are as follows:

A. The terms of the Interim Federal Health Program, 2012 have threatened the health of the individual applicants as well as refugee claimants and privately sponsored refugees generally:

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

> The Board recommends that Order in Council P.C. 4/3263 of June 6, 1952, be revoked, and that the Department of National Health and Welfare be authorized to pay the costs of medical and dental care, hospitalization, and any expenses incidental thereto, on behalf of:
>
> (a) an immigrant, after being admitted at a port of entry and prior to his arrival at destination, or while receiving care and maintenance pending placement in employment, and
>
> (b) a person who at any time is subject to Immigration jurisdiction or for whom the Immigration authorities feel responsible and who has been referred for examination and/or treatment by an authorized Immigration officer,
>
> in cases where the immigrant or such a person lacks the financial resources to pay these expenses, chargeable to funds provided annually by Parliament for the Immigration Medical Services of the Department National Health and Welfare.

2. The 1957 Order in Council gave rise to what was later known as the Federal Interim Health Program, or IFHP. Although the spending of public monies requires appropriation by Parliament, the Order-In-Council was not a regulation authorized by the Immigration Act, 1952. The inference is that it was, ostensibly, an exercise of the Crown Prerogative.

3. The 1957 Order in Council was promulgated the same year that the federal government passed the *Hospital and Insurance and Diagnostic Services Act* SC 1957, c.28, under which the federal government offered a 50/50 cost share to all provinces who adopted universal hospital coverage for their residents. When it was enacted, about four provinces had a hospital coverage regime. By 1961, all provinces were participating. Thus the federal scheme resulted in all residents, and non-transient potential residents, having guaranteed access to a certain level of health care. No one was to be left out.

4. Through the early 1960s, other provinces began to develop more robust public programs for their residents. The federal government continued to directly finance and administer health care for those who fell outside of provincial jurisdiction. This included inmates, the military, Aboriginal people who had status under the *Indian Act*, as well as people in refugee-like situations. The federal government's interstitial health care funding of these classes is tied to federal jurisdiction over prisons, the military, Aboriginal people and 'aliens' under s. 91 of the Constitution Act, 1867.As provincial health care programs grew, publicly funded health care lost the character of an ex gratia charitable payment, and became embedded as a core element of Canadian governance.

5. The 1976 *Immigration Act* formally incorporated the refugee definition and the non-refoulement obligation into Canadian law. Persons seeking refugee status are lawfully in Canada. Refugee claimants tend to be socially and economically disadvantaged and may be vulnerable and in poor health. If their claims to refugee status are refused, they may be eligible to seek complementary forms of protection from within Canada. Even once all claims have been rejected, international norms require that they be treated humanely and with dignity while they remain in the territory of the host country.

6. The IFHP was designed as an interim measure to provide basic health, vision and dental insurance to resettled refugees, detainees, trafficked persons and to refugee claimants up until the time they were either accepted and eligible for provincial health care or their claim was refused and they left Canadian territory and jurisdiction. The scope and content of the IFHP was revised several times between 1957 and 2012 to ensure refugee health needs were being met and that costs were not de facto being passed on to the provinces. Consultations with provincial health authorities and Memoranda of Understanding ensured the co-ordination of coverage.

7. As recently as 2011, representatives of the respondent acknowledged publically to a Parliamentary committee that the IFHP was inspired by Canada's international obligations toward persons seeking its protection, a commitment to protect their health, a desire to protect the Canadian public from infectious diseases and an undertaking to ease the strain on provincial and territorial health systems. In 2009, the annual per-capita cost per recipient under the IFHP was only $552.

8. IFHP coverage system was simple and provided the same basket of services to all eligible refugees and refugee claimants without regard to category or stage of proceeding. The basket of services available under the IFHP was roughly equivalent to the basket of services available to Canadians on social assistance. IFHP coverage forms were issued to resettled refugees and refugee claimants upon arrival in Canada. The system functioned well and stakeholders (insured persons and medical professionals) were happy with it.

9. Without warning, advance notice, or consultation with provinces, private refugee sponsorship groups such as churches, health care providers or other stakeholders, the *Order respecting the Interim Federal Health Program, 2012* of April 5, 2012 was issued. It rescinded the 1957 Order in Council and instituted drastic cuts to health benefits paid by the federal government for refugee claimants, government sponsored refugees and privately sponsored refugees. It was to come into effect on June 30, 2012, except for the part affecting claimants from "designated countries of origin", which would not be operative until section 12 of *Balanced Refugee Reform Act* was declared in force.

10. On June 28, 2012, again without notice or consultation, the *Order respecting the Interim Federal Health Program, 2012* was amended. This second version restored interim federal health benefits to government-assisted refugees, but maintained the deep cuts for privately sponsored refugees and all categories of refugee claimants.

11. The justification for the changes and withdrawal of coverage was said to be cost savings, deterrence of bogus claims and equity—i.e. to ensure that refugees and refugee claimants did not receive better public health coverage than Canadian residents in the same economic circumstances.

12. On June 30, 2012, the *Order respecting the Interim Federal Health Program 2012*, as amended, (hereinafter referred to as "the OIC") came into force. Under the new IFHP, insurance coverage for refugees and refugee claimants is no longer universal and uniform; coverage is now based on a classification system that allocates health care according to a hierarchy of putative merit.

13. The following is a summary of the changes to IFHP, by category:

Government-Assisted Refugees (GARs): During their first year in Canada, GARs have full coverage of all diagnostic, medical and hospital services, as well as medications and many supplemental services through a combination of federal and provincial coverage. Afterwards, they have the same coverage as other permanent residents.

Privately sponsored refugees (PSRs):
Medical services: During their first year in Canada, PSRs have coverage for most diagnostic, medical, and hospital services , but are not covered for elective surgery (including vasectomy and tubal ligation), home care, and long term care.
Medication: PSRs have no medication coverage except for contagious diseases and psychotic states involving a risk to others. They are generally not eligible for social assistance (and any ensuing medication benefits) during their first year in Canada, except in Manitoba.

Refugee claimants not from designated countries of origin (DCOs)
Medical services: For non-DCO refugee claimants, most diagnostic, medical, and hospital services are still covered by the IFH. The services that are not covered are elective surgery (including vasectomy and tubal ligation), home care, and long term care.
Medication: The federal government covers only medication for conditions posing a risk to public health or public safety. This means contagious diseases and psychotic states involving a risk to others, but not psychotic states that cause a risk to oneself. Some refugee claimants who are destitute can obtain medication coverage through provincial programs (Ontario, Quebec, BC, Alberta) or provincial pharmacare plans (Quebec, BC).

Refugee claimants from Designated Countries of Origin): New refugee claimants from Designated Countries of Origin arriving after the coming into force of the DCO policy on December 15, 2012 have no coverage for medical services or for medications except for contagious diseases and psychotic states involving a risk to others.

Rejected claimants: A claimant is categorized as 'rejected' from the moment they exhaust all legal proceedings against the IRB decision rejecting their claim until their removal. Refused claimants from "moratorium countries" (that is, states to which Canada has suspended deportations due to country conditions) fall into this category, regardless of how long the moratorium is expected to last.
Medical services and medications: For refused claimants, there is no IFH coverage of medical services except for conditions posing a risk to public health or public safety. This means that refused claimants are covered for those diagnostic tests, doctors' appointments and medications that are related to contagious diseases like tuberculosis, HIV-AIDS, sexually transmitted infections, measles, etc. - but not

medications for other health conditions such as controlling a chronic health condition like type 1 diabetes.

PRRA-only, ineligible claimants, claimants with abandoned or withdrawn claims:
Ineligible for any medical coverage even if they have a contagious disease

14. The amended OIC (in section 7) also provided for the possibility of applying to the Minister for discretionary coverage under the IFHP in "exceptional circumstances". However, there is no possibility of obtaining prescription medication (unless it is needed to treat a condition that is a danger to public health or safety) under this clause. The procedures or criteria for the exercise of this discretion were not publicized, nor was the existence of the clause itself. The clause is largely unknown within both the medical and legal communities. A protocol for urgent IFHP requests was not established until October 2012 and it was not disseminated or accessible online. The protocol requests individuals to send a request accompanied by a doctor's letter by mail or to place it in a dropbox at the local CIC office in an envelope marked "urgent". No mailing address is provided. The protocol indicates that there is no guarantee that applications will be processed urgently and that the determination as to whether a health situation is urgent is made by CIC. If urgency is determined to exist, the applicant is supposed to be contacted within 24-72 hours, possibly for an interview. In practice, those individuals who have applied for this discretionary coverage have not consistently received answers in a timely fashion, if at all. A recent CIC notice announced that a request for urgent coverage by a refugee claimant may be treated as evidence that the request warrants the adversarial intervention of the Minister to oppose the claim.

15. Although not required under the IFHP 2012, after June 30, 2012 federal officials began withholding IFHP authorization from refugee claimants until they had scheduled an "eligibility interview'. This bureaucratic discretion inserted days, weeks or even months of delay in access to the health care coverage to which claimants were entitled. Medical conditions that arise during this period will not be covered, and other chronic and acute conditions are left to worsen.

16. After the coming into force of the changes to the IFHP on June 30, 2012, there was a great deal of confusion among health care providers as to what was covered by the IFHP and who was

eligible. Significant numbers of doctors and clinics began either turning away refugee claimants or demanding cash upfront – often for services that were still actually covered.

17. Most importantly, the health status of refugee claimants and privately sponsored refugees in Canada began to be adversely affected, as their federal health coverage was suddenly lost or no longer available.

18. For instance, the applicant, Ahmad Awatt, a Kurd from Iraq, had fled to Canada in 1999. Although his refugee claim was denied he cannot be removed from Canada because Iraq was placed on a list of several countries subject to moratorium on removals in 2003. He has a work permit and has been paying taxes. It is medically documented that the Applicant Awatt suffers from Wilson Disease—a genetic disorder that prevents the body from getting rid of extra copper. Over time, high copper levels can cause life-threatening organ damage. As a result, Applicant Awatt is in need of constant blood and urine examinations, as well as monthly ultra-sounds of his liver. These were covered under the previous IFHP, but after the coming into force of the changes to the IFHP on June 30, 2012, he lost health care coverage, because, classified as a rejected claimant, he was no longer eligible. Although a Wilson-related speech impediment that emerged after a beating that he received in Iraq entitles him to Ontario disability coverage for his numerous medications, he has no coverage for the tests or specialist visits he most urgently needs to control his Wilson disease. Applicant Awatt is a minimum wage occasional laborer and cannot afford to pay for these medical services. He was not aware of the possibility of applying for discretionary coverage until January, 2013 and his application has not been answered. The changes to the IFHP have thus resulted in a threat to Applicant Awatt's life and health as well as considerable psychological stress beginning on June 30, 2012.

19. Similarly, on August 13, 2012, the applicant, Daniel Garcia Rodrigues, a refused refugee claimant from Colombia whose wife was recognized as a refugee and who is now sponsoring him, was refused a sight-saving operation to repair a retinal detachment on the grounds that he no longer had healthcare coverage under the IFHP and could not afford the $3000-5000 fee for the operation. Prior to the changes, this operation would have been covered by the IFHP. As his sight was in direct jeopardy, his doctor wrote to the respondent's medical service explaining the urgency of his

situation and requesting help. On August 17, 2012 the doctor was told that no IFHP coverage would be available for the operation, since he was now classified as a rejected refugee claimant.

20. On August 20, 2012, Daniel's doctor agreed to perform the eye surgery at a fraction of the cost. Further delay could have resulted in Daniel losing his vision. The withdrawal of IFHP coverage put Daniel's vision at risk and caused him considerable psychological stress as he faced the prospect of no longer being able to support his family due to blindness given his inability to pay for the sight-saving surgery. He was also subjected to further degrading treatment in that he was explicitly denied help in saving his vision by the federal government—despite the fact that he was the husband of a recognized Convention refugee, was being duly sponsored by her, had a valid work permit and had been paying the same rates of federal and provincial tax on his modest income as Canadian residents.

21. Likewise, the applicant, Hanif Ayubi, who has a medically documented diagnosis of type 1 diabetes since the age of 10, came to Canada as a refugee claimant from Afghanistan in April, 2001 in fear of the Taliban. His claim was ultimately rejected, but Afghanistan has been on a removals moratorium list since 1994. Up until June 30, 2012 he was receiving insulin and medical care under the IFHP. After that date he lost coverage for these items since he has now been classified as a refused refugee and no longer eligible for health care coverage. He is therefore unable to access the necessary blood tests he needs to monitor his diabetes. He is being kept alive on free samples of insulin from a community medical clinic in Ottawa. No discretionary coverage is available for medications. He has a work permit and has been paying federal and provincial taxes, but is a low-income individual and cannot afford the cost of medication and diagnostics. His health has been put at risk and his situation has been extremely worrisome for him since June 30, 2012.

22. Other documented instances of adverse health consequences to refugee claimants and privately sponsored refugees resulting from the terms of the IFHP 2012 have been reported by lawyers and NGOs. In some of such instances, costs have been downloaded onto health care providers, health clinics, provincial hospitals, etc. In one case, medical services were also denied due to confusion around eligibility.

a. Patient 1: A refugee claimant arrived in Saskatoon after fleeing a Middle Eastern country where he was persecuted for being Christian. While waiting for his hearing, he began having abdominal pain and was diagnosed with cancer. However, the IFHP no longer covered the costs of chemo-therapy medications. He could not afford to pay for these medications. Church groups advocated on his behalf, and they were ultimately provided by a hospital pharmacy which absorbed the costs.

b. Patient 2: A 76 year old failed refugee claimant from Sri Lanka living in Calgary was undergoing chemotherapy for bladder cancer when his IFHP was cancelled. He also requires numerous prescription medications for diabetes mellitus, hypertension, aortic valve endocarditis, anemia, and must take intravenous antibiotics regularly. For now, his doctors are covering the costs of his care, but he has to beg family members for the $600 needed each month to cover the costs of life sustaining medications.

c. Patient 3: A failed refugee claimant from Mexico living in Red Deer, Alberta was diagnosed with testicular cancer in October 2012. He has no IFHP coverage for his hospital treatments. Two doctors in Red Deer donated their time to perform surgery on him, but he needs chemotherapy and radiation therapy medications which are also not covered.

d. Patient 4: A failed refugee claimant from Libya who has been in Toronto for about 25 years due to the fact that Libya had previously been on a moratorium list had his right leg amputated below the knee in the fall of 2012 due to infection, likely related to diabetes. The infection is continuing and is now in the bone. The hospital is currently carrying the cost of the operation, and needs payment. The claimant cannot go to rehab to be fitted for prosthesis without IFH coverage.

e. Patient 5: A stateless HIV-positive Bosnian woman in Montreal who had been a victim of human trafficking had abandoned her refugee claim due to poor advice. As persons who abandon their claims do not have access even to Public Health and Public Safety IFH coverage after June 30, 2012, public safety concerns are raised in her case and in similar cases involving diseases categorized as being a threat to public health or safety.

f. Patient 6: An elderly man from Cuba living in Toronto lost his refugee claim but has serious mental health issues and is no longer covered for treatment or medication.

g. Patient 7: A privately sponsored refugee arrived in Ottawa in October 2012 suffering from serious abdominal pain and needing to see a gynecologist. She was not covered for medications and could not afford them, so this cost was born by her sponsors. In addition, a community health centre refused to refer her to a specialist based on a false perception that she was not entitled to IFHP coverage during the waiting period for provincial coverage. She suffered in pain for several months her situation was clarified for the attending physicians by a lawyer.

23. The Community Volunteer Clinic for the Medically Uninsured (CVCMU) in Toronto reported the following documented instances of adverse health consequences to refugee-patients that lost their eligibility under the IFHP due to reclassification.

a. Patient 8: In early July 2012, a young 24-year old woman in Canada for 4 years, 35 weeks pregnant, arrived at the CVCMU crying, with severe abdominal pain. Her obstetrician had told her she was required to pay $130.00 for a visit because her IFH coverage had been cancelled. She stayed at home with her pain, unable to pay the $130, but eventually was examined at the CVCMU.

b. Patient 9: In early July, 2012 a 61 year old gentleman residing in a refugee shelter ran out of his 12 heart medications. Since he had no IFH coverage, he could no longer afford medication renewals or doctor's visits. He was suffering from heart failure and atrial fibrillation. He arrived at the CVCMU sweating profusely and frightened.

c. Patient 10: In late July, 2012 a six year old child awaiting his refugee hearing with his parents developed a dental abscess. He had had open heart surgery when he was 15 days old and required pediatric cardiology follow up. However, his parents' IFH dental care coverage had been cancelled as of July 1, 2012, which posed a serious health risk since the abscess could infect his heart. His family doctor was requesting payment before continuing any care.

d. Patient 11: In late July 2012, a 42 year old failed refugee claimant from Africa who had been beaten and left for dead in the street and who was suffering from chronic severe abdominal pain as a result was dropped by her physician once her IFH coverage was cancelled and she was unable to afford the fees.

e. Patient 12: Three weeks after his IFH coverage was revoked, a rejected refugee suffering from sickle cell anemia developed recurring leg ulcers due to lack of affordable regular medical follow-up.

f. Patient 13: On July 31, 2012 a four year old refugee claimant child from Iran came to the CVCMU crying and in severe pain from an ear-infection that had gone untreated because her parents could not afford to pay their doctor once their IFH coverage was cancelled.

g. Patient 14: A refugee claimant from Iran with cancelled IFH coverage could not afford hospital treatment for her broken foot for one week. She arrived at the CVCMU limping badly on July 31, 2012.

h. Patient 15: In August, 2012 a claimant who was 7 months pregnant was in a panic and desperate after her IFH coverage was cancelled, as she could not afford doctor's fees for pre-natal care or delivery. She was referred to a volunteer midwife and told to report to the emergency room when she went into labour.

i. Patient 16: In September, 2012, an 8 year old rejected refugee claimant from Africa who suffers from asthma began coughing and wheezing more severely because he and his mother could no longer afford medical care after their IFH coverage was revoked.

j. Patient 17: A rejected refugee claimant became ill with a common, treatable condition. As he had had no IFH coverage since June 30, 2012 and could not afford a doctor's visit, by December 2012, his condition had reached a life threatening level. He had to be sent to the hospital.

24. The following are some patient outcomes documented by and reported to the applicant, Canadian Doctors for Refugee Care, by physicians across Canada in situations where patients had either lost IFHP coverage due to reclassification (i.e. classification as a "rejected refugee", under the IFHP 2012) or where the terms of the IFHP 2012 did not provide for adequate medical services:

a. Patient 18: A male refugee claimant experiencing chest pain and having characteristics that made his physician suspicious of tuberculosis was not eligible for a chest x-ray.

b. Patient 19: A female accepted refugee with asthma had an avoidable emergency room visit and hospitalization because of a lack of medication.

c. Patient 20: A female refugee claimant with fibroids and adenomyosis had surgery cancelled due to her IFH status. As a result, the patient had numerous emergency room and doctor's office visits for severe pain.

d. Patient 21: A male refugee applicant with expiring IFH coverage had three children, two requiring immunizations and a third requiring follow-up on an operation on his aorta at birth. They were turned away from two clinics and unable to see a physician.

e. Patient 22: A female refugee claimant who was a senior with diabetes and chronic kidney disease saw her condition deteriorate because of lack of access to medication, regular blood testing and monitoring, and dietician education.

f. Patient 23: A refugee claimant who was a mother of two was unable to seek treatment for high blood pressure after June 30, 2012.

g. Patient 24: A refugee claimant, 32 weeks pregnant, presented at two emergency rooms suffering from lower abdominal pain. On both occasions she was told that she would have to sign a document stating that she would be responsible for the costs of her visit. She left the emergency room on both occasions without being seen.

h. Patient 25: A man admitted to hospital with congestive heart failure and 12 other medical conditions was discharged home without the necessary home care follow up, placing him at a much higher risk of readmission.

25. Some refugee claimants and privately sponsored refugees have been denied interim federal health coverage to which they were entitled, simply because of deficiencies in the rollout of the IFHP 2012. With no advance notice, stakeholder consultation, or preparatory education, confusion within the medical community as to who is covered and for what has led to a de facto denial of access to health care for otherwise eligible individuals. Thus, some IFHP-entitled refugee claimants and privately sponsored refugees have nonetheless been refused coverage and care due to perceived IFHP ineligibility by doctors. Health care has also been inaccessible due to processing delays with respect to IFHP applications by CIC. The following is a sampling of individuals in either of these types of situations, as documented by physicians working with refugee-patients, including the applicant, Canadian Doctors for Refugee Care:

a. Patient 26: In September, 2012 a 12-month old baby whose mother was awaiting her refugee hearing was suffering from a fever and had not been eating properly for a month. Their doctor was charging for treatment based on perceived lack of IFH coverage. The baby had infections in both ears, infected tonsils and was in considerable discomfort.

b. Patient 27: A woman fled her country despite the fact that she was 33 weeks pregnant in order to save her 13 year old daughter from female genital mutilation. Issuance of her IFH coverage document was delayed until after her expected delivery date and she therefore faced the prospect of having to pay for pre-natal care and hospital services she could not afford.

c. Patient 28: In November, 2012 a child refugee claimant with a cleft lip and palate that had become infected was denied care by a doctor despite the fact that he had valid IFH coverage.

d. Patient 29: A 28 year old pregnant diabetic claimant with a history of miscarriage and high blood pressure with valid IFH coverage was refused medical care by a family doctor due to a perceived lack of coverage.

e. Patient 30: A young child from Africa had a high fever but had no health insurance because his IFHP had not been activated.

f. Patient 31: A woman in her third trimester of pregnancy developed preeclampsia, a potentially lethal disease, but had no coverage to treat her condition due to delays in processing her IFHP application

g. Patient 32: A man with a rectal mass was turned away from care a multitude of times although he should have had interim federal health insurance.

h. Patient 33: A young child from Africa could not get a chest X-ray after her IFHP was issued but there was a delay in its implementation. She eventually was found to have pneumonia.

i. Patients 34 and 35: Two young children with multiple hospitalizations for asthma could not get access to their inhalers due to IFHP processing delays, leaving them at risk for seeking out care through emergency departments.

j. Patient 36: A teenager with Post Traumatic Stress Disorder and previous suicide attempts who had valid IFHP coverage was cut off from essential psychiatric medications;

k. Patient 37: A young girl from an area with malaria had a high fever but did not have health coverage to rule out malaria as she awaited her IFHP coverage to be initiated.

26. The changes to the IFHP have had a particularly severe impact on children and pregnant women. A lack of adequate pre-natal care can have an adverse impact after birth.

27. Instances of adverse health consequences will continue to proliferate. On December 15, 2012 section 12 of the *Balanced Refugee Reform Act* was proclaimed in force and a Designated Country of Origin (DCO) list was established. The list includes Hungary (December 15, 2012) and Mexico (February 14, 2013) which have been the major source countries for refugee claims in Canada in recent years. Most of the claims from Hungary have been made by members of the Roma community. Claimants from these major source countries are no longer eligible for interim federal health care coverage (i.e. hospital services, physician and nursing services, diagnostic and laboratory services and ambulance services). They are only eligible for interim federal public health and public safety coverage, which only becomes operative if they have a disease which is considered to pose a public health risk, or if they have a psychotic disorder which involves a risk to others. Other countries may be added to the DCO list at any time.

28. The consequences of the lapse, denial or delay of urgent and essential health care coverage for refugee claimants and privately sponsored refugees under the IFHP are that health problems go untreated until they become emergencies. Hospitals must provide care at that time, but the costs of such care will ultimately be borne by the provincial health care system and the Canadian taxpayer. Providing emergency care at a hospital is far more costly than providing insurance coverage for preventive care.

B. The Order respecting the Interim Federal Health Program 2012 is ultra vires as an improper exercise of the Prerogative Power

28. In 1957, when the original OIC was proclaimed, Canada had not yet signed the Refugee Convention, and had not occupied the legislative field through enacting substantive domestic laws regarding asylum-seekers or other non-citizens seeking humanitarian assistance from the Canadian government on Canadian soil. Nor had it promulgated the 1984 Canada Health Act (CHA) which uses the federal spending power to "establish criteria and conditions in respect of insured health services and extended health care services provided under provincial law that must be met before a full cash contribution can be made". The five criteria of the CHA are universality, portability, comprehensiveness, accessibility and public administration. The universality criteria requires provinces to insure all of its "insured persons … on uniform terms and conditions" and defines insured persons as all residents of a province with the exception of members of the Canadian Forces, RCMP (until 2012), inmates in federal penitentiaries and persons who have not been resident in the province for a minimum period of time that does not exceed three months. It further defines "resident" as meaning, "in relation to a province, a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province." Through the CHA, Canada and the provinces legislatively identified their respective responsibilities for health services for categories of persons in Canada.

29. The now-repealed *Immigration Act* and its successor legislation, the current *Immigration and Refugee Protection Act*, and/or the CHA has supplanted any prior Crown prerogative that existed to permit the characterization of health care funding for refugees, asylum-seekers, and those in refugee-like situations as being ad hoc, ex gratia payments that can be authorized under new assertions of Crown prerogative. This position is affirmed by Crown law experts Peter Hogg and Patrick Monahan, who do not include immigration or health in their list of areas over which Crown prerogative still persists.

30. The fact that governance of health care and of refugees had been overtaken by legislation

did not require the rescission of OIC 1957. However, once the government elected to rescind the 1957 Order in Council and introduce new rules, it was required to do so in a manner that recognized that IRPA and CHA superseded the prerogative power. The government was required to act legislatively or via regulation under either IRPA or the CHA, and in accordance with their respective manner and form requirements.

C. The changes to the IFHP were effected in a manner that did not comply with procedural fairness or the Bill of Rights

30. In *Canada v. Khadr* [2010] 1 SCR 44 the Federal Court of Appeal held that the executive must exercise its prerogative power in accordance with legal norms under the Charter and the duty of fairness (para 92). Courts have also determined that decisions by the executive branch, which affect the legal rights or legitimate expectations of an individual, are subject to judicial review [*Black v. Canada (Prime Minister*), 2001 at para 47-51; *Copello v. Canada (Minister of Foreign Affairs)*, 2003 FCA at para 17].

31. The duty of fairness does not, however, apply to purely legislative functions. The use of an Order in Council to enact the IFHP circumvented the procedural mechanisms that accompany the exercise of the legislative function by Parliament or by Cabinet, and the absence of such procedure has been conceded by the Respondents.

32. Although the revised IFHP implemented through the 2012 Order in Council does not impact the rights of only one particular individual, it does affect the legal rights of a particular delineated group of individuals—asylum seekers, refugee claimants and privately sponsored refugees. Through the IFHP this group of individuals, who are already subject to vulnerabilities due to their unique social, economic, and emotional circumstances, are deprived of the health care that they were once entitled to. Under the new IFHP, even the most preferred category of refugee claimant under the new scheme, as well as privately sponsored refugees, have lost drug benefits. This means that even if such individuals are diagnosed with diabetes, they will be refused insulin to treat it unless they have the money to pay for it out of their own pockets. Given the economic hardships many resettled refugees and asylum seekers face, affording such medication out of their own pockets may be close

to impossible for the vast majority. The cases listed in paragraphs 21 to 25, as well as the situation of the individual applicants herein, provide examples of individual cases where the change in the IFHP has resulted in these very expectable hardships.

33. The doctrine of legitimate expectations imposes procedural obligations on a public official in two circumstances. The first arises when a party, based on past practice, has a legitimate expectation of receiving a benefit or entitlement, and that expectation is defeated. In these cases, the doctrine of legitimate expectations imposes procedural fairness requirements of notice and participation prior to departing from a past practice. The second arises where a pattern of prior participation by an affected party has been abruptly halted or curtailed. In these circumstances, the doctrine of legitimate expectations will require that the prior procedures be honoured. Both branches of legitimate expectations are apposite in this case. The changes made to the IFHP are reviewable due to the fact that the previously held health care benefits and entitlements of these individuals, which had been committed to with the formality of an Order in Council, have been restricted or taken away from them. This exercise of the prerogative power is judicially reviewable with respect to procedural fairness, and in particular legitimate expectations.

34. In *Khadr*, the Federal Court of Appeal outlined that the principle of legitimate expectations "requires that government, at a minimum, follow the processes, procedures and regular practices which it has held out to either an individual or the public at large" (para 119). Where it is found to exist the duty of fairness will require that the expected procedures be followed (*Khadr* para 119).

35. The history of the IFHP demonstrated ongoing consultation and collaboration with provincial health ministries. As the IFHP evolved since 1957, many of its provisions were contained in Memoranda of Understanding with provincial counterparts, thereby evidencing an ongoing practice of notification, consultation, and cooperation. There was a legitimate expectation on the part of provincial health ministries that the executive them before making any changes which reduce healthcare coverage to the IFHP. As there was no prior consultation, there has been a breach of this expectation which encompasses non-government stakeholder parties. There was also no prior consultation with non-government stakeholders on the changes to the IFHP as well as no consultations with provincial governments. The situation meets the threshold for quashing a

decision as set out in *Mount Sinai Hospital Centre v Quebec (Minister of Health and Social Services)* 2001 SCC 41 (at para 21) where Binnie J found

> Even minimal procedural fairness was not extended to the respondents in this case. They had no notice that the Minister was about to reverse his position, or the reasons for the reversal, and no opportunity to present argument as to why the Minister's earlier and long-standing view that the public interest favoured a modified Mount Sinai Hospital Center should prevail. These defects enable the respondents to achieve the first of their objectives, namely the setting aside of the Minister's October 3, 1991 decision…

36. The case at bar can be distinguished from the SCC's decision in *Reference re Canada Assistance Plan* (1991) on several key grounds. In the case of the IFHP, the funding cuts were not executed through the formal Parliamentary process or under any statute. They were instead done through an ad hoc exercise of prerogative power. When exercising funding cuts to refugee healthcare through a prerogative power, the doctrine of legitimate expectations can apply if there are such expectations created and the decision is judicially reviewable as outlined above.

37. The procedure followed by the Government was also inconsistent with section 1 of the Bill of Rights. When the Government of Canada of Canada makes determinations that affect the rights of individuals then the Government is, pursuant to section 1 of the Bill of Rights, required to provide notice before it extinguishes individual rights. By failing to provide notice the Government breached the provisions of the Bill of Rights.

D. The terms of the IFHP 2012 violate Section 12 of the Charter

38. Section 12 of the Charter provides that: "Everyone has the right not to be subjected to any cruel and unusual treatment or punishment." The denial of basic and/or life-sustaining health care that may occur pursuant to the IFHP 2012 constitutes "treatment" within the meaning of section 12.

39. Section 12 may apply outside the context of penal sentencing. "Treatment" under section 12 may be interpreted broadly so as to include any conduct, action or behavior by the state towards a person under state control and may extend to all forms of disability or

disadvantage and not merely those imposed as a penalty to ensure the enforcement of the law. *(R. v. Blakeman* (1988), 48 C.R.R. 222 (Ont. H.C.) cited in *Rodriguez* at para. 181 *Rodriguez*, at para. 180)

40. When an affected refugee claimant is deemed eligible by the Canadian government to make a claim for refugee protection or complementary human rights protection and is awaiting determination of that claim, he/she is effectively under the administrative control of the state—as are privately sponsored refugees. As stated by the Supreme Court of Canada in *Rodriguez*: "[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.".

41. Internationally, in *R. v. Secretary of State for the Home Department ex parte Adam, ex parte Limbuela, ex parte Teseam (hereinafter "Adam & Limbuela")* the House of Lords unanimously held that the denial of subsistence constituted "treatment" within the meaning of Article 3 of *the European Convention on Human Rights*, which prohibits member states from subjecting persons within their jurisdiction to "torture or inhuman or degrading treatment or punishment".

42. Lord Scott concluded, by way of illustration, that a refusal to provide health care services would constitute "treatment" under Article 3 where the government provides such services and determines entitlement to them.

43. The amendments to the IFHP are "treatment" because they establish a radically altered administrative system of classification that determines entitlement to health care services.. The IFHP amendments set up a new regime imposed on an individual, or on a class to which the individual belongs, barring that individual from basic health care benefits to which he or she would, were it not for that new regime, have been entitled.

44. "Treatment" can be found where government action *or inaciton* is responsible for hardship.

(Dunmore v. Attorney General (Ontario) 2001 SCC 94) Thus government action amounting to "treatment" within the meaning of s. 12 can be found where a refugee claimant is denied health services under the amendments to the IFHP and cannot otherwise access health services.

45. Treatment or punishment is cruel and unusual if it is "so excessive as to outrage [our] standards of decency." (*R.v Smith* 1987 1 SCR 1045) The considerations identified in *Smith* should be applied to the question of whether a "treatment" is grossly disproportionate.

46. It is also cruel and unusual for the state to allocate access to medical care – including life-saving treatment – in accordance with the pre-determined and arbitrary factors that are unrelated to the health needs of the individual.

47. Moreover, in assessing whether the amendments to the IFHP are cruel and unusual the Applicants can rely on facts beyond those encountered by one individual applicant.

48. In *Smith*, Justice Lamer stated that the question of whether punishment is cruel and unusual is determined by the particular circumstances of the individual facing the punishment, not the general societal purpose underlying the government action.

49. International law practice confirms that access to health care is at the core of the preservation of human dignity and Charter rights are informed by international obligations.

50. In *International Federation of Human Rights Leagues (FIDH) v. France (Complaint 14/2003)*, the European Committee of Social Rights held that access to health care is a prerequisite for the preservation of human dignity. The Committee stated that legislation or practice which denies entitlement to medical assistance to foreign nationals within the territory of a State Party is contrary to the European Social Charter.

51. Access to basic health services for refugee claimants is a norm among developed countries.

52. A blanket denial of health care services would be an anomaly among health care policies of similarly situated developed countries, supporting a finding of cruel and unusual treatment within the meaning of s. 12. Migrants with and without legal status are entitled to free health care services in Spain, Italy, Belgium, and the Netherlands. In Portugal, asylum seekers are entitled to health service on equal grounds as citizens, and undocumented migrants are entitled to extensive health coverage after residing in the country for 90 days. In France, documented and undocumented migrants under a certain economic threshold are able to access health care services free of charge after residing in the country for more than three months. In Great Britain, asylum seekers are entitled to access health care on equal grounds as citizens, while undocumented migrants can access free primary care, emergency care, family planning, treatment of communicable diseases (except HIV), and services for those with serious mental health issues. In Sweden, asylum seekers are entitled to access free of charge "care that cannot be postponed," ante-post natal care, family planning and abortion, although some of these services require a patient contribution. Children of asylum seekers, asylum seeking children and those whose application for asylum failed are entitled to free health care. In Germany, asylum seekers in their first four years in the country are entitled to free medical treatment in cases of "serious illness or acute pain" as well as "everything necessary for recovery, improvement or relief of illnesses and their consequences," including ante-post natal care and HIV treatment.

53. The Reception Directive of the European Union provides rules to be applied in Europe for the treatment of refugees and refugee claimants and assures that all applicants regardless of country of origin, even those seeking complementary forms of protection receive necessary health care (including medications) and that decisions withdrawing such health care be made on an individual based taking into account the principle of proportionality.

54. The amendments to the IFHP in as much as they cancel, diminish or deny basic and life-sustaining health care coverage for refugee claimants and privately sponsored refugees are inconsistent with international practice, and constitutes cruel and inhumane treatment. The withdrawal of assured entitlement to health care is not mitigated by the availability of discretion under s. 7 of the OIC allowing the Minister to extend certain benefits on an ad hoc basis. Health

care needs may arise suddenly, the population affected by the IFHP may lack knowledge, resources or capacity to apply for favourable discretion and, in any event, access to basic, essential, emergency, pre-natal or life-saving care cannot be administered through a discretionary bureaucratic process in a manner that complies with fundamental justice (*R. v. Morgentaler).* Furthermore, the availability of this discretionary coverage is illusory in practice, and essentially having to beg for access to basic health care is itself degrading.

E. The terms of the IFHP 2012 violate Section 7 of the Charter

55. The changes to the IFHP create a situation where individuals will not have access to basic and necessary health care which will affect them both physically and psychologically thus engaging life and security of the person interests guaranteed by s. 7. (*Chaoulli v Quebec* 2005 1 SCR 791; *R. v. Morgenthaler* 1988 1 SCR 30). For people with conditions such as asthma, angina and epilepsy the cuts to the benefits provided previously could have serious health problems and potentially deadly consequences for those who cannot afford to buy the prescribed medication themselves. In *Chaoulli* the conduct of the Government that was in play was the prohibition against private health insurance. In the case at bar it is the changes in the IFHP that constitute the government conduct.

56. The case at bar is distinguishable from *Toussaint v. MCI* 2011 FCA 213. in which the Federal Court of Appeal concluded that the Federal Government's conduct was not at play because the Applicant Toussaint was being denied coverage due to the restrictions imposed by the Provincial Health Plan. However, in Toussaint the Applicant was a person without any status in Canada who had never claimed refugee status, had never been eligible for coverage under the IFHP and to whom no international obligations were owed by the government of Canada. In contrast, in the case at bar, the affected persons are all either resettled refugees or refugee claimants, were previously entitled to coverage under the IFHP and had come to Canada, not as tourists, but to seek protection from persecution, and it was only as a result of the changes that they are now not receiving coverage. Moreover, it is clear, that the Federal Government has assumed responsibility over refugee health care for many years and hence, in the case of privately sponsored refugees and

refugee claimants it is clear that it is the change in the IFHP that is the cause of the denial of medical care. As such section seven is engaged.

57. The principle of fundamental justice at play is that "laws that affect the life, liberty or security of the person shall not be arbitrary." (*Chaoulli* para. 128) In *Chaoulli* the Court held that:

> **131** In order not to be arbitrary, the limit on life, liberty and security requires not only a theoretical connection between the limit and the legislative goal, but a real connection on the facts. The onus of showing lack of connection in this sense rests with the claimant. The question in every case is whether the measure is arbitrary in the sense of bearing no real relation to the goal and hence being manifestly unfair. The more serious the impingement on the person's liberty and security, the more clear must be the connection. Where the individual's very life may be at stake, the reasonable person would expect a clear connection, in theory and in fact, between the measure that puts life at risk and the legislative goals.

58. In *Chaoulli* the Court found that there was no evidence of a clear link between a prohibition on private health care and the protection of the public health care system. In *Toussaint* the Federal Court of Appeal concluded at par 82 that

> As a general matter, as the analysis in paragraphs 31-46 above shows, the Order in Council is meant to provide temporary, emergency assistance to those who lawfully enter Canada and find themselves under the jurisdiction of the immigration authorities, or for whom the immigration authorities feel responsible. The Order in Council is not meant to provide ongoing medical coverage to all persons who have entered and who remain in Canada, lawfully or unlawfully.

59. As opposed to the situation in *Toussaint*, the amendments to the IFHP are clearly arbitrary. No rational justification has been provided by the government for the sudden changes. Privately sponsored refugees and refugee claimants who were eligible for coverage have had their coverage reduced or revoked. Future claimants and privately sponsored refugees who would have been eligible for coverage are now arbitrarily denied it. As in the case of *Chaoulli*, there is no rational connection between the changes and their stated purpose. There is no evidence that denying IFHP to refugee claimants will have the desired effect of discouraging frivolous claims. There will be no cost savings to taxpayers, only cost transfers. No equity is achieved either, since the IFHP never provided significantly better coverage to resettled refugees and refugee claimants than to Canadians in the same economic circumstances in the first place. Rather, the changes expose persons already in Canada to a grave risk to their health. Allocating basic, primary, urgent, and essential health care according to moral desert, or to achieve punitive goals, is arbitrary. The amendments to the IFHP

are arbitrary and therefore inconsistent with the principles of fundamental justice.

60. The principles of fundamental justice are not satisfied by the theoretical availability of discretion under s. 7 of the OIC allowing the Minister to extend certain benefits on an ad hoc basis. Health care needs may arise suddenly, the population affected by the IFHP may lack knowledge, resources or capacity to apply for favourable discretion and, in any event, access to basic, essential, emergency, pre-natal or life-saving care cannot be administered through a discretionary bureaucratic process in a manner that complies with fundamental justice. (*R. v. Morgentaler).* Furthermore, the availability of this discretionary coverage is illusory in practice.

F. The terms of the IFHP 2012 violate Section 15 of the Charter

61. In determining whether the legislation in question violates s. 15 of the *Charter,* a two-part test must be applied. Specifically, it must be determined 1) whether the law creates a distinction that is based on an enumerated or analogous ground and 2) whether the distinction creates a disadvantage by perpetuating prejudice or stereotyping. The key is whether a distinction has the effect of perpetuating arbitrary disadvantage on an individual because of his or her membership in an enumerated or analogous group. 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. Both branches of the test are met in the case at bar.(*Withler v. Canada (Attorney General)* 2011 SCC 12 at para. 30;*R. v. Kapp,* 2008 SCC 41 at para. 17; *AG of Quebec v. A* 2013 SCC 5 (CanLII))

62. There are two key distinctions made by the IFHP 2012 in this case. The first is between refugee claimants from designated countries of origin and refugee claimants that are not from a designated country of origin. The second is based on immigration status, specifically the status of the claimants as individuals in Canada for the purpose of seeking protection. In both cases the distinctions are based on enumerated or analogous grounds and in both cases the end result is discriminatory.

63. The current IFHP draws a distinction in terms health benefits between individuals who are claiming refugee protection from countries that have been designated by the Minister as Designated Countries of Origin (DCOs) and those that are claiming refugee protection from any other country. This is a clear distinction based on national or ethnic origin—an enumerated ground under s. 15 of the *Charter.*

64. More broadly, the Applicants in the case at bar are being treated in a differential manner based on their status as individuals who are in Canada for the purposes of seeking protection. That is, the Applicants are being denied healthcare coverage on the basis of their particular immigration status. The distinction in this case is therefore between individuals who are legally in Canada for the purpose of seeking protection who do not receive full health benefits as a result of that status and other legal residents who are provided health benefits by the government.

65. Whether or not a person's immigration status is considered to be an analogous ground depends on the specific nature of the person's status and the rights at issue. Some cases have found immigration status to be an analogous ground *(Pawar v. Canada* [1999] 1 FC 158 at para. 23;*R. v. Church of Scientology*, 33 OR (3d) 65 at para 125) and some have not *(Toussaint v. Canada (Attorney General)*, 2011 FCA 213, *Irshad (Litigation Guardian of) v. Ontario (Minister of Health)* (2001), 55 O.R. (3d) 43 (C.A.)), in obiter or otherwise.

66. Given this case law, it appears that whether or not a person's immigration status is considered to be an analogous ground will depend on the particular circumstances of each case. That is, it will depend on the particular nature of the person's immigration status and the right that is being asserted. A key factor in this determination from the case law seems to be whether or not the person's immigration status is immutable. However, immutability is not the only factor to be considered when determining whether an analogous ground exists. Indeed, the case law from the Federal Court has indicated that the focus of an analysis to determine whether or not a characteristic constitutes an analogous ground should focus on historic disadvantage rather than simply on immutability which is a good indicator, but not determinative. (*Lee v. Canada (Minister of Citizenship & Immigration)* [2008] 4 FCR 193;*Al-Ghamdi v. Canada (Minister of Foreign Affairs and International Trade)* [2007] FC 559 at para. 58)

67. The nature of the status of persons affected by the changes to the IFHP is immutable. according to the Supreme Court's test in *Corbiere v. Canada (Ministry of Indian and Northern Affairs),* [1999] 2 S.C.R. 203. Privately sponsored refugees cannot change their status. As for refugee claimants, while they seek Canada's protection in various forms, they have no power to themselves cause this to happen. Until that happens, their status is immutable. Nor can they change the history that led them to seek asylum, or the conditions in their countries of origin. Their presence in Canada is not "voluntary" or "optional" in the sense that Ms. Toussaint's was, as their migration was forced. Unlike *Toussaint,* they immediately submitted themselves to Canada's bureaucratic and administrative processes.

68. Moreover, individuals who are in Canada for the purpose of claiming or receiving protection also make up a historically disadvantaged group. They are generally individuals who have already been marginalized and are fleeing persecution on the grounds of race, religion, ethnicity, gender, sexual orientation or political opinion. These individuals have been forced to leave their home countries to seek a new home in a country like Canada in spite of many financial, physical and psychological hardships in doing so. Finally, these individuals' lack of citizenship in Canada perpetuates their disadvantage, as does public perception of them as "bogus". As noted by Justice Bastarache in *Lavoie:* "it is settled law that non-citizens suffer from political marginalization, stereotyping and historical disadvantage." Similarly, Justice LaForest held in *Andrews,* that "Non-citizens are a group of person who are relatively powerless politically and whose interests are likely to be compromised by legislative decisions." *(Lavoie v. Canada,* [2002] 1 SCR 769 at para. 45';*Law Society of British Columbia v. Andrews,* [1989] 1 SCR 143 at para. 68).

69. Given the practical immutability of the status of refugee claimants and privately sponsored refugees and the fact that they are individuals who have historically been discriminated against and are at a disadvantage, their status as individuals in Canada for the purpose of claiming protection is an analogous ground for the purpose of s. 15 of the *Charter.*

70. Both distinctions (country of origin and protection-seeking immigration status) create a

disadvantage by perpetuating prejudice or stereotyping (*Auton (Guardian ad litem of) v. British Columbia (Attorney General),* 2004 SCC 78). In the case of claimants from a DCO, the discrimination is direct. It is predicated on a judgment that a refugee or asylum seeker deserves health care that is commensurate with the Minister's belief regarding the statistically likely future outcome of the refugee claim and perpetuates the idea that individuals who come from these countries seeking protection are undesirable. It also further marginalizes minorities from these countries that still face significant persecution such as the Roma from Hungary (a DCO) or the LGBTQ communities in Mexico, which is another listed country, even though many members of these groups are found each year in Canada to have legitimate refugee claims. As such the distinction is discriminatory.

71. The distinctions made in the IFHP widen the gap between historically disadvantaged groups and the rest of society. In *Eldridge v. British Columbia (AG)* 1997 3 SCR 624 the Supreme Court found that the impact of the impugned law or program will be more severe in scope if the law or program restricts access to a fundamental social institution. Thus, the Court ordered the reinstatement of public funding of translation service for deaf patients after these services had been withdrawn. The deaf patients were not seeking more care than what was provided to others; rather the translation services were needed simply in order for them to have the same services as others without disadvantage or discrimination. In the case at bar, the cuts to health services to privately sponsored refugees and refugee claimants in the IFHP 2012 creates a risk that these individuals will go without much needed, and potentially life-saving, treatments. Accordingly, the Applicants are asking for basic health care services at the same level as other persons lawfully in Canada in similar economic circumstances—i.e. access to prescription medications, and urgent and essential medical care—without discrimination.

72. In the recent case of *Finch v. The Commonwealth of Massachusetts* 959 NE 2d 970 (2012) the Supreme Judicial Court of Massachusetts ruled that a scheme to exclude certain lawful residents from the state's public health insurance plan constituted impermissible discrimination on the basis of alienage and national origin.

73. In this case, the persons affected by the IFHP 2012 are lawfully in Canada. They are relying

on the undertaking Canada has given pursuant to the 1951 Refugee Convention not to return persons who present themselves on our shores seeking protection. Many individuals who have abandoned their claims, who have been excluded from protection or had their claims rejected, are likely seeking a subsidiary form of protection either through a Pre-Removal Risk Assessment or a Humanitarian and Compassionate Application which can both be lawfully be done from within Canada. Furthermore, all the individual applicants, despite having seen their refugee claims refused, are nonetheless in refugee-like situations. Applicant Garcia Rodrigues' wife was recognized as a Convention refugee and he is therefore to be treated as a Convention refugee according to the principle of family unity. Applicants Awatt and Ayubi are from countries under a temporary suspension of removals (moratorium) because Canada has determined that conditions in those countries pose a generalized risk to the entire civilian population. When all prescribed avenues have been exhausted, unsuccessful refugee claimants will be removed from Canada. But until the government does so, they are entitled to be treated in a humane manner, free from discrimination on the basis of their status as people who are in Canada seeking protection.

G. The terms of the IFHP 2012 are contrary to Canada's obligations under the Refugee Convention:

74. Canada is a party to the *1951 Convention relating to the Status of Refugees*. International human rights law plays an important role in Charter interpretation. The Charter should be presumed to provide at least as great a level of protection as is found in the international human rights documents which Canada has ratified. (*Health Services and Support-Facilities Subsector Bargaining Assn.* v, *British Columbia* 2007 SCC 27).

75. UNHCR *Handbook on Procedures and Criteria for Determining Refugee Status* states "A person is a refugee within the meaning of the 1951 Convention as soon as he fulfills the criteria contained in the definition. This would necessarily occur prior to the time at which his refugee status is formally determined. Recognition of his refugee status does not therefore make him a refugee but declares him to be one. He does not become a refugee because of recognition, but is recognized because he is a refugee." (Handbook paragraph 28).

76. Thus all refugee claimants (including those from DCOs) have treaty rights under the Convention until they are finally determined not to be Convention refugees. Privately sponsored refugees have these rights as well since they have been determined to be Convention refugees.

77. Article 3 of the refugee Convention prohibits discrimination between and among refugees.

78. The terms of the 2012 IFHP provide different (and inferior) health care coverage for refugee claimants from DCOs vis-à-vis claimants who are not from such countries of origin. This constitutes discrimination between and among refugees on the basis of country of origin and is prohibited under the Convention. The terms of the IFHP 2012 also distinguish between privately sponsored refugees, and government sponsored refugees.

79. Article 7 of the Convention applies to refugees (and claimants) physically present in the host state and includes the right to physical security. Access to health care is included in the right to physical security. Since the IFHP 2012 has resulted in impairment of the access to adequate health care for non-DCO and DCO-claimants alike, Canada is not abiding by its international obligations under the refugee Convention. Non-DCO claimants awaiting determination have no coverage for prescription medications, even life-sustaining ones like insulin, and there is no exemption from this rule. DCO claimants awaiting determination are likewise not covered for prescription medication, nor are they eligible for health care coverage.

H. The terms of the IFHP 2012 are contrary to Canada's obligations under the Convention on the Rights of the Child

80. The IFHP as currently constituted applies to children without exemption.

81. Canada is a party to the *Convention on the Rights of the Child* and has ratified it. International human rights law plays an important role in Charter interpretation. The Charter should be presumed to provide at least as great a level of protection as is found in the international human rights documents which Canada has ratified. (*Health Services and Support-Facilities Subsector*

Bargaining Assn. v, *British Columbia* 2007 SCC 27).

82. The rights contained in this Convention apply without discrimination based on country of origin (Article 2) and apply equally to children seeking refugee status (Article 23).

83. The 2012 changes to the IFHP, in as much as they apply to children and pregnant women, put Canada violation of Article 24 of the Convention which requires states to ensure "the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care and to ensure appropriate pre-natal and post-natal health care for mothers….."

84. The UNHCR in its guidelines on the protection and care of refugee children stipulates that

> Protection and promotion of children's health requires that children have access to the essential services of a health system. Refugee children should have access to the national health services of the host country. Sometimes supplementary health mechanisms must be established specifically for refugee populations. Special efforts are always required to address the unique health needs of refugee children…

85. The changes to the IFHP significant reduce the access of refugee children and pregnant women to essential services. In-process child refugee claimants and pregnant women have no access to medication for non-contagious health conditions unless there is an ability to pay. The same is true of privately sponsored refugees who are children or happen to be pregnant. Child refugee claimants and pregnant women who have been refused or who are from a designated country of origin are not entitled to "health care coverage" under the IFHP and must rely on a vague and highly discretionary exemption clause in order to achieve this most fundamental of rights.

86. No process or inquiry appears to have been undertaken to ensure that the changes to the IFHP not only complied with Canada's obligations under the *Convention on the Rights of the Child*, but also took into account the best interests of children. This lack of process and inquiry itself violates Article 3 of the Convention which states that:

> **Article 3**
> 1. In all actions concerning children, whether undertaken by public or private social welfare

> institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration…

87. The changes to the IFHP are in violation of international law in as much as they fail to protect the interests of children and pregnant women.

88. Obligations towards children extend to them regardless of lawful or unlawful presence in the State's territory as long as they are under the State's jurisdiction. (*Defence for Children International v. the Netherlands* Complaint No 47/2008, European Committee on Social Rights). Impairing a child's right to basic health care is particularly egregious in view of the fact that children have no say as to the country to which they are brought.

I. Such further and other grounds as counsel may advise and this Honourable Court may permit.

This application will be supported by the following material:

1. The affidavits of the applicants herein;
2. Other affidavit material, including affidavits from health care providers and persons directly affected by the changes to the Interim Federal Health Program;
3. Such further and other material as counsel may advise and this Court may permit .

The applicants request the Minister of Citizenship and Immigration to send the following material that is not in the possession of the applicants but is in the possession of the Minister of Citizenship and Immigration to the applicants and the Registry:

> All material relevant to the decision to alter the Interim Federal Health Program.

February 25, 2013

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