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EXCESSIVE DEMANDS ON HEALTH AND SOCIAL SERVICES: s. 19(1)(a)(ii) IMMIGRATION ACT – WHAT IS THE STANDARD TO SPONSOR INFIRM AND ELDERLY PARENTS?

Kenneth H. Post*

RÉSUMÉ
Les personnes âgées et les personnes handicapées qui sont parrainées comme faisant partie de la catégorie de la famille peuvent ne pas être admissibles si on estime, de manière raisonnable, que leurs handicaps médicaux représentent une charge trop lourde pour les services de santé et les services sociaux canadiens. L’auteur met l’accent sur deux aspects de la non-admissibilité médicale en vertu de l’article S.19(1)(a)(ii). Tout d’abord la notion de demande excessive est sans fondement rationnel et, deuxièmement, l’exclusion de parents âgés a créé des mécanismes d’admission systématiques et arbitraires.

INTRODUCTION
The policy of the Immigration Act, 1978 [hereinafter the Act] has an explicit objective of facilitating “the reunion in Canada of Canadian citizens and permanent residents with their close relatives from abroad”. Yet section 11(1) of the Act requires taking a medical examination and section 19(1)(a)(ii) forbids entry to those suffering health impairments which “might reasonably be expected to cause excessive demands on health or social services.” Thus, “family members, as defined in the Immigration Act and Regulations, must by law be accepted as permanent residents”; but this is “provided they pass health and security requirements.” Since elderly parents are more likely to be inadmissible on medical grounds than other people, the Act seems to be ordered to thwart its own purposes. This paper explores how the process of determination of medical inadmissibility works below and the problems in that process for those who are clearly infirm.

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1. Immigration Act, R.S.C. 1985, c. I-2, s.3(c) [hereinafter the Act].

Excessive Demands on Health and Social Services

Inspite of the likelihood that elderly parents will be denied admission for medical reasons, immigration rates for the elderly imply that significant numbers are gaining admission. To date, this suggests that the actual practice of the Immigration Department is following an alternate route: elderly parents are being admitted on humanitarian and compassionate grounds and then given a Minister’s Permit. This practice raises the question why the Immigration Act or Regulations should not simply be altered to permit automatic entry for sponsored, elderly, infirm parents without requiring any medical checks at all. The answer would likely be that by rendering elderly parents inadmissible and then as a matter of policy using discretion to allow admission, it is much easier to change policy and immediately alter admission. In other words, the Federal Government wants the option to quietly and quickly change its mind. While some immigration lawyers would maintain that discretion is more often not exercised in favour of the infirm elderly, it would be untrue to say that it is rarely if ever exercised in this way. Nonetheless a number of recent changes and proposed changes may imply a policy of greater restrictiveness which could easily and inobtrusively be implemented. The “impact statement” of the proposed new Regulations explain that an unintended effect of the 1978 Regulations was that “Greater numbers of sponsored parents were seeking to emigrate to Canada with greater numbers of their own children.” It goes on to report in dismay that “at one post in 1989 the number of applications from older parents doubled.” The weaknesses in procedures noted in the first section of this essay may therefore become more important as grounds of appeal. Moreover, the more general recommendation that automatic entry be granted elderly parents regardless of their condition takes on new importance. It would save the costs of the entire process which appears to be largely unnecessary insofar as the policy is to admit elderly parents; it would end the agony of uncertainty and bureaucratic delay; and it would establish elderly parents’ right of entry free from invisible shifts in policy and discretion.

On June 25, 1992 substantial changes to the Act were proposed by the Federal Government. The changes were accompanied by a major press release,

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3. Immigration Act, supra, note 1; Immigration Regulations, 1978, SOR/78-172 [hereinafter the Regulations].
4. Supra, note 2.
5. Supra, note 3.
6. Supra, note 2 at 3579.
7. Ibid.
background paper and summary the thrust of which was to focus attention on changes in the rules concerning refugees and business immigrants. Medical inadmissibility is a very small part of the proposed changes. The significant changes in this area are first to remove ambiguity around the authority of medical officers and visa officers in determining medical inadmissibility. Secondly, the government has promised to cease using “disabled” when referring to the infirm; but it remains to be seen what substantial difference this will make in admissions. Thirdly, the apparent shift in authority is accompanied by an admission that the criteria used by medical officers in determining what constitutes an “excessive demand on health and social services” requires definition. This admission is supported by the argument of this paper which shows in detail how ambiguous that definition is at present. But further definition will have to wait for “consultation” and hence for new regulations. The Annual Report to Parliament Immigration Plan For 1991-1995 Year Two promised a report on medical admissibility would be “released shortly” which has yet to occur. Thus the government clearly recognizes the problem indicated by this paper (and has at least since 1986); yet, it is slow to rectify it. And, as we show below, by increasing the authority of the medical officers it actually exacerbates the problem by giving more authority to those less able to exercise it properly. It is hoped that this paper can contribute to that current consultative process.

By focussing this essay on infirm, elderly parents, we focus on an area likely to be of increasing concern since the parents of the large group of immigrants between 1965 and 1975 will need care. This is an area in which none of the usual arguments for immigration exist except that it is the humane and compassionate thing to do. When that element is absent the immigration regime is capable of the callous treatment accorded those in the Mong and Ng cases described below.


9. Ibid. Press Release with Background at 6; Managing Immigration at 19.


Parents often have some kind of disabling condition which is nonetheless not a threat to the health and safety of others. Thus only the second ground of medical inadmissibility is relevant: the ground of excessive demands on health or social services. It also means the focus is not on independent immigrants but on those sponsored by family members. These three characteristics—that elderly parents are likely to be ruled inadmissible for fear that they will cost taxpayers money, that they need care, and that they are sponsored by Canadian family members—focusses our attention on two aspects of medical inadmissibility: 1) that the ground of excessive demand on health or social services, while perhaps intuitively making sense, is without rational basis in the application of the law; 2) and that the undoubted inhumanity of excluding elderly parents has created relatively systematic discretionary mechanisms for admission.

I. APPLICATIONS FOR PERMANENT RESIDENCY BY SPONSORED PARENTS

A. Authorization

Infirm parents seek entry as sponsored members of the “family class”. Section 114(1) of the Act authorizes regulations to be made regarding those who could include parents of citizens or permanent residents and the Regulations (s. 4(1)(b)) authorize the sponsorship of parents for landing.¹³ The purposes of the Act are manifest in the Regulations which accord first priority to processing of members of the family class: s.3(a). The term “family class” is defined implicitly by sections 4-6 of the Regulations.

B. Practical Considerations

Section 9(1) of the Act requires sponsored parents to apply from outside of Canada. However, because elderly and infirm parents require the help of their children as quickly as possible, it is possible that, if they are visiting their children, they could decide to immigrate from within Canada and stay with their children during the process. This is not to recommend entering Canada by deception. The punishment for even counselling such a thing is described in s.94 of the Act. But the considerations which allow application from within Canada on humanitarian and compassionate grounds are the same considerations that at the end of the process of application for permanent residency

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¹² Ng v. Minister of Employment and Immigration (1986), 1 Imm. L.R. (2d) 307 at 316 (I.A.B.) [hereinafter Ng].

¹³ Regulations, supra, note 3. These Regulations have also been incorporated in a policy manual called Immigration Manual: Legislation (Ottawa: Employment and Immigration Canada), [hereinafter IL Manual].
will allow the parents to receive Minister's Permits. As well, this practice, is
now relatively common. Therefore, because of the time it takes to gain
approval for entry into Canada, such a method of immigration has much to
recommend it, particularly for citizens of those countries not requiring
visitor's visas. The list of such countries is authorized by s.13(1) and listed
under Schedule II of the Regulations. This is, of course, provided that the
infirmity is neither too advanced nor too debilitating so as to prevent entry
as a visitor under the Act.

C. Procedure

Thus by authority s.114(2) of the Act an exemption from the requirement to
apply from outside Canada may be granted and the IE and IS immigration policy
Manuals so direct officers. Note however, as Mr. Justice Jerome points out at
length in the Yhap decision, that the immigration policy manuals are guidelines
only for matters which are largely discretionary. They must not be adhered to so
as to completely fetter the visa officer's discretion. Moreover, it is interpretive
and hence may be wrong in substantial matters of law. At this point however the
IE Manual's guidance seems unobjectionable. Applications for exemption from
applying from outside Canada are submitted on form IMM 1454. Discretion
to allow those who are medically inadmissible to apply from within Canada is
permitted. Under s.114(2) the reasons for allowing application from within
Canada are to be either humanitarian and compassionate or public policy
grounds. Because we are concerned with those who are infirm and likely to be
denied admissibility on medical grounds, the same humanitarian and compas-
sionate reasons likely to result in Minister's Permits being granted, once the
applicant has been ruled medically inadmissible, form the reasons for being
allowed to apply from within Canada: see IS Manual Chapter 10, paragraph

Crucial among those humanitarian and compassionate grounds will be facts
established by the requirements for applying for Permanent Residency. An
undertaking must be made to support the parents in which it is proved that

14. Along with Immigration Manual: Legislation, Ibid. there are 2 other policy manu-
c.9; Immigration Manual: Selection and Controls [hereinafter IS Manual].
15. Yhap v. Minister of Employment and Immigration (1990), 9 Imm.LR (2d) 243 at
17. Ibid. at c.9, para. 9.10.4.
the sponsor possesses finances above the low income cut-off figure in accord with s.10(2) of the Regulations and as developed by IS Manual Chapter 4, paragraph 4.26-4.27. Other considerations of consequence may be gleaned from cases in which there were appeals from medical inadmissibility on humanitarian and compassionate grounds. Thus in Mong, a case involving medical inadmissibility of the sponsor’s mother who was diagnosed with senile dementia at age 61, the character of the country (poor, tyrannical and discriminatory against this ethnic group), the pennilessness of the parents, the regular sending of money by the sponsor to the parents, the sponsor’s wife’s training in gerontology, the strong desire of the sponsor and his wife to have his parents live with them, and the possibility that the mother’s condition may have improved were all factors of consequence. The application in this case took two years to be rejected and three years for a decision on appeal, a shocking length of time, especially considering the vulnerability of the applicants. Mean times for processing may be found in IS Manual Chapter 4, Appendix A, Annex I and suggest again the desirability of applying from within Canada if infirmity is a consideration. Another example involving a person from India took only two years from date of application until refusal by a Board decision. There, it seemed decisive in not allowing the appeal on humanitarian and compassionate grounds, that the sponsored mother was living with two of her daughters both of whom had university degrees and that two other siblings also lived in India. In another case, shocking in its crass sense of the meaning of humanitarian and compassionate grounds, the sponsor put $246,000 in a trust to pay an irrevocable joint life policy for the benefit of a step-brother with Down’s Syndrome in order to bring in his aged father, step-brother and step-sister. The board noted in addition that the father’s worth was $1.5-2 million.

II. MEDICAL EXAMINATION AUTHORIZED BY STATUTE
A. Authorization
The requirement that every person who is seeking permanent residency must undergo a medical examination is established by s.11 (1). The Act then

20. Supra, note 11.
prohibits admission to Canada on particular findings related to medical condition by s.19 (1) (a):

19. (1) No person shall be granted admission who is a member of any of the following classes:

(a) persons who are suffering from any diseases, disorder, disability or other health impairment as a result of the nature, severity or probable duration of which, in the opinion of a medical officer concurred in by at least one other medical officer,

(i) they are or are likely to be a danger to public health or to public safety, or

(ii) their admission would cause or might reasonably be expected to cause excessive demands on health or social services;

The opinion of the medical officers concerning the two criteria of s.19.(1)(a)(i) and(ii) is to be determined in accordance with the factors set out in s.22 of the Regulations pursuant to the authorization in s.114(1)(m).

The proposed new wording for this section is

(a) persons who, in the opinion of a medical officer concurred in by at least one other medical officer, are persons

(i) who are or are likely to be a danger to public health or to public safety, or

(ii) whose admission would cause or might be expected to cause excessive demands, within the meaning assigned to that expression by the regulations, on health or prescribed social services;\(^2\)

The ambiguity around the authority of the medical officer which this wording attempts to resolve is described below. That resolution may have been intended to address the authority of the Immigration Appeal Board in addition to the authority of the visa officer, but it is hard to believe that the tribunal would accept that interpretation without the statute being more specific. The attempt to define standards of excessive demands on health or social services is anticipated by the phrase "within the meaning ... services." The use of "prescribed" would seem to imply that the physician who provides the initial report to the medical officer would have to have prescribed a social service for it to be taken into consideration by the medical officer but it could also mean that medical officers may find a social service prescribed in the Medical

23. Bill C-86, supra note 4 at 18, s. 11.
Officer's Handbook\textsuperscript{24} which we describe below. If the latter, then problems of fettered discretion would be increased; if the former, then applicants would have an increased ability to influence the application of this standard by discussing care and services with physicians before the report is sent.

B. Meaning of the Statute
Many of the terms in s.19.(1)(a)(ii) of the \textit{Act} have been litigated and bear examination.

1. \textit{Medical Officer}
This term is defined in s.2(1) of the \textit{Act}. It is not the case that the person referred to here is the person who actually examines the applicant. The medical officer in fact reviews the report of another physician of the applicant's own choosing in Canada or the United States or a physician chosen from among a prescribed list in other countries. The medical officer reports to the Department of National Health and Welfare and is authorized to perform his or her duties by the \textit{Department of National Health and Welfare Act}.\textsuperscript{25}

The qualifications of medical officers are not that they be knowledgeable about demands in Canada for various types of health and social services and the type of strain that any additional users might put on these services. Medical officers must merely be “qualified medical practitioners”: s.2 of the \textit{Act}. They have no training in economics and few economic facts on which to base decisions. They do not consider individual economic factors when making economic decisions. They are both without training in law and uninformed about legal determinations regarding their decisions.

While waiting lists for some health services (an irrelevant criteria according to \textit{Ng}\textsuperscript{26}) might be known to medical officers as physicians, it is unclear how other determinations about demands for health and social services are related to their special fields of knowledge and their decisions. In \textit{Ahir},\textsuperscript{27} it was evident that in ignoring the visitor/immigrant distinction, the actual needs of the applicant had also been ignored. A particular condition had somehow been rubber-stamped as creating an excessive demand on services. In \textit{Hong Ngoc}...
it was found that "there was no evidence whatsoever that the government medical officers ever turned their attention to the social services that might be required." How can that be? In hearings on this process in 1986, it was said by a witness for Health and Welfare Canada that "guidelines" on "cost factors" are available to the medical officers and these are considered with respect, for example, to "excessive demands on your social welfare systems" in weighing admissibility. Yet nowhere is the training as economists that would be necessary to make the sort of complicated calculation and study of various conditions indicated. This testimony was flatly contradicted in the *Handbook* used by Medical Officers which was revised the same month as the 1986 hearings. The absence of any quantitative basis on which to form judgements regarding the demand on services as required by the *Act* was frankly admitted: "It follows then that it is not possible at present to establish quantitative guidelines based on statistical analysis of Canadian health and social care experience in order to differentiate the [categories related to excessive demand on health and social services]." The type of sophisticated considerations which should go into such guidelines are usefully outlined in the *Handbook* prior to this admission.

In addition to a lack of quantitative information and the training to analyze it, medical officers do not have before them the documentation which could help the officer to decide who would be bearing the cost in the particular case and, hence, who would be deprived of services as a consequence. In fact, medical officers are specifically directed not to take such individual factors into account: "It is not the function of a medical officer to form an opinion based on or influenced by civil factors, such as the economic circumstances of the applicant, but solely on the medical considerations specified in the *Act* and *Regulations*." Yet, of course, those "medical" considerations include

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factual, statistical and economic questions unrelated to medical training. Among those listed in s.22 of the Regulations are these:

(e) whether the supply of health or social services that the person may require in Canada is limited to such an extent that

(i) the use of such services by the person might reasonably be expected to prevent or delay provision of those services to Canadian citizens or permanent residents, or

(ii) the use of such services may not be available or accessible to the person;

... (g) whether potential employability or productivity is affected, and

(h) whether prompt and effective medical treatment can be provided.

Contrary to this concept of the appropriate mode of decision making is the reasoning in Ng on the determination of the demand on social services: “We beg leave to doubt that, given the evident love of Mrs. Ng for her mother, there will be any demand on social services.”33 It is important to note, as well, that the ability to show that there are services in the area in which the applicant will reside which are sufficient to meet the needs of the applicant and that the use of them will not strain the services is a defence to this ground of inadmissibility.34

Because there has been much litigation around the terms of the criteria, one would expect that medical officers would also need some training in legal matters regarding the meaning of the considerations and judgements to be made and regarding how new case law is delineating that meaning. Yet one authority states that most medical officers are unaware of the existence of section 22 [the Regulation which defines the considerations to be taken into account by the medical officer].35 In fact, the Handbook quotes s.22 without identifying it as such.36 However, Dr. B.S. Leslie, Director of Immigration Medical Services, Department of National Health and Welfare, has stated that Immigration Appeal Board reversals of medical decisions have “no impact on guidelines.”37

Thus while fully half the opinion to be reached by the medical officers is based on analysis of service demands and the ability of a complex and varied

33. Supra, note 12, at 316.
34. Hong Ngoc Le, supra, note 28.
35. McCrea, supra, note 28 at 2.1.04.
36. Supra, note 24 at 3-1 to 3-2.
37. Supra note 29 at 9:44.
socio-political structure to meet them; they have neither the training to
determine the capacity of the structure nor are they given anyone else's
studies on which to base their estimates. Quite simply, their opinion on
these matters is based on no evidence. John Evans, in discussing the
significance of the decision in *Keeprite*, states that it established "that
a complete absence of evidence for a material finding of fact constitutes
jurisdictional error by an administrative tribunal." Alternatively, according
to *Keeprite*, this is established by s.2(3) of the *Judicial Review
Procedure Act*. Most importantly this thrust of *Keeprite* is similar to that
in *CUPE*:

> "On matters primarily entrusted to the determination of administrative agencies, fact-finding and the interpretation of the governing legal framework, the courts are entitled to insist upon a minimum standard of rationality."

It follows that if the opinion of the medical officers is meant to decide any
of the non-medical issues raised by s.22 of the *Regulations* then the opinion
must be regarded as an error of law or of jurisdiction. If the statute intended
that the decision be based on s.22 (e) but without any evidence about the
existing social services then, in accordance with the *Canadian Bill of Rights* following the opinion of Beetz J. in *Singh*, it must be declared of no force
and effect. There Beetz J. quotes with approval the opinion of Pigeon J. that
decisions to be in accord with fundamental justice must be based on reasons:

> "In the present case no indication was given to the appellant of the reasons for which her claim to refugee status was denied and, in my view, this raises a very serious question."

Since the sponsor would be the appellant in this case, there should be no problem of standing. Only if the opinion is regarded

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42. *Supra*, note 39 at 515.
43. *Canadian Bill of Rights*, (1960) 8-9 Eliz.II, c.44.
as authoritative on the medical diagnosis and the consequences of that diagnosis for the patient's needs, but not as determining whether the patient's needs will create excessive demands on the health and social services available in Canada, can the medical opinion stand.

The courts, in deferring to medical opinions, have been following a well-established principle of deference to expertise in administrative tribunals. Just as clearly, however, courts have not failed to limit that expertise to the area of knowledge in which it has training, experience and knowledge. Deference cannot be justified in these circumstances.

2. "In the opinion of"

Following *Uppal* and the discussion above, the question of the degree to which the opinion of the medical officer is binding on the visa officer is of some consequence. Should this be read to mean that the medical officer's opinion determines the question or that, without a medical officer's opinion to the effect that one of the two conditions for inadmissibility exists, it is not possible to arrive at the conclusion that the person is medically inadmissible? The medical officers *Handbook* states that the medical officer's opinion is legally binding as far as medical matters (meaning those in s.19(1)(a) of the Act) are concerned. This view has been adopted in *Stefanska* as well: "As that officer had before her a medical notification meeting the requirements of s.19(1)(a)(ii) of the Act ... she no longer had any discretion and had no alternative but to find the applicants, husband and wife, inadmissible." The *IS Manual* concurs but says such persons may belong to a category which can be processed by a Minister's Permit.

Yet the contrary would seem to be implied by the reasoning in *Uppal* that the Immigration Appeal Board must reconsider the opinion offered by the medical officer. The majority agreed that the Board must not "shirk its responsibility by claiming that it is not medically qualified." The dissent in *Uppal* argued that the Board was in exactly the same position as the visa officer and that the medical officer's opinion was binding on both. The dissent like the


47. *Supra*, note 14, c.8, para. 8.19.4.

majority in *Sharma*\(^{49}\) seems to ignore the wide range of non-medical considerations that enter into the medical officer’s opinion. As well, it tends to ignore the scheme of the *Act* which allows appeals and discretion to issue Minister’s Permits to overcome what seems like the insurmountable barrier of s.19. But most importantly, the dissent seems to imply that if the Board is not bound, neither is the visa officer. This seems like the correct implication, for the considerations, which according to the *Regulations* go into the medical officer’s opinion, include matters explicitly assigned to the visa officer’s decision by the *Act*. For example, s.19(1)(b) is substantially the same as s.22(g) of the *Regulation*. This implies that the medical officer’s opinion is to be taken by the visa officer as advice in forming her or his own decision about admissibility except insofar as it concerns medical diagnosis of the individual without regard to health and social services. Thus in *Liaquat* the Board stated a view opposite to that expressed in the *IS Manual* and the *Handbook*: “The medical officer is not to determine inadmissibility ... the admissibility or inadmissibility of the person examined is not for the medical officer to determine. That is for an immigration officer after receipt of the proper opinion as defined in the *Act*.\(^{50}\) Visa officers following the *IS Manual* would appear in most cases to have allowed their discretion and decision making to have been improperly fettered because s.19(1)(a), as it currently stands, may be interpreted to mean that the visa officer has discretion and the power to decide admissibility after receiving the medical officer’s advice. The officer is bound insofar as in their opinion (i) or (ii) exists but it is their decision whether or not (i) or (ii) exists. This problem will be addressed further on. It is this issue which the new proposed *Act* would appear to be trying to resolve by overturning *Liaquat* and affirming *Stefanska*.\(^{51}\) It does this without affecting the decision in *Uppal*\(^{52}\) insofar as that decision is taken merely to have established that the Appeal Board must reconsider the opinion offered by the medical officer. The new proposed *Act* does not affect the conflict between s.19(1)(b) and s.22(g) of the *Regulations*.

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51. *Supra*, note 46.

52. *Supra*, note 45.
3. "are likely to be"/"might ... be expected"
While these two terms which occupy parallel positions in the Act may seem to imply probability in the first case and mere possibility in the second case, on examination it may be seen that to construe the second term in that way would yield a criterion which could only be applied arbitrarily. Hence the two terms must be read alike as requiring probability and any statement of mere possibility is insufficient warrant for an opinion of medical inadmissibility. This is stated clearly with respect to "might ... be expected" in Hiramen\(^5\) a decision re-affirmed recently in Badwal.\(^4\) Of interest in these two decisions is their definition of the role of the visa officer in assessing the medical opinion. While Badwal is adamant that medical officer's opinions (including opinions about the availability and use of services) cannot be second guessed, it agrees with Hiramen that they must be scrutinized carefully for inconsistencies between the numbers assigned on the medical profile or statements about inadmissibility and explanatory statements which imply a different opinion.

Nonetheless, "probability" has been reduced by recent decisions to "possibility" by requiring it to cover an indefinite length of time including perhaps the entire lifetime of the individual. The longer the time span, the closer possibility comes to probability. Recently admission was refused on excessive cost grounds due to the "probability" that a child with Down's Syndrome would develop senile dementia or Alzheimers thirty or more years hence. In another case an evaluation over the "long-term" for a woman 55 years old was required, again implying an estimate of the entire course of her life.\(^5\) Such a criterion if applied consistently would render everyone inadmissible. Clearly such a criterion has to be applied either arbitrarily or discriminatorily. The time span in which the probability estimate should be made would


perhaps best be matched with other waiting periods in the Act, for example, the five year period before holders of Minister's Permits can be processed for permanent residency.

4. "reasonably be expected"
In Ahir56 this requirement was held to mean that the medical officer's opinion must be formed by having regard to the individual circumstances of each case. The test must be relevant to the purpose and duration for which admission is sought. Finally, and perhaps least examined, the expectation must be reasonable.57 Mohammed suggests that not only must the medical diagnosis be reasonable, which is the most common ground of appeal, but that the opinion as to the consequences of the medical condition must also be reasonable.58 Reasonableness is not established by "parroting a section number" which implies that merely quoting the same section also does not establish reasons for an opinion.59 Again the frank admission in the medical officer's Handbook that there is no quantitative data on which to base a view of consequences for social and health services implies the absence of reasonableness.

5. "excessive"
One of the most thorough and useful definitions of "excessive" has been set out in Ng:

"That centres, of an unstated type, to which Mrs. Chan would or might reasonably be expected to have resort, are overtaxed does not necessarily mean that she would or might reasonably be expected to cause excessive demands on those centres. 'Excessive' must indicate something out of the ordinary; a superabundant demand or demand of an extreme degree. If hospitals or health services are overtaxed, anyone having resort to them may cause a further stretching or straining of resources. That is not consistent with saying that their demands will be excessive. The test in the Act to which a medical officer must turn his mind is not whether or not in his opinion an applicant will place a demand on health services or social services or whether those services or any of them are overtaxed or overstretched but whether in his opinion the applicant's admission to Canada would cause or might reasonably be expected to cause excessive demands on health or social services."60

56. Supra note 27.
57. Ibid. at 188.
59. Liaquat, supra note 50.
60. Supra, note 12 at 313.
There are two significant elements in this definition. The first is that the demand must be out of the ordinary which suggests a comparison not with healthy immigrants but with users of the service or, less rigorously, with some population sub-group having characteristics similar to that of the immigrant, for example, the class of all elderly people over age 65. Secondly, the test cannot be whether there is a waiting list for the services required by the immigrant or that those services are already much in demand. To add to that demand would not be excessive since the demand is already very strong.

The two points are useful in establishing that the medical officer's opinion must address these questions and be far more specific. Given the dearth of information available to medical officers on the actual services available and the amount of use of these services made by various population groups, the decision is useful in laying out questions which then will demonstrate the vacuum in which this aspect of the medical officer's opinion is made.

_Bala_ overturned the ruling in _Ng_ by saying simply "I cannot, therefore, agree with Mr. Eglington's test which would appear to ignore subss. 22(e) and (f) of the Regulations which are quoted above." Vice-Chairman Davey says no more about how excessive demand is to be determined and what relation the considerations in the regulations are to have to that decision. The Vice-Chairman appears to believe that pursuant to s.22(e), any medical care or hospitalization being required by the applicant or pursuant to s.22(f), any service that may be needed (regardless of the stated or actual needs of the applicant) which has any waiting list would yield a decision of inadmissibility. Yet the Regulations only require these factors to be considered; there is no demand that they yield a particular result.

_Ng_ notices that problem and describes what the condition related to these considerations would have to be such that the person having it would be inadmissible. Davey has, moreover, failed to distinguish the functions of the categories in the medical profile whereby the opinion is conveyed and their relation to the Act (in the case of the decisive "M" category) and to the Regulations (in the case of the other categories which properly are more advisory).

The problem is that this, decision like many others other than _Ng_, has not asked how "excessive" is actually being decided by the officers and what standard should be applied. In _Bala_ and _Ng_, since the demand was clearly to be borne by the family, no distinction was being made between publicly

financed services and privately financed services. It seems obvious in the Act, and certainly was assumed in the Committee testimony reported above, that the demand with which the Act was concerned was that on publicly financed services. In Bala, the slightest possibility of demand (made without any comparisons with the rest of the population, much less in accord with the Ng standard) was held to be sufficient to hold that the immigrant is inadmissible. Again this standard is clearly one which could only be applied arbitrarily since everyone will at some point in their life (at the very least, when they die) become a greater burden on the rest of the population than the average person at that time is. To see how arbitrary and discriminatory the standard adopted in overturning Ng is, consider the immediate medical costs of pregnancy and the long term social costs of childrearing. Yet, it would be obscene to make entry conditional on never becoming pregnant. The Ng standard suffers none of these problems.

Fortunately, in Jiwanpuri, Ng was upheld but, less happily, without explanation or reasons. This was decided the same year as Bala in which the overturning of Ng was also upheld. Thus the law cannot be regarded as settled on this point. Ng is particularly relevant to our specific concerns as it involved the sponsored immigration of elderly parents. The failure of medical officers to apply standards which are related to the unique characteristics of this group—that they are likely to be or become infirm (but, for example, that they also will not become pregnant), that they are also likely to be immigrating because they will be cared for by their children, and that they are not likely to create any more of a burden on public services than any other elderly person—implies systematic discrimination against this group.

C. Ambiguity of the statute

Section 19 (1) (a) (ii) of the Act reveals two fundamental flaws. First, the requirement of reasonableness is virtually impossible for medical officers to meet. This arises because of ambiguity around the meaning of the words in the Act, because medical officers by training are not able to decide the sorts of questions required by s.19.(1)(a)(ii). Even if they had the training, the type of information needed to answer these questions is not available. Specialists in Epidemiology and Biostatistics might be able to provide the information needed if it was clear what the Act was seeking. Secondly, these difficulties are exacerbated by the lack of clarity about the degree to which the medical


officer's opinion is decisive in ruling on the two issues determining admissibility. Thus the ambiguity around who decides still leaves open the fact that a decision about excessive demand cannot be arrived at by reason. Thus within the requirements of the Act itself compliance is not possible.

The failure to achieve clarity in the Act and to ground decisions in reason open the Act to attack by Section 1 of the Charter:

"The 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."64

The meaning of "reasonable limits prescribed by law" has been held to have two dimensions. The first bare minimum is that there be "an intelligible standard".65 The second is that "it should be expressed in terms sufficiently clear to permit a determination of where and what the limit is."66 This latter requirement is related specifically to the definition of terms. Since "excessive" enjoys no consensus about what it means and in any event there is no informational basis on which to determine reasonably the use and availability of social and health services, the Act meets neither test.

III. PROCESS LEADING TO DETERMINATION OF ADMISSIBILITY

A. Forms and Physical

Applicants for permanent residency are to be given three forms: one is an explanation of the medical admission process, a second is a list of designated physicians for those applying from outside of Canada or the United States and a third is the form to be filled out by the examining physician, form MS 1017. The form consists largely of check lists of various types of conditions with the request that the physician explain any conditions indicated. The form requires three other tests: a chest x-ray for anyone over 11, a blood seriological test for syphilis for those over 15, and a urinalysis for those over 5. The medical officer may request at their discretion specialists' reports or may write to examining physicians for further information. Medical examinations other than those done in Canada, are valid for 12 months only.

B. Determination by the Medical Officer

Form 1017 together with the x-rays and laboratory reports are sent to the medical officers for evaluation. The evaluation is reported on form MS 1014 in the form of a "Medical Profile" which consists of six categories designated by letters and the rating in those categories designated by numbers. A summary of these categories appears in the *IS Manual* Chapter 8 Appendix A. Only if the applicant is free of problems and hence admissible is this form to be sent to the visa officer. Not only is the visa officer therefore unaware of the basis of the medical officers' opinion, but the medical diagnosis conveyed, which includes the medical profile, is to be phrased in lay language so as to minimize "sensitive" information. For example, sexually transmitted diseases are to be called simply "infectious diseases". Thus the visa officer trying to exercise the discretion which is his or hers is prevented from developing an informed opinion and from being able to judge whether the medical officer has considered all relevant factors. We may see this with greater clarity by looking at the categories in the medical profile.

The overall judgement about admissibility is a reflection of the categories in s.19.

- **M1** = no health impairment
- **M2-M3** = risky health but may still be admitted
- **M4-M5** = not presently admissible but may be in the future
- **M-6** = inadmissible due to danger to public health
- **M-7** = inadmissible due to excessive demand on services

The other categories of the profile are based on a reduction of s.22 of the *Regulations* to 4 categories and a 5th category based on s.19(1)(b) of the *Act*. Each category has a letter as follows:

- **H** = Risk to Public Health or Safety - s.22(b)(d) of the *Regulations*;
- **D** = Expected Demand on Health or Social Services - s.22(e);
- **S** = Surveillance - s.22(c). This alerts the Province so that if a Minister's Permit is issued, the applicant will be kept under surveillance;
- **E** = Potential Employability or Productivity - s.22(g) of the *Regulations* and s.19(1)(b) of the *Act*;
- **T** = Response to Medical Treatment - the degree to which H and D might be reduced as well as s.19(1)(b).
Only H, T and S are within the expertise of physicians. The *Handbook* says that E and T are related to s.19(1)(b) of the *Act*. Yet this section is not within the purview of the medical officer under the *Act* and the *Handbook* admits as much. Thus this aspect of the profile while influencing the judgment arrived at under category M in accordance with s.22 of the *Regulations* is still to be decided by the visa officer.

It is important to note, inspite of the description by the IS Manual and in profiles issued by the medical officers of the profile of the M category as a “summation” of H, D, T, S, and E, that there is no overall score which is derived from the numbers assigned under each of H, D, T, S, and E in order to arrive at the score under M. While some scores are related to other scores, each one is in principle independent of the others. In other words, the considerations leading to a judgement of inadmissibility are not thought of as gradually building a case one way or the other and in fact, as we show next, they operate more like a translation of a particular specific medical condition into a specific set of letters and numbers. The “medical profile” in effect is just another way to state a medical condition rather than constituting an evaluation of an individual. This is why in *Ahir* rubber-stamping was possible.

Medical officers are guided by the physician’s evaluation to classify the applicant by a particular ailment, provided he or she has one. The officer then looks up the condition in the *Handbook* where the medical profile would normally be found. Thus, for example, one finds the following entry:

6. Acute or chronic untreated or inadequately treated venereal disease would usually be coded under criteria H6, D2, T2, E2, S5 and composite M4—as a communicable disease with serious consequences when transmitted; regarding medical care—usually ambulatory and usually effective, but requiring surveillance; i.e., inadmissible, as likely to endanger public health, but subject to review when adequate treatment has been completed.

Similarly, but more perfunctorily: “Patients with clearly established dementia in the absence of the treatable cause [i.e., senile dementia or Alzheimer’s disease] are totally dependent and require considerable social service support (M7).” Note that there is not the slightest hint of discretion allowed to the

68. *Supra*, note 27.
69. *Supra*, note 24 at 4-3.
medical officer in assigning "M7". While "opinion" suggests a professional opinion and hence the intervention of discretionary judgement, the Handbook has here completely fettered the discretion of the medical officer. The implication of the Handbook's assertion about senile dementia is clearly that not family support but social service support, that is, publicly funded support is required. Yet authority suggests the contrary: "...not all people with dementia need to be institutionalized. It depends on severity and it depends on the 'support systems,' such as a caring spouse."71 For another example, in the case of a D6, D7 or D8, the Handbook prescribes an M7. Similarly, those who are disabled are assessed by an additional set of functional categories.72 For example, degree of continence, which yield an evaluation which automatically places the applicant in M7 if help is required in any of the categories or if the person is incontinent (see Appendix A attached).

C. Problems with the Process of Evaluation
The description of medical profiles above is derived from a study of the Medical Officer's Handbook. It is instructive to compare that description with the description in the IS Manual which may be presumed to be the view of the profile adopted by the visa officer, an officer likely to believe that the medical officer's opinion is "legally binding". Two important differences exist, one in the description of the M category and the other in the explanation of the relation of the other categories to the Act. The M category is described in the IS Manual as "the summation" of H,D,T,S & E whereas we have seen that an M7 may be assigned simply on the basis of a D categorization which in itself may be based on a misconstrual of the meaning of "excessive" and in any event is not based on any quantified or particular information about the health or social services that are available. Secondly, the E category, which is based on s.19(1)(b) of the Act and hence according to the Handbook is merely by way of advice to the visa officer, is described in the IS Manual as related to s.19(1)(a)(i) and (ii) of the Act.73 The effect of the opinion is thus misconstrued insofar as the visa officer feels he or she has no discretion

72. Supra, note 24, at 3-12, 3-13.
73. IS Manual, supra, note 14 at c.8 Appendix "A" p. 2. The Handbook, supra, note 24 at 3-3, para.10(a) describes this as related to s.19(1)(b) of the Act. A very recent case reports the medical profile received by the immigration section. There the categories are labelled in relation to the Act but category E is simply (if not coyly) left blank. See Singh v. Minister of Employment and Immigration (1991), 13 Imm. L.R. (2d) 194 at 197 (I.R.B.A.D.)
while the medical officer feels free to offer an opinion believing it may be disregarded. The components of the M category which are not within the competence of the medical officer and hence make it incumbent on the visa officer to exercise discretion are rendered invisible. This removal of discretion must, of course, be qualified by the option left to the officer of recommending the issuing of a Minister's Permit.

The visa officer is thus both misinformed about the degree to which the medical officers themselves regard the visa officer to be bound by their opinion as well as by the actual legal requirement that they not be bound not to admit those thought to be medically inadmissible in the opinion of the medical officers. The medical officers themselves have their own discretion improperly fettered because the entire profile in many cases and the question of inadmissibility in most cases is determined by the classifications in the *Handbook*. Thus, as Auerbach points out, the applicant is entirely alienated from the process by which they are being judged. The decision they receive from the visa officer has been dictated by the medical officer which has been determined by the *Handbook* which in the case of D categorizations and hence M7's are determined by guesswork based on neither quantified information nor the individual's specific situation.

This pattern of discretion being improperly fettered has been carefully censured by the courts. Allowing another branch of government to dictate the decision for which one has responsibility under a separate act was forbidden in *Multi-Malls*. Moreover agencies cannot give up all possibilities of discretion by the adoption of rules, guidelines or general policies. The decision in *Yhap* shows that such fettering of discretion is a jurisdictional error: "The criteria much more strongly resemble inflexible self-imposed limitations on discretion, which clearly result in the pursuit of consistency at the expense of the merits of individual cases. I am of the opinion that this fettering of discretion constitutes a jurisdictional error .... "

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74. P. Harris Auerbach, "Discretion, Policy and Section 19 (1) (a) of the Immigration Act" (1990) 6 J. L. & Social Pol'y 133.
75. *Re Multi-Malls Inc. and Minister of Transportation and Communications* (1976), 61 DLR (3d) 430 (Ont. HC Div. Ct.); rev'd (1977) 73 DLR (3d) 18 (Ont. CA).
76. *In re North Coast Air Services Limited* [1972] FC 390, 406 (CA).
77. *Supra*, note 15 at 261.
IV. WHEN MEDICAL INADMISSIBILITY IS DETERMINED

A. Minister's Permit

By authority of s.37.(1)(a) of the Act and more specifically as directed by IS Manual Chapter 10, Paragraph 10.10 re family reunification and IS Manual Paragraph 10.12 re medical inadmissibility, those who are not deemed medically admissible may be admitted by a Minister's Permit.78 The Manual states that issuing such a permit should be preceded by consultation between the Director/Director General for Immigration in the Province to which the applicant is going and the responsible medical officer and Provincial officials. Consultation is to concern public safety, financial and jurisdictional factors IS Manual Chapter 10, Paragraph 10.26.1(b). Minister's Permits which thereby surmount inadmissability are reserved in this case to sponsored members of the family class but may also include, depending on circumstances, other close family members or refugees.79 The Ontario Ministry of Health is not to be involved unless the applicant has tuberculosis. Thus, for those destined for Ontario, the visa officer makes a recommendation to the Regional office. If the Regional office decides against a permit, the visa officer is so informed. If the Regional office agrees with the recommendation for a permit, the Regional Executive Director must concur. The visa officer is then advised to issue the permit.80 Under s.38(2) of the Act and according to the IE Manual Chapter 9, Paragraph 9.04(1)81 any person who has resided continuously in Canada for at least five years under a Minister's Permit may be landed from within Canada.

B. Appeals

If the application for a Minister's Permit is refused an appeal is possible to the Federal Court (Trial Division) under the new Federal Court Act amendments passed in February, 1992.82 However, unless it can be shown that in the decision regarding the Permit procedural fairness was not granted to the applicant there will be no ground of appeal.83 Thus it is more likely that an appeal of the medical inadmissibility decision itself would be the route chosen if the Minister's Permit is not granted. In that case, an appeal to the

79. Ibid. at c.10, paragraph 10.26.3.
80. Ibid. at 10.26.7.
82. R.S.C., c.10 (2nd Supp.) as revised February 1992 in accordance with Bill C-38.
Excessive Demands on Health and Social Services

Immigration Appeal Board is allowed under sections 77 and 70 of the Act and may be granted either on the grounds of law, fact or mixed law and fact including jurisdiction or on humanitarian and compassionate grounds. The considerations described above, under Applications for Permanent Residency by Sponsored Parents – Procedure, above, for gaining permission to apply from within Canada on humanitarian and compassionate grounds are relevant here. The Board is established by s.57(1) of the Act and its jurisdiction with respect to family class appeals is granted under s.69.4(2) If the Immigration Appeal Board refuses to grant the appeal on either ground, then there is an appeal to the Federal Court of Appeal under the new Federal Court Act and, with leave, under s.83 of the Act. Appeals must be on questions of law including jurisdiction. If the appeal is turned down one might be able to apply for leave to appeal to the Supreme Court of Canada.

C. The Time to Receive Reasons
A problem associated particularly with the appeal process in immigration matters and rendered more complex by the discretionary relief provided by Minister’s Permits is that of the timing around appeals. Clearly, from the perspective of a client with limited means, obtaining a Minister’s Permit after the applicant has been declared medically inadmissible is the best course. But much depends on whether the Minister’s Permit is granted at the time of the decision or that only the intention to request it is given by the visa officer at the time of delivering the decision to the applicants. If the latter then the limitation period in which one can file an appeal will be running while one is waiting for the Permit. If an appeal is launched while waiting for a Permit and the appeal is lost, then by s.37(2) of the Act a Permit cannot be issued. Appeals by sponsors must be filed within 30 days after the date the sponsor has been informed of the reasons for the refusal. The reasons for refusal are to be given at the time of the refusal to the sponsor under s. 77(1) of the Act and s.41(1) of the Regulation. This however is not the complete documentation of the reasoning that went into the decision. That documentation is to be supplied only after the commencement of an appeal. 


85. Supra, note 82.

is not the complete record insofar as the medical decision is concerned. The record supplied in event of an appeal is to include form MS-1014 described above, which the visa officer may still have to obtain from the medical officer. To receive the medical record prepared on the applicant by the medical officers, which includes the “sensitive information” not contained on the MS-1014, a separate request must be made and the record will only be released if the applicant has signed the release on form MS-1017 (see III.B. above). This will still not necessarily include the reports of the examining physicians and, of course, it will not include the Medical Officer’s *Handbook* to which even most visa officers do not have access. If an appeal is then to be made after the Board makes its decision the application for leave to appeal must be filed within 15 days of the Board’s decision under s.83(2) of the *Act*; yet, under s.69.4(2) reasons for Board decisions are only given on request. Thus in all of these cases appeals must be launched without the benefit of the reasons for the decision against which one is appealing or with very little time to study them. Judging the chances of success is thus very difficult. The Law Reform Commission has made suggestions for the improvement of some aspects of this situation as yet to no avail.

V. DOES MEDICAL INADMISSIBILITY THWART THE PURPOSES OF THE ACT?

A. Policy

With the process outlined above, several things should be noted. Those with infirmities are likely to be determined to be medically inadmissible. The flawed process whereby this will occur mechanically assumes that infirmities which require assistance or require health care automatically render the applicant medically inadmissible. There are two possible routes out of this situation: Minister’s Permits and by appeal, through the humanitarian and compassionate clause or through a challenge on legal grounds. The second is time consuming and costly. Both involve discretion. Finally the elderly are more likely to need health and social services as we note in Table I. Hence, it should follow that the elderly would be ruled inadmissible in disproportion

87. *Stefanska, supra,* note 46 at 70; *Bala, supra,* note 61 at 312.


to their numbers. Note there that it is not until age 75 that the health costs of
the elderly generally exceed the total costs of childrearing. Thus, even
compared to other age groups where health and social service needs have not
been considered, it is likely that the elderly will be considered medically
inadmissible out of proportion to other groups who use medical and social
services to the same degree. But regardless of that, clearly the discriminatory
effects of the excessive services standard will necessarily fall dis-
proportionately on the elderly. This meets the test for discrimination in
Brooks v. Canada Safeway, a case concerning health needs related to partic-
ular groups disadvantaged by society. Only if their health and social service
needs are measured against their peers could one expect a correct proportion
of admissions and there is no indication in the Handbook or the case law that
this is occurring.

The most fundamental reason that the Act should be interpreted in order to
respond to the peculiar needs of the elderly is that the interpretation should
be based on the purposes of the Act. The objectives or purposes of enabling
legislation have often been held to determine the proper interpretation of that
legislation. Having explored the ambiguities and potential for abuse latent
in the Act it is crucial to understand the purposes of the Act so that interpre-
tation will not operate to subvert its intent.

Section 3 of the Act defines the objects of the Act and hence immigration
policy in Canada. Two of those purposes are particularly relevant to our
concerns. First the reunification of families, to facilitate the reunion in
Canada of Canadian citizens and permanent residents with their close rela-
tives from abroad: s.3(c). Secondly “standards of admission that do not
discriminate in a manner inconsistent with the Canadian Charter of Rights
and Freedoms: s.3(f)”. This second purpose means that s. 15 of the Charter has
been extended by the Act to applicants regardless of their presence inside
of Canada. Thus the Act must not be interpreted in such a way as to
discriminate against the elderly. That discrimination against the elderly is a
common phenomenon has been well documented. The capacity of the

92. National Labour Relations Board v. Hearst Publications Inc. 322 US 111 (1944);
(CLRB, Dorsey, Vice-Chair).
93. Supra, note 64.
94. J. Botwinick, supra, note 71 at 34-36.
Table 1
Expenditures per Capita on Health, Education, and Social Security, by Sex and Age Group, Canada, 1985

medical inadmissibility procedure to generate systematic discrimination has also been shown above.

The Act clearly can be seen to have been structured in accordance with the purpose of family reunification. We have seen above that the Act and the Regulations describe carefully the processes for admitting family members and the priority to be given to them. This purpose of the Act is explained with some care in Mohamed as "facilitating the reunion in Canada of Canadian citizens with their close relatives from abroad."95 The concern in the Federal Immigration Act should be understood broadly in accord with the importance placed by the Provinces on the duty of care for one's parents. The Family Law Act, s. 32 obliges children to provide support for parents where needed.96 While on a narrow interpretation, this means financial support, in Ramaswami v. Andrew,97 a case where parents successfully sued for support promised by their son in his undertaking as their sponsor for permanent residency, it could be interpreted more broadly. Certainly, providing necessities and care is less expensive and more in the spirit of the Act when the parent is close by so that need can be recognized and met. Thus even if Provincial and Federal vires may overcome any conflicting obligations under these two Acts, the Family Law Act is still an indication of the broader intent of family reunification. Then taking it as a principle of statutory interpretation that the statute should be read as a whole and one provision cannot be read so as to negate another, the fact of sponsorship by a Canadian of their infirm parents should yield admission because of the needs of the parents not inspite of those needs.

B. Statistics

The question then is to what degree have Minister's Permits and the purposes of the Act acted to counter-balance the potential for thwarting immigration of infirm parents? Is the discretion allowed by the Act working? Canada has for some time had a population of which 16% are immigrants.98 Of current immigrants roughly half came between the ages of 20 and 39 for a total of 1,845,385.99 It is fair to say that each of these immigrants would likely have

95. Supra, note 58 at 222-223.
97. (January 18, 1984) (Provincial Court (Family Division) of the Judicial District of York) [unreported].
left their parents behind. More specifically, between 1967 and 1977, 612,020 in this age group came to Canada and hence at this time have parents who are or are approaching the need of their children’s care due to old age and the infirmities which accompany it. This implies a potential 1.2 million parental immigrants. In 1988, 20,256 people over 50 immigrated to Canada (Table II). While this is significant if multiplied by ten it is still only a maximum of one sixth of the parents of the children who have immigrated to Canada. Yet the immigration Minister in the Federal government’s five year plan regards this as too high. This rough estimate of potential immigrants, of course, would have to be reduced by the emigration of the children, by the death of parents and by those parents who simply want to remain in their home country.

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
<th>Total 1988 Immigration:</th>
<th>Total 1988 Family Class:</th>
<th>1988 Assisted Relative</th>
</tr>
</thead>
<tbody>
<tr>
<td>50-54</td>
<td>1959</td>
<td>2360</td>
<td>4319</td>
<td>161,929</td>
<td>51,331</td>
<td>15,567</td>
</tr>
<tr>
<td>55-59</td>
<td>1876</td>
<td>2450</td>
<td>4326</td>
<td></td>
<td></td>
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<td>60-64</td>
<td>1987</td>
<td>2422</td>
<td>4409</td>
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</tr>
<tr>
<td>65 plus</td>
<td>3089</td>
<td>4113</td>
<td>7202</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>8911</td>
<td>11345</td>
<td>20256</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As well a proper statistical picture should include those who arrived in the same period on Minister’s Permits discounted by the subsequent landing rate. The number of Minister’s Permits issued is significant as shown in Table III, but it is unknown what number of these were issued to infirm parents. While by s.37(7) of the Act, statistics about the number of Minister’s Permits are to be made available annually, it was not possible to obtain statistics either more detailed or more recent than those in this Table. The Director of Immigra-

99. Ibid. Table I at 1-5.

100. Ibid. at 1-7.


102. QLaw, database HWQ, Tuesday Oct. 10, 1978, Question No. 1,395 – Mr. Schumacher; Ans. by Hon. Bud Cullen. Mr. Cullen also said no statistics are kept on the number of conversions to landing or on the number of re-issues.
tion and Medical Services claimed in testimony in 1988 that of 200,000 applicants considered for medical admissibility, only about 4,000 were rejected and of these many are able to enter Canada through Minister’s Permits and the humanitarian and compassionate clause. Since it is conceivable that perhaps two-thirds of Minister’s Permits are renewals, it is conceivable that two to three thousand new permits are issued each year and possibly a similar number of humanitarian and compassionate appeal board permanent residencies are granted as well. It could be that those elderly parents who have sought entry are able to gain admission in these ways. This is all guesswork. Looked at from the other side, given the process and the standards of admission, it is just as likely that thousands of elderly, infirm, parental applicants are rejected every year. The cases of rejected parents we have looked at must indicate common experiences. The number of those accepted over 65 is, after all, quite small relative to the potential. Moreover, there is no way to know how many Canadians inquired about the prospects of gaining admission for their parents and then gave up.

Table III
Ministers Permits Issued Annually

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No.</td>
<td>485</td>
<td>642</td>
<td>723</td>
<td>4,392</td>
<td>17,445</td>
<td>21,198</td>
<td>11,420</td>
<td>10,555</td>
</tr>
</tbody>
</table>

C. Conclusions
This examination of statistics suggests that discretion may be having a significant impact but that it is likely there is still a significant problem of rejections. Moreover, new proposals suggest that there may be increased restrictions on the immigration of elderly parents. In order to judge the degree to which discretion is working effectively to promote the purposes of the Act, much more precise data is needed and it should be made readily available. Among the statistics needed are 1) numbers of sponsored applicants by age and relationship; 2) time to admission; 3) number of rejections by age, relationship and by reason; 4) number of rejections subsequently admitted by mode of admission; 5) number and type of medical inadmissibility by age;

and 6) numbers of Minister’s Permits, as renewals, by number of times renewed, and by category of person using them. In the light of the problem outlined above, it is astounding that none of this factual background is supplied by the large package of materials supporting the new proposed Act.

Secondly, the interpretation of the Act and Regulations regarding medical inadmissibility has significantly confused the roles and decisions of the medical officer and the visa officer. While the medical officer’s opinion about medical inadmissibility should be a minimum requirement for a determination of medical inadmissibility, it is a misreading of the intent and concerns of the Act to make it decisive and final. The medical opinion that an applicant will need help should specify the range of care or services that seem to be needed, leaving it up to the visa officer to determine in the particular case and with regard to the particular destination what kind of demand will be created.

Section 19(1)(a)(ii) of the Act is incoherent and without rational basis. When applied to the elderly it is inherently more likely that they will be held medically inadmissible than those in other age groups. Unfortunately, while the problem is potentially large, the exercise of discretion to correct it is not subject to empirical observation. Finally, if there are 4,000 rejections out of 200,000 applications and the system of discretion is working, why is the entire system of medical inadmissibility required for sponsored parents over age 65? Either the system is systematically discriminating and systematically judging on the irrational basis described above or discretion is overcoming the built-in tendency of the system. In either case, the only purpose for continuing this system for elderly parents is to contradict the explicit intent of the Act.
APPENDIX A

FUNCTIONAL ASSESSMENT FOR THE DISABLED (INFIRM) FROM MEDICAL OFFICERS HANDBOOK 104

L.R.E.S. – FUNCTIONAL ASSESSMENT

<table>
<thead>
<tr>
<th></th>
<th>Intact</th>
<th>Limited</th>
<th>Helper</th>
<th>Null</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>With ease, no devices, no prior preparation</td>
<td>With difficulty, or with device, or prior preparation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feed/Drink</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Dress Upper Body</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Dress Lower Body</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Don Brace/Prosthesis</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Grooming</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Wash/Bathe</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Perineum (at toilet)</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
</tbody>
</table>

Note performance without help: Note degree of assistance:

104. Supra, note 24.
### SPHINCTERS

<table>
<thead>
<tr>
<th></th>
<th>Intact</th>
<th>Limited</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Note control without help:</strong></td>
<td>Complete, voluntary</td>
<td>Control, but with urgency, or use of cath, appl, supp.</td>
</tr>
<tr>
<td><strong>Note frequency of accidents:</strong></td>
<td>Occasional some help needed</td>
<td>Frequent or much wet/soil</td>
</tr>
<tr>
<td><strong>Bladder Control</strong></td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td><strong>Bowel Control</strong></td>
<td>( )</td>
<td>( )</td>
</tr>
</tbody>
</table>

### MOBILITY

<table>
<thead>
<tr>
<th></th>
<th>Intact</th>
<th>Limited</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Note performance without help:</strong></td>
<td>With ease, no devices, no prior preparation</td>
<td>With difficulty, or with device, or with prior preparation</td>
</tr>
<tr>
<td><strong>Note degree of assistance:</strong></td>
<td>Some help</td>
<td>Totally dependent</td>
</tr>
<tr>
<td><strong>Transfer Chair</strong></td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td><strong>Transfer Toilet</strong></td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td><strong>Transfer Tub/Shower</strong></td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td><strong>Transfer Auto-mobile</strong></td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td><strong>Walk 50 Yards – Level</strong></td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td><strong>Stairs, Up/Down 1 Fl.</strong></td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td><strong>Walk Outdoors – 50 Yards</strong></td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td><strong>Wheelchair, – 50 Yards</strong></td>
<td>( )</td>
<td>( )</td>
</tr>
</tbody>
</table>

**N.B.** In the context of the functional assessment, devices includes such things as feeding cuffs, special cutlery/dishes, dressing aids, transfer boards/poles.

### 6. Explanation

(a) Individuals falling into the Intact category are performing independently and would pose no demand for services apart from routine medical supervision. If such an individual is employable, the requirement for replacement of wheel chairs, orthoses or prostheses would not constitute an excessive demand.
(b) Individuals having limited functions constitute the group which will require the most careful evaluation. The number and availability of the devices required and the level of ongoing care/supervision by medical/social agencies in order to maintain the individual in the community will have to be weighed against the individual’s ability to be productive prior to reaching a decision regarding admissibility.

(c) Individuals requiring the assistance of others (Helper or Null categories on the personal care activities scale) constitute and excessive demand for services and would be categorized as M7.

(d) Application of the personal care activities scale to applicants having disabilities secondary to ongoing medical conditions (rheumatoid arthritis, multiple sclerosis) or conditions which may subsequently undergo significant change (e.g. polio with occurrence of post-polio syndrome) is recommended as well. An assessment of the applicant’s present functional status can be a valuable aid in assessing future disease course and predicting demand for services. (See 3.02 (2 & 3))
### APPENDIX B

#### SUMMARY OF ASSESSMENT FROM MEDICAL OFFICERS HANDBOOK

**3.09 SUMMARY OF ASSESSMENT**

<table>
<thead>
<tr>
<th>Health/ Safety Risk</th>
<th>Demand for Services</th>
<th>Treatment</th>
<th>Surveillance</th>
<th>Employability</th>
<th>Medical Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>H</strong></td>
<td><strong>D</strong></td>
<td><strong>T</strong></td>
<td><strong>S</strong></td>
<td><strong>E</strong></td>
<td><strong>M</strong></td>
</tr>
<tr>
<td>1 No risk to health or safety</td>
<td>Same as for Canadians</td>
<td>No medical treatment required</td>
<td>No surveillance</td>
<td>Employable in general labour market</td>
<td>Admission not barred by health or demand for services</td>
</tr>
<tr>
<td>2 Risk of sudden incapacity</td>
<td>Regular medical care; minimum hospitalization</td>
<td>Generally effective; non-recurring</td>
<td>Surveillance required; conditional for admission</td>
<td>Restricted now fully employable in near future or productive</td>
<td>Risk insufficient to bar; no demand for services</td>
</tr>
<tr>
<td>3 Risk of abnormal behaviour</td>
<td>At least one major hospitalization within 5-7 years</td>
<td>Generally effective; condition expected to continued or recur</td>
<td>Surveillance required; not conditional for admission</td>
<td>Employable or productive under permanently restricted conditions</td>
<td>Demand insufficient to bar; no risk to public health or safety</td>
</tr>
<tr>
<td>4 Disease not readily communicable; no precautions necessary</td>
<td>Regular medical care and recurrent hospitalization</td>
<td>Partially effective; condition expected to continue, possibility of deterioration</td>
<td>Surveillance by agreement</td>
<td>Likely to deteriorate</td>
<td>Admission advisable (health or safety); reconsider admission in future</td>
</tr>
</tbody>
</table>

*Continued on next page*
<table>
<thead>
<tr>
<th>Health/Safety Risk</th>
<th>Demand for Services</th>
<th>Treatment</th>
<th>Surveillance</th>
<th>Employability</th>
<th>Medical Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>H</td>
<td>D</td>
<td>T</td>
<td>S</td>
<td>E</td>
<td>M</td>
</tr>
<tr>
<td>5</td>
<td>Disease not readily communicable but surveillance necessary</td>
<td>Supervision and special care but may become self-supporting</td>
<td>No effective medical treatment</td>
<td>Surveillance of those inadmissible but who enter anyway</td>
<td>Unemployable or unproductive</td>
</tr>
<tr>
<td>6</td>
<td>Disease readily communicable: dangerous</td>
<td>Family care at home indefinitely plus supervision</td>
<td></td>
<td>Retired</td>
<td>Inadmissible: public health or safety reasons</td>
</tr>
<tr>
<td>7</td>
<td>Continuous care in hospital or other institution</td>
<td></td>
<td></td>
<td></td>
<td>Inadmissible: excessive demand for services</td>
</tr>
<tr>
<td>8</td>
<td>Rare or limited health or social services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>