Evaluation of the Health Screening and Notification Program

Evaluation Division

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Canada

Table of contents

List of tables and figures

Acronyms

AUD	Australian Dollar
CBSA	Canada Border Services Agency
CIC	Citizenship and Immigration Canada
CMM	Cost Management Model
DIAC	Department of Immigration and Citizenship (Australia)
DMP	Designated Medical Practitioner
FCC	Five Country Conference
FOSS	Field Operations Support System
FY	Fiscal Year
GCMS	Global Case Management System
HIV	Human Immunodeficiency Virus
HSN	Health Screening and Notification
IMA	Immigration Medical Assessment
IME	Immigration Medical Examination
IMS	Immigration Medical System
IRPA	*Immigration and Refugee Protection Act*
IRPR	*Immigration and Refugee Protection Regulations*
MHB	Migration Health Branch
MSUCM	Medical Surveillance Unit Case Management
NHQ	National Headquarters
NZD	New Zealand Dollar
OGD	Other Government Department
PAA	Program Alignment Architecture
P/T	Province/Territory
PHAC	Public Health Agency of Canada
PHLU	Public Health Liaison Unit
PHU	Public Health Unit
POE	Port of Entry
PR	Permanent Resident
PTI	Pulmonary Tuberculosis Inactive
QA	Quality Assurance
RMO	Regional Medical Office
SOP	Standard Operating Procedure
TB	Tuberculosis
TR	Temporary Resident

Executive Summary

Purpose of the Evaluation

The evaluation of Citizenship and Immigration Canada's (CIC) Health Screening and Notification (HSN) Program was conducted in fulfillment of the requirements of the 2009 Treasury Board's *Policy on Evaluation*. It was undertaken in-house by CIC's Research and Evaluation Branch between November 2013 and December 2014. The HSN Program includes both the Health Screening program, and Medical Surveillance and Notification program. Based on the outcomes identified in the program logic model, the evaluation examined the relevance and performance of the HSN program from fiscal years (FY) 2008/09 to 2012/13, as well as the HSN policy, and program design and management.

Program profile

Section 38 of the *Immigration and Refugee Protection Act* (IRPA) outlines the considerations involved in determining whether certain foreign nationals applying to come to Canada are inadmissible on health grounds, while Section 16.2 (b) outlines the medical examination requirement which informs health based admission decisions. Additionally, Section 32 of the *Immigration and Refugee Protection Regulations* (IRPR) further stipulates the health-based conditions placed on foreign nationals who are determined to require medical surveillance.

Health screening

As part of the health screening component, foreign nationals have their health assessed via an immigration medical examination (IME), which is performed by panel physicians who are designated by CIC. CIC medical officers and/or delegated staff located in CIC regional medical offices (RMO) use the results of the IME and conduct an immigration medical assessment (IMA) to determine whether an applicant is inadmissible to Canada based on three grounds outlined in IRPA, section 38(1) (a)-(c):

- Danger to public health: considers a foreign national's health condition regarding the communicability of any disease and the impact that the disease could have on other persons living in Canada (e.g., active pulmonary tuberculosis (TB) and untreated syphilis).

- Danger to public safety: considers a foreign national's health condition regarding the risk of a sudden incapacity or unpredictable or violent behaviour that would create a danger to the health or safety of persons living in Canada (e.g., mental health conditions, sociopathic disorders).

- Excessive demand on health or social services: considers (a) a demand on health or social services for which the anticipated costs would likely exceed average Canadian per capita health services and social services costs over a period of five consecutive years immediately following the most recent medical examination, unless there is evidence that significant costs are likely to be incurred beyond that period, in which case the period is no more than 10 consecutive years; or (b) a demand on health or social services that would add to existing waiting lists and would increase the rate of mortality and morbidity in Canada as a result of an inability to provide timely services to Canadian citizens or permanent residents (PR).

Medical surveillance and notification

In certain cases, foreign nationals with an inactive public health condition are admissible to Canada but are required to undertake medical surveillance upon arrival. The conditions that currently require medical surveillance are inactive TB and complex inactive TB.[1] In addition, although the human immunodeficiency virus (HIV) is not a condition that requires medical surveillance, CIC reports HIV-positive cases to provinces and territories (P/T) that have chosen to be notified, upon the individual's entry into Canada.[2]

As part of the notification process, CIC provides individuals that require medical surveillance with a Medical Surveillance Undertaking form and a Medical Surveillance Handout, which they are then required to provide to the Canada Border Services Agency (CBSA) upon arrival in Canada. The CBSA provides the forms to CIC and upon receipt, CIC notifies the appropriate P/T health authority of the individuals' arrival. Those requiring medical surveillance must report to a P/T health authority within 30 days of arrival (or within seven days for complex cases). The P/T health authorities are responsible for conducting any medical follow-up required according to the protocols developed by that P/T.

Program management

The Migration Health Branch is the organizational unit within CIC that is responsible for the administration and delivery of the health screening component and the medical surveillance and notification component. The HSN Program is delivered in collaboration with, or with the support of, a number of government departments and external organizations including the Public Health Agency of Canada (PHAC), CBSA, P/T health authorities and the network of Panel Physicians/Panel Radiologists.

Between 2007 and 2012[3], CIC conducted approximately 3.2 million immigration medical assessments (IMA) representing an average of approximately 525,000 IMAs per year. Between 2007 and 2013, CIC notified the P/T health authorities of 52,351 clients who entered Canada with inactive TB[4], syphilis, or HIV.

The total costs for the medical screening component for a three-year period (FY 2011/12 - FY 2013/14[5]) was $24.5 million and total spending for the medical surveillance and notification component for a two-year period (FY 2012/13 - FY 2013/14[6]) was $2.3 million.

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[1] CIC previously required medical surveillance for adequately treated syphilis; however that requirement was removed in May, 2014.

[2] The purpose of this notification is link HIV-positive newcomers with the health care system.

[3] Data in CIC's Global Case Management System (GCMS) for 2013 only includes cases assessed overseas; therefore the data for that year have not been included.

[4] This includes both inactive and complex inactive TB.

[5] Costs for the health screening component prior to FY 2011/12 were calculated differently, thus were not included.

[6] Costs for the medical surveillance and notification component are not available for years prior to FY 2012/13 as it was not yet systematically reported by CIC within the Cost Management Model (CMM).

Evaluation Findings

Findings related to program relevance and policies

There is a continued need for CIC to assess migrants' health status before admission to Canada as the health screening component allows for the identification of health and safety risks and contributes to the reduction of the burden of immigration on Canada's health and social system. There is also a continued need to require medical surveillance for certain migrants with conditions of public health significance, namely inactive TB, as the medical surveillance component contributes to the management of risks associated with spreading and reactivation of this disease.

The HSN Program is aligned with the Government of Canada's priorities to protect the health, safety, and security of Canadians and the sustainability of Canadian health and social services. Federal and P/T roles are clearly defined and aligned with respective federal and P/T mandates and responsibilities.

The examination of CIC's policies on Danger to Public Health, Danger to Public Safety, and Excessive Demand found that they allow the federal government to address health and safety risks associated with migration. The policies are aligned with the overall objectives of the HSN Program and are generally consistent with Five Country Conference (FCC) partners' health screening policies. However, some issues were identified:

- *Danger to Public Health*: The current policy on Danger to Public Health was found to be restrictive and unable to adapt quickly to conditions that may become more prevalent; or conditions that may temporarily pose a risk to public health.

- *Danger to Public Safety*: While the objectives of the policy on Danger to Public Safety remain relevant, it is difficult to apply during assessment because public safety-related health concerns are often hard to detect and can overlap with inadmissibility issues related to criminality.

- *Excessive Demand*: With respect to the policy on Excessive Demand, the evaluation found that preventing undue burdens on Canada's health and social services from migration is important; however, several issues that limit the application and intended results of this policy were identified. These issues include a lack of enforcement, specifically an inability to enforce an applicant's inadmissibility mitigation plan; exemption of certain applicants from this policy who pose an excessive demand; a considerable number of overturned excessive demand cases through the appeals process, and limitations in the operationalization of the policy (e.g., complex and time-consuming nature of processing cases, consistency in decision-making, and lack of up-to-date health and social service cost information from P/Ts).

Lastly, in regard to the type of applicants that fall under CIC's screening policy, gaps were identified related to the health risks posed by temporary residents, and while not feasible or efficient to screen all applicants, a risk-based policy screening approach across all categories may be more effective in mitigating risks associated with migration.

Findings related to program design and management

Overall, the delivery of the health screening component of the HSN Program was viewed as effective, with the exception of quality assurance (QA) tools and procedures. While a QA framework and standardized tools have been developed, they have not been applied consistently across the HSN Program.

The health screening component of the program has benefitted from recent modernization efforts, making it more efficient to process standard (M1) medical files, however, GCMS limitations (e.g., speed, usability) have resulted in processing inefficiencies when assessing complex cases. Furthermore, because the surveillance notification component is entirely paper-based, modernization efforts could bring about further efficiencies.

The evaluation identified a number of communication and coordination issues between CIC and the P/Ts, whereby P/Ts felt they were not provided with sufficient or timely information related to the notification process and client medical information. It was also found that there is a lack of formal mechanisms to facilitate engagement between CIC and P/T ministries of health, particularly with respect to coordination on issues related to excessive demand.

Findings related to performance

The health screening component of the program has allowed CIC to identify individuals with medical conditions of concern, and in turn, has contributed to reducing the burden on Canadian health and social services and protecting the health and safety of Canadians. However, the evaluation identified gaps in the current screening processes and policies that may render the program less effective. It was also found that service standards for IMA processing times had not been met but were improving with the implementation of eMedical.

Overall, the medical notification process has been successful in notifying P/Ts of clients that require surveillance, and while P/Ts felt they did not have sufficient client information from the notification forms, available program information suggests that a large proportion of clients are complying with the surveillance requirement. Although, the evaluation also found that the CBSA was not providing CIC with notification information in a timely manner as the cases at Ports of Entry are infrequent and are being batched. CBSA officers at the Ports of Entry may be unaware of the need to provide notification immediately.

Findings Related to Efficiency and Economy

The cost of the HSN Program has been reduced as a result of the modernization efforts made by CIC (introduction of eMedical), allowing the department to spend fewer resources while conducting the same level of IMAs. In addition, the minimum estimated cost-savings on Canadian health and social services, as a result of the HSN Program, are significantly greater than overall program costs.

Conclusions and Recommendations

Evaluation findings indicate that the HSN Program continues to be relevant and aligned with both federal and P/T government priorities. The program helps to decrease public health risks and the risks posed by migration to the sustainability of Canada's health and social services. Due to modernization, program efficiencies have been achieved. Lastly, both the health screening and surveillance and notification components are generally effective in protecting the health and safety of Canadians. However, due to the issues identified in relation to program policies, management and governance, the evaluation's recommendations are as follows:

Recommendation #1: CIC should review its policy on Danger to Public Health to consider addressing other conditions that may pose public health risks and to make it more flexible to address emerging communicable diseases.

Recommendation #2: CIC should review its policy on Excessive Demand to:
– Engage more effectively with the P/Ts on issues related to Excessive Demand.
– Address the policy gaps that limit its effectiveness.
– Streamline the assessment process for excessive demand cases to ensure that decision-making is more straightforward, consistent, and timely.

Recommendation #3: With respect to health screening, CIC should:
– Review the feasibility of implementing a risk-based screening approach, which considers epidemiological risk factors.
– Examine its current protocol for screening for latent TB to determine whether it can be expanded to include other TB reactivation risk factors.

Recommendation #4: CIC should review, update, and implement its QA framework to ensure that QA is conducted consistently across the RMO network. The update of the framework should consider the type of QA to be undertaken on the various components of the health screening process (e.g., IME, IMA, auto-cleared files), the schedule/frequency of QA activities, and the reporting requirements.

Recommendation #5: CIC should examine whether:
– The medical component of GCMS could be improved to address processing challenges (e.g. speed, usability) related to complex cases.
– The notification process could be modernized through its integration into GCMS.
– An electronic information sharing system could be established between IRCC and the P/Ts for the exchange of notification-related information.

Recommendation #6: CIC should strengthen the P/T component of its screening and notification process by:
– Improving/increasing the information that is available to P/Ts with respect to the notification process.
– Determining whether client medical information can be automatically shared with the P/Ts.

Recommendation #7: CIC should ensure that surveillance information is being provided to clients at visa offices and by the CBSA in a consistent and timely manner.

This could include: ensuring the surveillance required is flagged on the main screen in GCMS, integrating the surveillance notification forms and handouts into the e-application system, and providing updated operational guidance to visa offices (including Centralized Processing Centres and the CBSA).

Evaluation of the Health Screening and Notification Program—Management Response Action Plan

Recommendations	Response	Action	Accountability	Completion Date
Recommendation #1: CIC should review its policy on danger to public health to consider addressing other conditions that may pose public health risks and to make it more flexible to address emerging communicable diseases.	CIC agrees with the recommendation. CIC recognizes the need to manage public health risks throughout the migration continuum while balancing CIC's role in facilitating travel. In that regard, CIC continues to explore options to address additional public health threats. To date, a diagnostique that identifies gaps and opportunities has been presented to Policy Committee (DG level), including a data analysis related to danger to public health. Options on public health interventions are also being explored	• CIC will finalize a diagnostique to identify gaps in addressing public health risks for presentation to the departmental Executive Committee.	Migration Health Branch Support: IR, Legal, Admissibility, OMC	Q4 2015-2016
		• CIC will identify key areas of focus for priority action for which policy options are needed.		Q1 2016-2017
		• CIC will develop policy options, for senior management consideration, to realign health admissibility towards a more evidence- and risk-based approach. In particular, the options will consider how to address other conditions that may pose a public health risk.		Q2 2016-2017
Recommendation #2: CIC should review its policy on Excessive Demand to: • Engage more effectively with the P/Ts on issues related to Excessive Demand.	CIC agrees with this recommendation. CIC recognizes that P/T engagement on the excessive demand issue is important given their role in health care services and CIC is committed to working to engage P/Ts on this issue. Over the past several years, challenges have been encountered in engaging P/Ts in discussion on the "excessive demand" provision*, including the lack of CIC representation at F/P/T health care tables, where this issue would most appropriately be addressed. * Under Paragraph 38(1)(c) of the Immigration and Refugee Protection Act, one reason that a foreign national is inadmissible is if their health condition could cause excessive demand on health or social services. The definition of excessive demand falls under sub-section 1(1) of the immigration regulations.	• CIC will develop an engagement strategy to identify how best to secure P/T participation in policy work on excessive demand.	Migration Health Branch Support: IIR	Q4 2015-2016
		• CIC will begin implementation of the engagement strategy.		Q1 2016-2017

Recommendations	Response	Action	Accountability	Completion Date
	A key step in engaging P/Ts in discussion of the "excessive demand" provision would involve demonstrating its relevance and benefits for their health-care systems. With this in mind, CIC has begun a cost-benefit analysis of the excessive demand provision as a key component to engage P/Ts as part of the review.	• CIC will complete the excessive demand cost-benefit analysis.	Migration Health Branch	Q4 2015-2016
		• CIC will share the findings of the cost-benefit analysis with P/Ts.	Migration Health Branch Support: IIR	Q2 2016-2017
	Another key area where CIC can engage P/Ts is on special education, which is included in the concept of excessive demand on social services. The requirement for assessment of special education costs has involved high levels of media attention and litigation for CIC. Because P/Ts have mainstreamed special needs students in classrooms, individualized costs are no longer available in many jurisdictions. CIC is, therefore, undertaking a pilot project to assess a qualitative approach to assessing the need for special education services. Results of this pilot project will be used to engage P/Ts on the aspect of special education.	• CIC will complete the pilot project to assess a qualitative approach to assessing the need for special education services.	Migration Health Branch	Q1 2016-2017
		• CIC will present the findings to P/Ts.	Migration Health Branch Support: IIR	Q3 2016-2017
• Address the policy gaps that limit its effectiveness.	CIC recognizes the gaps that exist in the excessive demand policy. However, addressing these gaps would first require collaborative work with P/Ts on policy development, followed by significant legislative, regulatory, program policy and operational changes.	• CIC will begin work on developing options for changes to the excessive demand provision.	Migration Health Branch	Q4 2015-2016
		• CIC will begin to engage P/Ts to inform how best to address the policy gaps.		Q1 2016-2017
		• CIC will present policy options to the Department's Executive Committee.		Q4 2016-2017

Recommendations	Response	Action	Accountability	Completion Date
• Streamline the assessment process for excessive demand cases to ensure that decision-making is more straightforward, consistent, and timely.	The Centralized Medical Admissibility Unit (CMAU) in the Migration Health Branch has been set up to standardize and coordinate medical evaluations for medically inadmissible cases and to provide advice on medical admissibility of applicants. This unit will be a centre of expertise on medically inadmissible cases, optimizing both expertise and capacity. The consistent standardization and coordination will improve risk analysis/management and will streamline and enhance client service. Over 2015-2016, all medically inadmissible cases are being forwarded to CMAU from overseas offices in a phased approach. CMAU has successfully implemented Phase 1, which was the centralized review and processing of all excessive demand (M5) cases; which will now always be sent to CMAU for processing. Phase 2 will be for files related to danger to public health, and Phase 3 will be for files related to danger to public safety	• CIC will fully implement the centralization of all medically inadmissible cases, including excessive demand cases, in the Centralized Medical Admissibility Unit.	Migration Health Branch	Q4 2015-2016
Recommendation #3: With respect to health screening, CIC should: • Review the feasibility of implementing a risk-based screening approach, which considers epidemiological risk factors.	CIC agrees with this recommendation. In support of an evidence- and risk-based approach to health admissibility, as set out in Recommendation 1, CIC is exploring the use of epidemiologic knowledge of source countries and migration health-related factors to determine alternative options for a more targeted approach to health screening. For example, the requirement to undergo an Immigration Medical Examination could be based on epidemiological risks.	• CIC will review the feasibility of implementing a risk-based approached and develop a policy proposal in order to expand and apply epidemiological knowledge and risks used for the health assessments of migrants for senior management consideration.	Migration Health Branch	Q3 2016-2017
• Examine its current protocol for screening for latent TB to determine whether it can be expanded to include other TB reactivation risk factors.	Latent TB is not infectious and, therefore, cannot be considered a reason for inadmissibility for public health reasons. However, there could be certain risk factors that could reactivate latent TB; thus, CIC is looking at how best to approach the issue. CIC is a member of the TB in Migrants Working Group which will present, by the end of fiscal year, to CIC, PHAC, and the Public Health Network, recommendations for optimizing TB prevention and control for migrant populations as they move from pre-departure to post-arrival and resettlement in Canada. The main focus of these recommendations will be to address Latent TB Infection in migrants.	• CIC will review recommendations provided by the *TB in Migrants Working Group* to assess CIC's current health screening protocol for Latent TB Infection. Based on this review, CIC will determine whether revisions are required for its screening protocol for latent TB, including risk factors that could lead to reactivation, and will begin to address those revisions, as needed.	Migration Health Branch	Q1 2016-2017

Recommendations	Response	Action	Accountability	Completion Date
Recommendation #4: CIC should review, update, and implement its QA framework to ensure that QA is conducted consistently across the RMO network. The update of the framework should consider the type of QA to be undertaken on the various components of the health screening process (e.g., IME, IMA, auto-cleared files), the schedule/frequency of QA activities, and the reporting requirements.	CIC agrees with this recommendation, and work is underway. CIC is currently reviewing its existing Quality Assurance (QA) framework and, expanding on it, will develop a comprehensive Migration Health Branch (MHB) Program Integrity Framework, which will identify the type of QA required for the health screening process and the stakeholders involved and will be aligned with the overall departmental Program Integrity Strategy. There will be a three-year implementation plan detailing the schedule and frequency of each activity. CIC is also updating its QA tools to facilitate uniform implementation across Regional Medical Offices.	• CIC will finalize the new MHB Program Integrity framework that ensures quality assurance is conducted consistently across the RMO network and develop a three-year implementation plan.	Migration Health Branch	Q4 2015-2016
		• CIC will begin implementation of the three-year plan with the first program integrity activities being completed using standardized QA tools and associated reports being produced.		Q1 2016-2017

Recommendations	Response	Action	Accountability	Completion Date
Recommendation #5: CIC should examine whether: • The medical component of GCMS could be improved to address processing challenges (e.g. speed, usability) related to complex cases.	CIC agrees with this recommendation, and will address it through its new governance structure for changes to GCMS. The eMedical/GCMS interface was introduced in December 2012. Since that time, issues have been identified, with improvements made to increase speed and efficiency. The medical component of GCMS is regularly monitored to identify issues. As these are found, CIC identifies priority issues that require correction. Since GCMS is a multi-department platform, CIC Operations' Sector has established a central office to coordinate its requests for GCMS changes / corrections. The central unit prioritizes requests from the various program areas and submits them as part of a departmental GCMS action plan. If the changes are substantial in nature, the changes would be governed through an appropriate level of project management.	• CIC will identify priority changes related to the medical component of GCMS that need correction.	Migration Health Branch	Q1 2016-2017 and ongoing
		• CIC will prioritize these changes in its overall departmental plans for GCMS updates.	OMC	Q1 2016-2017 and ongoing
		• CIC will confirm the scope and level of effort for the changes, determine timelines, and begin implementation of the changes.	SIMB Support: OMC, MHB	Q1 2016-2017 and ongoing
• The notification process could be modernized through its integration into GCMS.	Following the immigration medical assessment, codes that indicate whether a client needs medical surveillance are entered into GCMS and consulted when the visa is issued. At the Port of Entry, officers (visa/border) provide the medical surveillance requirement, in paper format, to both the client and the Public Health Liaison Unit at CIC.	• CIC will launch the e-notification system.	Migration Health Branch Support: SIMB	Q2 2016-2017
• An electronic information sharing system could be established between CIC and the P/Ts for the exchange of notification-related information.	CIC has been exploring the integration of the notification process by CBSA to CIC into GCMS to eliminate the paper processing. Following identification of requirements and scope, CIC has begun system development for a web-based portal, as part of GCMS, which would include: 1) the automated notification to CIC that a person requiring surveillance has landed and 2) e-notifications to P/Ts to inform them of people arriving in Canada who require medical surveillance. Automation will help expedite the notification process upon arrival of individuals and allow P/THAs to initiate the surveillance process in a timely manner. CIC is working to finalize a Privacy Impact Assessment (PIA) to determine CIC's authorities, risks and mitigation strategies for sharing personal notification information with P/Ts. Some legislative and regulatory amendments may be needed for allowing the sharing of personal notification information with P/Ts.	• CIC will complete the PIA and develop an action plan to address its recommendations.	Migration Health Branch	Q2 2016-2017

Recommendations	Response	Action	Accountability	Completion Date
Recommendation #6: CIC should strengthen the P/T component of its screening and notification process by:	CIC agrees with this recommendation. This area requires engagement at F/P/T public health tables (e.g., the Council of Chief Medical Officers of Health), where CIC has observer status. CIC will explore ways to further leverage its access at these venues.			
• Improving/increasing the information that is available to P/Ts with respect to the notification process.	CIC already provides both online and paper-based information to P/Ts on the notification process. CIC is reviewing this information to identify possible gaps and will review the gaps with P/Ts to strengthen its information sharing on the notification process.	• CIC will solicit interest at the Council of Chief Medical Officers of Health (CCMOH) to work with the Department on strengthening information sharing on the notification process.	Migration Health Branch	Q4 2015-2016
		• CIC will create an F/P/T working group to strengthen information sharing on the notification process.		Q1 2016-2017
		• CIC will work with P/Ts to identify gaps in information on the notification process.		Q3 2016-2017
		• CIC will present the results of this gap analysis to the F/P/T Council of Chief Medical Officers of Health, to identify which issues can be addressed within current program parameters and where broader agreements might be needed (e.g., bilateral memoranda of understanding) to improve information sharing.		Q4 2016-2017
		• Following F/P/T discussions, develop an action plan to address agreed-upon actions.		Q4 2016-2017
• Determining whether client medical information can be automatically shared with the P/Ts	CIC is working on a Privacy Impact Assessment (PIA) on sharing personal information with P/Ts. It is expected that the PIA will be completed in March 2016. Some legislative and regulatory amendments may be needed for allowing the sharing of personal notification information with P/Ts.	• CIC will share the findings of the PIA with P/Ts to explore possible new information-sharing agreements and will identify those P/Ts interested in pursuing agreements to automatically share client medical information.	Migration Health Branch Support: IIR	Q2 2016-2017

Recommendations	Response	Action	Accountability	Completion Date
Recommendation #7: CIC should ensure that surveillance information is being provided to clients at visa offices and by the CBSA in a consistent and timely manner. This could include: ensuring the surveillance required is flagged on the main screen in GCMS, integrating the surveillance notification forms and handouts into the e-application system, and providing updated operational guidance to visa offices (including Centralized Processing Centres and the CBSA).	CIC agrees with this recommendation. CIC continuously reviews processes and makes changes, as needed, to ensure program effectiveness. CIC also provides updated instructions to visa officers and CBSA. This work is ongoing. CIC has begun work on incorporating notification information into the Global Case Management System (GCMS) (see Recommendation 5), which would reduce reliance on a paper/mailing process and improve consistency of information provided at visa offices and by CBSA. Following implementation in GCMS in Q2 of 2016-2017, CIC will review instructions and manuals and revise, as needed.	• CIC will review the current notification program delivery instructions, manuals, etc. for visa offices and Border Service Officers, determine what modifications need to be made to ensure consistency or fill any gaps, and issue revised guidance as needed.	Migration Health Branch Support: IR, OMC	Q3 2016-2017
		• CIC will assess, in collaboration with the CBSA, the effectiveness of new guidance and tools.	Migration Health Branch Support: OMC	Q3 2016-2017
		• CIC will undertake a gap analysis with respect to meeting client needs for notification information as part of the Department's client service improvement initiatives.	Migration Health Branch Support: CPR (client service)	Q4 2016-2017

1. Introduction

1.1. Purpose of the Evaluation

This report presents the results of the evaluation of Citizenship and Immigration Canada's (CIC) Health Screening and Notification (HSN) Program. The evaluation was conducted in fulfilment of the requirements of the 2009 Treasury Board *Policy on Evaluation*[7] to evaluate all direct program spending on a five-year cycle. The evaluation was conducted by CIC's Research and Evaluation Branch. Data collection and analysis was undertaken between November, 2013 and December, 2014. The evaluation report is organized in four main sections[8]:

- Section 1 presents background information on the HSN Program;

- Section 2 presents the methodology for the evaluation and discusses strengths and limitations;

- Section 3 presents the findings, organized by evaluation issue; and

- Section 4 presents the conclusions and recommendations.

1.2. Program Profile and Context

1.2.1. Program Description

Section 38 of the *Immigration and Refugee Protection Act* (IRPA) outlines the considerations involved in determining whether certain foreign nationals applying to come to Canada are inadmissible on health grounds, while Section 16.2 (b) outlines the medical examination requirement which informs health based admission decisions. Additionally, Section 32 of the *Immigration and Refugee Protection Regulations* (IRPR) further stipulates the health based conditions placed on foreign nationals who are determined to require medical surveillance. The Migration Health Branch[9] is the organizational unit within CIC that is responsible for the administration and delivery of the CIC's health programs including the health screening component and the medical surveillance and notification component. Together, these components are referred to as the HSN Program and form sub-activities 4.1.1 and 4.1.2 (Health Screening and Medical Surveillance and Notification, respectively) under program activity 4.1 (Health Management) in CIC's Program Alignment Architecture (PAA). With regard to CIC's strategic outcomes, the program contributes to *Managed migration that promotes Canadian interests and protects the health, safety and security of Canadians* (Strategic Outcome 4).

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[7] Canada, Treasury Board Secretariat (2009) *Policy on Evaluation Function.* www.tbs-sct.gc.ca/pol/doc-eng.aspx?id=15024

[8] Supporting material for the evaluation report (e.g., list of documents reviewed, interview guides, survey response frequencies) is included under separate cover in the Technical Appendices.

[9] Health Branch was renamed Migration Health Branch in April 2015.

Health Screening Component

As part of the health screening component, foreign nationals have their health assessed via an immigration medical examination (IME), which is performed by panel physicians[10] who are designated by CIC. An IME includes: a review of an applicant's medical history, a mental examination, a physical examination, laboratory and diagnostic tests[11], and an assessment of the applicant's medical records. A panel physician may also conduct other medical investigations or order additional specialized tests (i.e., furtherance) as necessary to complete the IME.

The results of the IME are entered into eMedical[12], which are then uploaded into CIC's Global Case Management System (GCMS). CIC medical officers and/or delegated staff located in CIC regional medical offices (RMO) use the results of the IME and conduct an immigration medical assessment (IMA) to determine whether an applicant is inadmissible to Canada based on the three grounds outlined in IRPA, section 38(1) (a)-(c):

- *Danger to public health:* considers a foreign national's health condition regarding the communicability of any disease that the foreign national is affected by or carries, and the impact that the disease could have on other persons living in Canada. Active pulmonary tuberculosis (TB)[13] and untreated syphilis are considered dangers to public health.

- *Danger to public safety:* considers a foreign national's health condition regarding the risk of a sudden incapacity or unpredictable or violent behaviour of the foreign national that would create a danger to the health or safety of persons living in Canada (e.g., certain mental health conditions, sociopathic disorders).

- *Excessive demand on health or social services:* considers (a) a demand on health or social services for which the anticipated costs would likely exceed average Canadian per capita health services and social services costs over a period of five consecutive years immediately following the most recent medical examination, unless there is evidence that significant costs are likely to be incurred beyond that period, in which case the period is no more than 10 consecutive years; or (b) a demand on health or social services that would add to existing waiting lists and would likely increase the rate of mortality and morbidity in Canada as a result of an inability to provide timely services to Canadian citizens or permanent residents (PRs).

Subsequently, medical officers then enter the IMA results into GCMS and visa officers use those results to assess health admissibility.

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[10] Panel physicians were previously referred to as Designated Medical Practitioners (DMPs). Panel physicians are located around the world and are authorized to perform IMEs on behalf of CIC.

[11] This includes chest x-ray (aged 11 and older), syphilis and HIV blood tests (age 15 and older), and urine test (age 5 and older).

[12] CIC's eMedical system, launched in January 2013, is a web-based health processing system (replacing the paper-based system) developed by Australia's Department of Immigration and Citizenship (DIAC) for electronic submission and processing of IMEs. CIC and DIAC collaborated to deliver the system for both Canadian and Australian clients and in 2010, DIAC and CIC signed an umbrella Memorandum of Understanding to cover the management and implementation of eMedical.

[13] TB is an infectious disease caused by a group of bacteria, mycobacterium tuberculosis complex. Individuals with active TB have active TB germs in the body and can spread the disease to other individuals.

Medical Surveillance and Notification Component

In certain cases, foreign nationals with an inactive public health condition are admissible to Canada but are required to undertake medical surveillance upon arrival. The conditions that currently require medical surveillance are inactive TB[14] and complex inactive TB[15] due to the risk of reactivation. CIC previously required medical surveillance for adequately treated syphilis; however that requirement was removed in May, 2014.[16] In addition, although the human immunodeficiency virus (HIV) is not a condition that requires medical surveillance, CIC reports HIV-positive cases to provinces and territories (P/T) that have chosen to be notified, upon the individual's entry into Canada.[17]

As part of the notification process, CIC provides individuals that require medical surveillance a *Medical Surveillance Undertaking* form (IMM0535B) and a *Medical Surveillance Handout*. These individuals are required to provide the form to the Canada Border Services Agency (CBSA) upon arrival in Canada. The CBSA provides the forms to CIC and upon receipt, CIC notifies the appropriate P/T health authority[18] of the individuals' arrival. Those requiring medical surveillance must report to a P/T health authority within 30 days of arrival (or within seven days for complex cases). The P/T health authorities are responsible for conducting any medical follow-up required according to the protocols developed by that P/T. CIC works in close collaboration with P/Ts to obtain proof of compliance with the medical surveillance requirement but CIC has no formal mechanism to do so. Any further care or treatment of that individual is the responsibility of the P/T in which the individual resides.

1.2.2. Program Governance

CIC's Migration Health Branch (MHB) is responsible for the administration and delivery of the HSN Program.

Health Operations Division oversees the operational aspects of the program, including the operation of the RMOs; the management of panel physicians, radiologists, and laboratories (collectively referred to as the panel network);[19] the centralization and management of complicated cases; and the development of training and reference materials used by panel physicians and CIC medical staff to conduct the IMEs and IMAs. The Public Health Liaison Unit (PHLU) is responsible for the medical surveillance and notification component of the HSN Program, including notifying the P/Ts of individuals that require surveillance upon their arrival.

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[14] Inactive pulmonary TB (also known as pulmonary tuberculosis inactive (PTI)) is: a history of treated active TB; and/or an abnormal chest x-ray suggestive of TB (with two chest x-rays taken at an interval of 3 months apart with stable appearance and three negative sputum smears and cultures; or two chest x-rays taken at an interval of 6 months apart with stable appearance).

[15] Complex inactive TB (also known as complex pulmonary tuberculosis inactive (PTI)) is a sub-set of inactive pulmonary TB with a greater risk of reactivation.

[16] The elimination of this requirement was done in consultation with provinces and territories.

[17] The purpose of this notification is link HIV-positive newcomers with the health care system. Surveillance of HIV is not a condition of entry.

[18] P/T health authority can refer to the provincial or territorial Ministry responsible for health or public health units (i.e., at the municipal level), depending upon the notification process used in each P/T (i.e., centralized or decentralized).

[19] This includes selecting, appointing, monitoring, evaluating and, when required, suspending or terminating designated panel physicians, radiologists, and laboratories.

Migration Health Policy and Partnership Division: is responsible for the policy framework that governs the HSN Program.

Regional Medical Offices: are responsible for the delivery of the HSN Program in their respective geographic areas.[20] CIC's four RMOs are located in Ottawa, New Delhi, Manila, and London. They work directly with the panel network, providing support and oversight for IME activities; complete the IMAs; and consult with visa offices, as necessary. A co-management framework between (MHB) and the International Region defines the respective roles of the MHB Senior Director of Operations and the Immigration Program Manager in the management of CIC medical officers and medical programs in overseas RMOs.[21]

Visa offices, CIC inland and centralized processing offices support the delivery of the program by instructing applicants to undertake and complete the IME, using medical results to determine admissibility to Canada, and issuing notifications for surveillance.

1.2.3. Delivery Partners and Stakeholders

The HSN Program is delivered in collaboration with, or the support of, a number of government departments and external organizations.

Public Health Agency of Canada (PHAC): CIC and PHAC collaborate to ensure that their respective mandates related to immigration and public health are fulfilled. This includes: exchanging information on mutual areas of interest, facilitating access to federal/provincial/territorial networks related to health and immigration, and ensuring alignment of the department's respective policies related to public health and immigration.

Canada Border Services Agency: CIC and the CBSA collaborate to ensure that individuals arriving in Canada who are diagnosed with medical conditions requiring surveillance are identified and reported to P/T health authorities. The CBSA is also responsible for identifying foreign nationals who arrive at ports of entry (POEs), or those already in Canada, with health conditions which may render them medically inadmissible on health grounds, as per its role in relation to IRPA and the *Quarantine Act*.[22]

Provincial and Territorial Health Authorities: P/T health authorities support the objectives of the HSN Program by being the point of contact for individuals that require medical surveillance, and assessing individuals following their arrival in Canada.

Panel Physicians/Panel Radiologists: Panel physicians are designated and authorized by CIC to perform IMEs, arrange for diagnostics and investigations, and complete immigration medical forms. Panel physicians do not have the authority to assess or determine whether an individual's medical conditions could make them inadmissible, as that determination is the responsibility of visa officers. Panel radiologists are authorized by CIC to perform, grade, and submit chest x-rays requested for the IME.

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[20] The number of RMOs has been reduced from ten to four. RMO-Vienna closed June, 2011 and files were transferred to RMO-London. RMO-Nairobi closed September, 2011 and files were transferred to RMO-London. RMO-Port of Spain closed May, 2012 and files were transferred to RMO-Americas. RMO-Singapore closed June 2012 and files were transferred to RMO-Manila, with the exception of Bhutanese refugees, which are processed by RMO-New Delhi. RMO-Paris closed in December, 2013 and the files were transferred to RMO-London. RMO-Beijing closed December, 2013 and the files were transferred to RMO-Manila.

[21] With the exception of the medical staff in RMO-Ottawa (RMO-Americas), who report to Health Operations Division.

[22] Canada, Department of Justice (2005) *Quarantine Act*.

1.2.4. Program Costs

Prior to fiscal year (FY) 2014/15, planned spending within Strategic Outcome 4 was not captured at the sub-level of CIC's program activity architecture (i.e., financial data were not available at the 4.1.1 - health screening and 4.1.2 - medical surveillance and notification components of the HSN Program). As well, prior to 2011, planned spending for the HSN Program was rolled up into the permanent and temporary resident migration PAA activity. Therefore, to identify costs for the HSN Program, the evaluation used data from CIC's Cost Management Model (CMM)[23], which include estimates of salary, non-salary, and statutory costs. As shown in Table 1.1a and Table 1.1b, and further explained in Section 3.5.1, total costs for the medical screening component for a three-year period (FY 2011/12 - FY 2013/14[24]) was $24.5 million and total spending for the medical surveillance and notification component for a two-year period (FY 2012/13 - FY 2013/14[25]) was $2.3 million.

Table 1.1:   Estimated Cost of the HSN Program

Health Screening Component

	Salary	Non-Salary	Sub-total	Statutory*	Total
FY 2011/12	$6,338,764	$925,608	$7,264,372	$994,102	**$8,258,474**
FY 2012/13	$6,780,764	$1,809,658	$8,590,422	$1,123,531	**$9,713,953**
FY 2013/14	$4,661,688	$1,069,176	$5,730,864	$756,824	**$6,487,688**
Total	**$17,781,216**	**$3,804,442**	**$21,585,658**	**$2,874,457**	**$24,460,115**

Medical Surveillance and Notification Component

	Salary	Non-Salary	Sub-total	Statutory*	Total
FY 2012/13	$816,256	$149,033	$965,289	$135,196	**$1,100,485**
FY 2013/14	$1,019,899	$61,394	$1,081,293	$166,996	**$1,248,289**
Total	**$1,836,155**	**$210,427**	**$2,046,582**	**$302,192**	**$2,348,774**

Statutory costs are Employee Benefit Plan costs such as Canadian Pension Program, severance, Employment Insurance, departmental contribution, etc.

Source: CIC Cost Management Model

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[23] CIC's CMM is an activity-based costing model, which uses time and volume data to develop total cost estimates for CIC's business lines. The CMM is tracked through an online tool that integrates financial and non-financial data, based on business processes. Updating the CMM begins with fund centre managers reviewing their individual activities and expenditures over a given fiscal year, coordinated through a data-gathering exercise. Fund centres are typically aligned with divisions of work. The CMM is updated yearly (except for FY 2008/09 when no CMM exercise was conducted) to provide information on how resources were used to deliver programs and services.

[24] Costs for the health screening component prior to FY 2011/12 were calculated differently, thus were not included.

[25] Costs for the medical surveillance and notification component are not available for years prior to FY 2012/13 as it was not yet systematically reported by CIC within the CMM.

1.2.5. Program Statistics

Health Screening Component

Between 2007 and 2012[26], CIC conducted approximately 3.2 million IMAs, representing an average of approximately 525,000 IMAs per year (Table 1.2). The largest proportion of IMAs were conducted out of RMO-Americas (formally called RMO-Ottawa), which accounted for approximately 30% of all IMAs conducted during that time period.

Table 1.2: Number of Immigration Medical Assessments Completed, by Regional Medical Office (2007-2012)

Regional Medical Office	2007	2008	2009	2010	2011	*2012	Total
Americas	144,937	152,250	161,022	153,057	152,448	184,217	**947,931**
London	37,136	38,622	49,575	50,044	41,934	72,597	**289,908**
Manila	63,467	71,592	66,197	65,801	58,704	84,333	**410,094**
Nairobi	11,319	11,221	12,047	11,313	8,429	-	**54,329**
New Delhi	48,607	49,063	47,936	61,001	63,796	77,646	**348,049**
Paris	49,184	50,316	57,789	59,429	47,540	51,912	**316,170**
Beijing	57,332	57,889	60,970	62,287	65,384	69,649	**373,511**
Port of Spain	40,866	42,952	41,995	39,964	34,931	-	**200,708**
Singapore	29,601	30,207	33,056	28,357	23,270	-	**144,491**
Vienna	17,122	15,703	14,425	14,493	4,475	-	**66,218**
Total	**499,571**	**519,815**	**545,012**	**545,746**	**500,911**	**540,354**	**3,151,409**

* Numbers are not provided for all RMOs as many offices closed following network changes as a result of eMedical implementation.
Source: Migration Health Branch annual/quarterly reports based on Immigration Medical System (IMS)/GCMS/Field Operations Management System (FOSS) data.

Immigrant[27] applications accounted for the majority of IMAs processed between 2007 and 2012, with approximately 320,000 IMAs, or 61% of all assessments on a yearly basis (Table 1.3). Temporary residents (TRs) and refugees accounted for approximately 28% and 10% per year, respectively.

Table 1.3: Number of Immigration Medical Assessments Completed, by Immigration Category (2007-2012)

Immigration Category	2007	2008	2009	2010	2011	2012	Total
Immigrants (family, economic, and humanitarian and compassionate)	310,141	308,379	337,438	347,386	308,798	312,885	**1,925,027**
Refugees (convention and claimants)	56,730	51,271	64,042	51,128	57,108	35,130	**315,409**
Temporary residents	132,559	160,031	143,071	147,043	134,176	162,331	**879,211**
Total	**499,571**	**519,830**	**545,012**	**545,746**	**500,911**	**540,354**	**3,151,424**

Source: Migration Health Branch annual/quarterly reports based on IMS/GCMS/FOSS data.

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[26] Data in GCMS for 2013 only includes cases assessed overseas; therefore the data for that year have not been included.

[27] For the purpose of this report, immigrants are defined as migrants who received permanent resident status through all permanent immigration streams excluding refugees (convention and claimants).

Medical Surveillance and Notification Component

Between 2007 and 2013, CIC notified the P/T health authorities of 52,351 clients who entered Canada with inactive TB[28], syphilis, and HIV (Table 1.4). On average, this represents 7,500 notifications per year. The majority of notifications are for clients with inactive TB (87%), followed by syphilis (11%) and HIV (1.6%).

Table 1.4: **Notifications to Provincial and Territorial Public Health Authorities, by Condition Type (2007-2013)**

Conditions	2007	2008	2009	2010	2011	2012	2013	Total
Inactive TB	6,963	6,836	5,940	6,670	6,078	6,580	**6,458**	**45,525**
Syphilis	961	962	984	898	738	711	**476**	**5,730**
HIV	109	148	101	107	115	144	**372**	**1,096**
Total	**8,033**	**7,946**	**7,025**	**7,675**	**6,931**	**7,435**	**7,306**	**52,351**

Source: Migration Health Branch reports and Medical Surveillance Unit Case Management (MSUCM) data extract.

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[28] This includes both inactive and complex inactive TB.

2. Evaluation Methodology

2.1. Evaluation Approach

The approach and scope for the evaluation was established during a planning phase undertaken prior to the commencement of the evaluation. The terms of reference for the evaluation were approved by CIC's Departmental Evaluation Committee in October, 2013.

A large-scale evaluation was conducted with the level of effort based on several factors including:

- the health screening component of the HSN Program had not previously been evaluated;

- the HSN Program spans all of CIC's immigration and refugee programs;

- the HSN Program has domestic and international components;

- there are a high number of stakeholders and delivery partners involved in the HSN Program; and

- Migration Health Branch was conducting a policy review and there was a desire to explore policy issues in the evaluation.

2.2. Evaluation Issues and Questions

The evaluation of the HSN Program was conducted as per the requirements of the Treasury Board Secretariat's *Directive on the Evaluation Function*[29] and examined issues of relevance and performance. The relevance and performance, along with the HSN policy, and program design and management, were assessed through the following expected outcomes, which are also outlined in the HSN Program logic model (see Appendix A: Logic Model):

- Immigration medical examinations are conducted (immediate);

- Applicants who have a disease of public health significance or a condition imposing excessive demand are identified (immediate);

- Individuals who have the potential of posing public health risks are connected to the provincial health system (immediate);

- Migrants who pose risks to public health or public safety are admitted with conditions, are refused entry, or are declared an excessive demand to Canada (intermediate);

- Reduced burden of migration on the health and social services in Canada (ultimate); and

- Managed migration that promotes Canadian interests and protects the health and safety of Canadians (CIC Strategic Outcome 4).

The evaluation questions, organized by core evaluation issue, are presented in Table 2.1 (see Technical Appendices for the full set of evaluation questions, indicators, and methodologies).

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[29] Canada, Treasury Board Secretariat (2009) *Directive on the Evaluation Function*. www.tbs-sct.gc.ca/pol/doc-eng.aspx?id=15681

Table 2.1: Evaluation questions

Relevance (need, alignment, and federal role)	Report section
1.1 a) Is there a continued need to examine and assess migrants' health status before admission to Canada?	3.1.1
1.1 b) Is there a continued need for applicants diagnosed with conditions of public health significance to require medical surveillance?	3.1.2
1.2 Is the CIC Health Screening and Notification (HSN) Program aligned with departmental and government-wide priorities?	3.1.3
1.3 a) Is the federal government role in the delivery of the Health Screening Program appropriate?	3.1.4
1.3 b) Is the federal government role in the delivery of the Medical Surveillance and Notification Program appropriate?	3.1.4
Performance (achievement of expected outcomes)	
2.1 Are the immigration medical examinations screening for medical conditions relevant to the migration context? 2.3 Are the policies on excessive demand, danger to public health and public safety still relevant?	3.2.1 3.2.2 3.2.3
2.2 Does the requirement for health screening include the appropriate applicants and populations?	3.2.4
3.1 Are the necessary tools in place to support program delivery and to what extent are they being used and applied consistently?	3.3.1 3.3.2 3.3.3
3.2 What impact are modernization activities and tools (e.g., eMedical, GCMS) having on the effectiveness and efficiency of the health screening and notification program?	3.3.4
4.1 To what extent are IMEs being conducted and assessed in a timely manner?	3.4.1
4.2 To what extent are migrants with diseases deemed of public health significance identified?	3.4.2
4.3 Are migrants aware of their requirement to undertake medical surveillance?	3.4.3
4.4 To what extent are individuals with conditions of public health significance a) being referred to provincial public health systems and b) complying with surveillance requirements?	3.4.3
4.5 To what extent is the HSN Program reducing the burden of migration on the health and social services in Canada?	3.4.4
4.6 To what extent is the HSN Program protecting the health and safety of Canadians?	3.4.4
Performance (economy and efficiency)	
5.1 To what extent is the HSN Program operating efficiently given its resources?	3.5.1 3.5.2

2.3. Evaluation Scope

The evaluation included both the health screening and the medical surveillance and notification components because these activities are part of a continuum of health activities, and also to optimize resources and efficiencies (i.e., there was some overlap in data collection). The timeframe for the evaluation covered a five-year period from 2008/09 to 2012/13. This time period was selected based on the fact that the medical surveillance and notification component was last evaluated in 2007/08. The health screening component had not previously been evaluated. An assessment of the panel radiologists and laboratories, as well as an assessment of the effectiveness of the screening methods used to identify conditions of concern, were outside the scope of the evaluation.

2.4. Data Collection Methods

Data collection for this evaluation took place between November, 2013 and December, 2014, and included multiple lines of evidence to ensure the strength of information and data collected, which are briefly described in Table 2.2.[30]

Table 2.2: Summary of Data Collection Methods

Data Collection Method	Description
Document review	Review of federal government and corporate documents (e.g., speeches from the Throne, reports on plans and priorities, relevant legislation), program documentation (e.g., manuals, guidance documents, quality assurance templates) and public health documents (e.g., P/T TB priorities, federal TB strategy, PHAC reports and publications).
Literature review	Review of Canadian academic literature to gather information to address questions related to program relevance and performance. A total of 106 pieces of literature were reviewed.
Interviews	Interviews with individuals with knowledge of the HSN Program and/or experience with its delivery. A total of 91 interviews (107 people) were completed with: • CIC (Migration Health Branch, International Region, visa offers, CIC medical officers); • other government departments (PHAC, Health Canada, the CBSA) • panel physicians (sample from each RMO); • P/T representatives (Chief Medical Officers of Health, TB and syphilis representatives); and • external experts/academics
Site visits	Four site visits were conducted to CIC's RMOs. Data collection during the site visits included: interviews with CIC medical officers, visa office staff, locally-engaged staff, and panel physicians; collection of RMO-specific documents; and observation of the health screening process.
Survey of visa officers	Online survey administered to 240 Canadian-based visa officers, with 125 responses received, for a response rate of 52% (the margin of error is ±6.08% using a 95% confidence level).
Survey of panel physicians	Online survey administered to 904 active panel physicians, with 521 responses received, for a response rate of 57.6% (the margin of error is ±2.80% using a 95% confidence level).
Survey of public health units (PHU)	Telephone survey administered to public health units (PHUs) that receive notification of individuals that require medical surveillance. A total 55 responses were obtained.[31]
Analysis of program data	Data were extracted from Migration Health Branch annual and quarterly reports, the Immigrant Medical System (IMS)[32], GCMS, the Field Operations Support System (FOSS), and the Medical Surveillance Unit Client Manager[33] (MSUCM), and CIC Financial data (Cost Management Model).
Country comparison	Review of publicly available documents for Five Country Conference (FCC) partners was conducted to gather information on similarities and differences with Canada's HSN Program.

[30] A detailed description of the methodologies and supporting information (e.g., list of documents reviewed, interview guides) can be found in the Technical Appendices.

[31] Due to the approach for the notification process, not all PHUs were surveyed (i.e., some did not receive the notifications). In some cases, it was a representative of a P/T health authority that participated in the survey. Also in some cases more than one individual in an office was surveyed. Therefore, it is not possible to calculate response rates for the survey.

[32] IMS is the system that was used to collect information for the health screening component prior to the implementation of GCMS in 2012.

[33] The MSUCM database tracks all data related to the medical surveillance and notification component.

2.5. Strengths and Limitations

The methodology for the evaluation had a number of strengths:

- the use of multiple lines of evidence;

- comprehensive input from all areas of the program, including domestic and overseas staff, other government departments, and P/Ts;

- high level of confidence in response rates and quality of information gathered from the visa office and panel physician survey;

- high quality of information gathered from the PHU survey; and

- comprehensive approach to identify literature for the literature review.

There are a few limitations to note, although overall, they did not have a major impact on the evaluation findings:

- interviews were not conducted with P/T representatives with respect to excessive demand[34];

- the comparison of similar migration health programs in FCC partner countries was limited to publically available documents;

- limited program-related quantitative information was available to assess the implementation and impact of eMedical due to the timing of the roll out of eMedical;

- some stakeholders interviewed had limited knowledge of the HSN Program, so were limited in their ability to comment on its process and its effectiveness; and

- changes in CIC health data systems prevented the evaluation from obtaining consistent data across all elements of the health screening process.[35]

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[34] The representatives of the Director General-level Federal/Provincial/Territorial Health Table led by Health Canada were invited to participate in an interview for the evaluation. The majority of P/Ts declined to participate, thus no interviews with this stakeholder group were conducted.

[35] The transition from IMS to GCMS and the decommissioning of FOSS has created data consistency challenges across transition years.

3. Evaluation Findings

3.1. Relevance

3.1.1. Need for Health Screening

> **Finding**: As a result of the increasing number of migrants to Canada and the health risks associated with migration, there is a need to assess migrants' health status before admission to Canada to prevent individuals with infectious diseases/conditions of concern from entering Canada and to prevent undue economic burden on the Canadian health care system and taxpayers.

Globalization, Migration, and Health Risks

Increased globalization has led to increased migration, worldwide, which has resulted in increased health risks. In 2013, Canada was ranked eight out of the top twenty-five countries in an assessment of the number and share of international migrants, globally.[36] Between 2008 and 2012, Canada admitted approximately 6.2 million permanent and temporary residents (TR),[37] as seen in Table 3.1.

Table 3.1:   Number of Permanent Residents and Temporary Residents Admitted to Canada (2008-2012)

Category	2008	2009	2010	2011	2012	Total
Permanent residents	247,245	252,172	280,688	248,749	257,895	**1,286,749**
Temporary residents	881,685	938,441	982,495	1,021,070	1,091,876	**4,915,567**
Total	**1,130,938**	**1,192,622**	**1,265,193**	**1,271,830**	**1,351,783**	**6,202,316**

Source: CIC Facts and Figures, 2012.

Reviewed literature and information from interviews showed that increased migration results in increased health risks. In particular, countries that have low prevalence rates of certain infectious diseases are placed at risk when they receive migrants from countries with high prevalence rates. Canada is an immigrant receiving country with low incidence rates of certain infectious diseases that receives migrants from countries with high incidence rates of certain diseases. As a result, these diseases can remain prevalent in the foreign born population in Canada. For example, Canadian tuberculosis rates in 2012 among foreign born individuals accounted for 64% of reported cases of active TB disease and experienced a rate of tuberculosis 20 times higher than that of the Canadian-born non-Aboriginal population.[38]

Furthermore, migration brings about a growth and change in the number and nature of diseases of concern[39] over time. According to reviewed literature, the migration of people from countries with high prevalence rates of infectious diseases to countries with low prevalence rates influences the epidemiology of certain diseases globally and in immigrant receiving nations. Examples of this trend include diseases such as tuberculosis and sexually transmitted diseases,[40] as seen in the

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[36] Migration Policy Institute (2015) *Programs*.

[37] This includes visitors, students, and temporary foreign workers.

[38] Canada, PHAC (2014) *Tuberculosis Prevention and Control in Canada: A Federal Framework for Action*.

[39] Diseases that are considered significant in the context of migration.

[40] B.D. Gushulak and D.W. MacPherson (2006) "The basic principles of migration health: Population mobility and gaps in disease prevalence". *Emerging Themes in Epidemiology*. 3:3.

growth of Hepatitis B and C in foreign-born populations.[41] All of these factors support the need to examine and assess migrants' health prior to admission to Canada, given that Canada is highly connected globally by migration and travel.

Interview information also supported this, with the majority of interviewees across all groups noting that the health status of migrants needs to be assessed before being admitted into Canada because screening catches certain diseases and conditions, which would pose a risk to the health and safety of Canadians. In addition, the concept of health screening is supported by FCC partners, as all have their own respective health screening programs for examining and assessing migrants' health status prior to admission to their respective countries.

Reducing the Burden on Health and Social Services

The evaluation also associated the need for screening with the reduction of burden from Canada's public health care system. Public documentation from P/Ts suggests that P/T public health care systems in Canada are strained, noting the cost of health care and wait times as particular issues. This was supported by many interviewees (in particular among CIC medical officers) and PHU survey respondents, who indicated that health screening can prevent undue economic burden on the Canadian health care system and taxpayers by screening out applicants with conditions likely to pose an excessive burden.

3.1.2. Need for Medical Surveillance

> **Finding**: There is a continued need for applicants diagnosed with conditions of public health significance to require medical surveillance, primarily due to the risk of spreading and reactivation of infectious diseases. In addition, medical surveillance can have the added benefit of connecting immigrants to the health care system.

Risk of Spreading and Reactivation of Infectious Diseases

The evaluation found that the need to place clients with inactive TB under surveillance is largely linked to the risk of reactivation. Reviewed literature[42] found that the majority of cases of active TB in Canada among the foreign-born population were associated with reactivation of latent TB[43], generally acquired prior to immigration and most commonly occurring within the first two years following arrival in Canada. It was found that "among those who arrived in Canada with latent TB between 1998 and 2008, 11% were diagnosed with active TB during the first year

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[41] B.D. Gushulak and D.W. MacPherson (2011) "Health Aspects of the Pre-Departure Phase of Migration". *PLoS Med* 8(5).

[42] [1] A. Houde et al.(2010) "HIV/AIDS and TB in Migrants to Canada". *Health Policy Research Bulletin*. Issue 17.
[2] M. Beiser et al. (2005) "The Health of Immigrants and Refugees in Canada". *Canadian Journal of Public Health*, March-April.
[3] K. Dasgupta and D. Menzies (2005) "Cost-effectiveness of tuberculosis control strategies among immigrants and refugees". *European Respiratory Journal*, Vol. 25, Number 6.
[4] M. Beiser (2005) "The Health of Immigrants and Refugees in Canada" *Canadian Journal of Public Health, March-April.*

[43] Individuals with latent TB infection have been infected with the bacterium, but it is dormant and does not cause symptoms nor make the person infectious. In these cases, infection can be identified through a skin test or a blood test. Without treatment, a small proportion of these infected individuals will develop active TB disease in their lifetime.

following arrival into Canada and another 11% were diagnosed during the second year. A total of 44% of active TB cases were diagnosed within the first five years following arrival into Canada."[44]

The 2013 Chief Public Health Officer's Report on the State of Public Health in Canada also confirmed these findings. It found that those with latent TB infection are more likely to develop active TB disease within five years after arrival, and although the overall number of reported cases of TB has not increased significantly since 1970; the proportion of the foreign-born population with TB infection or disease remains high relative to the general Canadian population. Of all the reported TB cases in 2011, 67% were among foreign-born individuals, 19% were among Canadian-born Aboriginal individuals, 12% were among Canadian-born non-Aboriginal individuals, and 2% were of unknown origin.[45]

According to the literature, the continued need for the medical surveillance program can also be linked to the fact that the transmission rate of TB to the Canadian-born population remains low. Surveillance of those with inactive TB has been proposed as one possible reason for low transmission rates from the foreign-born population to the Canadian-born population.[46]

The continuing need for surveillance was also supported by interview information, as a clear majority of interviewees across all response groups and many PHU survey respondents agreed that medical surveillance is needed to protect the health of Canadians by monitoring and identifying clients that pose a risk of reactivation. Most PHU survey respondents also stated that CIC should continue to require medical surveillance to ensure proper tracking and monitoring of inactive TB which has a risk of reactivation, especially in the initial period after landing. Some interviewees, particularly representatives from provinces, stated that there was less of a need for the surveillance of clients with syphilis.[47] Finally, similar to Canada, three of the four FCC countries examined (Australia, the United Kingdom and the United States) indicate that they have a need for migrants identified with conditions of public health significance to undergo medical surveillance upon arrival.

Connection to Health Care System

Reviewed literature and PHU survey respondents noted that an added benefit of CIC's surveillance requirement is that it connects migrants with conditions of public health significance with P/T health care systems. This provides migrants with an opportunity to enter the health care system and receive an examination from a Canadian physician to determine if there are any additional health risks. Those referred by way of the surveillance program are also then able to be tested for other infectious diseases that presented during or post migration, and can be given other interventions like vaccinations.[48]

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[44] A. Houde et al. (2010) "HIV/AIDS and TB in Migrants to Canada". *Health Policy Research Bulletin*, Issue 17.

[45] Canada, PHAC (2013) *The Chief Public Health Officer's Report on the State of Public Health in Canada, 2013: Infectious Disease—The Never-ending Threat.*

[46] M. Dara, B.D. Gushulak, D.L. Posey , J.P Zellweger, G.B Migliori (2013) "The history and evolution of immigration medical screening for tuberculosis". *Expert Review of Anti-infective Therapy*. 11(2).

[47] As previously noted, the syphilis surveillance requirement was removed in May 2014.

[48] K. Pottie et al. (2007) "Prevalence of selected preventable and treatable diseases among government-assisted refugees Implications for primary care providers". *Canadian Family Physician*, Vol. 53.

3.1.3. Alignment with Departmental and Government-wide Priorities

> **Finding**: HSN objectives and policies are well-aligned with federal government priorities to protect the health safety and security of Canadians and the sustainability of Canadian health and social services; and with provincial priorities with respect to the cost of health care and the prevention of tuberculosis.

Alignment with Departmental and Federal Government Priorities

The evaluation found that the HSN Program is aligned with Government of Canada (GoC) priorities to protect the health and safety of Canadians and to work with the P/Ts to ensure that the health care system is sustainable, as indicated in the 2010 and 2011 Speeches from the Throne.

The program is also aligned with CIC and government-wide priorities and specifically those of the Public Health Agency of Canada, related to protecting Canadians from health risks. These priorities are outlined in CIC and PHAC annual reports, departmental performance reports, reports on planning and priorities and departmental strategic plans. In particular, the HSN Program outcome related to protecting Canadians from health risks is aligned to CIC's Strategic Outcome 4 (*Managed migration that promotes Canadian interests and protects the health, safety and security of Canadians*) and with PHAC's strategic outcome (*Canada is able to promote health, reduce health inequalities, and prevent and mitigate disease and injury*).

CIC's HSN Program activities and collaborations also contribute to meeting Canada's international commitments and goals, such as the *Global Plan to Stop TB* and the *International Health Regulations*, which help the international community prevent, respond to, and assist in reducing public health risks globally.[49]

Alignment with Provincial and Territorial Priorities

A review of publicly available P/T documents indicates that the HSN Program is aligned and consistent with P/T public health priorities, namely regarding provincial TB prevention and control priorities. Eleven out of the thirteen provinces and territories indicated through their publicly available documentation (e.g., TB surveillance reports, guidelines, TB manuals, etc.) that there is alignment between the HSN Program and provincial health TB strategies. For example, the province of Ontario has a tuberculosis prevention and control protocol with the objective of preventing and reducing the burden of TB.[50] This aligns with the federal government's priority to protect the health and safety of Canadians from public health risks through the health screening and surveillance requirement.

P/T documents also showed that while the excessive demand policy was not mentioned specifically, all 13 provinces and territories indicated P/T priorities related to decreasing health care costs and wait times, and preventing excess burden on health care systems.

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[49] World Health Organization (2015) *International Health Regulations* (IHR).

[50] Ontario, Ministry of Health and Long-Term Care (2014) *Ontario Public Health Standards - Tuberculosis Prevention and Control.*

3.1.4. Appropriateness of Federal and Provincial Roles

Finding: The federal and provincial roles in the delivery of the HSN Program are appropriate, as they are aligned with federal and provincial mandates and responsibilities. Interviewees saw other potential roles for CIC related to the provision of client medical information, health promotion, and vaccination.

Given that health is a shared federal, provincial, and territorial responsibility, the evaluation examined the roles and responsibilities of the main partners involved in immigration health (Table 3.2).

Table 3.2: Summary of Federal and Provincial Responsibilities for Health

	Immigration Health Responsibilities
Citizenship and Immigration Canada	CIC is responsible for screening migrants for infectious diseases/conditions of concern prior to entering Canada and notifying P/Ts of individuals that enter Canada who have conditions that constitute a risk to public health.
Public Health Agency of Canada	PHAC is responsible for acting as the Government of Canada's central coordinating point for health security issues, for providing expertise on infectious diseases and the *Quarantine Act*, and working to build Canada's capacity in responding to public health emergencies, in collaboration with other federal departments, other levels of governments and stakeholders.[51]
Canada Border Services Agency	CBSA supports the implementation of the *Quarantine Act* and, as screening officers, must refer travellers to PHAC's quarantine offices for medical review when warranted; and for gathering and issuing surveillance documents at the ports of entry.
Provinces and Territories	P/Ts are responsible for health care and public health service delivery within Canada. P/Ts are also responsible for the surveillance of migrants that have been referred by CIC.

The evaluation found that the division of CIC and partners' roles and responsibilities related to immigration health are clear. Memoranda of Understanding exist between CIC and the CBSA and between CIC and PHAC that outline roles and responsibilities for health. *The Constitution* defines health care as being within P/T jurisdiction. CIC has legal responsibility as per IRPA/IRPR for medical screening of immigrants and refugees and for coordinating the post arrival notification process linked to medical surveillance with the P/Ts.

Almost all interviewees across every stakeholder group felt that the federal government's role in the HSN Program is appropriate in terms of medical screening and notifying P/T health authorities of clients that require medical surveillance. Interviewees, ranging from multiple federal departments and the provinces felt that the GoC's health screening role is appropriate given its legal/constitutional mandate over admissibility and responsibility to ensure the health and safety of Canadians (from migration related risks); and given the need for a central body to coordinate and inform P/Ts of screened immigrants with health conditions of concern.

In addition to the high level of general agreement over the appropriateness of the federal government's role in the HSN Program, many interviewees also noted other responsibilities which could potentially be a part of the federal role, including:

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[51] [1] Canada, PHAC (2007) *The Public Health Agency of Canada – Strategic Plan: 2007 – 2012, Information, Knowledge, Action.*
[2] Canada, PHAC (2010) *Departmental Performance Report 2009-2010.*

- *Provision of client information to P/Ts:* CIC could increase its role and responsibilities when handling referrals to P/Ts by more routinely sending necessary medical information on clients' health obtained during the IME.

- *Health promotion:* CIC could offer more health information (beyond that used solely for admissibility purposes) and education to migrants within the health screening process.

- *Immunization and screening for immunization:* CIC could include screening for immunization as part of screening, which would move the HSN Program from one which currently focuses on admissibility to that of "health promotion."

3.2. Health Screening and Notification Policy

As previously discussed, the assessment of health inadmissibility is based on three grounds outlined in IRPA. While there are no formal policy statements on how CIC is to meet these legislated requirements when considering inadmissibility based on health, CIC has identified the three health grounds as policy areas which have been operationalized through the guidance and medical instructions provided in relation to the medical examination and assessment of applicants. These three grounds correspond to CIC's three policies related to danger to public health, danger to public safety, and excessive demand. The evaluation examined the relevance of each of these policies and any associated implementation challenges.

3.2.1. Danger to Public Health

In order to conclude that a foreign national's health condition is likely to be a danger to public health, medical officers consider any report made by a health practitioner or medical laboratory, the communicability of any disease that the foreign national is affected by or carries, and the impact that the disease could have on other persons living in Canada. Foreign nationals are inadmissible due to danger to public health if they are found to have active TB or untreated syphilis.[52]

Relevance of the policy on Danger to Public Health

> **Finding**: Given CIC's legislative responsibilities and strategic objectives to protect the health and safety of Canadians and given the risks associated with the transmission of infectious disease related to migration, CIC's policy on Danger to Public Health remains relevant.

Under the objectives stipulated in Section 3 of IRPA, CIC is responsible for facilitating the entry of foreign nationals into Canada while protecting the health and safety of Canadians. Further, CIC's strategic outcome 4 aims to manage migration that promotes Canadian interests and protects the health, safety and security of Canadians. As discussed in Section 3.1.1, Canada is an immigrant receiving country and the risk of importation of infectious diseases remains high. Thus, CIC's policy on Danger to Public Health continues to be relevant in that it allows the federal government to ensure individuals with infectious diseases that may pose a risk to public health are not admitted to Canada.

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[52] Although HIV is not considered a danger to public health, CIC is committed to public health risk mitigation, and provides foreign nationals with HIV with information to help reduce the risk of transmission.

The continuing relevance of this policy was also supported by interview information, as almost all interviewees, especially among Medical Officers and Chief Medical Officers of Health, agreed that the policy on Danger to Public Health is still relevant to protect the health of Canadians. This policy is also consistent with FCC partners' policies, which require immigration screening to protect their respective populations from illnesses that are a danger to public health.

In exploring the relevance of the policy, the evaluation assessed whether there were any challenges for CIC in implementing the policy. Information from the visa officer survey and many responses from RMO and visa office staff interviewed showed that the implementation of the policy on Danger to Public Health is clear with few operational challenges.[53]

Appropriateness of Conditions that are a Danger to Public Health

Finding: It is appropriate to screen for TB as part of health screening due to the prevalence of the disease in the migrant population and to meet Canada's commitment to reduce the rate of TB in Canada. However, the rationale for screening for syphilis is less clear. There are potential gaps in CIC's screening process related to Hepatitis B and C and latent TB.

Screening for Tuberculosis

Literature and government documents reviewed demonstrate that TB continues to be a global health burden, with an estimated 1 billion people infected with latent TB in 2011, resulting in 9.2 million new active cases and 1.5 million deaths per year in 2011.[54] A 2014 PHAC report confirmed that TB continues to be major global health problem that affects millions of people each year and is ranked as the second leading cause of death from an infectious disease worldwide.[55] Research also shows that major source countries for immigration, such as the Philippines and China have high rates of TB[56] and over the past decade, 80% of the immigrants and refugees who have come to Canada have originated from countries with a high incidence rate of TB.[57] CIC's administrative data confirm that China, India and the Philippines represent Canada's top source countries for PR migration-countries that have significantly higher TB incidence rates (Table 3.3).

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[53] The majority of visa officer survey respondents indicated that they found processing public health cases easy or very easy (79%). Only 15% of respondents found processing these cases difficult or very difficult.

[54] C. Greenaway et Al. (2011) "Canadian Guidelines for Immigrant Health: Tuberculosis: evidence review for newly arriving immigrants and refugees". *Canadian Medical Association Journal*. 183(12).

[55] Canada, PHAC (2014) *Tuberculosis Prevention and Control in Canada A Federal Framework for Action.*

[56] M. Beiser (2005) "The Health of Immigrants and Refugees in Canada". *Canadian Journal of Public Health*, Volume 96, No. 2.

[57] A. Houde et al. (2010) "HIV/AIDS and TB in Migrants to Canada". *Health Policy Research Bulletin*, Issue 17.

Table 3.3: Canada's Top Immigration Source Countries and Their TB Incidence Rate (2008-2013)

Permanent Resident Source Country	TB Incidence Rate 2011*	2008	2009	2010	2011	2012	2013
China	80	30,037	29,622	30,391	28,503	33,024	34,126
India	190	28,261	29,457	34,235	27,509	30,932	33,085
Philippines	280	24,888	28,573	38,617	36,765	34,314	29,539
Pakistan	231	8,994	7,217	6,811	7,468	11,227	12,602
Iran	19	6,475	6,580	7,477	7,479	7,533	11,291
United States	4	10,190	8,995	8,142	7,675	7,891	8,495
United Kingdom	13	8,979	8,876	8,724	6,204	6,195	5,826
France	10	4,532	5,051	4,646	4,080	6,280	5,624
Iraq	64	3,543	5,450	5,941	6,196	4,041	4,918
South Korea	95	7,294	5,874	5,537	4,589	5,315	4,509
Canada	**5**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

* The incidence rates are based on the World Health Organization's most recently available three years (2008, 2009 and 2010) of estimated incidence (all forms of TB) per 100,000 population.
Source: CIC Facts and Figures 2013; World Health Organization.

In addition, the literature indicates that most migrants are coming from countries where the incidence rate of active TB is high and going to countries where the incidence rate is low, as is the case for Canada.[58] According to the World Health Organization, Canada's TB incidence rate is five per 100,000. While Canada's TB incidence rate has declined, the Government of Canada has committed to reduce the incidence rate to 3.6 cases per 100,000, by 2015.[59] All of these factors confirm that it is appropriate for TB to be screened as part of CIC's policy on Danger to Public Health.

This is supported by other information gathered for the evaluation. Many interviewees, ranging from CIC national headquarter (NHQ) staff, medical officers, health experts, and provincial representatives felt strongly that it was appropriate to screen for TB, as it is seen as a significant and continuing risk to public health. In particular, it was noted that active TB is easily spread, difficult and costly to treat, and ranks high on the list of communicable diseases globally. In addition, the majority of Public Health Unit (PHU) survey respondents (89%) noted a strong need to prevent active TB cases from entering Canada through screening and treatment, and the majority (89%) indicated that CIC should continue to prevent the entry of individuals that are found to have active TB. This policy is also consistent with FCC partners, who screen for TB due to the fact they have noted a high percentage of TB cases in their foreign-born populations.

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[58] D. Zenner et al. (2013) "Active case finding for tuberculosis among high-risk groups in low-incidence countries". *The International Journal of Tuberculosis and Lung Disease.* 17(5).

[59] [1] Canada, PHAC (2012) *Pan-Canadian Public Health Network: Guidance for Tuberculosis Prevention and Control Programs in Canada*
[2] Canada, PHAC (2013) *Framework for Action on Tuberculosis Prevention and Control, OGD Engagement, Presentation - March 2013*;
[3] Stop TB Partnership (2015) *The Global Plan to Stop TB 2011–2015*;
[4] World Health Organization (2006) *Tuberculosis (TB): The Stop TB Strategy*.

Screening for Syphilis

In contrast to the evidence to support the need to screen for TB, the evaluation found limited evidence to support screening for syphilis based on public health risk. Although one study on immigrants and syphilis conducted in 2008 noted that screening for syphilis can help to identify populations that may be at higher risk for the disease.[60] Many interviewees, in particular CIC medical officers and provincial TB/Syphilis representatives also questioned the need to screen for syphilis although a few health experts, and medical officers noted that syphilis screening is needed because the testing procedure (i.e., blood testing) helps to uncover other medical conditions.

Gaps in Screening

A few medical experts and many medical officer interviewees noted a few potential gaps in screening. They suggested that Hepatitis B and C are not presently conditions that lead to inadmissibility, however they do constitute a risk to public health. These diseases were also noted as conditions that should require screening due to costly treatment, their ability to cause longer term chronic health issues, and their possible transmission as a sexually transmitted infection. Other diseases which were felt to be of equal or greater risk to public health as syphilis (but not screened) included polio, measles, gonorrhoea, and serious flu strains (e.g., avian flu).

Another gap noted by a few provincial interviewees (TB/Syphilis representatives and Chief Medical Officers of Health) and supported by the literature, is CIC's current screening protocol related to latent TB. CIC has testing protocols that allow medical officers to request a tuberculin skin test and interferon gamma release assay when a close contact (i.e., family member) has been identified to have active TB. However, CIC does not routinely administer these tests, which are considered the best option to detect latent TB.[61] As previously stated in Section 3.1.2, PHAC documentation and literature noted that latent TB has the greatest risk of reactivating. The World Health Organization estimates that approximately one-third of the world population has latent TB, the majority of which is distributed in 22 high-burden countries, many of which are source countries for migrants to Canada such as India and China. As such, a few interviewees, particularly from the provinces, stated that CIC's current screening protocol to detect cases of latent TB may not be adequate. It was suggested that CIC use tuberculin skin testing and the interferon gamma release assay and skin tests more broadly/in a more targeted way based on the TB risks in particular countries areas.

In addition to screening for various other illnesses, some FCC partners request confirmation of vaccinations as part of their admissibility determination. For example, the United States requests proof of a variety of vaccinations (e.g., mumps, polio, measles, hepatitis), while Australia requires proof of the international vaccination certificate for yellow fever. Some interviewees felt that this was one area in which CIC could expand its current screening protocol.

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[60] D.W. MacPherson and B.D. Gushulak (2008) "Syphilis in Immigrants and the Canadian Immigration Medical Examination". *J Immigrant Minority Health*, 10:1-6.

[61] [1] M. Dara et al. (2013) "The history and evolution of immigration medical screening for tuberculosis". Expert Rev. Anti Infect. Ther., 11 (2).
[2] N. Heywood et al. (2003) "Guidelines for the investigation and follow-up of individuals under medical surveillance for tuberculosis after arriving in Canada: A summary." *CMAJ*, 168 (12).
[3] K. Dasgupta and D. Menzies (2005) "Cost-effectiveness of tuberculosis control strategies among immigrants and refugees". *European Respiratory Journal*, 25 (6).
[4] Greenaway et al. (2011) "Tuberculosis: evidence review for newly arriving immigrants and refugees." *Canadian Guidelines for Immigrant Health*, CMAJ, 183 (12).

In line with the thinking on gaps in the danger to public health policy, a few medical officers, CIC staff, other government departments (OGD), and Chief Medical Officers of Health interviewees suggested that the current screening policy lacked flexibility or that the policy could not quickly and easily deal with emerging diseases or shifts in world health patterns. These interviewees noted that a better screening method would be to screen conditions based on identified risk indicators rather than a list of itemized conditions.

3.2.2. Danger to Public Safety

Foreign nationals are inadmissible due to danger to public safety if they are found to create a danger to the safety of persons living in Canada. Conditions that are likely to be a danger to public safety include serious mental health problems such as: certain impulsive sociopathic behaviour disorders; some aberrant sexual disorders such as pedophilia; certain paranoid states or some organic brain syndromes associated with violence or risk of harm to others; applicants with substance abuse leading to antisocial behaviours such as violence, and impaired driving; and other types of hostile, disruptive behaviour.[62] As per the FCC country comparison analysis, the United States is aligned with Canada in terms of immigration health screening policies related to public safety. Similar to Canada, the USA screens individuals who have physical or mental disorders associated with harmful behaviour.

> **Finding**: Given CIC's legislative responsibilities and strategic objectives to protect the health and safety of Canadians, CIC's policy on Danger to Public Safety is relevant. However, the policy is difficult to apply as cases are hard to detect and it overlaps with potential inadmissibilities related to criminality.

Relevance of the policy on Danger to Public Safety

As noted with respect to the policy on Danger to Public Health, CIC is responsible for facilitating the entry of foreign nationals into Canada while protecting the health and safety of Canadians (IRPA, Section 3), which links to CIC's Strategic Outcome 4 to manage migration that promotes Canadian interests and protects the health, safety and security of Canadians. CIC's policy on Danger to Public Safety is relevant in that it allows the federal government to ensure individuals who pose a risk to public safety are not admitted to Canada. Almost all interviewees across all groups supported this, with the majority noting that the policy on Danger to Public Safety is relevant in that it safeguards Canadians from harm and may act as deterrent for these types of applicants.

Challenges with Implementation

Despite the support for the policy, many visa officers interviewed and approximately half of all visa officers surveyed found assessing public safety cases difficult, noting that very few applications related to public safety are identified through the IME process.[63] In addition, CIC visa officers, medical officers and CIC NHQ interviewees noted the difficulty of identifying or assessing public safety cases, primarily due to the fact that the assessment relies on clients to self-

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[62] Canada, Department of Justice (2002) *Immigration and Refugee Protection Regulations*, Section 33; internal medical requirements program delivery instructions.

[63] Between 2007 and 2012, CIC identified approximately seven dangers to public safety cases per year, which represents 0.5% of the clients found inadmissible for health reasons.

identify mental health conditions and if the condition(s) are not obvious or present at the time of the IME, it is very difficult for the panel physician to detect.

Furthermore, CIC operational staff, including visa officers, and medical officers noted during interviews a lack of a clear understanding on what constitutes a public safety concern under medical admissibility. Some interviewees also questioned whether the policy should be solely about public safety (dangerous individuals) or whether the scope could include mental disorders that prevent individuals from functioning in society. A few CIC interviewees and some visa officer survey respondents noted that there is overlap between the objectives of the policy on Danger to Public Safety and criminal inadmissibility, as both assessments require evidence of criminal or dangerous activities. It was noted that determining an applicant inadmissible on the grounds of criminality was more straightforward than doing so for public safety as the latter requires specialist assessments in addition to any other documentary evidence. As such, it was felt that the public safety policy requires further review to better define the policy objectives and improve implementation.

3.2.3. Excessive Demand on Health and Social Services

CIC's policy on Excessive Demand allows the federal government to ensure that individuals that may pose an excessive demand on health and social services are not admitted to Canada. In order to conclude that a foreign national's health condition is likely to cause excessive demand, a medical officer must examine whether the anticipated costs for a client's medical condition would likely exceed average Canadian per capita health services and social services costs over a period of five consecutive years[64] and examine if the admission of the individual would add to existing waiting lists and would increase the rate of mortality and morbidity in Canada as a result of an inability to provide timely services to Canadian citizens or PRs.

Individuals who are deemed to be an excessive demand are provided with an opportunity to provide a mitigation plan to demonstrate how they will not be a burden on Canada (i.e., through the use of privately funded treatment and social services). If it is determined that the applicant's mitigation plan is reasonable, he/she is no longer considered inadmissible for excessive demand provided they follow-through with their mitigation plan once in Canada.

> **Finding:** CIC's policy on Excessive Demand continues to be relevant to prevent migration from imposing an undue burden on health and social services in Canada; however, factors such as mitigation plans, exemptions, and legal challenges, may be limiting its effectiveness. In addition, there are challenges related to the application of the policy due to the complexity of the cases and the lack of standard cost data.

Relevance of the policy on Excessive Demand

As noted in Section 3.1.1, the policy on Excessive Demand is relevant because P/Ts have identified the cost of health care, wait times, and the prevention of burdening the health and social services as concerns. Information from interviews supports this, with the majority noting that the policy on Excessive Demand is relevant, highlighting the fact that P/T health care systems are strained and that the policy on Excessive Demand contributes to the reduction of burden that some conditions could pose. A few interviewees among CIC staff also noted that the

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[64] Unless there is evidence that significant costs are likely to be incurred beyond that period, in which case the period is no more than 10 consecutive years.

policy could have a deterrence effect on potential applicants that would pose an excessive demand.[65]

CIC's policy on Excessive Demand is consistent with FCC policies. While FCC partners differ in some details (e.g., significant cost threshold), overall, the United Kingdom, Australia and New Zealand are comparable to Canada in terms of excessive demand, as they all use screening as a way to prevent undue burden on their health care systems. Additionally, Australia and New Zealand both have a significant cost threshold (Australia's is $35,000 AUD; New Zealand's is $41,000 NZD over five years or the life of the condition).

Policy Gaps

Despite the strong support for the policy on Excessive Demand, visa office survey respondents as well as many interviewees noted gaps that may be having an impact on the effectiveness of the policy.

Compliance with mitigation plans: Applicants have the ability to overcome inadmissibility based on excessive demand if they provide a plan to mitigate the use/costs of health and social services within Canada that are associated with their conditions. These mitigation plans are limited in their effectiveness because the majority of health and social services are publically funded, thus migrants cannot be denied access to services. In addition, there is no in-Canada enforcement mechanism to ensure that migrants are following their mitigation plans.

Excessive demand exempt category: Certain applicants are exempt from excessive demand and although they must undertake a full IME, they are not assessed for excessive demand admissibility.[66] This exemption category, in particular, those in the family class, can reduce the effectiveness of the policy, as burden is still transferred to Canada by these applicants. Some interviewees noted that applicants, who would be inadmissible in other immigration categories, may apply under the family class in order to overcome their potential inadmissibility (the evaluation did not have any evidence to quantify this). This issue was seen as especially important due to the significant proportion of applicants to which the exemption applies. Between 2008 and 2012, approximately 27% (of the 525,000 IMAs per year) were excessive demand exempt.

Litigation and appeals of excessive demand decisions: CIC medical officers and visa officers noted that excessive demand refusals are frequently appealed, which often result in positive decisions (i.e., the refusal is overturned). Furthermore, visa officers felt that these cases are difficult to process because of the jurisprudence they are required to understand in order to make their decisions legally defensible. It was felt that frequent litigation and successful appeals limit the effectiveness of the policy and cost significant resources. While the evaluation was unable to obtain reliable appeals data related to federal court decisions on excessive demand cases, sponsorship appeals data was obtained from the Immigration and Refugee Board of Canada,

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[65] The evaluation did not have any data to assess deterrence effects.

[66] Excessive demand exempt foreign nationals include: spouse, common-law partner or conjugal partner; a dependent child (including an adopted a child) of the sponsor, or of the sponsor's spouse, common-law partner or conjugal partner; convention refugees (including their spouses/common-law partners/conjugal partners and dependent children); and protected persons (including their spouses/common-law partners/conjugal partners and dependent children).

which showed that between 2008 and 2013, 34% of all sponsorship appeals refused on health grounds[67] were allowed.

Implementation Challenges

In addition to these policy gaps, the evaluation identified a number of challenges with the implementation of the policy on Excessive Demand.

Processing complexity/difficulty: The majority of visa officers surveyed (68.8%) indicated that processing excessive demand cases is difficult or very difficult. Visa officers found the process of reviewing excessive demand cases to be complex and time consuming, requiring several steps such as drafting procedural fairness letters, reviewing mitigation plans, reviewing medical officer notes and supporting the decision with a defensible argument. Visa officers also noted that they lacked medical knowledge or expertise to understand medical conditions, treatment costs, and potential demand on social services.

Consistency of medical recommendations: Visa officers and interviewees noted that medical recommendations and the approach taken to assess excessive demand cases differed across RMOs.

Lack of up-to-date medical and social service cost information from P/Ts: CIC medical officers and visa officers noted that assessing and processing excessive demand cases is difficult due to lack of access to and/or knowledge of current medical cost information, which differs across P/Ts. This was considered important because medical officers and visa officers require accurate information to defend their decision should it be challenged in federal court.

Interviewees noted a need to review the policy on Excessive Demand to address the gaps that were identified and improve the assessment process. More specifically, the following suggestions were raised:

- further define excessive demand by identifying the specific conditions that would render someone inadmissible, thus allowing for a more straight-forwarded decision-making process;

- remove the ability of clients to mitigate excessive demand;

- require clients to submit a secure bond to cover the costs of treatment; and

- have better alignment, information-sharing (such as health costs), and coordination of the policy on Excessive Demand among different P/Ts and between the federal government and P/Ts.

3.2.4. Appropriateness of Applicants and Populations that Undergo Screening

> **Finding**: Stakeholders felt that CIC's screening policy related to permanent residents was appropriate, but less so for temporary residents as a number of potential gaps were noted which may expose Canada to public health risks. The literature and interviews identified factors that support a risk-based approach to screening.

As noted in Section 3.1.1, between 2008 and 2012, Canada admitted approximately 1.3 million PRs and 4.9 million TRs.[68] All foreign nationals applying for permanent residence[69] are required to undergo an IME and only certain TRs are required to undergo an IME:

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[67] 95% of health refusals are based on excessive demand legislation.

- those seeking to work temporarily in Canada in an occupation in which the protection of public health is essential; and

- those seeking to enter Canada for more than six months and have resided in a designated country/territory[70] for more than six consecutive months in the past 12 months.[71]

The evaluation assessed whether CIC's health screening requirement includes appropriate applicants and populations to undertake an IME. PHU survey respondents and many interviewees from CIC NHQ and the RMOs felt that screening PRs is appropriate due to their intention to remain in Canada and their potential impact on health and social services. They were less positive about CIC's screening policies related to TRs, noting the following gaps in policies related to TR that may expose Canada to public health risks:

Six month threshold (i.e., anyone entering Canada for less than six months is not required to undertake an IME): this policy was identified as a primary gap due to the fact that, from a public health perspective, foreign nationals from countries with a high prevalence of TB still pose a significant health risk once in Canada despite the six month threshold (i.e., the threshold does not mitigate the risk). Furthermore, a few interviewees among CIC officers were unclear about the origins or rationale for this threshold and suggested a review is required to determine if the current approach is the most effective and efficient.

Multiple-entry / super visa: Multiple entry visas and super visas allow visitors to leave and re-enter Canada for designated lengths of time without having to reapply each time. Interviewees noted that these types of visas introduce a public health risk because migrants can return to their countries of origin (those that have high incidence rates of TB) without needing to repeat an IME or be re-examined upon re-entry to Canada. The risk posed by return migration was also confirmed in the academic literature,[72] given the extent that return migrants travel to countries with higher prevalence rates of infectious diseases. Increased travel options and the increased potential for re-exposure to infectious diseases, according to the literature, means return migrants who are only screened once may pose a risk to public health and remain a potentially risky category of immigrants.

Temporary foreign workers and international students: Some interviewees across several interview groups from CIC to PTs felt that the lack of screening for certain temporary foreign workers and international students constituted a risk to public health because they can come from regions with high incidence rates of TB, live in close proximity to others, and stay in Canada for extended periods of time. PHU survey respondents felt that the screening of these

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[68] This includes visitors, students, and temporary workers who either apply from outside of Canada or who arrive at the port of entry.

[69] This includes Government Assisted Refugees, Privately Sponsored Refugees, protected persons, and in-Canada asylum seekers.

[70] According to CIC, a designated country is defined as having a three-year average estimated sputum smear positive pulmonary tuberculosis incidence rate equal to or greater than 15/100,000.

[71] Note that a visa officer may also require those applying for PR or TR to undergo an IME if there are reasonable grounds to believe that the individual is inadmissible on health grounds.

[72] [1] B. Gushulak et al. (2010) "Canadian Guidelines for Immigrant Health Migration and Health in Canada: Health in the global village." *CMAJ.*
[2] A. Davies et al. (2011) "The Dynamics of Health and Return Migration." *PLoS Medicine*, 8(6).
[3] K. Dasgupta and D. Menzies (2005) "Cost-effectiveness of tuberculosis control strategies among immigrants and refugees". *European Respiratory Journal*, 25 (6).

applicants should be based more so on individual risk assessments, one of which being an applicant's last country of residence and its associated TB rate.

Inland extensions/changes of status: a few CIC and PT interviewees noted that the medical requirement for certain applicants who apply inland, for a visa extension or for a different category (e.g., temporary foreign workers who transition to permanent status), may be missed by inland officers as a result of a lack of understanding, training or guidance.

A review of administrative data showed that a very low percentage of the TRs admitted to Canada require medical screening. It is estimated that approximately 15%[73] of the TRs that arrived in Canada during that time were subject to an IME. Yet data also show that TRs represented 28% of the cases identified as having active TB (rendered inactive) during the IME process, which suggests that TRs do pose a public health risk.

There is also evidence to suggest that TRs that are not undergoing health screening are being found with TB-related issues after arrival in Canada. PHU survey respondents noted instances of cases where TRs were found to have TB but had not been referred to them by CIC. Specifically, PHU survey respondents indicated that approximately 50% of recent migrants they see with TB-related issues, who were not referred by CIC, are in the TR category.[74]

While TR screening policy was identified as a gap, interviewees and PHU survey respondents recognized that it is neither feasible nor efficient to screen all applicants. In terms of a more efficient approach, some interviewees mentioned the need to consider epidemiological risk factors when screening applicants, suggesting the application of a risk-based policy approach.

In considering a risk-based screening approach for all immigration categories, evidence from the literature review suggests that there are factors that must be considered when evaluating the health risks posed by potential applicants to Canada. These factors include: a migrant's geographic location, their circumstance, and ethnicity.[75] Migrants arrive in Canada from particular geographic regions of the world that have populations that are more greatly impacted by infectious disease and other medical conditions than other regions. Also, the circumstance in which a migrant finds themselves may indicate the level of risk they pose to Canada. For example, refugees in camps, living in crowded and poor sanitary conditions increase the likelihood of exposure to infectious disease. Lastly, particular ethnicities may have a predisposition to certain health conditions (i.e., cardiovascular). As such, these factors could be considered in conjunction with, or as an alternative to, CIC's current screening approach.

The FCC country comparison found that all partners screen the same populations and/or types of applicants as Canada. However, the United States and Australia differ slightly from Canada, as both countries screen more populations. The United States has an all encompassing screening requirement, with all applicants 15 years and older requiring a medical history, physical examination and chest x-ray. Australia requires health screening from all applicants from all

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[73] This number was estimated based on the number of TR admittances between 2008 and 2012 and the number of TRs that underwent IMEs in that same time period.

[74] The remainder were either recently landed immigrants, refugees, or refugees claimants.

[75] [1] B. Gushulak et al. (2010) "Canadian Guidelines for Immigrant Health Migration and Health in Canada: Health in the global village". *CMAJ*.
[2] M. Beiser (2005) "The Health of Immigrants and Refugees in Canada." *Canadian Journal of Public Health*.
[3] K. Pottie et al. (2007) "Prevalence of selected preventable and treatable diseases among government-assisted refugees: Implications for primary care providers." *Canadian Family Physician*, Vol. 53.
[4] Greenaway et al. (2011) "Tuberculosis: evidence review for newly arriving immigrants and refugees." Canadian Guidelines for Immigrant Health, *CMAJ*, 183 (12).

countries, however, the health examinations required may vary (e.g., TR screening is dependent on duration of stay, intended activities, their country's risk level for TB).

3.3. Program Design and Management

The evaluation assessed the design and management of the HSN Program through an examination of: the availability of tools, guidance and training that support program delivery and the consistency of decision making; communication and coordination within CIC and with stakeholders; quality assurance; and the impact of program modernization activities / initiatives.

3.3.1. Tools and Guidance for Program Delivery

Health Screening Component

> **Finding**: Guidance and tools are in place for panel physicians, medical officers, and visa officers to support the delivery of the health screening component of the HSN Program and are viewed as effective by the users.

Availability of Tools and Guidance

The evaluation found that an extensive number of program management tools, guidance, and trainings are in place to support the health screening component[76] of the HSN program, including:

- medical forms, handbooks, instructions, training sessions/materials, which are available to panel physicians to perform IMEs;

- training opportunities, processing manuals, operational bulletins, standard operating procedures (SOPs), online resources, and internal guidance are available to medical officers and visa officers to perform IMAs and to make medical admissibility determinations; and

- a variety of other tools and guides that support quality assurance (see section 3.3.3 (*Quality Assurance*) for more information).

The effectiveness of these tools was assessed using information from program representatives from Migration Health Branch, CIC medical officers, panel physicians, and visa officers. The majority of interviewees, as well as most respondents to the panel physician and visa officer surveys, said that the guidance and tools that are available are effective in supporting health screening. During site visits to the RMOs, the evaluation also found that support staff, including locally engaged medical officers, medical assistants, and health adjudicators, receive adequate training on the IMA process.[77] In terms of improvements, CIC interviewees suggested that the *Medical Officer Handbook* and the standard operating procedures should be updated (especially in light of recent changes to the RMO network and introduction of eMedical); and suggested that it would be useful to have more formal training available for medical officers (e.g., assessing chest x-rays).

The majority of visa officers surveyed (85%) also felt that they have sufficient tools and training with respect to medical admissibility (either to 'some extent' or to a 'great extent').

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[76] A complete list of all tools and guidance materials is available in the Technical Appendices.
[77] This is largely done through on-the-job training.

Almost all panel physicians who were interviewed and surveyed found the *Panel Member's Handbook*, medical forms, and *Immigration Medical Examination Instructions* offered by CIC to be useful, clear, easy to use, and relevant in supporting their work.[78] Overall, the majority of panel physicians felt that they had the tools needed to do their job (95.3% agreeing or strongly agreeing). While a large majority did not think any improvements to the three main tools were necessary, it is worth noting that:

- one fifth (20.0%) of panel physicians said that the handbook needed to be improved by making it more simplified, better organized, more user-friendly and easier to find information (e.g., with an index);

- 17.9% said the medical forms need to be improved (with some suggesting very medical- or condition- specific changes to the forms); and

- 15.3% said the *Immigration Medical Examination Instructions* needed to be updated more regularly.

Panel physicians received various forms of training (e.g., CD, webinar, teleconference and on-site training) for the implementation of eMedical and were positive with respect to the training they received:

- 87.0% agreed or strongly agreed that the quality of the training was good;

- 93.6% agreed or strongly agreed that the information provided via the training was useful; and

- 79.1% agreed or strongly agreed that they received enough training on eMedical.

However, almost one-fifth of panel physicians (19.2% or 81 of 422) disagreed or strongly disagreed that they received enough training. These results varied by RMO, with panel physicians located in the RMO-Americas being less positive about the availability of eMedical training than panel physicians in other areas (31.6% disagreed or strongly disagreed). The Panel Physician survey results showed that panel physicians in the Americas received less in-person training than other panel physicians, which could explain the differences in opinion (see Technical Appendices for the survey frequencies).

Medical Surveillance and Notification Component

> **Finding**: Guidance and tools are in place for visa officers and the CBSA to support the delivery of the medical surveillance and notification component of the HSN Program and are viewed as effective. There are few tools and guidance for P/Ts, which was a gap identified by P/Ts.

There are a number of guidelines and tools available to delivery partners to support the delivery of the medical surveillance and notification component of the HSN program,[79] including:

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[78] Panel physicians were asked in the survey to rate the usefulness of the three main tools that they have available to them to conduct IMEs (the Panel Member's Handbook, the medical forms, and the Immigration Medical Examination Instructions). They felt that the Handbook was easy to use (94.8% agreed or strongly agreed), easy to understand (97.1% agreed or strongly agreed), and provided the needed information (97.1% agreed or strongly agreed). The medical forms and the Immigration Medical Examination Instruction Is were also viewed as easy to use (96.7% and 95.6% agreed or strongly agreed, respectively).

[79] A complete list of all tools and guidance materials is available in the Technical Appendices.

- instructions and tools for visa officers for the notification process (e.g., medical undertaking form, handout);

- enforcement manuals for Border Services Agents with guidance on medical admissibility and inadmissibility requirements, instructions for incoming passengers that require surveillance, and instruction on providing notifications to CIC;

- urgent referral guidelines for tuberculosis cases for P/T health authorities; and

- notification forms, which CIC provides to P/T health authorities.

Almost all CIC and CBSA interviewees felt that tools, training, and guidance are sufficient and effective in supporting the delivery of the medical surveillance and notification process. P/T interviewees (TB representatives) were less positive about the availability of tools and guidance, with the majority stating that they receive either very little or no tools, training or guidance from CIC related to the surveillance process. In particular, interviewees indicated that roles and responsibilities lacked clarity, as well as some of the procedures related to the surveillance notification process (i.e., conditions screened for and those requiring surveillance, and the surveillance compliance process). These views were also reflected in the PHU survey. When asked whether they have enough information on CIC's medical surveillance and notification process, only 40% of PHU survey respondents agreed that they did. As well, only 39% of PHU survey respondents indicated they knew who to contact within CIC for questions. To address this challenge, interviewees recommended that more information should be provided by CIC, such as better online information, guidance and outreach that define roles and responsibilities, and CIC's expectations regarding surveillance conditions and compliance reporting procedures.

P/T interviewees and PHU survey respondents also noted some challenges related to the notification form, which CIC provides to P/T health authorities. Specifically, P/Ts indicated that notifications are sometimes hand written, difficult to read (either too faint or illegible), lack of a naming convention (i.e., how the first and last name is ordered), or that the contact information is not accurate or complete. This creates challenges for P/Ts when trying to locate and contact clients. In addition, P/T interviewees felt that more information could be provided on the surveillance notification form such as the client's immigration category, country of last permanent residence, and language.

3.3.2. Communication and Coordination

Communication and Coordination across the CIC Network

Finding: Communication and coordination among stakeholders in the HSN Program is generally effective, although a decline in the level of communication between RMOs and panel physicians was noted following the implementation of eMedical, which was noted as a gap by panel physicians.

There are various mechanisms in place across the HSN Program to facilitate communication and coordination among various stakeholders. Interviewees across all groups felt that communication and coordination between various partners and stakeholders of the program are effective.

Information from the panel physician survey showed that communication with the RMO is done primarily via e-mail and the frequency of contact varies from a few times per year (48.3%) to about once per month (20.1%) to a few times per month (15.8%). Almost all panel physicians who were interviewed felt that communication and coordination is generally effective with their

RMO. Similarly, panel physician survey respondents were very positive with respect to communication with the RMOs:

- 93% agreed or strongly agreed that they are satisfied with the quality of the information that they received after making a request;

- 92% agreed or strongly agreed that they are happy with the methods of communication with their RMO;

- 90% agreed or strongly agreed that they feel they can contact their RMO anytime they have questions; and

- 90% of panel physicians agreed or strongly agreed that quick responses are received from the RMOs when they have questions.[80]

Despite these positive results, almost one-quarter (23.1% or 120 of 520) of panel physicians surveyed suggested that improvements were needed with respect to communication with their RMO.[81] The main improvement noted by panel physicians was the need to have better access and/or direct contact with the RMO. Information from panel physicians and medical officers that were interviewed noted that face-to-face and more personal contact and communication with panel physicians has decreased following the implementation of eMedical. Medical officers noted that following the implementation of eMedical, there were limited resources available to continue the level of communication that had previously existed.

Information from the evaluation also showed that communication and coordination between RMOs and visa offices is effective, with the majority of visa officers surveyed (89.4%) saying that communication with their RMO was effective. Although many survey respondents (58.5%) felt that there were areas for improvement, particularly with respect to the turn-around time related to requests sent to the general mailbox (which were not always timely) and the need to have more frequent operational / policy updates from RMOs, especially when there are issues that could affect the processing of visa applications.

Communication and Coordination with Other Government Departments and Provinces and Territories

Finding: The evaluation found that communication and coordination between CIC and OGDs was generally effective. Conversely, there is a lack of formal mechanisms to facilitate engagement between CIC and P/T ministries of health, which is a gap particularly with respect to coordination on issues related to excessive demand. P/T health authorities also identified challenges related to the sharing of medical results for surveillance clients between CIC and their respective organizations.

CIC has signed information and data sharing agreements with both the CBSA and PHAC, which cover the exchange of medical-related information. The CBSA notifies CIC when a person under medical surveillance first lands in Canada, and PHAC coordinates with CIC through various working groups, monthly teleconferences, and senior-level meetings on responses to new trends

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[80] Panel physicians that are overseen by RMO-New Delhi had consistently higher levels of agreement on all statements than panel physicians overseen by other RMOs (although the overall level of agreement is still high).

[81] Panel physicians that are overseen by RMO-Americas were more likely to say that improvements to communication were needed than panel physicians overseen by other RMOs.

and issues related to migration health. Interviewees felt communication and coordination is generally effective between CIC and the CBSA and between CIC and PHAC.[82]

While P/T interviewees and PHU survey respondents did not comment on any major communication issues with CIC, it was noted that CIC notifications sometimes arrive after some surveillance clients have already contacted the P/T health authority. In addition, P/T interviewees (TB representatives) indicated that CIC does not, as a general practice, automatically send them medical records for surveillance clients. Rather, the P/T health authorities must request them from CIC and they noted that this process takes too long (usually 2-4 weeks or up to several months[83]). Given that just over one-quarter (27.3%) of PHU survey respondents noted that they request medical results for 100 percent of their clients and that many clients are not being given copies of their medical results[84], this is a gap in information sharing between CIC and P/Ts.

CIC interviewees also noted that apart from the communication with P/T health authorities for the purposes of medical surveillance and notification, there are a lack of formal mechanisms to facilitate communication and engagement between CIC and P/T ministries of health. This has resulted in limited interaction and coordination on medical costing information to support the assessment of excessive demand and on a discussion of CIC's excessive demand policy and procedures as they relate to P/Ts. While Migration Health Branch has made attempts to engage P/Ts ministries of health through Health Canada's Federal/Provincial/Territorial Health Table, the level of engagement from P/Ts on this issue has been limited.

3.3.3. Quality Assurance for the HSN Program

Finding: While standardized tools for quality assurance have been developed, they have not been applied consistently across the HSN Program and centrally-compiled, program-level quality assurance results were not available for the evaluation.

In 2011, the Office of the Auditor General of Canada examined the quality assurance (QA) mechanisms employed by CIC related to the health screening process. This Auditor General report found that activities to assess the quality and reliability of the medical examinations performed by medical officers varied from one regional medical office to another, and a standard approach based on risks was not developed.[85] In response to the report, CIC agreed to implement a QA framework for its IME and IMA processes.

The evaluation found that CIC has developed a QA framework, as well as a number of templates to report on QA activities,[86] including those to monitor:

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[82] However, it was noted that sometimes notification forms do not get sent by the CBSA to CIC in a timely manner (see section 3.4.4 for more on this).

[83] This is consistent with the PHU survey: 29.1% said it takes 2-4 weeks to get the medical information once it is requested; 20.0% said it takes 1-2 months.

[84] 4.0% of panel physician surveyed said they give all clients a copy of their medical results; 57.2% said that they only provide medical results if a client requests them; 33.6% said they provide them if the client has a serious medical condition; 18.6% said that they never give clients a copy of their medical results.

[85] Auditor General of Canada (2011) "Chapter 2 – Issuing Visas". *2011 Fall Report of the Auditor General of Canada*. www.oag-bvg.gc.ca/internet/English/parl_oag_201111_02_e_35934.html.

[86] A full list of quality assurance tools can be found in the Technical Appendices.

- panel physician work (e.g., site visit checklist, client complaints, adherence to service standards, reports on panel physician errors);

- the IMA process (e.g., data entry quality, concurrence, adherence to delegation authorities, GCMS audit tool);

- the medical files that are auto cleared; and

- the medical surveillance and notification process (e.g., adherence to standards, quality of data entry).

While all of these templates have been developed by Migration Health Branch, the evaluation found that they have not been consistently used or implemented across all RMOs. Information from site visits and interviews with CIC medical officers and RMO staff showed that some RMOs have developed and used their own QA tools, in addition to the use of some of the standardized tools, to assess the quality of IMEs and IMAs, however, these practices vary by office. For example, RMO-New Delhi has completed a desktop audit[87] that was developed by Migration Health Branch but other RMOs have not completed this exercise. Some RMOs also review files which are not auto-cleared and track input errors made by panel physicians and follow-up with the panel physicians to correct the errors.

With respect to QA on the IMEs, Migration Health Branch has developed a process to conduct QA on a sample of eMedical files that have been auto-cleared. While some RMOs have reviewed small samples of auto-cleared cases in their respective RMOs, the evaluation was unable to obtain any data to show that QA is being done on auto-cleared files using a centralized, systematic approach.

Prior to the introduction of eMedical, RMO staff saw 100 percent of the lower risk cases. However, with the introduction of the auto-clearance function, RMO staff no longer see these cases, thus there is a need for systematic QA to ensure that this function is working effectively. To ensure the reliability of the health screening process and to mitigate program integrity risks, medical officers recommended more standardization of QA procedures across the RMO network. As well, medical officers felt that more resources should be devoted to conducting regular QA of auto-cleared cases and for site visits to clinics based on a determined schedule that takes risk into account.

With respect to QA on the IMAs, it was noted during the site visits that the RMOs conduct some QA on the IMAs performed by medical adjudicators and assistants; however, how it is done, and the extent to which it is done varied across the RMOs.

Medical officers interviewed also noted that in recent years the number of on-site visits to panel physicians has decreased and even ceased in certain regions due to limited resources. Many RMOs were also not aware of the GCMS audit tool, and most of those who were familiar with the function, did not use it in GCMS.

Information from the site visits showed that while some RMOs report the results of their QA activities to Migration Health Branch, it is not done using the QA templates that have been developed and it is not done consistently across the RMOs. In addition, there is little systematic collection, compilation, or regular reporting of QA results by Migration Health Branch. Similarly,

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[87] The desktop audit process assesses the performance of panel physicians through three criteria: an annual panel site self-audit; client complaints; and, RMO error reports.

while QA templates have been developed for the medical surveillance and notification component, there was no evidence that this QA process has been applied.

3.3.4. Impact of Modernization Activities and Initiatives on the HSN Program

Health Screening Component

> **Finding**: CIC's modernization efforts have improved the efficiency within the health screening component of the HSN Program, particularly around assessing standard cases. Nevertheless, some modernization activities have created a number of operational challenges.

Between 2009 and 2013, CIC implemented a number of initiatives to modernize its application processing network. A number of these were related to the health screening component of the HSN Program and were implemented with the aim of increasing the efficiency, economy, and integrity of the health screening process. They included:

- *eMedical:* an electronic immigration medical processing system, used by panel physicians, which automated the manual, paper-based processes of conducting IMEs and the transfer of IME results to CIC.[88]

- *Centralization of medical processing:* in conjunction with the implementation of eMedical and GCMS CIC was able to centralize medical processing and close several RMOs.[89]

At the same time, a new medical module and an auto-clearance function were integrated into GCMS, which facilitated the processing of medical admissibility and allowed standard (low-risk) medical files to be automatically cleared (allowing officers to focus on more complex files).[90]

eMedical

Most CIC interviewees indicated that eMedical has been successful at making CIC's medical assessment process more efficient, as it has allowed for the faster processing of applications (for more on this, see Section 4.3.1). In addition to faster processing times, CIC NHQ staff, medical officers, and visa officers noted other efficiencies that have been gained as a result of eMedical:

- the electronic transfer of files has reduced paperwork and storage space, file transportation time, and postage costs;

- the electronic system has facilitated the movement of processing work across the CIC network, thus allowing for more flexibility to transfer the volume of work based on capacity;

- the information being provided by panel physicians has become more standardized because the system regulates the information that must be entered before results may be submitted, thus resolving the issue of incomplete IMEs being sent to RMOs; and

- the integrity, security, and completeness of the IMEs has been increased by ensuring secure transfers of files and requiring photo identification to be uploaded into the system.

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[88] Developed and operated by Australia, Canada began rolling out the eMedical system in January, 2013.

[89] Referred to commonly as "rightsizing" within CIC, this initiative involved the closure of two RMOs (Port of Spain and Singapore) in FY 2012/13 and two in FY 2013/14 (Paris and Beijing).

[90] The GCMS medical module was incorporated into GCMS in 2010 and the auto-clearance function in November, 2012.

Panel physicians surveyed were positive with respect to the implementation of eMedical, noting that is it a good system for their office (94.6% agreed or strongly agreed) and that it is easy to use (91.7% agreed or strongly agreed) (Figure 3.1).

Figure 3.1: Panel Physician Survey Respondent Views on eMedical
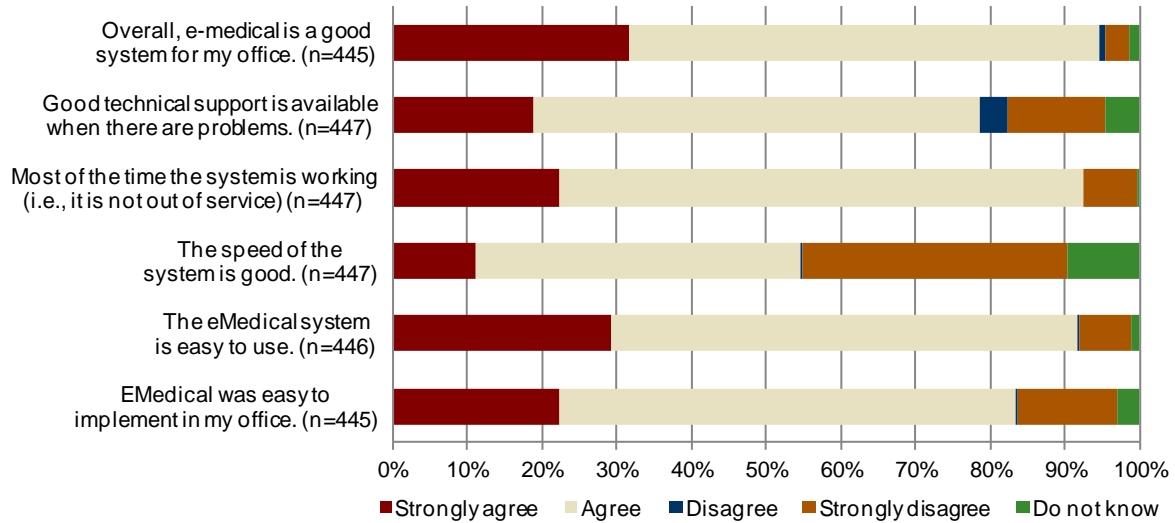
Source: Panel physician survey

However, the evaluation found that eMedical has created inefficiencies in the conduct of IMEs for panel physicians. In particular, panel physicians that were interviewed noted the speed of eMedical and the usability of the system (i.e., the number of 'clicks' and screens that are required) as the main challenges related to the efficiency of conducting IMEs using the system. Similarly, approximately 45.1% of panel physicians surveyed disagreed or strongly disagreed that the speed of the system was good and many noted in the open-ended comments that the system could be much more user-friendly (e.g., there are too many boxes to check and too many screens to navigate through). These issues seem to have had an impact on the efficiency of conducting the IME, as 40.6% of panel physicians surveyed said that it takes more time to conduct an IME since the implementation of eMedical (31.7% said it takes less time; 27.7% said it takes the same amount of time).

Further, eMedical was designed to eliminate the need for a paper IME and allow users to enter medical information directly into the system interface for submission to the RMO. Yet, many panel physicians interviewed and 52.8% of those surveyed noted that they still record the results of the IMEs on paper and then enter (or have a staff member enter) the results into the system at a later date. This is due to the speed/usability of the system and technical issues encountered.

From a CIC perspective, RMO support staff interviewed during the site visits also noted that the introduction of eMedical has created additional work, as the number of requests or questions from panel physicians has significantly increased since its introduction. While eMedical has a designated helpdesk,[91] the RMOs noted that they still receive process-related questions that the helpdesk cannot answer. It was cited by interviewees that the volume of requests related to eMedical has put pressure on RMO resources (in particular RMO-Americas) and has reduced the timeliness of responses. As well, some RMO staff noted that it is challenging to make any

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[91] The helpdesk is called Panel Gateway (located in Australia).

improvements to eMedical as it is a joint system with Australia, thus CIC needs to coordinate with its Australian counterpart before system changes can be made.

GCMS Medical Modules and the Auto-clearance Function

Once the panel physicians submit the medical results via eMedical, they are uploaded to GCMS. As part of the modernization of the medical screening component, a medical modules page was added to GCMS as was the capability to auto-clear standard cases (i.e., M1s).[92] As with the implementation of eMedical, most interviewees agreed that the auto-clearance function has added efficiencies to the process as it allows for a large proportion of the lower risk medical cases to be cleared by the system, thus eliminating the need for a manual review and allowing staff to focus resources on the complex cases. Detailed administrative data on the number of IMEs being auto-cleared was not available[93]; however, information from Migration Health Branch documentation (2013/14) showed that an average of 74%-75% of standard cases were auto-cleared.[94]

While previous and ongoing departmental evaluations of various programs have demonstrated that GCMS has enabled overall efficiencies in case management and the processing of various types of immigration applications, the GCMS medical modules[95] have created additional processing challenges. RMO staff and the evaluators during the site visits noted a number of issues, including:

- the GCMS medical interface can be slow to use when inputting or assessing IMEs;

- there are time lags when switching between screens and was not considered user-friendly;

- bandwidth constraints and system limitations affect the ability of processing staff to load medical information and images quickly and staff download all attachments to a common drive so that medical officers can access them more quickly;

- the image viewer in GCMS has difficulty showing x-rays, often presenting them on the screen as too light or too dark; and

- GCMS does not allow users to open multiple x-ray files at once for easy comparison between images.

Interviewees noted that all of these issues have introduced challenges with the medical assessment process and many felt that the assessment process for more complex files is more time consuming now than when the system was paper-based.

Centralization of Medical Processing

The implementation of eMedical and the auto-clearance function allowed for optimization of the RMO network by centralizing medical processing in four locations. This resulted in savings through a reduction in required support staff, salary and operations and management costs (for more on this see Section 3.5.1). While interviewees noted that efficiencies were gained with

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[92] Standard cases are those cases with no medical issues. With the auto-clearance function, these cases are system reviewed and automatically cleared without having to review the case manually.

[93] As noted in the previous section, no administrative or quality assurance data were available with respect to the operation of eMedical.

[94] The expected outcome for M1 IMEs is an auto-clearance rate of 70-80% according to CIC's 2013 eMedical implementation update.

[95] Specific screens within GCMS that download eMedical results and allow RMO and Visa Office staff to process medical admissibility.

centralization, a few CIC medical officers indicated that they have been less able to conduct QA activities as a result of limited resources (as previously discussed in Section 3.3.3).

Modernization of the Medical Surveillance and Notification Component

Finding: The medical surveillance and notification component of the HSN Program continues to be largely paper-based, as there has been no modernization of this process.

While a number of modernization efforts have been introduced to the medical screening component of the HSN Program, CIC, other government departments and P/T interviewees all noted that there has been little to no innovation or modernization of the medical surveillance and notification component of the HSN Program. The current process for providing notifications involves the issuance and collection of paper forms with clients, the faxing or mailing of paper forms from the CBSA to CIC, and the faxing of paper forms to P/T health authorities. Data for this component are also captured in a stand-alone system (i.e., MSUCM), which is not integrated with GCMS.

This paper-based process has led to inefficiencies with the medical surveillance process and has had an impact on the timely notification of surveillance clients to P/T health authorities (for more on this see Section 3.4.3.

3.4. Performance

3.4.1. Timely Assessment of Immigration Medical Examinations

The first expected immediate outcome of the medical screening component of the HSN Program is to conduct IMEs. The evaluation aimed to assess the extent to which the IMEs were being conducted and assessed in a timely manner. The evaluation was not able to assess the average length of time it takes for a panel physician to conduct an IME as a result of the nature of the IME process and corresponding data collection and analysis difficulties.[96] As a result, the evaluation focussed on assessing the timeliness of CIC's assessment of the IMEs.

Finding: While visa officers felt that medical results are provided by medical offices in a timely manner, the service standards for processing immigration medical assessments have not been met; although the time required to assess a standard case has improved in 2014, corresponding to the introduction of eMedical.

Overall, respondents of the visa office survey did not identify the medical screening process as an impediment to visa processing timeliness. Survey respondents were asked how long it takes to receive a medical assessment once a visa office has issued the medical to an applicant and whether this is timely. Half of all respondents (52.5%) said the information is received in less than four weeks and another 21.8% said it was received in five to eight weeks.[97] In general,

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[96] The following factors prevented an accurate assessment of IME data: while panel physicians have service standards that they follow, this data is not compiled; applicants have a 30 day window (or longer if granted an extension) to complete their medical examination and some clients can apply for an upfront medical; there are differences in IMEs that require further tests versus those that that are standard; the transition from IMS to GCMS; and the introduction of eMedical and the move from paper files (courier service to the RMO).

[97] 20% of respondents were unaware of how long it takes.

respondents felt that they were receiving the assessment in a timely manner (55% stating to a great extent; 34% stating to some extent).

All medical officers felt that most the assessments are done in timely manner, especially those that have few medical issues, as the majority are now auto-cleared automatically through GCMS, although they did note some issues that could impact the timeliness of the assessment process, including, complex cases (e.g., excessive demand, chest x-rays indicating possible TB, etc.); staffing and resource issues to conduct IMAs; incorrect matching of upfront medicals with applications; and, systems issues (i.e., reviewing x-ray images, data entry takes longer in GCMS).

The evaluation examined the extent to which IMEs are assessed within Migration Health Branch service standards, which are:

- 80% of all paper-based IMEs are to be data entered in GCMS within 3 calendar days of receipt from panel physicians;

- 80% of medical files are to be finalized or furthered in GCMS within 3 calendar days from their receipt from panel physicians (i.e., via eMedical or via data entry for paper-based IMEs); and

- 80% of inadmissible medical files (i.e., M4, M5 and M6[98]) are to be finalized within 90 calendar days from their receipt in GCMS (i.e., via eMedical or via data entry for paper-based IMEs).

Prior to 2014, medical assessments conducted overseas on standard (M1) cases did not meet the service standard of 6 days.[99] Between 2008 and 2013, the average number of days to assess 80% of standard cases increased from 7 days in 2010 to 15 days in 2013 in overseas RMOs (Table 3.4). The increase in assessment times in 2012 and 2013 corresponds to the introduction of eMedical and the closure of a number of RMOs. Both of these factors likely had an impact on the length of assessment times. In the first half of 2014, assessment times decreased to 4 days, corresponding to efficiencies gained through the introduction of eMedical and the auto-clearance function introduced in late 2012/2013. Because a large majority of applications submitted in 2014 were via eMedical and did not require the data entry step (3 days), the service standard used for 2014 is 3 days (instead of 6 days, which includes data entry). While the assessment time in 2014 has significantly improved from previous years, the service standard remained unmet by one day.[100]

Furthermore, a review of administrative data indicates that the assessment of excessive demand cases is not timely. Medical assessments conducted overseas on excessive demand cases did not meet the service standard for inadmissible medical files (90 days), taking 2.5 to 4.5 times longer to

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[98] Medical profile codes are entered into the system to indicate medical admissibility/inadmissibility. M1: no public health risk or danger, no public safety danger, and no excessive demand; M2: potential risk to public health - medical surveillance required; M3: health condition(s) is present but is not expected to place an excessive demand on health or social services; M4: inadmissible due to danger to public health (e.g., active infectious tuberculosis); M5: inadmissible due to excessive demand on health and social services; M6: inadmissible due to danger to public safety; M19: excessive demand exempt.

[99] The evaluation defined 'assessment time' as the time between when an RMO receives an IME (paper or electronic) and the assessment decision. Because Migration Health Branch considers service standards related to data entry for paper IMEs (3 day standard) and assessment time to finalization (3 day standard), the service standard threshold used for the purpose of the evaluation is 6 days.

[100] 2014 was the first full year of that the majority of panel physicians were using eMedical. Additional years of data will be required to see whether the time required to process M1 cases continues to decrease.

assess than the noted standard. The average number of days to assess 80% of excessive demand cases increased from 230 to 398 days in overseas RMOs, from 2008 to 2013.

Table 3.4: **Number of Days to Process 80% of Standard Cases and Excessive Demand Cases**

Type of Case	2008	2009	2010	2011	2012	2013	2014
Standard cases (M1)	8	9	7	9	13	15	4
Excessive demand cases (M5)	230	250	237	252	269	398	N/A *

* Data in 2014 were not analyzed for M5 cases due to cases not being finalized at the time of the data extract.
Source: IMS/GCMS data extract (excluding inland data)

3.4.2. Identification of Medical Conditions of Concern

The second expected immediate outcome of the health screening component of the HSN Program, identifying individuals with medical conditions of concern, was assessed by examining the extent to which CIC's current screening process allowed for the identification these medical conditions.

> **Finding**: The health screening process has allowed CIC to identify individuals with medical conditions of concern, although latent TB, public safety and excessive demand cases are considered harder to identify with the current approach.

Between 2008 and 2012, CIC identified almost 65,000 individuals with medical conditions of concern through its screening process (Table 3.5). The majority of these cases related to conditions that constituted a risk to public health (59,317), with inactive TB comprising the majority of those cases (51,407). The remainder of the cases were primarily related to excessive demand (5,090), with only 32 cases related to risk to public safety.

Table 3.5: **Number of Medical Conditions of Concern Identified**

Condition of Concern	2008	2009	2010	2011	2012	Total
Inactive TB	10,460	10,045	10,265	10,453	10,184	**51,407**
Active TB	307	340	409	460	367	**1,883**
Untreated syphilis	1,333	1,273	1,257	1,049	1,115	**6,027**
Danger to public health	**12,100**	**11,658**	**11,931**	**11,962**	**11,666**	59,317
Danger to public safety	6	4	2	13	7	**32**
Excessive demand	984	1,204	1,180	791	931	**5,090**
Total	**13,090**	**12,866**	**13,113**	**12,766**	**12,604**	**64,439**

Source: Migration Health Branch annual/quarterly reports based on IMS/GCMS/FOSS data.

While the scope of the evaluation did not include a full assessment of the effectiveness of the screening techniques currently being used to detect these conditions, it was found that CIC's screening processes for tuberculosis are in line with the *Canadian Tuberculosis Standards* and the *Guidance for Tuberculosis Prevention and Control Programs in Canada*.[101] In addition, the majority of interviewees as well as PHU survey and panel physician survey respondents were confident that

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[101] [1] Canada, PHAC (2012) *Pan-Canadian Public Health Network: Guidance for Tuberculosis Prevention and Control Programs in Canada.*
  [2] Canadian Thoracic Society (2007) *Canadian Tuberculosis Standards*, 6th edition.
  [3] Canadian Thoracic Society (2014) *Canadian Tuberculosis Standards*, 7th edition

CIC's screening process is effective at identifying most cases that would constitute danger to public health (i.e., active TB, untreated syphilis). With respect to active TB in particular:

- many PHU survey respondents (55%) felt that CIC's screening procedures were either capable or very capable of detecting tuberculosis infection in applicants (25% rated them as somewhat capable);

- the vast majority of panel physician survey respondents felt confident that CIC's IME process allows them to identify active tuberculosis (90.0% said 'yes, very much') and syphilis (90.0% said 'yes, very much'); and

- panel physicians were slightly less confident about the identification of inactive tuberculosis, although 74.4% still said 'yes, very much' when asked if CIC's IME process allows them to identify inactive TB.

Issues with Screening Process

While stakeholders generally felt the screening process is effective, some potential issues were noted that could have an impact on effectiveness. A few P/T interviewees noted that they see some newcomers with conditions that are of a public health concern, but they had not received a medical notification from CIC, which is a possible indication that the screening is not catching everyone.[102] Some PHU survey respondents and some P/T interviewees also believe CIC's current protocol is not as effective at identifying latent tuberculosis and should be expanded to include testing on more individuals using interferon gamma release assay or skin testing. Panel physicians surveyed were also less confident (compared to active or inactive TB) that current protocols allow them to identify latent TB (50.9% said 'very much', 34.9% said 'somewhat', 11.0% said 'not at all').[103] Other challenges related to the identification of conditions that constitute a danger to public health identified by interviewees include:

- the quality of panel physicians or clinics in conducting an IME may impact the quality of the IME;

- the time period between when the IME is conducted and when a client lands may increase the risk in contracting a condition of concern; and

- IMEs are not conducted for everyone (i.e., for short term stay, certain minors, certain immigration streams, and for people from certain countries), thus this could pose a gap.

Stakeholders were less confident that the current screening processes allows for the identification of conditions related to public safety risks or excessive demand. Panel physician surveyed were less confident (compared to conditions that pose a public health risk) that the screening process allows them to identify conditions that would pose a risk to public safety (52.2% said 'very much', 37.5% said 'somewhat', 7.9% said 'not at all'). Many CIC medical officers and panel physicians interviewed noted that it was challenging to identify clients with conditions that constitute a danger to public safety, primarily due to the largely self-reported nature of these types of conditions. As previously discussed in Section 3.2.2, panel physicians rely on clients to provide

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[102] P/Ts are required to report active TB cases to PHAC. However, this reporting does not include whether the individual is a recent immigrant, whether they were screened prior to arrival, or whether they were under medical surveillance. Therefore, no data were available to assess the extent to which CIC's screening procedures may be missing cases.

[103] Screening gaps with respect to latent TB were discussed in Section 3.2.1.

accurate medical history as part of their IME. If a client fails to provide details related to their conditions, it is difficult for panel physicians to accurately assess, unless symptoms are present at the time of IME. Interviewees also noted that there is a lack of tools, information and guidance for both panel physicians and medical officers on how to determine/assess public safety conditions. Interviewees noted similar challenges in assessing conditions that would pose an excessive demand because these conditions are largely self-reported.

3.4.3. Extent to Which Surveillance Clients are Connected to Provincial / Territorial Health Care Systems

The expected immediate outcome of the medical surveillance and notification component of the HSN Program is that individuals who have the potential of posing public health risks are connected to the P/T health system. The evaluation assessed this outcome by examining the extent to which there are processes in place to inform individuals of the surveillance requirement and the impact on client awareness, the timeliness of notification process, and the extent to which surveillance clients comply with the surveillance requirement.

Processes in Place to Inform Individuals of the Medical Surveillance Requirement and Impact on Client Awareness

Finding: There is information available to inform clients about their condition and surveillance requirement; however, views on the sufficiency of that information are mixed. In addition, the process used to provide clients with surveillance information is approached inconsistently by visa offices and the CBSA, which could be having an impact on client knowledge of their surveillance requirements.

There are several points in the medical surveillance and notification process in which a client is made aware of their condition and surveillance requirement: during the IME process, by panel physicians; via CIC visa offices, by administrative staff or visa officers; and at the POE, by CBSA boarder services officers.

Information Provided by Panel Physicians

The panel physician survey showed that clients are being informed of their medical conditions and being provided additional information to understand their conditions at the IME stage. The vast majority of panel physicians surveyed said they inform clients when they have medical conditions of concern (98.6% when client has active TB; 97.5% when client has syphilis); and provide them with information to understand these conditions (95.5% when client has active TB; 95.2% when client has syphilis). Note that at this point in the process, clients have not been identified for surveillance; however, it is the beginning of the process at which point clients would be provided with information to help understand their condition–which may have an impact on compliance with the surveillance requirement upon arrival to Canada.

Surveillance Information Provided by Visa Offices

Clients who require medical surveillance are identified in GCMS with an M2 medical code and must be provided with a Medical Surveillance Undertaking Form (IMM0535B) and a *Medical Surveillance Handout* by the visa office. The IMM535B contains information explaining a client's medical condition and their surveillance requirements, and the handout contains information on key medical contact information in Canada and how to meet compliance obligations. The visa

counterfoil also contains a code that indicates the surveillance requirement. Information from the sites visits[104] showed some gaps in the surveillance notification process that could have an impact on client awareness of their surveillance requirement.

- *Inconsistent practices across visa offices and within visa offices (PR and TR units):* Visa offices undertake varying processes to determine whether a client requires the medical surveillance forms. For example, some offices identify the surveillance requirement by reviewing the file during the course of processing the application and other offices run a daily query to identify clients that require medical surveillance, which is then flagged in GCMS to ensure the IMM0535 form is included.

- *Visa staff familiarity with the medical surveillance form process:* medical surveillance forms and handouts may not be consistently provided to clients as a result of a lack of familiarity with the process. This may be due to staff turnover; lack of internal processes/operating procedures to ensure these files are indentified; or, the relatively small volume of cases that require surveillance.

- *Medical surveillance requirement is not obvious in GCMS:* information about a client's surveillance requirement may be missed by visa officers and locally-engaged staff as a result of the medical code associated with surveillance (M2) not being located on the main GCMS screen.[105]

- *Medical surveillance handout is not consistently provided to the client:* visa offices visited inconsistently provided clients with the handout and many were unaware that translated versions of the handout (in multiple languages) were available in some offices. As a result, when handouts are provided, they are often not provided in a translated local language, which may decrease the likelihood of the client's understanding of their requirement once in Canada.

- *Integration with e-application:* medical surveillance forms and handouts have not been seamlessly integrated into the e-application process across visa offices and many officers interviewed were unaware of the surveillance procedure related to e-application. With this system, the visa officer is responsible for sending the IMM0535 form through a client's MyCIC account[106], which then requires the client to print the form and bring it with them when landing in Canada. The handout can be missed in this scenario because it is not a standard attachment through the MyCIC account. In addition, the onus is on the applicant to print these forms and bring them with them to the POE.

Surveillance Information Provided by the CBSA

Individuals that require surveillance must present the IMM0535 form at the POE upon arrival to Canada to ensure that proper medical follow-up takes place. Upon receiving the IMM0535 form from the applicant, the Border Service Officer must complete the form, explain the requirement to the individual, and make a copy of the signed form to be sent to CIC (via prepaid envelopes or fax).

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[104] Site visits included discussions with staff in charge of printing surveillance forms. Telephone interviews were also conducted with staff in Vietnam and Beijing (visa offices that process large numbers of surveillance cases) to gather information related to the notification process.

[105] The main screen shows if the client has passed the medical but not whether they require surveillance. Because visa officers and locally-engaged staff face pressure to meet processing targets, this information may be missed if the medical admissibility tab is not reviewed.

[106] MyCIC account is the online portal that allows clients to submit applications electronically (i.e., an e-application).

Many CBSA interviewees were aware of the medical surveillance process; however, had not seen many cases. As well, interviewees from CIC-NHQ and CIC medical offices felt that some clients (e.g., certain TRs) may be missed at POEs due to inconsistent practices and a lack of knowledge of the surveillance requirement. For example, TRs may not be referred to secondary inspection if primary inspection does not observe the surveillance code on the visa. In this scenario, the migrant would enter Canada without providing the form to the Border Service Officer. In order to ensure TRs are identified, some visa offices mark the visa to explicitly flag the requirement to the officer at the POE; however this practice was not standard across the visa offices that were visited.

Impact on Client Awareness

While there are processes in place to provide information to surveillance clients and inform them of their requirement, as a result of the issues noted above, applicants' level of awareness of their responsibility to undertake medical surveillance in Canada may vary. CIC interviewees made a number of suggestions to strengthen the surveillance process (see Appendix B).

In addition, while many CIC interviewees stated that they think the information provided to surveillance clients is sufficient, some interviewees from CIC and the CBSA stated that they felt some clients are not aware or do not understand their conditions and requirements. Similarly, a large percentage of PHU survey respondents (42%) did not feel that clients receive enough information on their condition prior to connecting with a P/T health authority. PHU survey respondents also suggested that there are clarity issues with the information that clients receive (50% of respondents felt that the information surveillance clients receive from CIC about their condition was not clear). This may also have an impact on client awareness of their condition and surveillance requirement.

Timeliness of Notification Process

> **Finding**: CIC sends the majority of surveillance notifications to P/T health authorities within the established service standard; however, CIC does not receive surveillance undertaking forms from the CBSA in a consistent or timely manner.

CBSA Medical Surveillance and Notification Role

As previously noted, once a Border Service Officer completes the IMM0535 form and explains the requirement to the client, a copy of the form is to be sent to CIC's Public Health Liaison Unit (PHLU) via fax or courier on the same day the client lands. A review of data from MSUCM showed that between 2008 and 2013, CIC's PHLU did not receive the surveillance undertaking forms from the CBSA in a timely manner (Table 3.6). Only 14% of all IMM0535 forms were provided to PHLU on the same day a client landed in Canada. Thirty-three percent were provided within one to three days of landing; 36% were provided between four and eight days; and, 17% were provided after nine days. This is consistent with the interview information, as most CBSA interviewees at POEs noted that due to the infrequent nature of notification cases, they tend to batch medical notification forms and send them to CIC every few days, rather than within the same day.

Table 3.6:   Percent of Surveillance Notifications Sent to CIC within Required Timeframe (2008-2013)

Timeframe	2008	2009	2010	2011	2012	2013	Total
Same day	12.8%	15.7%	17.5%	13.6%	10.5%	13.2%	13.2%
1-3 days	34.1%	39.3%	36.5%	38.6%	25.6%	25.4%	25.4%
4-8 days	39.9%	32.0%	35.8%	33.9%	42.5%	33.0%	33.0%
9-12 days	5.7%	5.1%	4.3%	4.2%	8.1%	7.2%	7.2%
13-30 days	5.5%	5.0%	3.5%	3.3%	5.3%	9.0%	9.0%
31-60 days	1.6%	1.6%	1.1%	1.7%	2.8%	3.8%	3.8%
>60 days	0.4%	1.3%	1.2%	4.8%	5.2%	8.4%	8.4%

Source: MSUCM

Notifying the Provinces and Territories

Upon receipt of the surveillance form from the CBSA, the PHLU is to notify the P/T health authorities of individuals who require medical surveillance within three calendar days.[107] Migration Health Branch reporting (using MSUCM data) confirmed that the majority of surveillance notifications were sent to P/T health authorities within the established three day service standard (between 2007 and 2012, over 90% of notifications were sent to P/T health authorities within three calendar days).

PHU survey respondents were asked how frequently their office receives a surveillance notification after that individual has already made contact with their office; 20% of respondents said "often", while 35% (17/49) said "sometimes". This suggests that P/Ts are not always being notified in a timely manner, most likely due to the time it is taking the notification to go from the CBSA to CIC (as noted above).

Compliance with Medical Surveillance Requirement

Finding: Based on the information available, a large proportion of clients are complying with the medical surveillance requirement; however, compliance information is not reported by all provinces and territories, as they are not required to.

CIC requires surveillance clients to contact P/T health authorities within 30 days of arrival to arrange a follow-up medical assessment (seven days for complex cases).[108] Once the client completes the follow-up assessment, CIC asks that the P/T health authority send confirmation of compliance to the PHLU. At this point in the process, CIC considers the client compliant with the terms and conditions of landing. Note that there are no agreements in place between CIC and the P/Ts requiring that compliance be reported back to CIC; currently CIC requests compliance information and all P/Ts provide it.

P/T interviewees (TB representatives) were asked their views on whether clients in their P/Ts comply with surveillance requirements and the possible reasons for barriers to compliance. Almost all interviewees believe the majority of clients are compliant; however, a few interviewees

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[107] Migration Health Branch Service Standard: The P/T health authorities are notified of 80% of all clients that require medical surveillance within 3 calendar days of PHLU of receiving the IMM535 form from the CBSA or the Printout Notification from RMO-Americas.

[108] Although P/Ts are not required to contact clients who do not report within the required time frame, some proactively attempt to locate clients who do not report to them. In Quebec, the standard process is for P/T health authorities to contact the surveillance client.

said that it is difficult to know precisely because they do not keep track of compliance figures. Interviewees noted many reasons why clients may not be compliant, including: lack of awareness of the requirement, difficulties getting to the clinic location, fear of the process, and TRs without health insurance who do not want to incur the cost.

A large majority of PHU survey respondents also said that clients are complying with the surveillance requirement[109] to some or a great extent and that they actively contact the clients once they receive the notification from either CIC or their P/T health authority.[110] PHU survey respondents also noted that contact with the clients is usually easily established and when contact cannot be established, it is usually due to the movement of clients or incorrect contact information on file.

CIC receives compliance information from P/T health authorities on approximately 70% of all clients who enter Canada. Between 2009 and 2013 this represented approximately 26,000 clients with recorded compliance. When analyzed by migrant category, compliance figures were fairly consistent, with the exception of refugees who had the lowest recorded compliance (Table 3.7).

Table 3.7: Compliance Information, by Immigration Category (2009-2013)

	Economic Class	Family Class	Other	Refugee	Temporary Resident
No compliance recorded in database	30.0%	28.0%	29.0%	41.0%	30.0%
Compliance recorded in database	70.0%	72.0%	71.0%	59.0%	70.0%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source: MSUCM

The thirty percent of clients without recorded compliance in the medical notification database does not necessarily signify clients not complying with their conditions, but that the compliance status of those clients is unknown. Full compliance figures are difficult to establish because there is no mandated requirement for P/Ts to send compliance information to CIC. In addition, information from the PHU survey showed that while many (41.8%) send confirmation of compliance to CIC once the client has completed their first medical assessment (which corresponds to CIC guidelines to P/Ts), a few respondents send confirmation once the client has made contact with them (10.9%) or once a client has completed the assessment and all follow-up treatments (9.1%). Thus, the definition of compliance varies amongst CIC and the P/Ts.

3.4.4. Reducing the Burden of Migration on the Health and Social Services in Canada and Protecting the Health and Safety of Canadians

The mid- to longer-term expected outcomes of the HSN Program are related to limiting entry to Canada of those that would pose health and safety risks or excessive demand (intermediate outcome), thus reducing the burden of migration on the health and social services (ultimate outcome) in Canada and protecting the health and safety of Canadians (CIC Strategic Outcome 4). The evaluation assessed these outcomes by examining the number of individuals that were inadmissible based on health grounds and those that were admitted with condition and the potential impact of those decisions.

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[109] Using a scale of 1 to 5, with 1 being 'not at all' and 5 being 'to a great extent', survey respondents were asked to indicate the extent to which surveillance clients comply with the CIC surveillance requirement (74.6% rated this a '4' or '5').

[110] 49.1% of PHU survey respondents said they contact the surveillance client when they receive the notification from CIC or the P/T health authority.

> **Finding**: The HSN Program has contributed to reducing the burden on Canadian health and social services and protecting the health and safety of Canadians through a screening process that has identified people with conditions of concern and treated them, deemed individuals medically inadmissible, or admitted them with conditions. There are, however, some gaps in the current screening processes and policies that may limit the full impact of the program.

Number of Foreign Nationals Deemed Medically Inadmissible

As a result of CIC's health screening process, between 2008 and 2012, just over 5,000 individuals were deemed medically inadmissible to Canada, with a very large majority of those cases (95.3%) inadmissible due to excessive demand (Table 3.8). The small number of inadmissible cases due to danger to public health can be explained by the fact that clients indentified with active TB are required to undergo treatment and once the disease is rendered inactive, they are admissible. A certain percentage of individuals will not undergo treatment or not complete treatment and therefore, are inadmissible. Also, as noted in Section 3.2.2, there have only been a small number of cases related to danger to public safety because of the challenges in detecting these types of cases.

Table 3.8: Number of Foreign Nationals Deemed Medically Inadmissible, by Type of Medical Inadmissibility (2008-2012)

Medical Inadmissibility	2008	2009	2010	2011	2012	Total
Excessive demand	984	1,204	1,180	791	931	**5,090**
Danger to public health	80	78	8	12	7	**185**
Danger to public safety	6	4	2	13	7	**32**
Excessive demand and public safety	6	6	11	2	3	**28**
Danger to public health and excessive demand	1	0	0	4	0	**5**
Total	**1,077**	**1,292**	**1,201**	**822**	**948**	**5,340**

Source: Migration Health Branch annual/quarterly reports based on IMS/GCMS/FOSS data.

In addition to these cases, CIC's administrative data showed that between 2008 and 2012 CIC identified and prevented approximately 1,780 cases of active TB (rendered inactive) from entering Canada[111] and identified approximately 51,000 cases of inactive TB and 6,000 cases of syphilis (which were treated), which required surveillance once in Canada.

Impact on the Health and Safety of Canadians

Based on the number of active TB cases identified and treated and the number of people deemed inadmissible to Canada based on public health or safety concerns, the HSN Program has contributed to protecting the health and safety of Canadians. Some interviewees agreed with this, noting that given CIC is identifying conditions, there is a natural assumption that the program offers protection. The extent to which this has occurred is difficult to measure. Many CIC NHQ, PHAC, and medical officer interviewees noted that there is a lack of research specifically related to the impact of the HSN Program, including the effectiveness of surveillance for inactive TB (i.e., there are no data to determine the extent to which people under surveillance experience reactivation of inactive TB).

As noted in previous sections, the evaluation did identify some potential gaps that could have an impact on the achievement of this outcome, namely the types of conditions being screened

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[111] Immigrants (61%) represent the majority of cases, followed by temporary residents (24%) and refugees (15%).

for/placed under surveillance (e.g., hepatitis B and C), the protocol for screening latent TB (i.e., risk-based) and the populations that may be missed in the screening process (i.e., some TR and inland cases).

Impact on Health and Social Services in Canada

Most interviewees stated that the impact of the HSN Program on health and social services in Canada was difficult to measure, as there is a lack of data and research on the subject. However, they also noted that it is reasonable to assume that the program reduces burden because it identifies conditions of concern that would constitute a cost to Canada.

The evaluation was able to examine the estimated potential cost savings related to treated cases of active TB overseas and finding applicants inadmissible due to excessive demand. On average, CIC detects and recommends treatment for 358 cases of active TB overseas each year. An internal assessment conducted by Migration Health Branch found this represents an in Canada savings of approximately $24 million per year (see table 3.9 for a detailed cost breakdown). Likewise, finding 1,000 applicants inadmissible per year as a result of excessive demand legislation saves Canada approximately $31 million.[112] These figures represent a portion of the quantifiable cost savings that contribute to reduction of the burden on the health and social services in Canada.

In addition to the direct cost-savings related to detecting conditions of concern, health screening activities have additional impacts that are difficult to quantify but important to consider. By detecting clients who may pose excessive demand, CIC may be freeing up capacity within the system (i.e. waiting lists, physician rosters) that can be used by Canadian residents.[113]

As noted in previous sections, there are gaps in the current policy related to excessive demand that may have an impact on the extent to which the program reduces the burden, including:

- the excessive demand exempt category results in individuals with excessive demand being admitted to Canada, thus adding to the burden on health and social services;

- Canada's public health system and the fact that mitigation plans for excessive demand cannot be enforced means that the burden is still likely transferred to Canadian health and social systems; and

- the considerable number of positive decisions on appeals related to excessive demand result in the burden still being transferred to Canada.[114]

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[112] This is based on the minimum legislative excessive demand cost threshold of $31,935 for 5 years. This is the minimum cost savings that does not account for applicants with treatment costs that far surpass the minimum cost threshold.

[113] There are no data or research available to quantify these potential impacts.

[114] This noted challenge is based on Immigration Appeals Division (IAD) data and interviews with visa and medical officers.

3.5. Resource Utilization

3.5.1. Efficiency of the Health Screening and Notification Program

Health Screening Component

> **Finding**: Recent investments related to modernization have reduced health screening program costs, allowing the department to spend fewer resources while conducting the same level of IMAs, although Information Technology system-related issues may have decreased the efficiency of assessing complex cases.

According to financial information from CIC's cost management model (CMM), between FY 2011/12 and 2012/13, the total estimated cost of the health screening component of the HSN Program increased from $8.26 million to $9.71 million. Divided by the number of IMAs conducted annually, the unit cost to conduct one IMA also increased during this period from $15.72 to $18.50. Internal financial records and information from interviews showed that these cost increases were due to the implementation of modernization initiatives, including a $1.58 million investment in the eMedical system and a $61,000 cost for planning for staff reductions in FY 2012/13 due to the centralization of medical processing in fewer RMOs.

The investment in modernization initiatives resulted in efficiencies in the health screening component. Following the implementation of eMedical and the auto-clearance function and the closure of some RMOs, the overall estimated cost of the health screening component decreased to $6.49 million in FY 2013/14. Similarly, the unit cost to conduct an IMA, decreased from $18.50 to $12.35 in FY 2013/14, as per Table 1.1a and Table 1.1b. Despite decreasing full time equivalent staff and a corresponding 31% decrease in salary dollars, CIC was able to complete a consistent number of yearly IMAs between FY 2011/12 to FY 2013/14 (i.e., roughly 530,000 IMAs each year). These decreases are attributable to the implementation of eMedical, which as noted in Section 3.4.1, has decreased the average processing time for standard cases.

Despite these efficiencies, the evaluation noted a few issues with modernization that have had a negative impact on the efficiency of the health screening component, particularly with respect to the assessment of complex medical files. These issues include system and design issues in eMedical and GCMS that slow down screening and assessment, bandwidth and support, and limited quality assurance activities.[115]

Medical Surveillance and Notification Component

Financial information from CIC's CMM showed that estimated costs for the medical surveillance and notification component of the HSN program increased from $1.1 million in FY 2012/13 to $1.25 million in FY 2013/14, translating into a unit cost increase from $148 to $168 per notification. Much of this increase in costs can be attributed to a 25% increase in the salary dollars attributed to this component.

The cost to make a single notification is significantly higher than the cost to conduct an IMA. One possible explanation offered by CIC staff was that the medical surveillance and notification component of the program lacks automation and modernized tools like those available for health screening. Interviewees suggested that the implementation of an electronic system could help to

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[115] These challenges were noted by the majority of Medical Officers and medical staff interviewed.

increase the efficiency of making notifications and/or sending medical/compliance information on surveillance clients.

3.5.2. Estimated Cost Savings

> **Finding**: The minimum estimated cost-savings on Canadian health and social services, as a result of the HSN Program, are significantly greater than overall program costs.

Discussions in academic literature on the full cost-savings of conducting medical screening and surveillance on health and social services are limited. However, some interviewees suggested that the approximate direct cost-savings is substantial[116].

In 2013, based on the average number of yearly cases of active TB found and those re-evaluated after treatment (358), CIC's Migration Health Branch estimated that the total cost-savings from TB detection alone amounted to roughly $24M per year or $67,000 per case of active TB (Table 3.9).

Table 3.9: Estimated Annual Savings from Detecting Active Pulmonary TB through Immigration Screening Prior to Arrival in Canada

Type of cost	Savings
Screening and treatment of regular TB cases (approx. 358/yr)	$7,095,000
Screening and treatment of multi drug-resistant TB cases (approx. 3/yr)	$600,000
Screening and treatment of extremely drug-resistant TB cases (approx. 0.25/yr)	$120,750
Active cases detected during immigration screening	**$7,815,750**
Contact investigation (each active TB case results in investigations with 50 contacts)	$1,790,000
Treatment and monitoring of latent cases	$2,658,150
Treatment of active cases	$11,723,625
Cases detected among contacts of primary cases	**$16,171,775**
Total	**$23,987,525**

Sources:

[1] Active Pulmonary Tuberculosis found during an IMA from January 1, 2008 to December 31, 2011.

[2] Database on Active TB, May 25, 2012. Health Branch. May 1, 2013.

[3] Cost Analysis for Treatment of Latent Tuberculosis Infection and Active TB Disease: Calculated per Patient. Province of Alberta.

In addition, CIC has identified approximately 1,000 cases of excessive demand per year. For 2014, this represents a minimum cost of $6,285 per year, per individual or $31,425 over 5 years. Therefore cost-savings for 1,000 cases per year saves Canada, at minimum, $6.3M each year. Note that these figures represent the minimum amount of savings per year. Treatment for client's conditions or requirements for social services often far exceed the minimum threshold and would require treatment and services over an extended time period.

Using these estimates, CIC's HSN Program is estimated to have saved a minimum of $30.3M in health and social service costs in one year, representing a generated savings of nearly five times the program cost.

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[116] Direct cost savings in this context refers to the total number of inadmissible cases (Danger to Public Health, Danger to Public Safety, and Excessive Demand) per year multiplied by the likely cost to Canada for each inadmissible case.

4. Conclusions and Recommendations

Relevance

There is a continued need for CIC to assess migrants' health status before admission to Canada and to require medical surveillance for certain migrants with conditions of public health significance. Screening migrants prior to arrival allows for the identification of health and safety risks and contributes to the reduction of the burden of immigration on Canada's health and social system. Surveillance of migrants with inactive TB (currently the only condition that requires surveillance) also contributes to the management of risks associated with spreading and reactivation of this disease.

The HSN Program is aligned with the Government of Canada's priorities to protect the health safety and security of Canadians and the sustainability of Canadian health and social services; and with provincial priorities with respect to the cost of health care and the prevention of TB. Furthermore, federal and provincial roles in the delivery of the HSN Program are clearly defined and aligned with respective federal and provincial mandates and responsibilities.

Health Screening Policies

The evaluation found that CIC's policies on Danger to Public Health, Danger to Public Safety, and Excessive Demand, are relevant because they allow the federal government to address the health and safety risks associated with migration. These policies are also aligned with the overall objectives of the HSN Program and are generally consistent with FCC partners' health screening policies.

With respect to the policy on Danger to Public Health, the evaluation found that active tuberculosis and syphilis were important conditions for screening under CIC's admissibility criteria. However, it was also noted by interviewees that the current policy is restrictive and unable to adapt quickly to conditions that may become more prevalent; or conditions that may temporarily pose a risk to public health. For example, CIC currently does not consider other conditions of concern such as Hepatitis B and C under this policy, which are considered significant in the context of immigration and public health.

> **Recommendation #1:** CIC should review its policy on danger to public health to consider addressing other conditions that may pose public health risks and to make it more flexible to address emerging communicable diseases.

With respect to the policy on Danger to Public Safety, the evaluation found that, while the objectives of the policy remain relevant, it is difficult to apply during assessment because public safety-related health concerns are often hard to detect and can overlap with inadmissibility issues related to criminality. CIC's Migration Health Branch has been working to develop additional assessment tools for this policy.

With respect to the policy on Excessive Demand, the evaluation found that preventing migration from imposing an undue burden on health and social services in Canada was considered an important objective. However, the evaluation noted several issues that limit the application and intended results of this policy, thus limiting its ability to reduce the burden on Canada's health and social services, including: an applicant's ability to mitigate their inadmissibility without further enforcement of the mitigation plan; exemption from the policy of certain applicants who would

pose an excessive demand; and the considerable number of overturned excessive demand cases through the appeals process. Stakeholders such as visa and medical officers also noted limitations in the application of the policy such as the complexity and time-consuming nature of processing these cases, consistency in decision-making, and lack of up-to-date health and social service cost information from P/Ts.

> **Recommendation #2:** CIC should review its policy on Excessive Demand to:
> – Engage more effectively with the P/Ts on issues related to Excessive Demand.
> – Address the policy gaps that limit its effectiveness.
> – Streamline the assessment process for excessive demand cases to ensure that decision-making is more straightforward, consistent, and timely.

CIC's screening policy related to PRs was considered appropriate. However, a number of gaps were noted in the screening policy for certain TRs which may expose Canada to public health risks. Regardless of the potential gaps in TR policy, it was noted that it is not feasible or efficient to screen all applicants and that a risk-based policy screening approach across all categories may be more effective in mitigating risks associated with migration. Furthermore, the evaluation found that CIC's current screening protocol for latent TB was considered limited in its ability to widely detect this disease across the population that CIC screens.

> **Recommendation #3:** With respect to health screening, CIC should:
> – Review the feasibility of implementing a risk-based screening approach, which considers epidemiological risk factors.
> – Examine its current protocol for screening for latent TB to determine whether it can be expanded to include other TB reactivation risk factors.

Program Design and Management

Overall, the delivery of the health screening component of the HSN Program was viewed as effective, with the exception of QA tools and procedures. While a QA framework and standardized tools have been developed, they have not been applied consistently across the HSN Program and centrally-compiled, program-level quality assurance results were not available for the evaluation.

> **Recommendation #4:** CIC should review, update, and implement its QA framework to ensure that QA is conducted consistently across the RMO network. The update of the framework should consider the type of QA to be undertaken on the various components of the health screening process (e.g., IME, IMA, auto-cleared files), the schedule/frequency of QA activities, and the reporting requirements.

Recent modernization efforts have benefitted health screening by making it more efficient to process standard (M1) medical files, which has allowed for a reduction in resources while being able to process the same number of cases. However, as a result of GCMS limitations (e.g., speed, usability), the assessment of complex cases has resulted in processing inefficiencies for these cases. Furthermore, the surveillance and notification component is entirely paper-based and could be made more efficient through modernization efforts.

> **Recommendation #5:** CIC should examine whether:
> – The medical component of GCMS could be improved to address processing challenges (e.g. speed, usability) related to complex cases.
> – The notification process could be modernized through its integration into GCMS.
> – An electronic information sharing system could be established between IRCC and the P/Ts for the exchange of notification-related information.

The evaluation identified a number of communication and coordination issues between CIC and the P/Ts. P/Ts felt that they did not have sufficient information about CIC's notification process, the information on the notification forms was not sufficient (e.g., incomplete or minimum information provided) and that, while client medical information was viewed as important, it was difficult to obtain in a timely manner. In addition, there lack of formal mechanisms to facilitate engagement between CIC and P/T ministries of health, particularly with respect to coordination on issues related to excessive demand.

> **Recommendation #6:** CIC should strengthen the P/T component of its screening and notification process by:
> – Improving/increasing the information that is available to P/Ts with respect to the notification process.
> – Determining whether client medical information can be automatically shared with the P/Ts.

Performance

The health screening process has allowed CIC to identify individuals with medical conditions of concern, and in turn, has contributed to reducing the burden on Canadian health and social services and protecting the health and safety of Canadians. However, the evaluation identified gaps in the current screening processes and policies that may lessen the full impact of the program. These gaps are addressed in the recommendations made in the policy section (above).

Overall, the medical notification process has been successful in notifying P/Ts of clients that require surveillance, and while P/Ts felt they did not have sufficient client information from the notification forms, available program information suggests that a large proportion of clients are complying with the surveillance requirement. However, the process used to provide clients with surveillance information is approached inconsistently by visa offices and the CBSA due to a lack of familiarity with the process and limited surveillance requirement-related GCMS/e-application functionality. This could have an impact on client knowledge of their surveillance requirements.

> **Recommendation #7:** CIC should ensure that surveillance information is being provided to clients at visa offices and by the CBSA in a consistent and timely manner.
> This could include: ensuring the surveillance required is flagged on the main screen in GCMS, integrating the surveillance notification forms and handouts into the e-application system, and providing updated operational guidance to visa offices (including Centralized Processing Centres and the CBSA).

Efficiency and Economy

The cost of the HSN program has been reduced as a result of the modernization efforts made by CIC (i.e. introduction of e-medical and closure of offices), allowing the department to spend fewer resources while conducting the same level of IMAs. Overall, the cost of the program is less than the minimum estimated savings as a result of the program.

Appendix A: Health Screening and Notification Program—Logic Model

	Medical Examination	**Medical Assessment**	**Medical Surveillance Notification**
ACTIVITIES	Issue Medical forms Conduct Medical Examinations Develop Guidelines and SOPs Establish quality standards Conduct QA activities Recruit, manage, terminate Panel Physicians Train PPs, RMOs and others	Assess IMEs Assess Excessive Demand Further cases for additional assessment Identify cases requiring surveillance Develop Guidelines and SOPs Conduct QA activities Enter data into Departmental IT systems	Develop Guidelines and SOPs Produce & disseminate communication materials to clients and stakeholders Support PHAs in medical surveillance Provide training and support to POEs Manage and analyze data Manage relationship with partners and stakeholders
OUTPUTS	Standard forms & evaluation criteria QA reports Site visits and reports Training sessions SOPs and Guidance Info sharing agreements Appointment and removal letters Completed medical forms Risk mitigation strategies	Assessment reports/input Furtherance forms Medical instructions Stats and referral reports Data sets in legacy systems SOPs and guidelines Affadavits Info sharing agreements	Forms and information materials Guidelines Training packages Monitoring and analysis reports Compliance reports Policy advice/papers Notification Reports
EXPECTED PROGRAM OUTCOMES — Immediate	Immigration Medical Examinations (IMEs) are conducted	Applicants who have a disease of public health significance or a condition imposing excessive demand are identified	Individuals who have the potential of posing public health risks are connected to the provincial health system
EXPECTED PROGRAM OUTCOMES — Intermediate	Migrants who pose risks to public health or public safety are admitted with condition, are refused entry, or are declared an excessive demand to Canada		
ULTIMATE OUTCOME	Reduced the burden of migration on the health and social services in Canada		
STRATEGIC OUTCOME	**Managed migration that promotes Canadian interests and protects the health, safety and security of Canadians (SO 4)**		

September 6, 2013

53

Appendix B: Other Suggested Improvements

1. Modernization of the Medical Surveillance and Notification Component

As a result of the notification process being paper-based, Interviewees across all stakeholder groups suggested that CIC should implement an electronic notification and surveillance case-management system that would facilitate the sending of notifications (from the CBSA to CIC, and from CIC to P/Ts) and allow for easier transfer and coordination of surveillance cases (i.e., sending of medical information, compliance reporting, and client tracking).

2. Surveillance Clients' Awareness

While there are processes in place to provide information to surveillance clients and inform them of their requirement, as a result of the issues noted above, applicants' level of awareness of their responsibility to undertake medical surveillance in Canada may vary. To strengthen the surveillance process, CIC interviewees suggested the following:

- there should be a standard approach to flagging files in GCMS that require medical surveillance (e.g., in notes);

- GCMS should flag on the main screen that surveillance is required (next to medical admissibility);

- GCMS should automatically generate the IMM0535 form when the medical results are entered into GCMS;

- pamphlets in different languages (including accessible) should be available and given to clients at the POE;

- surveillance clients be issued a special visa, which ensures an automatic referral to secondary inspection.