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Chair

Mr. Robert Oliphant

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• (0845)

[English]

The Chair (Mr. Robert Oliphant (Don Valley West, Lib.)):
Good morning, everyone.

I call this meeting to order. It's the 78th meeting of the Standing Committee on Citizenship and Immigration. We're here to begin our study regarding medical inadmissibility of immigrants to Canada.

We want to thank the officials from the department today, especially for coming on relatively short notice.

We're going to begin with an opening statement from Ms. Edlund.

I want to let the folks know that in these kinds of meetings, I give the benefit of the doubt to the witnesses to make sure they get to explain a technical point well, so if we start to go a little bit over the time on the questions, it will be because I'm trying to make sure they're given time to get us all the best answers. That doesn't necessarily mean that I'll let you go on forever if you start a question at 6:52 on the clock, but I am giving some leeway on this kind of briefing.

We're going to start with Ms. Edlund's opening remarks. Thank you.

Ms. Dawn Edlund (Associate Assistant Deputy Minister, Operations, Department of Citizenship and Immigration):
Thank you.

[Translation]

Mr. Chair, thank you for inviting us to appear before the committee today.

Immigration, Refugees and Citizenship Canada, or IRCC, appreciates the committee's decision to undertake this study.

[English]

Canada's medical admissibility policies and guidelines play a critical role in the immigration system. As a result of the increasing number of migrants to Canada and the health risks associated with migration, there is an ongoing need to assess the health status of immigrants. This screening identifies health and safety risks and helps reduce impacts on Canada's health and social systems.

As the committee is aware, under the Immigration and Refugee Protection Act, permanent resident applicants and some temporary resident applicants may be refused admission to Canada if they have a health condition that would pose a risk to public health or public

safety or would place an excessive demand on health or social services, which are mostly administered by provincial and territorial governments.

Health admissibility is determined through a two-stage process.

First, applicants undergo an immigration medical examination, including any supplementary tests, which are performed by a third party physician designated by IRCC. The department then performs an assessment of the examination's results to reach a decision on whether an individual is medically admissible. The department also notifies provincial and territorial public health authorities of the arrival of individuals who may require ongoing medical surveillance and follow-up for conditions such as inactive or previously treated tuberculosis.

[Translation]

In general, individuals are found to be inadmissible for public health reasons if they have a highly communicable disease that could have a serious impact on other persons living in Canada. Active tuberculosis and untreated syphilis are considered dangerous to the public, for example.

[English]

A finding of danger to public safety considers whether a foreign national's health condition could create a danger to the health or safety of persons living in Canada. This may include certain medical health conditions that could result in unpredictable or violent behaviour, such as sociopathic disorders.

In terms of the excessive demand provision, although the specific requirements have changed over time, there has been some form of screening for immigrants to Canada to minimize impacts on health and social services for most of our history. Currently, under the Immigration and Refugee Protection Act, this provision applies to all applicants for permanent residency, with the exception of convention refugees, protected persons, and some members of the family class—for example, spouses, partners, and direct dependents. Excessive demand also applies to some applicants for temporary residency, where these are eligible for provincial or territorial services.

● (0850)

[Translation]

The objective of the provision is to strike a balance between protecting publicly funded health and social services and facilitating immigration to Canada, while also supporting humanitarian and compassionate objectives in Canada's immigration policy.

[English]

Excessive demand considerations are determined by a departmental officer, usually referred to as a visa or immigration officer. These officers consider the assessment of an applicant's immigration medical exam by a departmental medical official, as well as projected health or social services needs, the cost of those services in Canada, and the effect on wait-lists.

This entails reviewing the medical diagnosis and prognosis, the required services, the costs for services in the intended jurisdiction of residence, and, in the case of social services or prescription medication, the ability and willingness of the applicant to pay out of pocket. If the individual's anticipated costs are expected to be above the average per capita cost of publicly funded services over five years, which is \$33,275 as of January 1, 2017, then the individual may be found inadmissible.

No specific health condition will result in an automatic rejection of an applicant. Each decision is made on an individual basis.

The provision has been found by our courts not to violate the Charter of Rights and Freedoms, as it does not exclude persons based on a specific health condition. Rather, the decision is made according to an individual's likely demand on Canada's health and social services.

Of the approximately half a million medical exams performed annually by IRCC in recent years, only 900 to 1,000 applicants, or 0.2% of all applicants, received a finding of excessive demand by a medical officer. This includes about 200 to 300 individuals needing special education services.

[Translation]

The health inadmissibility provisions are designed, in part, to reduce impacts on Canada's publicly funded health and social services systems. We recently undertook a cost-benefit analysis, using data from 2014 arrivals.

[English]

The conclusion from the cost-benefit analysis was that the excessive demand provision results in avoided costs for provincial-territorial health and social services on the order of \$135 million over five years, for each year of decision. That amount represents 0.1% of all the provincial and territorial health spending in 2015.

As you may know, IRCC has undertaken a fundamental review of the excessive demand provision. As part of this review, we launched consultations with provinces and territories in October 2016. Departmental officials also engaged stakeholders, including disability advocates.

The results of these discussions, together with consideration of public perspectives, judicial decisions, media reports, and internal

departmental analyses, will inform the development of options to be presented for decision by the government.

As Minister Hussen recently stated at a federal-provincial-territorial meeting of his counterparts, "...with the cooperation of the provinces and territories, I'm pretty confident that we will arrive at a place where we can both live up to the need to protect our health and social services from excessive costs, while also treating people fairly and including individuals with disabilities."

[Translation]

In summary, I will say that IRCC's medical screening program takes a risk-based approach that balances the facilitation of immigration with the protection of federal, provincial and territorial health and social services.

Once again, Immigration, Refugees and Citizenship Canada appreciates that the committee has chosen to undertake a study of the immigration medical screening policy.

Thank you very much.

We look forward to answering your questions.

[English]

The Chair: Thank you very much, Ms. Edlund.

We'll begin with Mr. Tabbara.

Mr. Marwan Tabbara (Kitchener South—Hespeler, Lib.): Thank you, Mr. Chair, and thank you to the witnesses for being here today.

On my first question, I'll let either of you choose.

If the family is a group of five, and the group of five has applied to come to Canada, but one individual within the family is deemed medically inadmissible, does the whole family get rejected in that application? Are they considered as one unit?

● (0855)

Ms. Dawn Edlund: It doesn't necessarily lead to a rejection, but yes, generally if one member of a family is inadmissible for whatever reason—criminality, security, medical, whatever—then the entire family unit would be considered to be inadmissible to Canada.

In the situation of medical inadmissibility, there are other avenues. Individuals can have their cases accepted on humanitarian and compassionate grounds, for example, or be provided with a temporary resident permit.

Mr. Marwan Tabbara: Can you tell us how many permanent resident and temporary resident visa applications have been deemed medically inadmissible to Canada in the past five years? I'm not sure if you have these figures on you. If you don't, can you table them for the committee?

Ms. Caitlin Imrie (Director General, Migration Health Branch, Department of Citizenship and Immigration): We will follow up with the full data, but I have brought some figures to this committee.

For the year 2014 we had a medical recommendation of excessive demand of 930; in 2015, it was 713; in 2016, it was 1,101. Generally speaking, we say it's between roughly 900 and 1,000 in any given year, which represents 0.2% of all applications.

Remember that those are findings of medical inadmissibility, but there is a process after that point. There is a procedural fairness process, and there is a review by a visa officer, so the number of rejected applications will be significantly lower.

We will follow up with those statistics. I have a breakdown by category if you would like that.

Mr. Marwan Tabbara: Yes, sure.

Ms. Caitlin Imrie: In 2014, just using that year as an example, for federal skilled workers, we had 114; Quebec skilled workers, 62; live-in caregivers, 150; provincial nominees, 101; parents and grandparents, 238; other family class, 6; students, 41; foreign workers, 36; temporary residents, 52; humanitarian and compassionate, 51; and unspecified, 64. Then there were roughly 50 who reapplied in other categories. That's the breakdown of that 930. Again, those were medical recommendations and not actual refusals, and we'll follow up with the full details.

Thank you.

Mr. Marwan Tabbara: Is there a specific health condition that results in an automatic rejection?

Ms. Dawn Edlund: No, there is not. The health conditions are identified during the immigration medical examination process and then that is assessed by departmental medical officers to see whether or not that condition represents a danger to public health, public safety, or the excessive demand provision. There is no condition that will automatically cause them to be found inadmissible.

Mr. Marwan Tabbara: The government wants to maintain a balance between welcoming new members into society and protecting our publicly funded health care and social services. We need to try to strike a balance with that, and also understand when a family does apply to come to Canada that we remain compassionate toward the whole family, because one member might need some health care, but many other members of the family can be very productive in our Canadian society.

Can you elaborate on the assessment that goes to determine medical inadmissibility?

Mr. Michael MacKinnon (Senior Director, Migration Health Policy and Partnerships, Migration Health Branch, Department of Citizenship and Immigration): Yes, we can provide additional details in that area.

To be clear, the assessment does not do a cost-benefit analysis on an individual basis. It is an assessment based on the results of the medical examination and supplementary testing, from which a medical officer assesses the severity of the illness and the degree of service that would be required to treat it, which then forms the initial medical recommendations that are given to a visa officer.

At that point, however, as part of a procedural fairness step, individuals are able to prepare a mitigation plan to identify if they are able to offset the costs that are related to things that can be paid for here in Canada.

In other words, under the Canada Health Act, if individuals cannot pay for medically necessary treatment, individuals who are applying to come to Canada can say that they would be able to offset the costs of prescription drugs or of other social services that can be provided through the market. To the degree possible, this is a way of identifying their ability to make a contribution to offset those costs.

Other countries have considered approaches that use something more resembling a cost-benefit analysis—specifically, Australia—but they found that it was unworkable because it involved too many unsupported assumptions as to what an individual's employment trajectory or income would be over the years following their arrival, so they abandoned this approach.

● (0900)

Mr. Marwan Tabbara: Mr. Chair, how much time do I have left?

The Chair: You have 30 seconds.

Mr. Marwan Tabbara: I read somewhere that the U.K. and the United States have a higher threshold than our \$33,000 for five years. Is that correct? Can this threshold be increased?

Mr. Michael MacKinnon: The U.K. and the United States have differing approaches, actually. Certainly in the United States it's difficult to argue that it's going to be a burden on publicly funded services, unless it's individuals who are very low income and who will be on Medicaid. In both of those cases that is left more to the equivalent of our visa officer's discretion and is done on a case-by-case assessment.

As for Australia and New Zealand, we do these comparisons with these large, immigrant-receiving countries that are like us. They also have a threshold-based approach, and the dollar values of their thresholds are remarkably similar to ours after you consider exchange rates.

The Chair: Thank you.

Ms. Rempel is next.

Hon. Michelle Rempel (Calgary Nose Hill, CPC): Thank you, Mr. Chair.

You mentioned, Ms. Edlund, in your opening remarks that you were preparing options for the government in terms of changes to this policy. Could you provide the committee with some details on what some of the potential options would be, and when you are planning to present them to the government?

Ms. Dawn Edlund: It's a bit difficult to answer that question as officials, because of course we provide our policy advice, options, and analysis to the government. When Minister Hussen appears before the committee later on during this study, he will be able to provide more details.

That said, I quoted Minister Hussen in my opening remarks. It's pretty clear from things that he said in the media and the guidance he's given us that he wants to strike that balance between excessive cost and making sure that continues to be part of the package, but also looking at fairness and equity for applicants and treating people reasonably, making sure that individuals....

He said publicly as well that the current provisions seem to be out of step with societal mores in terms of how we deal with individuals with disabilities and the contributions they can make. That will be part of our package.

Hon. Michelle Rempel: Sure.

You mentioned that the options you're preparing for the government were based on an aggregation of feedback from a wide variety of stakeholders. In terms of Minister Hussen's comments regarding a lack of fairness or a need to strike a balance, what feedback came forward from those consultations in terms of specific points that would suggest there isn't fairness right now?

Mr. Michael MacKinnon: Mr. Chair, to answer that question we received feedback from a wide range of stakeholder groups. We also considered other activities that the department was undertaking in terms of its outreach and contact with Canadians. In terms of the identification of concerns about a lack of fairness, disability advocacy groups were quite vocal in this area.

Hon. Michelle Rempel: What were their concerns?

Mr. Michael MacKinnon: Disability advocacy groups see this as being discriminatory against individuals with disabilities, despite that being the position that is—

Hon. Michelle Rempel: Just due to time, I'm sorry for interrupting you. It's just the nature of the beast.

Have there been any court rulings to date that have suggested that our current policy is discriminatory?

Mr. Michael MacKinnon: No, there have not.

• (0905)

Hon. Michelle Rempel: Thank you.

I'm wondering if you could also provide a breakdown by year over the last 10 years, in terms of the types or classifications of either diagnoses or symptoms that have been used to deem someone medically inadmissible, by number of cases. If you don't have that data here, could you provide it to committee?

Mr. Michael MacKinnon: We will provide that data.

Hon. Michelle Rempel: Thank you.

The other component that I wanted to touch upon was the figure of \$135 million over five years. Rather than a perspective on cost over five years, could you provide the committee with the cost-benefit analysis of it by fiscal year going forward, based on your analysis? I just want us to have an exact cost breakdown by fiscal year, if there was a replication of this policy, of what the actual cost would be. Also, what assumptions have you made in terms of the input costs to get to that figure?

Mr. Michael MacKinnon: The input costs in terms of the amount of effort by the department were relatively low.

Hon. Michelle Rempel: Sorry; to be clear, what I'm asking you to table with committee is a forecast. Just to clarify, in your cost-benefit analysis, how many years did you forecast into the future right now?

Mr. Michael MacKinnon: We used one year of representative data in order to conduct the cost-benefit analysis, and the determination is based on a five-year cost estimate. We used those cost estimates as the basis for the savings.

Hon. Michelle Rempel: Okay, so based on that analysis, could you provide two figures for the committee? I'm interested in, by year, the cost that you're projecting if this policy continues, and then how you came to that figure.

I'm not asking for your time to be calculated; I'm asking for costs to provincial health care systems, medical costs, anything, just so that as committee members we can get a sense of what costs are associated with this analysis.

Mr. Michael MacKinnon: The approximately 900 cases were reviewed by an analyst to identify the estimated cost savings from each of those cases, and we summed that up as being the estimated cost savings to provinces for that year. Given that we were using a year that had roughly balanced numbers in terms of the different types of conditions that were under consideration, our assumption would be that for each year of decisions, you would generate approximately that same order of magnitude of savings, so \$120 million to \$150 million per year, as you sum that out over each year of decisions.

Hon. Michelle Rempel: In terms of other assumptions you put into that figure, are you assuming other inputs such as the amount of taxation somebody might pay when they come to the country? Are you looking at any net economic benefit in terms of costing that out as well, or is it just the figures around what their potential costs to the health care system would be?

Mr. Michael MacKinnon: It is straight-up avoided costs for the health care systems. Net economic benefit would have been too complex to undertake in the analysis.

Hon. Michelle Rempel: Can you also provide us with a breakdown by country, let's say over the last 10 years, of how many cases are rejected due to medical inadmissibility?

Mr. Michael MacKinnon: We will get that data.

Ms. Dawn Edlund: Just to clarify, Mr. Chair, is that by the nationality of the applicants?

Hon. Michelle Rempel: Yes.

Can also you provide us with a bit of background on how doctors are selected to take part in these exercises—how the department would source physicians?

Ms. Dawn Edlund: I'll start, and then I'll refer to Dr. Saeed.

I referred in my opening remarks to what are called “panel physicians”, who are empanelled by the department according to a set of different standards. We do quality assurance and various checks on those medical professionals to make sure they're going to do the immigration medical exam under the standards we set out for them. We also have our own medical officers, who are departmental staff, who do the actual assessment.

Hon. Michelle Rempel: Is there a certification or quality assurance process that the department uses?

Ms. Dawn Edlund: Do you mean for the panel physicians? Absolutely. We monitor the activities—sometimes in combination with a country like Australia, because we share some of the same panel physicians—to make sure they're doing things as they're supposed to. If there are instances of serious problems, we no longer allow them to be our panel physicians.

• (0910)

The Chair: Thank you very much.

Just before we go to Ms. Kwan, could I clarify one thing that has come up in both rounds of questions? In your opening remarks, you state costs on the order of \$135 million over five years, for each year of decisions. That language is eluding me, because it says two different things. It says \$135 million aggregated over five years, but then it says “for each year of decision”, and Mr. MacKinnon's remarks just seemed to indicate it was \$135 million a year. I'm trying to understand that.

Hon. Michelle Rempel: As a point of clarification, Mr. Chair, thank you for raising this. I just want to clarify the data I was trying to get out of the witnesses. We have the same concern, so if it's \$135 million over five years, but it's a rolling scale, what is the actual cost per year? That would be a more meaningful figure.

The Chair: That's what I'm trying to understand, because I don't understand the syntax of that sentence.

Mr. Michael MacKinnon: Thank you, Mr. Chair, and to be clear, it is that each year of decisions in essence generates a five-year profile of avoided costs for the provinces. Because it involved a case-by-case review by an analyst in order to conduct the cost-benefit analysis, we used only one year, which was an exemplary year in terms of the levels of immigration, all the source countries, and those sorts of things.

We're using that as the assumption that savings will be, for each year of decisions, on the order of \$135 million over that five-year period of time, but then each subsequent year of decisions will generate a similar five-year profile of savings in turn, as Ms. Rempel indicated.

The Chair: It is difficult for us, because why is it five years and not 10 years or 20 years? It would seem to me that a year of decision would be one-fifth of that amount per year, but it could be 25 years, or four years, or two years, or the person could die in six months.

Mr. Michael MacKinnon: We used a five-year profile because that is the basis of the policy, which is that the assessment is done using the estimated costs over a five-year period for an individual's given health condition.

The Chair: Would it be fair to say \$27 million a year for maybe five years, or not?

Mr. Michael MacKinnon: It's more that with those rolling five-year profiles, in any given year, you will have five years' worth of decisions that are generating savings, so your savings will be on the order of \$135 million, perhaps as little as \$120—

The Chair: That's because of years.

It just depends on the vantage point you're using.

Mr. Michael MacKinnon: Yes.

The Chair: If you're a province, you're thinking it's \$27 million a year.

Mr. Michael MacKinnon: If you're a province, you're thinking it's \$27 million from this year, plus \$27 million from next year—

The Chair: —and from next year, from next year, from next year. Absolutely.

Mr. Michael MacKinnon: You're probably aggregating it as being roughly \$120 to \$150 million.

The Chair: Sorry. I find it difficult language, but I'm not too bright here.

Ms. Kwan is next.

Ms. Jenny Kwan (Vancouver East, NDP): Thank you, Mr. Chair.

I thank the officials for their presentation to the committee.

Mr. Chair, I have a series of questions. I know we're limited in time, so I'm going to put these questions on the record and ask the officials to undertake to provide answers to the committee with respect to them.

I think what's underpinning all of this is one of the most important questions, and that is the information and the evidence the officials can provide to us on how the government sets the current cost threshold for excessive demand. I don't believe that anyone is disputing the information provided by the Canadian Institute for Health Information, but I would like to get to how this figure is being derived. To that end, Mr. Chair, I would like to ask the officials for the following information.

First, how does IRCC set the cost threshold for excessive demand, particularly for social services? It is my understanding that the government uses a figure of \$356 for what it spends on social services per capita each year. Where did that figure come from, and is that the correct figure?

Does the current review aim to more clearly define the social services considered when setting the threshold for excessive demand? If yes, how will this be accomplished and accounted for to ensure transparency?

What about applicants who have been denied in previous years for amounts very near to this threshold? We have heard about the number of people who are being assessed in this context. How many people were denied? For those who have been denied, if their threshold was very close to this amount, does IRCC intend to launch a proactive review of these cases or at least provide an avenue for applicants to reapply without incurring additional costs?

We have seen major inconsistencies, at least anecdotally, in how applications involving medical inadmissibility are reviewed and handled, depending upon the medical officer or the immigration office responsible for a particular file. In some cases, medical officers failed to provide any sort of cost estimate to applicants in procedural fairness letters when stating that applicants may be deemed inadmissible, an apparent violation of existing case law, specifically in the *Sapru v. Canada* 2011 case, which requires that applicants be provided with cost estimates during the procedural fairness process so that they may put forward a reasonable challenge to the government's claims.

To that end, do the officials acknowledge that there are problems in terms of how applicants are handled by one officer or office versus another, and that these problems include significant inconsistencies in how medical officers review the anticipated costs of care in Canada?

Also, has IRCC's review of medical inadmissibility included a review of these inconsistencies? If yes, what efforts has IRCC undertaken to ensure medical officers are aware of and adhering to existing case law regarding procedural fairness?

The Canadian Bar Association has recommended that the processing of cases involving medical inadmissibility be centralized in Ottawa so that these more complicated cases can be given the care and attention they deserve. I wonder whether or not the officials agree. If yes, what is being done to make this happen? If not, why not?

We understand the provinces are being consulted on a range of possible policy changes, including the possibility of expanding groups of persons exempted from these provisions, something that is currently limited to refugees and protected persons. Is this true? If yes, what groups is the government considering for exemptions from medical inadmissibility and excessive demand provisions?

Also, disability advocates from across Canada have spoken out against these provisions, saying that medical inadmissibility discriminates against people with disabilities, forcing them to go through a process that able-bodied persons do not have to. Do the officials and the government acknowledge that this policy unfairly discriminates against persons with disabilities?

Specifically what I'm talking about is the process of forcing people with disabilities through a separate and segregated process of medical review, by virtue of the fact that they have a disability. This, to me, is a textbook case of discrimination, and the outcome, whether admitted or not, is irrelevant, in that the person with disabilities is discriminated against prior to these decisions ever even being made.

• (0915)

To that end, does IRCC intend to make persons with disabilities, particularly dependent children of economic applicants, exempt from these provisions? If yes, what disabilities will be exempted, and how will the government determine the list of exempted disabilities and conditions?

Ms. Dawn Edlund: Thank you for the questions.

The Chair: You have a minute and a half left.

Ms. Dawn Edlund: I'll touch on a couple of them. We'll provide written responses to the others.

Mr. Chair, the question was asked about how we establish the cost threshold. We have two different component parts to that cost threshold. The first is looking at the annual report from the Canadian Institute for Health Information. It provides an annual look at per capita usage by Canadians in relation to health and social services. In 2017 that number was \$6,299. A second component is that we then look at the definition of excessive demand and our definition of social services.

We compared the types of services that the Canadian Institute for Health Information covered, and some parts of our definitions of social services were not covered by the Canadian Institute for Health Information—

Ms. Jenny Kwan: I wonder if I can interject. Can the committee get your definition in writing, then, of what you define to be social services and get that list from you?

Ms. Dawn Edlund: Absolutely. It's actually part of the regulations. It's a defined term in the regulations.

Some of the pieces that are not covered in the Canadian Institute for Health Information for social services, for example, are global home care, some specialized residence and residential services, special education services, social and vocational rehabilitation services, and personal support services. Those are all part of our regulation, and the Canadian Institute for Health Information doesn't cover those.

In 2004 we undertook a study by looking to sources such as Statistics Canada and Health Canada, speaking with provinces and territories about their data, and then calculating those missing services that aren't in the CIHI numbers and what that actually turned out to be. We provided that baseline in 2004, and we've actually increased that by the cost of inflation every year, so in 2017 that's now \$356.

• (0920)

Ms. Jenny Kwan: Can the committee get that study so we can review what was undertaken and have that information?

Ms. Dawn Edlund: Do you mean the baseline study?

Ms. Jenny Kwan: Yes.

Ms. Dawn Edlund: Yes.

Ms. Jenny Kwan: Thank you.

The Chair: I think that's your time. You'll get another shot at this.

Go ahead, Ms. Zahid.

Mrs. Salma Zahid (Scarborough Centre, Lib.): Thank you, Chair, and thank you to our witnesses.

In your opening remarks, you gave us some numbers for the people who were medically inadmissible. I would like to know what percentage of the negative decisions due to excessive demand were overturned over the last few years by a ministerial intervention, the Federal Court, or the IRB.

Ms. Dawn Edlund: On the number of cases overturned, I don't think we have those numbers with us at the moment, but there certainly have been decisions by the Federal Court and by the immigration appeal division over the years, some of which have upheld the medical inadmissibility finding and some of which have overturned the medical inadmissibility finding. We can do further research and provide that to the committee.

In response to an earlier question, I also spoke about the possibility of people getting.... Sometimes after the medical inadmissibility recommendation by the medical officer, the individuals then provide information—for example, in relation to social services—and they satisfy the visa officer that they actually are not inadmissible. That happens there.

Some people withdraw their applications. Some people end up with temporary resident permits. Some people are granted visas on humanitarian and compassionate grounds. A range of results can happen after the initial medical officer recommendation.

Mrs. Salma Zahid: Is it possible to get some numbers on that?

Ms. Dawn Edlund: Yes.

Mrs. Salma Zahid: Next, when a decision of inadmissibility due to excessive medical demand is rendered, the applicant has the opportunity to submit a plan to show how they can mitigate the impact. Over the last few years, how many and what percentage of these plans have been accepted?

Ms. Caitlin Imrie: We'll have to follow up with the statistics, but I'd like to ask Dr. Saeed to speak to the process around how the mitigation plan is considered.

Dr. Arshad Saeed (Director, Centralized Medical Admissibility Unit, Migration Health Branch, Department of Citizenship and Immigration): Thank you, Mr. Chair.

The mitigation plan is submitted as part of the procedural fairness given to the applicant, whereby first they can challenge our diagnosis and then they can provide a detailed plan that includes how they're going to defray the cost of that service.

As we said earlier on, it's not a medical condition that renders them inadmissible, but the services, the health services and social services. If they have a detailed plan, we look at the feasibility, the practicality, and the applicability of the plan in a Canadian context. That is done, and then we provide our opinion to the visa officer to make the final decision.

Mrs. Salma Zahid: Would you have any numbers on how many of these plans have been accepted over the last two or three years?

Dr. Arshad Saeed: That number we can provide to you later on. We don't have it right now.

Mrs. Salma Zahid: Okay.

My next question is on your opening remarks. You mentioned “the exception of convention refugees, protected persons, and some members of the family class”, that is, “spouses, partners and direct dependents”. I would like to get more clarification on who is exempted, because we hear stories such as that of a live-in caregiver whose son was rejected because he was disabled. Can we have more clarity on who is exempted and who is not?

Ms. Dawn Edlund: The exempted groups are convention refugees, such as resettled refugees. They are protected persons, people found to be refugees in Canada. Then there are some members of the family class, the close family members. If I were sponsoring my spouse and my dependent children, they would be exempt from the medical inadmissibility provisions. We still do immigration medical exams because we want to know from a public health or public safety perspective whether there's something that we need to be concerned about.

Then there are folks who are not exempted. The kinds of cases you're talking about tend to be economic immigrants, and it's either the principal applicant or one of the dependants of that economic immigrant who has issues, who has a health condition that then raises concerns around excessive demand. It might be a live-in caregiver. It might be a federal skilled worker. It might be a student.

● (0925)

Mrs. Salma Zahid: Would they not be considered as dependants? Would an 18-year-old child not be considered a dependant of that live-in caregiver?

Ms. Dawn Edlund: They're considered as dependants, but they're not exempted in the way close family class members are under the policy as it currently stands.

Mrs. Salma Zahid: In the case of close family class, for example, if today I sponsored my husband and my two kids and one of them has a problem, they would be exempted.

Ms. Dawn Edlund: Yes.

Mrs. Salma Zahid: However, for the live-in caregiver, they will not be exempted?

Ms. Dawn Edlund: Yes.

Mrs. Salma Zahid: Next, does anything in the evaluation process consider the economic benefit of having the family in Canada as permanent residents and the contribution to our economy that would be lost should the family be denied?

Ms. Dawn Edlund: Under the current policy, no. That's considered as part of the selection decision in selecting individuals to become immigrants to Canada, but for the actual admissibility—medical, criminal, or otherwise—we don't then factor that back in again. We don't have that net economic benefit test that Australia tried to do a few years ago and found too complicated.

Mrs. Salma Zahid: Okay.

How much scope do officers have with regard to the interpretation of subsection 38(1) of IRPA? When were the most recent ministerial instructions issued? Have officers been told to interpret the act strictly, or do they have some flexibility while making their decisions?

Ms. Dawn Edlund: There are guidelines or instructions—program instructions, I think they're called—that are provided and updated on a regular basis, so we could look and see, particularly on the medical admissibility side, when those were last updated.

Visa officers look to apply the act and the regulations as they are written and as they have been interpreted by the courts, and we provide guidance to them to say, "Here's a recent court decision, and we need to modify our behaviour and do this and this instead." For example, when the Supreme Court of Canada made a very important decision in 2005 in a case called Hilewitz and De Jong, we modified the way in which we did medical admissibility screening at that point. The instructions were provided to officers and training was provided, etc.

The visa officer, then, is looking at the mitigation plan that's been presented and at humanitarian and compassionate considerations, so there are those areas of flexibility.

The Chair: That's it.

Mrs. Salma Zahid: Thank you.

The Chair: Mr. Saroya is next.

Mr. Bob Saroya (Markham—Unionville, CPC): Thank you, Chair, and thank you to the panel for coming out.

I'm still not crystal clear on this. Is it \$135 million annually or is it \$27 million annually? The cost is \$135 million for a year or...?

Mr. Michael MacKinnon: It's that at any given time for the provinces, or from a provincial perspective, there are five years' worth of decisions that are in play, right? If we pick this year, 2017, then decisions from 2016, 2015, 2014, 2013, and 2012 are all in play. Each of those years will generate a five-year-profile's worth of savings. As Ms. Rempel suggested, it's like a rolling amount that goes across those years. From the perspective of the province, they're getting five years' worth of savings.

Mr. Bob Saroya: You're saying that for five years, it's \$135 million.

Mr. Michael MacKinnon: Yes, roughly speaking, and recognizing that this is an estimate based on one year of data.

Ms. Dawn Edlund: We looked at the data from 2014 as being a representative sample, but the profile in 2012 of people who are medically inadmissible and the cost of health and social services for those particular conditions might be different.

Mr. Bob Saroya: Yes.

When we talk about \$27 million, or \$135 million over five years, does this include medical costs, education costs, social costs, or any other costs?

Mr. Michael MacKinnon: To be clear, it's an assessment against the basket of services that we have defined in the regulations. It is direct health care costs plus.... I'd have to dig through my binder to find the list of the specific things in the regulations.

There have been misperceptions in the media recently. For example, they were asking why we weren't calculating in the social assistance costs or the social housing costs or the amount of the Canada social transfer, but these amounts are out of scope, according to the regulations.

It's strictly the basket of services that are directly related to medical diagnoses. Occupational therapy, behavioural therapy, long-term care, and those sorts of costs are the ones that are considered in there.

• (0930)

Mr. Bob Saroya: These costs are on top of the \$135 million.

Mr. Michael MacKinnon: No. Those are the ones that are included in there. Social assistance or social housing are out of scope for this decision, because we can't forecast whether or not somebody is going to be poor on arrival in Canada. It's strictly speaking health care, plus the immediately affiliated social services that we have in the regulations.

Mr. Bob Saroya: How much of this cost is borne by the provinces, or is it all clumped in together?

Mr. Michael MacKinnon: The estimates are based primarily on the assessment of the individual conditions and the expected costs that those would impose on provincial services. The estimate of savings on the order of \$135 million from each year of decisions is what we would expect the provinces would have to bear if these individuals were allowed to be admitted into Canada.

Mr. Bob Saroya: Mr. MacKinnon, what year was this cost threshold developed?

Mr. Michael MacKinnon: I'm not certain. For many, many years the average per capita cost for Canadians for these services has been used as a basis.

Mr. Bob Saroya: How often do you reassess it?

Mr. Michael MacKinnon: The amount for health care costs adjusts automatically, because the Canadian Institute for Health Information reports this as an individual piece of data each year. On our way here, Dr. Saeed advised me that they're ready to publish the estimated cost of the adjustment for the next year based on revised population estimates and the total health care costs for Canadians for the previous year. That gets adjusted on an annual basis.

We also adjust the amount for the social services that aren't included in that estimate for inflation on an annual basis, using the inflation rate for the health sector as opposed to the general CPI.

Mr. Bob Saroya: Dr. Saeed, where are these physicians located? Are they throughout the world? Are they in Canada?

Dr. Arshad Saeed: You're talking about the panel physicians who conduct the medial examinations?

Mr. Bob Saroya: Yes.

Dr. Arshad Saeed: They're all around the world, in each country. They're in Canada as well, designated by IRCC. They're all around, everywhere.

Mr. Bob Saroya: How often—

The Chair: I'm afraid I need to end things there. We'll be around for another tour.

We'll go to Mr. Sarai.

Mr. Randeep Sarai (Surrey Centre, Lib.): Thank you to the panel.

Just to clarify, is the \$33,275 over five years indexed every year by inflation, or was that number established some time back?

Mr. Michael MacKinnon: The health component of that adjusts automatically each year. The smaller amount, the \$356, is for social services. We do the adjustment based on inflation, but the amount for health care costs that's reported by CIHI gets reported each year. In effect, because of that reporting, it self-adjusts for inflation each year.

Mr. Randeep Sarai: Do you know when that original number was established?

Mr. Michael MacKinnon: I'm not aware; it would have been probably more than a decade ago.

Ms. Dawn Edlund: The current definition in the regulations dates from when the Immigration and Refugee Protection Act was passed, which was 2002.

Mr. Randeep Sarai: What are the current limits on discretion when, say, a family is applying and one person has a disability? There's a discretion, as you said. What are the conditions or limits on that discretion?

Ms. Dawn Edlund: There are the usual conditions that an officer has in making a decision.

As I spoke earlier, they're looking at the response to the procedural fairness letter that was sent out. The family may dispute the medical condition, the prognosis, and bring their own specialist reports to bear in relation to the condition and the expected health and social services the individual may need over the next five years. For the social services side, then, after the Supreme Court decision in Hilewitz and De Jong, they can present one of their mitigation strategies for not having the same impact.

For example, if someone is going to be employed in Canada and the employer has a health care plan that will cover expensive prescription medications, that could be a mitigation plan. The officer would take that into account and say that expensive medication is covered off by their health care plan, so they find they're not medically inadmissible.

Generally, then, on the temporary resident permit, humanitarian and compassionate grounds are powers that officers have all the time, as does the minister.

● (0935)

Mr. Randeep Sarai: How many applications have applied for that discretion annually?

Ms. Dawn Edlund: We could try to get the numbers for you. There are thousands of people who apply for humanitarian and compassionate consideration writ large every single year.

Mr. Randeep Sarai: I'm talking just on the medical side.

Ms. Dawn Edlund: On specifically the medical side, we'll see if we can get that.

Mr. Randeep Sarai: I would also like to know how many of them get approved.

Ms. Dawn Edlund: Yes.

Mr. Randeep Sarai: I'd like to see the ratio in how many people apply.

My understanding is that very few who apply for discretion ever get through, nor do their mitigation plans ever get approved. I'd like to know the percentage, if you could get that in a timely manner.

Are there other countries that have a bond or mitigation guidelines that have been considered successful, specifically in western or developed countries, perhaps Australia?

Mr. Michael MacKinnon: We'd have to explore that more.

Ms. Dawn Edlund: We'd have to look into whether other countries like Australia or New Zealand have mitigation plans as part of the way they do medical admissibility decision-making.

Mr. Randeep Sarai: Then you're not aware of any that do that?

Ms. Dawn Edlund: No.

Mr. Randeep Sarai: No.

My colleague asked this earlier.

I understand that if a live-in caregiver's family member has a disability, they would be excluded, barring any mitigation. However, you're saying that a family class would not be excluded. What about other economic categories or economic immigrants? Would the entire family be excluded if one person were considered inadmissible under these guidelines?

Ms. Dawn Edlund: It's the balance that we try to strike between humanitarian considerations and family reunification. That is why certain categories of applicants are exempt from the provision, versus the concern about protecting social and health care services that are publicly funded. It's the balance between the two.

Every economic immigrant who applies to come to Canada with his or her family will be medically assessed. They will go through immigration medical examinations. They will be assessed. If one of them is found to be inadmissible, they don't benefit from that same exemption as the close family class members for the family reunification purpose.

Mr. Randeep Sarai: I'll pass.

The Vice-Chair (Hon. Michelle Rempel): For the record, I did want to give you an extra 10 seconds.

Mr. Randeep Sarai: The previous chair was more liberal.

The Vice-Chair (Hon. Michelle Rempel): Quite, indeed.

Mr. Maguire, you have the floor.

Mr. Larry Maguire (Brandon—Souris, CPC): Thank you, Madam Chair.

I just want to check again on the provisions that you have here.

You mentioned that approximately half a million medical exams are performed annually by IRCC. Does that mean that a half a million individuals have applied? Is there one exam per individual, or are there multiple exams for individuals?

Ms. Dawn Edlund: For example, if a family were applying to come to Canada, all the family members would go through the immigration medical exam. It's not a case; it's the entire family.

That number of 500,000 to 550,000 medical examinations goes up and down year over year, depending on the number of applicants, depending on how many temporary residents need to go through the medical examination process, etc.

Mr. Larry Maguire: Mr. MacKinnon, maybe this is what you were referring to, but can you provide a bit more expansion on the definition of "excessive demand"?

Mr. Michael MacKinnon: I have two pieces of paper on the definition of "excessive demand", and I have the legislative provision. The regulations specify that it is:

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 the period of five consecutive years immediately following the most recent medical examination.

The definition of "health services" is:

health services for which the majority of the funds are contributed by governments,...services of family physicians, medical specialists, nurses,...physiotherapists.

Social services, in the regulations, are:

any social services, such as home care, specialized residence and residential services, special education services, social and vocational rehabilitation services, personal support services and the provision of devices related to those services,

(a) that are intended to assist a person in functioning...; and

(b) for which the majority of the funding...is [provided] by governments....

It's a very specified basket of services that we're looking at. To interpret that, they're the ones directly related to medical diagnoses.

● (0940)

Mr. Larry Maguire: Thank you.

If you were looking at a situation in which a person or child was physically disabled and had some mental incapacities as well, and they required a teacher assistant full-time, would that automatically be a situation in which you would reject that applicant?

Mr. Michael MacKinnon: I'll forward that question to Dr. Saeed, because he conducts the medical assessments on those sorts of facts.

Dr. Arshad Saeed: Once again I'll say that it's not the disability or the condition that will render them inadmissible. We look at the severity of the diagnosis and the frequency with which they will require those services. If an extra teacher is required, yes, that will increase the cost of social services for that particular applicant. If they require speech therapy, occupational therapy, or other therapies on a regular basis, that can potentially make them inadmissible.

Mr. Larry Maguire: And therefore the whole family would be rejected.

Dr. Arshad Saeed: That's correct.

Mr. Larry Maguire: This is a situation that I think arose in my office before I became a federal member of Parliament. It is a situation in which I believe a whole community ended up looking at

the net benefit to having this person in their community. I know we've talked a little bit about the net benefit here, and I understand that it's a bit difficult to calculate, but this whole community—just about every community organization—wrote letters of support for this individual. The situation was very much accepted.

One reason they did that was that the community I come from is a mainly rural area with a very serious shortage of nurses, and the mother of this child was a very qualified nurse. The need for her in the hospital was greater than the cost of the rest of the care that this person was going to have to have. Eventually we were successful in keeping this family there. They have three other children, who are quite normal, in the school. There's all that to be taken into consideration.

I'm just wondering if there's any movement to look at the idea that maybe there's not just a hard and fast net dollar cost but a social net benefit to having a person of this type in a community as well.

Ms. Dawn Edlund: We do have a bit of a process that's used on an ad hoc basis, particularly for provincial nominee cases. The province will come forward to us with exactly the kind of situation you're describing: that there's someone in a rural community who is very important to them, to their economy, to the health services that are provided to the community. They will write a letter to the department, saying, "We recognize that there may be medical admissibility issues and excessive demand. We're telling you we fully support this individual and the family in our community."

That's then put in front of our decision-making officers. Frequently at that point the family ends up with a temporary resident permit. Once they're on a temporary resident permit for three years running, they can be granted permanent residency, with no further look at the medical admissibility.

We do have that process now. Provinces will come forward with those letters of support.

The Chair: I'm afraid I need to cut you off there, but I don't really want to, because I like your questioning.

Go ahead. Mr. Whalen.

Mr. Nick Whalen (St. John's East, Lib.): Thank you very much, Mr. Chair.

I have to say that this is all very interesting. Thank you for coming and giving us this tutorial on how the medical exclusions work in the Canadian immigration system, but I have to say, from a moral perspective, that I feel very sheepish just even talking about it.

I don't know where the objective of the provision explicitly recognizes the sanctity of human life and the equality of all people in our immigration system. Doing a cost-benefit analysis in advance on human beings and whether or not they should be in Canada makes me very morally squeamish. When I look at this situation, I think these are horrible things to be measuring, so I'm sorry you guys have to go through this.

In terms of the overall broader Canadian population, how many sociopathic disorders have you guys seen in the applications, as compared to the number in the general Canadian population?

• (0945)

The Chair: Excluding present company.

Voices: Oh, oh!

Mr. Nick Whalen: I mean, there are measures for this. What percentage of the Canadian population has sociopathic disorder and what percentage of applicants are being excluded on that basis?

Dr. Arshad Saeed: Very few are excluded on that basis, and it's not based on the cost but on the threat to public safety. If they have any aggressive or violent behaviour, they are deemed inadmissible based on that, not on the cost.

Mr. Nick Whalen: In terms of active tuberculosis and untreated syphilis, do you have numbers for those compared to those in Canada? How many are being rejected?

These are the three that you've highlighted, so I assume that you might have done some extra digging on those items in deciding to present those three.

Mr. Michael MacKinnon: We do have data related to these items. On the numbers, the outright decisions of inadmissibility for these conditions are extremely rare, because the practice of the department is to, as we call it, "further", or put on hold, the application.

An individual who is found to have active pulmonary tuberculosis by a medical examination in their home country is advised of those findings and also advised that we can put the application on hold while they get treatment for that condition. They can return, have a subsequent medical examination, and, assuming it finds that the treatment is successful, then they're admitted, but with the requirement to report to the provinces for medical surveillance, because there is a risk that the tuberculosis will become reactivated over their lifetime.

Again, the numbers of people found inadmissible for these causes are extremely small, and it would be—

Mr. Nick Whalen: When you were quoting these numbers back to us.... I know that we've been asking for rejections. Maybe you can also include the numbers of those on hold as well, so that we have a sense of how much the applications and the timelines are being impacted by these types of screenings, instead of their coming to Canada and being treated in Canada.

In terms of these averages, if a family of five is coming here, does each individual person have to meet the threshold, or does the family as a group have to meet a threshold that is five times the dollar value of this family of five, for instance?

Ms. Dawn Edlund: It's each individual.

Mr. Nick Whalen: Also, is the threshold based on the 2017 cost of services, or is it based on some point in time in the past? Is it a rolling forward or...?

Ms. Dawn Edlund: The majority of the costs annually comes from the Canadian Institute for Health Information. That's the one that's updated once a year. For 2017, that was \$6,299. They look at

the per capita cost of Canadians' usage of health and social services, they do the math, and that's the number they end up with. In 2017—

Mr. Nick Whalen: Canadians have this big, broad curve of costs of medical care, and here's your average point, and anyone who wants to be an immigrant to Canada has to be basically—I mean, there are all these other things—in the top 50%. We're not going to take immigrants who meet the overall Canadian threshold and represent what Canada looks like from a medical cost perspective. We're only going to take immigrants that beat the Canadian average.

Ms. Dawn Edlund: Yes. It is the Canadian average—

Mr. Nick Whalen: Not only that, even within a family, a family might totally blow out the Canadian average, but if one of their members doesn't meet the Canadian average, then the family gets excluded.

Ms. Dawn Edlund: Yes.

Mr. Nick Whalen: Okay. I think my questioning is done.

The Chair: Thank you. Because you have a few seconds left, I would like to use them.

In your remarks, you say, "We recently undertook a cost-benefit analysis, using data from 2014 arrivals." What did you count as the benefit? Of the cost-benefit analysis, I understand the costs. What were you counting as a benefit?

Mr. Michael MacKinnon: To be clear, for the cost-benefit analysis, the costs were largely the processing costs to the department, plus litigation costs and similar costs that were imposed on us. The benefit was the estimated savings to provincial and territorial health systems.

The Chair: Okay, so there's no benefit to society.... When I heard that in the remarks, I assumed that you had done something similar to Australia, to look at the benefit of immigration, as Mr. Whalen was just saying, but that has never been included.

• (0950)

Mr. Michael MacKinnon: No.

The Chair: Thank you.

Go ahead, Ms. Kwan.

Ms. Jenny Kwan: Thank you, Mr. Chair. I would like to follow up on other questions.

With respect to processing time for each of the categories involving cases of "excessive demand", can you tell us the average processing time and tell us how many families have had to do more than one medical because of the long wait time in getting the application processed?

Ms. Dawn Edlund: Mr. Chair, we can have a look in terms of the processing times when medical inadmissibility is an issue that has been raised by the immigration medical exam, because there can be furtherances, and there can be—as my colleague alluded to—someone with active tuberculosis who goes through a period of treatment, and that counts against the application time. The treatment, which I'm not very sophisticated about—and Dr. Saeed could undoubtedly speak to this—takes place over the course of a period of time, and then the application is picked back up again. Part of it will depend on how quickly the individual applicants act in the medical furtherances. If there are further tests that are required from other specialists, then it's in their hands as to how quickly they do those tests.

I believe your second question about people redoing medical examinations would relate more to individuals who haven't been issued a visa yet. Their application is in process, they have a valid medical examination, and they have not yet been issued a visa. The medical results are good for a period of one year, and if they don't get the visa within that one-year period, then they have to redo their medicals.

Ms. Jenny Kwan: Could I get those numbers from the officials? If you can undertake to provide that information to us, that would be greatly appreciated.

I have two specific cases I'd like to bring to the attention of the officials just by way of a snapshot of the examples.

One is the publicized case of Mercedes Benitez. She made her application in 2010. She has been waiting seven years for it to be processed. Her case involves a son who has an intellectual disability, so it's not TB or anything like that. Her application has been in process for seven years.

I have a case of another individual, Monica Mateo. She made her application in 2012. It's been five years since she made the application, and again it's not a contagious disease or anything like that with respect to her daughter. In fact, in her case, her employer has even offered to cover all expenses related to her daughter if there were excessive demands determined. Her employer has submitted her bank statements for verification. They are still waiting.

There is something wrong with our system in the way we are treating such individuals.

When the officials say that this is not an issue around discrimination and that people's rights are not being violated in accordance with our charter, the question I want to put to the officials and to the government is this: is not the process you are making people go through because of their disability deemed to be a violation of our charter? Any other person would not have to undergo this process. Only people with disabilities have to undergo this process. That is the argument the associations working with people with disabilities are advancing.

I'd like to have the officials comment on that.

Ms. Dawn Edlund: This matter has been considered by Canadian courts over the years. There have been many attempts by the private bar and disability associations to advance the argument that there is a charter violation, whether under section 7, “right to life, liberty and security of the person”, or under section 15, the equality provision.

There has been no court decision that has found that there is a violation of the charter.

Are these difficult sets of circumstances for the families and individuals? Absolutely, but they have not been found by Canadian courts to reach the level of a violation of the charter. That said, I think it's pretty clear from what Minister Hussen has said that he wants us, in our fundamental policy review, to actively look at these kinds of questions and address them. As well, that's part of the material we are looking at.

The Chair: I need to end you there. You got five minutes instead of three, just to let you know.

We are going to start round three.

Mr. Anandasangaree, you have seven minutes.

• (0955)

Mr. Gary Anandasangaree (Scarborough—Rouge Park, Lib.): Thank you, Mr. Chair.

Thank you, panel, for being here.

I want to pick up from where my colleague left off.

One of the concerns is that processing on medical admissibility happens at the stage when we are ready to process the application, so someone would have filed an application in 2010, and six or seven years later, they are going to be assessed. We have the family essentially waiting for upwards of five or seven years to get a decision from the department with respect to admissibility. Then they go through the process, which could drag on, and potentially eight, nine, or 10 years later, they find out they're not admissible to Canada.

I think the fact that somebody is waiting for 10 years and at the end isn't allowed to come here is highly problematic. How do we make sure this kind of assessment happens ahead of time so that the family doesn't have to wait that long?

Ms. Dawn Edlund: From a processing perspective, we have at times done what are called upfront medicals, meaning that before people actually apply, they do their immigration medical exams. Since we've instituted, though, our electronic examination of medical examinations, called eMedical, the lengthy delays that we used to see for the medical examination and assessment process are no longer the case.

Mr. Gary Anandasangaree: Just to clarify, the delay is not the medical itself. The delays are in processing, and the medical actually takes place at essentially the last phase.

Are upfront medicals available to everyone? Is that by invitation, or is that by someone who may have a concern about admissibility at the initial stages?

Ms. Dawn Edlund: We tend to discourage upfront medicals now. It's more complicated from a processing perspective for us to have a medical result in the system when we don't have a file to attach it to, because we don't have the application yet.

As I said, with eMedico, the results come much more quickly—

Mr. Gary Anandasangaree: Essentially, the point is that someone could wait for up to seven years or more, and then be deemed inadmissible based on their medical condition. Is that right? That's what we're basically saying.

Ms. Dawn Edlund: The number of spaces in the annual levels plan dictates how many visas we can issue in a given category in any particular year, for example, and if there's unlimited intake, then that builds big inventories of applications, as we saw in the recent program.

Mr. Gary Anandasangaree: We understand that is a timeline for some categories, and it's common knowledge.

Getting on to the issue of excessive demand with respect to education, how does a doctor in another jurisdiction look at something like autism, and what kind of impact will that have on education at the school? What kind of training must the doctor have to assess the kind of demand that will be imposed and the kind of support the individual child may require at the school itself?

Dr. Arshad Saeed: Autism is a spectrum disorder, and one person could be a very high-functioning child. Again, it's not just the diagnosis that will exclude children or make them inadmissible.

We look at the reports provided by the applicant from the specialist, such as a child developmental specialist or a psychologist, or a school report. Those detailed reports are reviewed by medical officers, and we look at the frequency of services required and the breadth of services required.

It's based on the report submitted by the applicant in support of their medical.

Mr. Gary Anandasangaree: It's not only the medical examiners that make that determination, correct?

Dr. Arshad Saeed: That's correct. They don't make the final judgment.

We look at all the reports, all the information, and then do our analysis. We then come up with the detailed list of services—social services, special education plans—and then make our recommendations.

• (1000)

Mr. Gary Anandasangaree: Potentially, for a child with autism, regardless of the spectrum, the costs will exceed \$6,300 a year. While we may not exclude individuals because of autism, essentially de facto they're excluded, because that is the cost of supporting those children through the school system. Am I correct?

Dr. Arshad Saeed: Yes. It's like any other medical diagnosis as well. If the cost of required services exceeds the threshold, they can potentially be rejected.

Mr. Gary Anandasangaree: How many children with autism have we admitted in the last year?

Dr. Arshad Saeed: I have a number here. We can provide it to the committee.

Mr. Gary Anandasangaree: Do you have it? Can you share it?

Dr. Arshad Saeed: With autism, there were 37 who were made inadmissible in 2014. In 2015, there were 16, and in 2016, there were 23.

Mr. Gary Anandasangaree: That's in the last three years.

Dr. Arshad Saeed: Yes.

Mr. Gary Anandasangaree: How many were able to provide support or were able to meet the threshold of \$33,000?

Dr. Arshad Saeed: How many were less than that?

Mr. Gary Anandasangaree: How many children with autism did we admit? These are the ones who were excluded. This is the first stage of the adjudication.

Ms. Dawn Edlund: To clarify, this is the medical officer's recommendation, which then goes through the procedural fairness process, etc. That can take a bit of time.

Mr. Gary Anandasangaree: How many have been...?

Ms. Dawn Edlund: We would have to dig in further to say for that particular line of recommendations, the 80-some in the last few years, how many actually ended up in refusals or in admissions.

Mr. Gary Anandasangaree: For us, it would be very helpful to have that kind of information, because that's what we are trying to determine. Would you be able to provide how many of the 84 went through the fairness process and were admitted to Canada?

Ms. Dawn Edlund: Yes.

The Chair: I need to cut you off there. I'm sorry.

Ms. Rempel and Mr. Saroya are sharing.

Hon. Michelle Rempel: Thank you.

My understanding is that there are actually two prongs to the component of excessive demand. There is the cost calculation that we've been talking about, and then there is the component around increases in wait times. Is that correct?

Ms. Dawn Edlund: Yes.

Hon. Michelle Rempel: Just to clarify, can somebody be deemed inadmissible on either of those two components, or is it combined?

Ms. Dawn Edlund: It's either of those two.

Hon. Michelle Rempel: We've spent a lot of time talking about the first component today. Could you provide the committee with a breakdown of how many people, over the last five years, let's say, have been deemed inadmissible on the first category, as opposed to the second category?

Ms. Caitlin Imrie: I would say they are often combined, whereas they are separate in the act. Often, cases actually meet the threshold and have a bearing on the wait time. We do what we can to apply that.

Ms. Dawn Edlund: You may have someone with chronic renal insufficiency, for example, who is going to require a transplant in the not-too-distant future, which would then have an impact on wait-lists.

It can be either/or, but it can be both.

Ms. Caitlin Imrie: It's often combined.

Hon. Michelle Rempel: Could you elaborate briefly on how you would determine the wait time component? What criteria are you using to evaluate that particular prong?

Dr. Arshad Saeed: The wait times are published by the provinces. They are available publicly. If we look at the wait times, we see that those are mainly for surgical operations or transplants and those kinds of cases. We look at the data available from the provinces.

Hon. Michelle Rempel: Okay.

What about mental health services and those sorts of things? Would that be considered as well, or is it typically just for surgical?

Dr. Arshad Saeed: It is typically for the surgical procedures.

Hon. Michelle Rempel: Would mental health services or care for complex or chronic conditions be included in that?

Dr. Arshad Saeed: With those services, usually one can pay for them and defray the cost, so the wait time for them is not a greater issue than it is for the surgical cases.

Ms. Dawn Edlund: The definition in the regulations about the wait times is related to whether they “would increase the rate of mortality and morbidity in Canada”. It's not just any wait-list. It's more specific than that.

Hon. Michelle Rempel: It would be acute or emergent sorts of diagnoses, then.

Dr. Arshad Saeed: That's correct.

•(1005)

Hon. Michelle Rempel: Okay, great. Thank you.

Mr. Saroya, go ahead.

Mr. Bob Saroya: Thank you.

Mr. Saeed—or anyone—we know how many cases got rejected: 930 in 2014, 713 in 2015, and 1,101 in 2016.

There must be some sort of threshold where we say, “This is on the borderline. This is not too bad. This is good. This would be good to let go. This is the final.... We're not going to allow these people to come into the country.”

With regard to these numbers, how many people were admitted to the country? Do we have some sort of numbers?

Ms. Caitlin Imrie: No. We've undertaken to come back with those numbers. These numbers represent the medical recommendation and not the final visa decision. We will actually come back with those numbers.

Mr. Bob Saroya: Mr. Saeed, when a panel recommends somebody as inadmissible, how often does the visa officer say, “Hmm, that's not too bad. I'm going to let this person go”? Is there any chance that the visa officer can reject the case from the medical officer and allow these people to come into the country?

Dr. Arshad Saeed: Ultimately, the visa officers have the discretion of making that decision. They do consider the medical officer's opinion seriously and look at that. They will often discuss it with us before making a decision if they are going to go against our recommendation.

Mr. Bob Saroya: Are there any cases that are overturned by the visa officer against the medical officer?

Dr. Arshad Saeed: Yes, they have the discretion to overturn that decision. As was said earlier, they can grant on a humanitarian and compassionate basis.

Mr. Bob Saroya: Somebody came to my office four weeks ago. I didn't even know about this thing we are discussing today. There was a medical issue, but they were not....

I don't want to tell you what country this guy is from, but his son has a number of issues. He understands the taxpayer costs and all those things. He was okay with that. I was surprised that this person was okay with this policy.

In any one of your personal opinions, does today's system work overall for the people? In your opinion, or in any of your opinions, is today's system working fine, or does the system need to be upgraded?

Any of you can respond.

Ms. Dawn Edlund: Well, we work with the legislative provisions we have and we apply the legislative provisions that we have. If the government chooses to go in a different direction and we have different legislative or regulatory provisions, we'll apply those. A matter of personal opinion isn't relevant.

Mr. Bob Saroya: It doesn't count. Okay, got it.

My next question is for Mr. Saeed.

When an individual applies to the system to come to the country, when is the time that somebody gets flagged and they say this person is not admissible? Who is the first person to flag that person and send it to your panel, or any of the panels?

Dr. Arshad Saeed: The medical is done, as we said earlier, by the panel physicians, which are designated by IRCC, but they're not IRCC positions. Once the medical is done, it is sent to one of the four regional medical offices that we have in Ottawa, New Delhi, Manila, and London. It's reviewed by the medical officers at that regional medical office, or RMO.

With most of the medicals, if they don't have a serious or significant problem, they are passed. Only the complicated cases are then sent to the specialized unit in Ottawa, which is called the centralized medical admissibility unit. We look at the file again and then make our recommendation to the visa officer. That is step one.

Then the applicant is given an opportunity to provide that mitigation plan through procedural fairness. Once that information is received by the visa officer, they send it back to us. We provide the second opinion, and the final decision is made by the visa officer.

The Chair: Thank you.

Go ahead, Ms. Kwan, for seven minutes.

Ms. Jenny Kwan: Oh, wow. Okay, great. Cool.

The Chair: It's not even your birthday. You should see what you get when it's your birthday here.

Ms. Jenny Kwan: I'm liking it more and more.

I would like to ask the officials to please confirm if the government uses Sykes Enterprises, a company based in Tampa, Florida, to determine the \$356 on social spending in determining excessive demand.

Is that correct?

• (1010)

Ms. Dawn Edlund: There was some media coverage that talked about that company recently, and there was a bit of confusion. We have a subscription to a magazine, or whatever it is they produce, and we look at that from time to time because they give us information about home care costs. To my knowledge, that information has never been part of our baselining of the social services costs, that \$356 that I referred to earlier.

Ms. Jenny Kwan: I asked earlier how the \$356 was determined so we can get a full set of information on that.

I'm going to ask another question then, which is equally important. How do we calculate the amount that the average Canadian spends in terms of social spending for people with disabilities?

Recently there was information provided to Global News by the Conference Board of Canada based on provincial public accounts. It suggests that the government does not take into account nearly \$27 billion in annual social spending by the provinces when assessing the limits for excessive demand. That number could be as high as \$40 billion if Canada's social transfer is included, or roughly \$1,105 a year per Canadian. That would mean that the \$6,655 limit for excessive demand set by the government could be at least \$7,404 if all social service spending in Canada is accurately accounted for.

I'd like to get the information from the government on how the government calculates the average Canadian's cost for those with disabilities, so we can then have assurances that the government's calculation of the average Canadian's cost is a complete set of accurate numbers.

Mr. Michael MacKinnon: Thank you for that question, because it gives a good opportunity to clarify this misrepresentation that's out there, which was reported by Global News.

As I said earlier, in our determination of excessive demand, we consider only a narrow basket of social services, and so things like social assistance, social housing, and the majority of provincial expenditures on social services, because they're not directly related to a medical diagnosis, are not calculated into the threshold, because they're not grounds for medical inadmissibility. It's solely—

Ms. Jenny Kwan: Sorry, but I'm going to interrupt there for a minute.

I wonder if you can provide the committee the information on how you calculate the average cost for a Canadian with a disability and where you get that information. If you can break that down for us, province by province, territory by territory, and how you calculate that, it would be appreciated.

Mr. Michael MacKinnon: What we can provide is the baselining for the basket of social services that we do assess. That is not a cost based on disability but is the total expenditure on those social

services that are assessed as part of excessive demand, which is then divided by the Canadian population.

Ms. Jenny Kwan: In that information, do you take into account, for example, provinces with special departments that provide for additional costs for people with disabilities?

Mr. Michael MacKinnon: We calculated the total costs as a baseline a number of years ago, in 2004, and we have been adjusting for inflation since that time.

Ms. Jenny Kwan: These figures have been used since 2004, and then you adjusted for inflation. If we can get the information, the full details on how you calculate both sets of numbers and where you get those numbers from, that would be appreciated.

Also, could you provide the committee with a complete list of medical diagnoses used to deny applicants? We're looking for the number of applicants denied in the last 10 years so that we can get a sense of what that looks like for each of the categories.

When I say each of the categories, I mean live-in caregivers, the economic class, and so on. Then for those numbers, can we get the reasons they were denied? I'm not asking for information for particular cases, but for a group, so that there's no breach of confidentiality.

• (1015)

Ms. Dawn Edlund: Mr. Chair, a written question was provided to the department, I think on October 17, that covers very much the same territory, and we're working away at producing those numbers and that analysis as requested in the written question.

I think what you've said, Ms. Kwan, mirrors what was in your written question. We will be providing that.

Ms. Jenny Kwan: Mr. Chair, I'm just wondering if the officials can give us a timeline on when we can expect to receive this information we're seeking, for the purposes of the work of this committee.

Ms. Dawn Edlund: There's a long list of things we've said we will provide to the committee, so we're going to have a lot of people working really hard on that in the coming weeks. I hesitate to say to you, "Oh, that will be two weeks", because I'm just not sure how much analytical work it's going to take to produce some of the numbers that have been asked for, but we will provide them as swiftly as we can.

Ms. Jenny Kwan: Dr. Saeed, to your knowledge, has anybody's application been denied based on excessive demand associated with a disability of deafness or blindness?

Dr. Arshad Saeed: Yes. If deafness or blindness will lead to a requirement for special services, social services for the child or for the individual, then they can potentially be denied.

Ms. Jenny Kwan: I would be very interested in looking at the information being provided on the reasons people have been denied.

For those who were denied, do you also collect this data on the basis of how much they exceeded the figure the government uses for excessive demand? Do you have that information, and if so, can you provide that to us?

Ms. Dawn Edlund: We have a snapshot of the cases we looked at—that 2014 caseload—when we were doing the analysis of the cost avoidance for the provinces and territories. We have a breakdown for 2014 of how many cases were under \$50,000 and up to over \$500,000. That is a very wide range.

The Chair: I'm afraid I need to end you there.

Go ahead, Mr. Tabbara.

Mr. Marwan Tabbara: I'll be sharing my time with Mr. Whalen.

I wanted to clarify some things on who's exempt and who may not be. As I understand the statements, refugees who are applying to Canada would be exempt, correct?

Ms. Dawn Edlund: We settle refugees, yes.

Mr. Marwan Tabbara: If a Canadian citizen applies for his or her family to come over with spouses, they're exempt.

Ms. Dawn Edlund: Yes.

Mr. Marwan Tabbara: However, in the economic class, if someone is deemed medically inadmissible, they're not exempt, correct?

Ms. Dawn Edlund: Yes.

Mr. Marwan Tabbara: I have an article here from the *Toronto Star*. A York University professor has been denied because her 13-year-old son has Down's syndrome. We have an individual who has a good profession, a professor at a university, but one of the children has a health condition, so the whole case is denied.

Is there not some way we can have a policy whereby we can see some changes and allow some leniency and acceptance to the family? I think we should measure the contributions of a family as a whole and not target one individual in the family and have the whole case denied.

Can you elaborate on that?

Ms. Dawn Edlund: Part of the fundamental policy review will cover these kinds of questions. Have we got the balance right that I spoke of earlier in trying to protect publicly funded health and social services versus the humanitarian, compassionate side, etc.? Those kinds of things will be factored in, and certainly if the committee were to make a recommendation in this regard, then that would be factored into our thinking as well.

Mr. Marwan Tabbara: Briefly, to add to that, you mentioned striking a balance. Have we been engaging with the provinces to strike that balance with them as well?

Ms. Dawn Edlund: When federal, provincial, and territorial ministers met in October of 2016, they jointly made a commitment that we would be looking at this world of medical inadmissibility because if there were to be changes and possible impacts on the provinces and territories, which administer health and social services, we wanted to make sure that we actively engaged with them. We sought their input, their feedback. That's been happening since October 2016, so that's about a year now.

• (1020)

Mr. Marwan Tabbara: Thank you.

I'll pass the remaining time to Mr. Whalen.

Mr. Nick Whalen: Thank you very much, Mr. Tabbara.

I'm trying to wrap my head around this, so thanks for teaching us.

There's a category of "a danger to public health". If someone comes forward who could be a danger to public health, their application could be delayed, in which case they would receive treatment, or it could be denied outright, presumably.

Then there is "a danger to public safety", and again, if it could be treated, it'll be treated, or they could be rejected.

Then there is this third category of "excessive demand on health or social services". Under that we have a couple of different interrelated definitions. One is being above the average health care cost threshold. The other one is the demand on health or social services that would add to existing wait lists and would increase the risk of mortality or morbidity.

I'm trying to see how this could be quantified. Do you have particular metrics that you use, and how do they interplay? In the data structure you use to assess applicants, are there particular fields within that data structure that go into whether or not this person is going to increase wait times or increase morbidity or increase mortality? Are there particular line items within the data structure for the applicants that go on these things together, and would it be easy for the department to assess family by family, rather than individual by individual, or maybe just exclude the children altogether?

I know it's a long-winded question, but maybe we can talk a little about how this data is presented to the department and stored.

Dr. Arshad Saeed: I think this question was partially answered before as well, but I'll repeat some of it again.

We look at the reports provided by the applicant and the severity of the condition and the needs for services, the frequency they require. An individualized approach is used because courts have told us again and again that you have to review the applicant individually, not on a generic or diagnosis-based assessment. We look at the diagnosis and we look at the prognosis for the next five years and what types of services are required for that particular individual.

Mr. Nick Whalen: Again, with this category, is this a definite “no”, or is this one that could be “Wait and see; delay your application until your condition isn't as severe”?

Dr. Arshad Saeed: They are provided an opportunity through procedural fairness to come back and tell us if they are going to defray the cost of these services. It's only delayed in the sense that they are given the opportunity to give us the medication plan.

Mr. Nick Whalen: Okay.

Ms. Kwan asked for a lot of information. I'd like to make sure that in there we're getting information not just on rejections but also on the people who are impacted by this test. Of all the 360,000 or 550,000 medical exams you look at, what percentage will trip the threshold of an issue or additional concerns regarding rate of mortality and morbidity? I'd like to have a sense of how often this becomes an issue for the assessment and how often an interaction has to occur as a result of that, just to make sure we get there.

With regard to families, what would the department recommend in terms of regulatory change to make sure that children aren't subject to this? Is it just these definitions, or are there other regulations we would have to look at if we were going to make children exempt from this?

Ms. Dawn Edlund: That's getting into what I referred to earlier as the awkward situation of officials speaking to policy advice that we will give to the government, so it's difficult to answer that question.

Various mechanisms can be used in redefining some of the services, redefining what excessive demand is, and creating other exempt categories. All kinds of things could be looked at as part of this.

The Chair: I need to end it there.

Hopefully, the officials will read our report, because I suspect that's what we will be giving to you. It will be exactly what Mr. Whalen is asking from you.

Next is Mr. Saroya or Mr. Maguire.

•(1025)

Mr. Bob Saroya: I just have one question, Mr. Chair.

We've been talking about fairness. In terms of fairness and in terms all these inadmissible people, all these rejected cases from 2014, 2015, and 2016, can you provide us with a list of what countries these rejected people were from, and the reasons? Is that possible?

Ms. Dawn Edlund: Yes. We've already discussed that. We have the list of the cases for which there were recommendations made by a medical officer based on services related to particular conditions. We have that list. Then we need to do the digging to see what happened next in terms of the actual cases themselves.

Mr. Bob Saroya: Does any country have zero problems bringing all their citizens here for any medical or other reasons?

Ms. Dawn Edlund: Do you mean the nationality of the applicants?

Mr. Bob Saroya: Yes.

Ms. Dawn Edlund: We did already say, I think, that we would have a look at the nationality of the applicants who've been found to be inadmissible.

Mr. Bob Saroya: Okay. Thank you.

Ms. Dawn Edlund: Off the top of my head, I can't say to you that, for example, Americans never have problems with medical inadmissibility, because I think that would be a ridiculous statement.

Mr. Bob Saroya: No problem.

Mr. Larry Maguire: In the presentation today, under the excessive demand considerations that you were talking about, you said they were “determined by a departmental officer, usually referred to as a visa or immigration officer”, and you referred to it as being opposed to what happens in the U.S. or some other countries that you mentioned. I just forget where else it was. Can you quickly elaborate on that?

Ms. Dawn Edlund: Under our legislation, the visa officers are the folks who make the decisions overseas. The immigration officers are the folks who make the decisions in Canada for people who have applied for permanent residency from within Canada. That's the distinction there.

I'm not sure about the reference to the Americans. We did talk about Australia and net benefit stuff.

Mr. Michael MacKinnon: To our understanding, the United States and the United Kingdom use an approach that is much more dependent on independent decisions by their equivalents of visa or immigration officers. They do not have a threshold-based system the way we do.

Mr. Larry Maguire: I guess that's what I was referring to.

You don't hire these positions. They are a monitoring position. Do we have offices in Canada to deal with it first on an upfront basis, or is it only after there is a concern and it comes back to the Ottawa office?

Ms. Dawn Edlund: The panel physicians are empanelled by us and assessed by us to make sure they meet our standards, and they are all over the world, including in Canada, but they are not employees of the Government of Canada.

Then we have our own medical officers, who are in four different locations: London, New Delhi, Manila, and then here in Ottawa. When only 0.2% of our cases end up clicking over into where we think there might be an issue around medical instability, that has been in a centralized medical unit for the last several years, and the medical officers who do that work are only in Ottawa.

Mr. Larry Maguire: Thank you.

You gave us the number of \$33,275 as of January 1, 2017, as the publicly funded service over five years, the average per capita cost that you use as a benchmark. That breaks down to about \$550 a month. Is it a rule or an objective that you have that the government covers that first amount of \$550 a month? I think you mentioned that if the individuals could cover the costs over and above that, they would more likely be allowed to stay as well. Is that a fair assessment?

Ms. Dawn Edlund: We don't look at it from a month-to-month cost. We look at in terms of that \$33,275 as the cost threshold. Then we see, in terms of the services that the individual would require of a health or social nature, what the cost of those services are and whether it takes you over the top in terms of the threshold. I would posit that if someone had a condition that would cost \$33,276, a dollar more, I don't think a visa officer would say, "Okay, that's it. We're done." There really are costs that are far above the cost threshold.

• (1030)

The Chair: We need to end there.

Mr. Larry Maguire: I'll just say that I noted it was an average, and that's why I was wondering.

Thank you.

The Chair: Very good.

Go ahead, Ms. Zahid.

Mrs. Salma Zahid: Thank you, Chair.

Ms. Kwan was referencing the article, the Global News story on July 4. In that report, Statistics Canada said: "With our current data sources, it would be difficult to quantify the value spent on social assistance programs targeting this specific group in the population...."

If Stats Canada doesn't think a real figure can be calculated, is it really fair to reject someone's application based on incomplete figures?

Ms. Dawn Edlund: We'll go back to the 2004 baseline activity that we engaged in.

We identified what wasn't covered in the Canadian Institute of Health Information's overall number as compared to our definitions in our regulations. Then we did a study by talking, at the time, to Statistics Canada and to Health Canada to get data from provincial officials to then come to that baseline idea of what that basket of social services is and what the costs of that are. That's the number we've been using and updating with inflation year over year. Stats Canada today may say they have difficulty doing that. Well, at the time they provided information to us as part of our baseline study that they must have been confident in.

Mr. Michael MacKinnon: To be clear, it's a bit how you ask the question. Global News asks Statistics Canada if they could quantify the total services provided to persons with disabilities, but we're not assessing it against the total cost of all services provided to persons with disabilities. We're assessing it against a specific basket of services that is specified in the regulations.

Mrs. Salma Zahid: We have talked a lot about people who are coming, whether permanent residency, the economic class, or family

reunification. I would like to get some numbers on people coming on TRVs, temporary resident visas, because when they apply, they don't have to go through medical examinations, and they don't need to submit....

Do we have some numbers? Were some people who landed in Canada rejected because the visa officer thought that they were medically inadmissible? Have there been any cases in the last few years?

Ms. Dawn Edlund: Yes, not all temporary residents have to go through immigration medical exams. There's a small subset of those—for example, individuals headed to work or study in areas where public health is very important. If someone is coming to Canada to work in the medical profession, for example, even if that's only temporarily, they will go through an immigration medical exam.

We also look at temporary residents who are coming to Canada for longer than six months if they come from a country that has a high incidence of infectious disease, such as tuberculosis. If people from those countries are coming for more than six months and they've lived continuously in that country for a year, we have them go through immigration medical exams, but there are—

Mrs. Salma Zahid: I'm talking about those people who don't have have to go through the—

Ms. Dawn Edlund: Sorry. Yes, there are people who do not go through immigration medical exams to become temporary residents and who later go through medical exams as part of the permanent residency process, and then at that point it's discovered that there's a health condition that would cause an issue from a medical inadmissibility perspective.

Mrs. Salma Zahid: I'm saying that for people coming here on a temporary resident visa for three months to visit their family—let's the parents are coming to visit their grandkids and their kids—has there been any case of those people being determined as medically inadmissible when they land in Canada?

Ms. Dawn Edlund: Not to my knowledge. They wouldn't have gone through an immigration medical exam. If they came off the plane and clearly had something that would be of concern from a public health perspective, there are quarantine provisions that would apply. I don't think that's what you're talking about.

Mrs. Salma Zahid: I will share the rest of my time with my colleague Mr. Anandasangaree.

Mr. Gary Anandasangaree: Thank you.

I'm picking up on something you said earlier with respect to the provincial nominee program. You had suggested that in one particular incident the province required an individual, and you were able to work with the province. What other ongoing conversations do you have with provinces? What kind of co-operation do you have with provinces whereby some of the rigid requirements as outlined can potentially be overridden?

•(1035)

Ms. Dawn Edlund: For privacy reasons, we don't tend to have conversations about individual cases with the provinces. I raised the example of provincial nominees because clearly those are cases the province knows about and to whom they've provided a nomination certificate, but then they become aware that there is an excessive demand angle to the file and they reach out to us.

The Chair: You can have one more quick question.

Mr. Gary Anandasangaree: Do you have ongoing conversations with the provinces with respect to the threshold? Do you have any input from them with respect to establishing a threshold?

Mr. Michael MacKinnon: The threshold is determined on a statistical basis based on national data, so it's not something that the provinces feed into. We have had conversations as part of our fundamental review with the provinces, as Ms. Edlund referred to, following the discussion at the level of the FPT ministers responsible for immigration. There have been working groups and discussions in terms of helping them to understand the provision and to understand the potential impacts that any changes might have on their systems.

The Chair: Thank you.

Go ahead, Ms. Rempel.

Hon. Michelle Rempel: Thank you.

Just to clarify, right now the medical inadmissibility category is not applied, for example, to people who are coming in as government-sponsored refugees. Is that correct?

Ms. Dawn Edlund: That's correct.

Hon. Michelle Rempel: Yes, because they would already be getting a permanent resident status. Do we track, within the government-sponsored refugee class, the utilization of Canada's health care service at all, at the federal level?

Ms. Dawn Edlund: For government-sponsored refugees who come into Canada, such as the Syrians, for example, they are landed as permanent residents—

Hon. Michelle Rempel: Right.

Ms. Dawn Edlund: —so they have an automatic qualification for provincial health services, but then our interim federal health program tops up health care services that they are not covered for under, say, OHIP.

Hon. Michelle Rempel: That's for how long?

Ms. Dawn Edlund: It's for a period of a year—

Hon. Michelle Rempel: It's a period of a year, but then—

Ms. Dawn Edlund: —while we're giving them the income support.

Hon. Michelle Rempel: Okay. After that point, there isn't any more top-up, correct?

Ms. Dawn Edlund: Yes.

Hon. Michelle Rempel: Ostensibly, if this committee is looking at recommendations around whether or not to change the formula for medical inadmissibility or whatnot, obviously cost and burden on the health care system in the provinces is going to be a consideration. Do you think it would be possible to provide the committee with some

sort of estimate or analysis on the estimated increase in cost past year one for, let's say, the Syrian refugee cohort?

For my colleagues opposite, my line of thinking is this. If we're going to look at amending the formula or recommending that it be amended, we have to also look at.... If the government is going to take in larger cohorts of government-sponsored refugees in shorter periods of time, we have to think about the cost to the health care system that compounds over that period.

Would it be possible to get some of that data to include in our report?

Ms. Dawn Edlund: I'll start, and then Michael can jump in.

Hon. Michelle Rempel: Okay.

Ms. Dawn Edlund: We really don't have a great line of sight on what Syrian refugees may use after our interim federal health top-up stops.

Hon. Michelle Rempel: Okay.

Ms. Dawn Edlund: We are working on information-sharing agreements with the provinces to try to get information about social service usage, health services, educational services, employment stuff writ large, but that has nothing to do with medical inadmissibility.

Hon. Michelle Rempel: Since you lack that data, could you provide us with the data that you do have for the utilization and top-up for year one?

Ms. Dawn Edlund: Yes.

Hon. Michelle Rempel: Okay. That would be fantastic.

The Chair: I'm going to caution the member to make sure we stay within the scope of this study.

Hon. Michelle Rempel: I was laying out my logic specifically for that reason, because we're looking at overall costs.

Going back to my previous line of questioning around the demand on wait times, has it always been applied only to surgical or acute conditions? Has there been any thought of looking at the definition of potential wait times? For mental health services or other chronic medical support, we know there are long wait times. Has there been any discussion in your consultation around expanding or reducing the definition for the burden on wait times?

•(1040)

Ms. Dawn Edlund: That's getting into the policy discussion angle again, but if there were to be such a discussion, and recommendations or decisions were made, we would need to be amending the regulations. Our wait times are only in relation to mortality and morbidity. A mental health issue and a mental health wait time isn't one that's going to run into that mortality and morbidity issue.

Hon. Michelle Rempel: If somebody presented with significant mental health support requirements, right now that wouldn't be considered in the medical inadmissibility determination.

Ms. Dawn Edlund: It wouldn't be considered in relation to the wait time.

Hon. Michelle Rempel: What about the cost?

Ms. Dawn Edlund: In terms of the cost, if it's a mental health issue that causes someone to be violent, for example, then that would come into the public danger angle.

Hon. Michelle Rempel: Great.

Larry or Bob, did you have any other questions?

Mr. Larry Maguire: No.

Hon. Michelle Rempel: Okay, I think we're done.

The Chair: Mr. Sarai is next.

Mr. Randeep Sarai: What occurs when new information is brought forward by an applicant? What mechanisms are in place to reopen an application if it's been denied based on a medical opinion? Is there a way to reassess it?

Ms. Dawn Edlund: You mean if the case has actually been refused?

Mr. Randeep Sarai: Yes, or it could be that the medical officer originally ruled that it passed the \$33,000 threshold and somebody now has new evidence. For example, if they're going through chemo or cancer treatment and now they're past that, or perhaps they're on a spectrum of autism and it's now managed better and they don't need these services as much, what would be the procedure?

Dr. Arshad Saeed: An application is sent to the medical officer by the visa officer, and we look at the validity of that information. If the treatment required for that person is completed and it is no longer going to exceed the cost threshold for the next five years, they can be admissible. An example would be somebody with hepatitis C. The treatment for that is very expensive, about \$70,000 to \$80,000, but it only lasts 12 weeks, and they're deemed cured after that. They can submit documentary evidence that they have gone through that treatment in their country and provide lab reports to confirm it. We can then send our new opinion back to the visa officer.

Mr. Randeep Sarai: I know of a situation of a child who required some special needs for schooling, and the father said he would pay for private schooling that offered those services. This is something I believe he was refused on. Is there a bond requirement when somebody commits to giving services in Canada, or is it just the ability to show sufficient financial means? What's the requirement when somebody offers to mitigate the cost to Canada or to just pay the cost himself? Is there a possibility of doing a bond? I don't think there is at this time. Is there any other way for someone to show that they would mitigate the cost to Canada?

The Chair: Be very brief.

Ms. Dawn Edlund: That would be part of the mitigation plan that the family would put forward. They would say, "We won't access these services, because we will do X, Y, or Z instead." Our medical officers will look at that and evaluate whether it is a practical plan. If, for example, they said, "We won't access special education services because we won't send our child to school at all", we would say that

is not a plan, in terms of overall Canadian morals, that we would find acceptable.

In terms of the mitigation plans themselves, if that then turns the switch off with regard to the medical inadmissibility concerns, we have no authority to enforce that mitigation plan once someone becomes a permanent resident.

The Chair: I'm going to turn to Ms. Kwan for one minute.

• (1045)

Ms. Jenny Kwan: I have one minute?

The Chair: We're at the end of the meeting.

Ms. Jenny Kwan: Okay. Thank you.

I want to clarify something. On the question of collecting data and providing the data back to the committee for the people who don't qualify based on the amount by which they exceed the acceptable government rate of excessive demand, can we have that number broken down by increments of \$500? Rather than getting the information to say that within \$50,000 they exceeded this amount and so they don't qualify, could you instead provide the smaller amounts so that we can get a fuller sense of who's being rejected in smaller increments?

I know of one case in which an immigration lawyer came forward to say that her client was rejected because the client exceeded the amount by \$400, so I would like to see by how much the people who are being rejected are exceeding the amount.

The Chair: Thank you.

That draws our meeting to a close.

As this meeting has progressed, my sense has been that probably for each of you new questions have arisen, questions you didn't have before this briefing.

For each party, if you have a new suggestion for a witness you would like to hear from because of the testimony we've heard today, we will entertain that. There are some issues on which maybe Stats Canada has been referenced here, and we haven't had a witness from there. We've had some provincial nominee issues raised. I think new requests for witnesses based on this testimony would be helpful, because a lot has been raised today.

Go ahead, Ms. Kwan.

Ms. Jenny Kwan: Thank you very much, Chair, for that. We appreciate it.

On that score, I think one of the officials mentioned that the minister was going to be coming to this committee on this issue. If that's the case, I wonder if the committee could get the information that we requested prior to the minister's arrival, because it would be useful and helpful to have that information so that we're not tempted to repeat our questions to the minister.

The Chair: Absolutely. For fear of changing the definition of excessive demand, in light of what we've given to the officials to do today, we'll work out a timeline regarding what's reasonable in terms of their ability to give us that information. We may need to adjust our study time, because we've asked for an awful lot of information today. I will work with the clerk and the analysts on a timeline.

My instinct is that now that we've heard from the officials, it is now time to truly scope the study. I think we now have an idea of what is involved in this study.

We're going to take a breather. We've invited provincial officials to come in on Thursday. We haven't had an overwhelming response, so stay tuned on that. We have the report next week, and then the Yazidis study, so we have a little bit of time to let the officials have a chance to get back to us. Then we'll look at where we are.

Members, if you would each think about anything from today's testimony that you think we need someone from civil society or another official from a different department to come to talk on, we'll entertain that idea.

Until we see each other again, the meeting is adjourned.

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