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REFUGEE CLAIMANTS, OHIP ELIGIBILITY, AND EQUALITY

STEVE SANSOM

RÉSUMÉ

Depuis le 1^{er} avril 1995, on a modifié la définition de «résident» en vertu de la *Loi sur l'assurance-santé*. En effet, les demandeurs de statut de réfugié qui vivent en Ontario ne peuvent plus bénéficier de la couverture du Régime d'assurance-maladie de l'Ontario (RAMO). Dans cet article, on se demande si la nouvelle définition de «résident» est conforme avec les dispositions de la *Loi canadienne sur santé* qui, selon le cas, pourrait forcer la province à modifier sa définition ou à renoncer à des paiements de transfert du gouvernement fédéral dans le cadre des paiements de transfert de santé et sociaux du Canada. De plus, dans cet article, on soutient qu'en refusant d'accorder aux demandeurs de statut de réfugié la même couverture en soins de santé qu'aux autres personnes qui vivent en Ontario, on enfreint l'article 15 de la Charte canadienne des droits et libertés qui porte sur un accès équitable garanti et qu'on ne saurait justifier par l'article 1.

The moral test of government is how it treats those who are in the dawn of life, the children; those who are in the twilight of life, the aged; and those who are in the shadows of life — the sick, the needy and the handicapped.¹

INTRODUCTION

On March 31, 1994, Ontario Health Minister Ruth Grier announced changes to the Ontario Health Insurance Plan (OHIP) eligibility rules.² Many people living in Ontario whom the government described as “temporary residents” ceased to be eligible for health care coverage, and a three month residency requirement was

* Copyright © 1996 Steve Sansom. Steve Sansom is a third year law student at the University of Toronto. This paper was originally written for the Intensive Poverty Law Program of Osgoode Hall Law School at Parkdale Community Legal Services, Winter Term 1996.

1. Former U.S. Vice-President Hubert Humphrey, quoted in M. Valpy, “Thoughts on a Winding Corner” *The Globe and Mail* (29 March 1996) A21.
2. The initial change came in the form of O. Reg. 490/94, made July 20, 1994, amending R.R.O. 1990, Reg. 552 [hereinafter Reg. 552]. Refugee claimants became ineligible following the enactment of O. Reg. 87/95, made February 22, 1995.

introduced before coverage begins for otherwise qualified applicants. Refugee claimants resident in Ontario were no longer eligible for OHIP following a one year transition period, at which time the federal government assumed responsibility for their health care costs under the Interim Federal Health Plan (IFH).³

The federal plan provides much less comprehensive coverage than OHIP. Only “emergency and essential health care”⁴ is covered. In addition, the coverage is not universal. In order to qualify, individuals must demonstrate that they have insufficient funds to pay for their own health care.⁵

By its actions, the government of Ontario has created a class of people, physically present in Ontario and legally entitled to remain, who do not receive the same level of health care as is provided to the majority of the population. In this article, it will be argued that this policy is inconsistent with the *Canada Health Act*,⁶ and further that it violates the equality guarantee of section 15 of the *Canadian Charter of Rights and Freedoms*⁷ and cannot be justified under section 1.

The effect of the change in OHIP regulations is not limited to refugee claimants.⁸ However, in order to provide some focus to this paper, it will be assumed throughout that the individual challenging the legislation is a refugee claimant. Therefore the deleterious effects of the legislation will be examined from the perspective of a refugee claimant.

I. THE HISTORY AND NATURE OF THE AMENDMENTS

The statutory authority for OHIP is the *Health Insurance Act*.⁹ Subsection 11(1) states that:

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3. "OHIP Eligibility Fact Sheet", July 8, 1994; "Fact Sheet – Health Insurance Coverage For Refugees" (circa March 1995).
 4. Citizenship and Immigration Canada, *Operations Memorandum IP 95-06* (revised 14 July 1995) at 5 [hereinafter *Operations Memorandum*].
 5. *Ibid.* at 1.
 6. R.S.C. 1985, c. C-6, s. 2.
 7. Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 [hereinafter *Charter*].
 8. In a statement to the Legislature, Ontario, Legislative Assembly, *Official Report of Debates (Hansard)*, (31 March 1994) at 5322, [hereinafter *Statement to the Legislature*] the Honourable Ruth Grier, Minister of Health, estimated the change in the definition of a resident would affect 66,000 people who were in the province at that time, of whom 28,000 were refugee claimants. The three month waiting period for a new resident to receive benefits, introduced at the same time, would affect an additional unspecified number of Ontarians.

Every person who is a resident of Ontario is entitled to become an insured person upon application therefor to the General Manager in accordance with this Act and the regulations.

Prior to April 1, 1994, "resident" was defined in section 1 of the Act:

"resident" means a person who is legally entitled to remain in Canada and who makes his or her home and is ordinarily present in Ontario, but does not include a tourist, a transient or visitor to Ontario, and the verb has a corresponding meaning.

This definition was interpreted by the OHIP General Manager and by the Health Services Appeal Board to include refugee claimants and others, such as foreign students, who had temporary permission to remain in Canada and made Ontario their home for that period.¹⁰

Effective April 1, 1994, this definition of resident was repealed¹¹ and section 1.1 was added to Reg. 552:

- 1.1 (1) For the purposes of the Act, "resident" means an individual,
- (a) who is present in Ontario by virtue of an employment authorization issued under the Caribbean Commonwealth and Mexican Seasonal Agricultural Workers Programme administered by the federal Department of Citizenship and Immigration; or
 - (b) who is ordinarily resident in Ontario and who is one of the following:
 1. A Canadian citizen or a landed immigrant under the *Immigration Act* (Canada).
 2. A person who is registered as an Indian under the *Indian Act* (Canada).
 3. A Convention refugee as defined in the *Immigration Act* (Canada).
 4. A person who has submitted an application for landing under the *Immigration Act* (Canada), who has not yet been granted landing and who has been confirmed by the federal Department of Citizenship and Immigration as having satisfied the medical requirements for landing.

9. R.S.O. 1990 c. H. 6.

10. *In the Matter of a Hearing under s. 20(1)(a) of the Health Insurance Act between Ian Clarken and the General Manager*, cf. note 23, *The Ontario Health Insurance Plan* (11 March 1996, H.S.A.B.) at 11–13 [hereinafter *Clarken*].

11. S.O. 1994, c. 17, s. 68(2) repealed the definition of resident and substituted the following:
 "resident" means a resident as defined in the regulations and the verb "reside" has a corresponding meaning.

5. [revoked]¹²
6. A person who has finalized a contract of employment or an agreement of employment with a Canadian employer situated in Ontario and who, at the time the person makes his or her application to become an insured person, holds an employment authorization under the *Immigration Act* (Canada) which,
 - i. names the Canadian employer,
 - ii. states the person's prospective occupation, and
 - iii. has been issued for a period of at least six months.
7. The spouse or dependent child under the age of 19 years of a person referred to in paragraph 6 if the Canadian employer provides the General Manager with written confirmation of the employer's intention to employ the person referred to in paragraph 6 for a period of three continuous years.
8. A member of the clergy of any religious denomination who has finalized an agreement of employment to minister on a full-time basis to a religious congregation in Ontario for a period of not less than six continuous months and whose duties will consist mainly of preaching doctrine, presiding at liturgical functions and spiritual counselling.
9. The spouse and dependent children under the age of 19 years of a member of the clergy referred to in paragraph 8 if the religious congregation provides the General Manager with written confirmation that it intends to employ the member for a period of at least three consecutive years.
10. A person granted a minister's permit under section 37 of the *Immigration Act* (Canada) which indicates on its face that the person is a member of an inadmissible class designated as case type 86, 87, 88 or 89, or, if the permit is issued for the purpose of an adoption by an insured person, as case type 80.
11. A person granted an employment authorization under the Live-in Care Givers in Canada Programme or the Foreign Domestic Move-

12. Prior to the enactment of O. Reg. 87/85, paragraph 5 read:

5. A person who has made a claim to be a Convention refugee under the *Immigration Act* (Canada) and in respect of whom,
 - i. a senior immigration officer has determined that the person is eligible to have his or her claim determined by the Refugee Division, and
 - ii. a removal order, as defined in the *Immigration Act* (Canada), has not been executed.

ment administered by the federal Department of Citizenship and Immigration.

- (2) For the purposes of subsection (1), a person is ordinarily resident in Ontario only if,
- (a) in the case of an insured person or of a person who comes to Ontario from another province or territory in which that person was insured by the provincial or territorial health insurance authority, the person,
 - (i) makes his or her permanent and principle home in Ontario, and
 - (ii) is present in Ontario for at least 183 days in any twelve-month period; and
 - (b) in the case of a person who is applying to be an insured person for the first time or who is re-establishing his or her entitlement after having been uninsured for a period of time, other than a person who comes to Ontario from another province or territory in which that person was insured by the provincial or territorial health insurance authority, the person,
 - (i) intends to make his or her permanent and principle home in Ontario, and
 - (ii) is present in Ontario for,
 - (A) at least 183 days in the twelve-month period immediately following the application, and
 - (B) at least 153 of the 183 days immediately following the application.

At the same time, subsection 3(3) of Reg. 552 was amended to impose a three-month waiting period before OHIP benefits accrue to a new resident other than a newborn born in Ontario to an insured person or certain other new residents.¹³ Interestingly, one of the groups exempt from the three-month waiting period is refugee claimants, and this exemption was not removed when refugee claimants became ineligible for OHIP.

II. ARE THE NEW AMENDMENTS CONSISTENT WITH THE CANADA HEALTH ACT?

The government of Ontario takes the position that the above definition of resident is consistent with that contained in the *Canada Health Act*:

13. O. Reg. 491/94, made July 20, 1994, s. 2.

“resident” means, in relation to a province, a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province¹⁴.

(A) Previous Judicial Interpretations of “Resident”

The judicial interpretation of the word “resident” differs depending on the purpose of the definition in the context of the impugned statute. Thus, the word resident has a different meaning for immigration purposes, for income tax purposes, and for health care purposes. There are two reported cases which interpret the definition of resident for the purpose of provincial health coverage. In both cases, the provincial statute at issue contained a definition of resident substantially the same as the one in the *Canada Health Act*.

In *Hernadi v. British Columbia (Minister of Health)*,¹⁵ McLachlin J.A. (as she then was) held for the court that persons in British Columbia who hold student visas, although visitors for the purpose of the *Immigration Act*,¹⁶ are eligible residents of B.C. for the purposes of the *Medical Service Act*¹⁷ and the *Hospital Insurance Act*.¹⁸ She based her interpretation on two grounds. First, the *Medical Service Act* also refers to a “permanent resident.” If the definition of “resident” excluded those with temporary authorization to remain in Canada, it would have the same meaning as “permanent resident.” By the principle of statutory interpretation that different words in the same statute must mean different things, “resident” must mean something different than “permanent resident” in the *Medical Service Act*.¹⁹

Her second, and I believe stronger, ground, is that if “resident” does not include persons with temporary immigration authorizations, it would be restricted to persons entitled “to remain” in Canada. This would render the words “to be” in the definition of resident meaningless, “violating the canon of statutory construction that every provision of an Act should, if possible, be given meaning.”²⁰ Thus, the *Medical Service Act* entitles two classes of B.C. residents to health

14. *Canada Health Act*, *supra*, note 6, s.2.

15. (1986), 34 D.L.R. (4th) 145 (B.C.C.A.) [hereinafter *Hernadi*].

16. R.S.C. 1985, c. I-2.

17. R.S.B.C. 1979, c. 255.

18. R.S.B.C. 1979, c. 180.

19. *Hernadi*, *supra*, note 15 at 148–49.

20. *Ibid.* at 149–50.

care benefits: those entitled to make their home in Canada permanently, and those entitled to make their home in Canada temporarily.

In *Manassian v. Alberta (Minister of Health)*,²¹ the opposite conclusion was reached. Murray J. held that the *Alberta Health Care Insurance Act*²² did not entitle a refugee claimant to health care benefits. Murray J. took the position that since the Act provided that one of the conditions of residence is that the person must be "entitled to be or to remain in Canada," that the list of persons in s. 4 of the *Immigration Act* who "have a right to come into or remain in Canada" was determinative. Since refugee claimants do not come within s. 4 of the *Immigration Act*, Murray J. concluded that they are not "lawfully entitled to be or to remain in Canada," and therefore not residents. He distinguished *Hernadi* by noting that in that case it was conceded that holders of visitor's visas are lawfully in Canada, and therefore capable of being residents of B.C.

There are two arguments against this reasoning. First, while it is clear from the *Immigration Act* that refugee claimants do not have the "right" to remain in Canada, by the implication of s. 5 they are granted that "privilege" until their claim is finally determined. It could be argued that one who has the "privilege" of remaining in Canada is "entitled" to remain in Canada. Second, the *Immigration Act* is silent on the question of who has the right "to be" in Canada. It is therefore of no assistance in determining who is "entitled to be" in Canada. If every word in the *Alberta Health Care Insurance Act* is to be given independent meaning, the class of persons entitled to be in Canada for the purpose of that Act must be broader than the class of persons with a right to remain in Canada for the purpose of the *Immigration Act*. If that is accepted, the only sensible interpretation is that persons who enjoy the privilege of remaining in Canada temporarily are "entitled" to be here for that time.

(B) Implications of Inconsistency With the Canada Health Act

There is no reported case in which a court has considered whether either the old or the new OHIP definition of resident is consistent with that of the *Canada Health Act*. The Health Services Appeal Board has interpreted the definition of resident in several cases,²³ but I am not aware of any in which the validity of

21. (1990), 65 D.L.R. (4th) 744 (Q.B.) [hereinafter *Manassian*].

22. R.S.A. 1980, c. A-24.

23. For example, *Clarcken, supra*, note 10; *In the Matter of a Hearing under s. 20(1)(a) of the Health Insurance Act Between Laura Horvat and the General Manager, the Ontario Health Insurance Plan* (10 August 1995, H.S.A.B.); *In the Matter of a Hearing under s. 20(1)(a) of the Health Insurance Act Between Michael David Shear and the General Manager, the Ontario Health Insurance Plan* (19 June 1992, H.S.A.B.).

the definition has been challenged on this basis.²⁴ Note that the old definition under the *Health Insurance Act* was restricted to those legally entitled “to remain” in Canada, whereas the *Canada Health Act* definition includes those lawfully entitled “to be or to remain” in Canada. Although the old definition of resident may have been inconsistent on its face, in practice it was interpreted to include those with temporary entitlement to be in Canada who made their home and were ordinarily present in Ontario.²⁵

The new definition clearly is not intended to be interpreted in such a manner, and has not been. However, an individual OHIP applicant would have to apply for leave of the court to litigate this issue in the public interest.

In *Finlay v. Canada (Minister of Finance)*,²⁶ a welfare recipient sought a declaration that the recovery of certain overpayments under the *Manitoba Social Allowances Act*²⁷ violated the provisions of the *Canada Assistance Plan*²⁸ and that the transfer payments to Manitoba under the Plan were therefore illegal, and for an injunction to halt those transfer payments. The Supreme Court of Canada held that Finlay did not have a direct interest in the sense that he would not necessarily gain any advantage if his action succeeded, because it “cannot be asserted for a certainty” that if the transfer payments were declared to be illegal or even enjoined that the province would change their overpayment recovery policy.²⁹ The court did grant him public interest standing, and held that the test for public interest standing to challenge the validity of a statute on constitutional grounds also applies to cases of “administrative validity”:

[T]o establish status as a plaintiff in a suit seeking a declaration that legislation is invalid, if there is a serious issue as to its invalidity, a person need only show that he is affected by it directly or that he has a genuine interest as a citizen in the validity of the legislation and that there is no other reasonable and effective manner in which the issue may be brought before the Court.³⁰

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24. In *Clarken, ibid.*, the new definition was challenged on the basis of inconsistency with sections 7 and 15 of the *Charter* and with the *Ontario Human Rights Code*, R.S.O. 1990 c. H-19.
 25. *Ibid.* at 11–13.
 26. [1986] 2 S.C.R. 607 (*sub nom. Canada (Minister of Finance) v. Finlay*), 33 D.L.R. (4th) 321 [hereinafter *Finlay* cited to S.C.R.].
 27. R.S.M. 1970, c. S160.
 28. R.S.C. 1985, c. C-1, repealed S.C. 1995, c. 17, s. 32 [hereinafter CAP].
 29. *Finlay, supra*, note 26 at 623.
 30. *Ibid.* at 626, quoting *Minister of Justice of Canada v. Borowski* [1981] 2 S.C.R. 575, 130 D.L.R. (3d) 588.

Assuming standing were granted and the (Federal) court adopted the reasoning in *Hernadi* over that in *Manassian*, it is open to the Ontario government to adopt a definition of resident which is inconsistent with the *Canada Health Act*, if it is prepared to forego the benefits which compliance with that Act confers. Given recent amendments to federal legislation and spending policies, it may continue to become easier for a province to contemplate foregoing those benefits.

In order to qualify for a cash contribution from the federal government under the *Canada Health Act*, a province must satisfy the criteria of universality, that is, entitle all residents³¹ to equal access to health care.³² Prior to April 1, 1996, these cash contributions were made under CAP. Since April 1, 1996, the contributions have been made under the *Canada Health and Social Transfer*.³³ While CAP was a straight cash transfer, the CHST consists of "a federal income tax reduction that would enable the provinces to impose their own tax measures without a net increase in taxation" and a cash transfer.³⁴ Over time, it is envisaged that the actual cash transfer will decrease.³⁵ At present, the transfer is still significant enough to ensure provincial compliance with the *Canada Health Act* criteria. If federal spending on health care continues to decline, eventually a *Charter* challenge may be the only way to constrain the Ontario government.

III. THE *CHARTER* – SECTION 15

Section 15(1) of the *Charter* states that:

Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.³⁶

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31. Subject to four exceptions listed in s. 2, including a minimum period of residence not exceeding three months which may be imposed by a province before eligibility commences. The other exceptions are not relevant to this article.
 32. *Canada Health Act*, *supra*, note 6, ss. 7 and 10.
 33. Created in Part V of the *Federal-Provincial Fiscal Arrangements Act*, R.S.C. 1985, c. F-8, ss. 13–25 [hereinafter CHST].
 34. *Ibid.* s.13.
 35. By 1998, it is expected that federal funding will decrease by 15% of its 1995 level (about \$7 billion): C.M. Scott, "Covenant Constitutionalism and the Canada Assistance Plan" (1995) 6 *Constitutional Forum* 79 at 80.
 36. *Charter*, *supra*, note 7.

The first pronouncement on this section by the Supreme Court of Canada was in *Law Society of British Columbia v. Andrews*,³⁷ in which McIntyre J. held that the prohibited grounds of discrimination are not limited to those listed in section 15, but include grounds analogous to them. He stated the test for a violation of s. 15 as follows:

The third or “enumerated and analogous grounds” approach most closely accords with the purposes of s. 15. ... However, in assessing whether a complainant’s rights have been infringed under s. 15(1), it is not enough to focus only on the alleged ground of discrimination and decide whether or not it is an enumerated or analogous ground. ... A complainant under s. 15(1) must show not only that he or she is not receiving equal treatment before and under the law or that the law has a differential impact on him or her in the protection or benefit accorded by law but, in addition, must show that the legislative impact of the law is discriminatory.³⁸

[D]iscrimination may be described as a distinction, whether intentional or not but based on grounds relating to personal characteristics of the individual or group, which has the effect of imposing burdens, obligations, or disadvantages on such individual or group not imposed upon others, or which withholds or limits access to opportunities, benefits, and advantages available to other members of society.³⁹

Thus, a claimant must show first that the law creates a distinction or has a differential impact, and second, that that distinction or differential impact creates a burden. If the discrimination is on an enumerated ground, this completes the analysis. If it is necessary to show that the ground of distinction is analogous, a claimant must go further:

The inquiry, in effect, concentrates upon the personal characteristics of those who claim to have been unequally treated. Questions of stereotyping, of historical disadvantage, in a word, of prejudice, are the focus ...⁴⁰

In *Andrews*, the court found that citizenship was an analogous ground. Wilson J. gave some further indications of why non-citizens receive the protection of s. 15(1) of the *Charter*:

Relative to citizens, non-citizens are a group lacking in political power and as such vulnerable to having their interests overlooked and their rights to

37. [1989] 1 S.C.R. 143, 56 D.L.R. (4th) 1 [hereinafter *Andrews* cited to S.C.R.].

38. *Ibid.* at 182.

39. *Ibid.* at 174.

40. *Ibid.* at 180, quoting *Smith, Kline & French Laboratories v. Canada (Attorney General)*, [1987] 2 F.C. 359 at 368–69.

equal concern and respect violated. They are among "those groups in society to whose needs and wishes elected officials have no apparent interest in attending."⁴¹

(A) Status to Invoke the Charter

Applying the s. 15 test to this case, a threshold question is whether a refugee claimant has status to invoke the protection of the *Charter*. In *Singh v. Minister of Employment and Immigration*, the Supreme Court of Canada held that the word "everyone" in s. 7 includes "every human being who is physically present in Canada and by virtue of such presence amenable to Canadian law,"⁴² and not simply citizens or permanent residents. The words "every individual" in s. 15 should be interpreted similarly, and thus extend to refugee claimants.

(B) Step I: Is there a distinction or a differential impact?

The definition of resident in Reg. 552 distinguishes between persons ordinarily resident in Ontario who are (a) members of a group listed in s. 1.1(b) of the Regulation, and (b) not members of those groups.

(C) Step II: Is the distinction discriminatory?

All of the criteria in section 1.1 are related to immigration status, which is a personal characteristic. The distinction imposes the burden, obligation or disadvantage of having to pay for medical care, or of receiving a more limited provision of health care (through IFH, or emergency care from hospitals or Community Health Clinics). Alternatively stated, the distinction withholds or limits access to the benefit or advantage of having health care provided by the government. Therefore, the distinction made by the regulation is discriminatory.

In *Egan v. Canada*, L'Heureux-Dube J. noted that:

[T]he Charter is not a document of economic rights and freedoms. Rather, it only protects "economic rights" when such protection is necessarily incidental to protection of the worth and dignity of the human person (i.e. necessary to the protection of a "human right").⁴³

What is at issue here is that a benefit is being provided by the state to some individuals but not to others in a discriminatory manner. This is not affected by the fact that the benefit has a monetary value. More is at stake than mere

41. *Ibid.* at 152.

42. [1985] 1 S.C.R. 177 at 202, 17 D.L.R. (4th) 422, Wilson J. [hereinafter *Singh* cited to S.C.R.].

43. [1995] 2 S.C.R. 513 at 555-56, (1995) 124 D.L.R. (4th) 609 [hereinafter *Egan* cited to S.C.R.].

“economic rights”, and this will be further discussed below in the section on proportionality.

Note also that in *Miron v. Trudel*⁴⁴ and *Egan*, four members of the Supreme Court of Canada would have limited the scope of s. 15 protection by requiring that, in order for a finding of discrimination to be made, the ground of distinction be irrelevant to the purposes of the legislation. Thus if immigration status were relevant to the purpose of the *Health Insurance Act*, there would be no s. 15 violation. That approach has been vigorously resisted by the majority of the court, and criticized in the literature.⁴⁵

(D) Step III: Is the discrimination on the basis of a prohibited ground?

There are two ways of characterizing the group which is discriminated against. One is to say that since refugee claimants are excluded from the list of potential residents in s. 1.1, the definition discriminates against refugee claimants. The other way is to assert that the list discriminates on the basis of national origin, in that persons born in Canada automatically receive Canadian citizenship and come within s. 1.1(1)(b)(1) of the Regulation, whereas persons born outside of Canada only qualify for OHIP if they fall within one of the listed categories.

As discussed below, the way the group is characterized will affect the appropriate remedy (if the list is discriminatory because it does not include refugee claimants, they should be “read in” to the list; if it discriminates on the basis of national origin then no amount of reading in of discrete groups will save it). If the goal is to return to the pre-April 1994 definition of resident, the national origin approach is preferable.

Note that not everyone born outside of Canada is discriminated against by the definition — some will be citizens or permanent residents, others will fit within the other listed categories. But it is well settled that it is not necessary that the regulation create a burden on all members of the group to discriminate against that group.⁴⁶

If the group is to be characterized as refugee claimants, it must be shown that they constitute an analogous ground. In *Andrews*, the Supreme Court of Canada

44. *Miron v. Trudel*, [1995] 2 S.C.R. 418, (1995) 124 D.L.R. (4th) 693.

45. See for instance J. Keene, “Discrimination in the Provision of Government Services and s. 15 of the Charter: Making the Best of the Judgements in *Egan*, *Thibaudeau*, and *Miron*” (1995) 11 J.L. & Soc. Pol’y 107 at 112–18.

46. See for instance *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519 at 556; *Brooks v. Canada Safeway Ltd.*, [1989] 1 S.C.R. 1219 at 1247; *Janzen v. Pharos Restaurant*, [1989] 1 S.C.R. 1252 at 1288–89.

held that citizenship is an analogous ground upon which discrimination is prohibited:

The rights guaranteed in s. 15(1) apply to all persons whether citizens or not. ... Non-citizens, lawfully permanent residents of Canada are — in the words of the U.S. Supreme Court — a good example of a “discrete and insular minority” who come within the protection of s. 15.⁴⁷

In *Andrews*, the disadvantaged group in question was permanent residents. In this case, the disadvantaged group is refugee claimants who are neither citizens nor permanent residents. The remarks of McIntyre and Wilson JJ. about the disadvantaged status of permanent residents are equally applicable to refugee claimants, if not more so. Refugee claimants are a vulnerable group lacking in political power. In fact, since as noted above a permanent resident has a right to remain in Canada, while a refugee claimant is merely extended that privilege temporarily, a refugee claimant is arguably more vulnerable to arbitrary government measures than a permanent resident.

Thus, a good case can be made for extending *Andrews* to add refugee claimants to the list of groups against which section 15 prohibits discrimination. On this reasoning, or on the basis of national origin, Reg. 552 violates s. 15 of the *Charter*. It remains to be seen whether the violation can be justified under s. 1.

IV. SECTION 1

Section 1 of the *Charter* states that:

The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.⁴⁸

(A) *The Standard of Justification*

The test for justification was set out in *R. v. Oakes*:

First, the objective, which the measures responsible for a limit on a Charter right or freedom are designed to serve, must be “of sufficient importance to warrant overriding a constitutionally protected right or freedom”. ... Second, once a sufficiently significant objective is recognized, then the party invoking s. 1 must show that the means chosen are reasonable and demonstrably justified. This involves “a form of proportionality test.”⁴⁹

47. *Supra*, note 37 at 183 [references omitted].

48. *Charter, supra*, note 7.

49. [1986] 1 S.C.R. 103 at 138–39, 26 D.L.R. (4th) 200 [hereinafter *Oakes* cited to S.C.R.].

In some later decisions, the court has suggested that the standard of justification might be lower if the legislation relates to the provision of a social service or a balancing of interests, rather than a direct conflict between the individual and the state. In *Irwin Toy Ltd. v. Quebec (Attorney General)*:

Where the legislature mediates between the competing claims of different groups in the community ... [i]f the legislature has made a reasonable assessment as to where the line is most properly drawn, especially if that assessment involves weighing conflicting scientific evidence and allocating scarce resources on this basis, it is not for the court to second guess.⁵⁰

However more recently in *Egan*, four members of the court rejected a more deferential approach. Iacobucci J. (Cory and McLachlin JJ. concurring) wrote in dissent:

... [Justice Sopinka] finds this violation to be justifiable in a free and democratic society under s. 1. In reaching this conclusion, he relies heavily on select passages from this court's judgment in *McKinney v. University of Guelph*. ... These passages from *McKinney* may seem to support the extremely deferential approach to s. 1 adopted by Sopinka J. However, a close examination of the *McKinney* decision reveals that La Forest J.'s comments therein can be said to be limited to Charter review of provincial human rights legislation governing private relations only ...

Furthermore, I find that the context of *McKinney* is wholly distinguishable from the present appeal. This appeal involves a closely held personal characteristic (potentially only shared by a minority) upon which a distinction is drawn without the array of competing interests that animated the s. 1 analysis in *McKinney*. The only competing interest in the case at bar is budgetary in nature.⁵¹

Moreover, the comments of Sopinka J, which were approved by Lamer C.J. and La Forest, Gonthier and Major JJ. on the s. 1 issue, seem to suggest that this increased deference would only be appropriate where the government has made some incremental attempt to address a social problem, and envisages social benefits gradually being extended to include larger segments of society:

... [G]overnment must be accorded some flexibility in extending social benefits and does not have to be proactive in recognizing new social relationships. It is not realistic for the court to assume that there are unlimited funds to address the needs of all. A judicial approach on this basis would

50. [1989] 1 S.C.R. 927 at 990, 58 D.L.R. (4th) 577, Dickson C.J. and Lamer and Wilson JJ. [hereinafter *Irwin Toy* cited to S.C.R.].

51. *Supra*, note 43 at 617–18 [emphasis added]. See also L'Heureux-Dube's comments at 560.

tend to make a government reluctant to create any new social benefit schemes ...

[quoting *McKinney*] ... [I]t is important to remember that a legislature should not be obliged to deal with all aspects of a problem at once. It must surely be permitted to take incremental measures. It must be given reasonable leeway to deal with problems one step at a time. ... But, generally, the courts should not lightly use the Charter to second-guess legislative judgment as to just how quickly it should proceed in moving forward towards the ideal of equality. The courts should adopt a stance that encourages legislative advances in the protection of human rights.⁵²

Nothing in Sopinka J.'s comments, or La Forest J.'s judgment in *McKinney*, contemplates retrograde actions by governments in removing benefits from a segment of society which has come to expect and rely on those benefits. Therefore, a lower standard of justification would be inappropriate here.

Regardless of the standard of justification, it is clear that the regulations are a "limit prescribed by law." In evaluating whether the limit is reasonable, the first step is to determine whether the objective of the legislation is sufficiently important. In order to do so, of course, it is necessary to define the objective.

(B) *Sufficiently Important Objective*

The following are excerpted from the Minister's *Statement to the Legislature*:

In last year's budget we promised to tighten OHIP rules by restricting benefits to residents of Ontario. The measures I am announcing today will save the taxpayers of this province about \$48 million annually. ...

Starting April 1st, most people who arrive in Ontario but do not plan to live here permanently, will no longer receive free health care benefits. ...

Our government has been implementing its plan to protect services by spending carefully and wisely. ... Maintaining the best possible care for Ontarians remains our priority and our commitment. ...

These measures I have outlined today ... will help us to preserve health care in Ontario now, and in years to come.⁵³

The following possible purposes can be gleaned from this Statement: (1) fulfilling a budget promise; (2) controlling costs; (3) preserving free health care

52. *Ibid.* at 572-73.

53. *Supra*, note 8.

in Ontario; (4) preserving free health care for those who intend to live in Ontario permanently.

The purpose of the three-month waiting period for benefits can be inferred from a news release accompanying the speech: "The waiting period is expected to prevent people from coming to Ontario just to receive medical care, then leaving."⁵⁴

In order for a justificatory purpose to be valid, it must be *intra vires* the level of government which seeks to invoke it (*R. v. Big M Drug Mart Ltd.*⁵⁵). Immigration is a federal power, and although citizenship is not explicitly enumerated, it has been deemed to fall within the purview of the federal government.⁵⁶ On this basis, I would argue that any purpose related to immigration status is *ultra vires* the province of Ontario, and cannot be used to justify a *Charter* violation under section 1. Thus, the province of Ontario could not argue that the purpose of the legislation is to provide health care access to "Canadian citizens and permanent residents ordinarily resident in Ontario." While an individual's province of residence might be relevant to a province, immigration status could not be.

Furthermore, an individual's motive for acquiring temporary immigration status could not be relevant. This means that while deterring opportunistic behaviour by non-citizens (such as visiting Canada to exploit health care resources) might be a valid purpose for the federal government, it could not be a subject of inquiry of the province of Ontario.

This is not to suggest that a province would be required under the *Charter* to provide health care to persons who are in Canada illegally. To begin with, it could be argued that such persons are not, by definition, "amenable to Canadian law". Even if they were, they would be unable to appear in court to mount a *Charter* challenge without risking deportation, and in any case any action would be barred as its basis would rest on the applicant's illegal act. The point is simply

54. Ministry of Health, *News Release 94/nr-056* (31 March 1994). See also the question and answer in the accompanying *Backgrounder*: "Will a waiting period help reduce fraud? The waiting period is to help ensure that only people who are really planning to live in Ontario get Health Cards. It will make it difficult for a person to come to Ontario just to receive medical care."

55. [1985] 1 S.C.R. 295 at 353, 18 D.L.R. (4th) 321 [hereinafter *Big M* cited to S.C.R.].

56. The *Constitution Act, 1867* (U.K.), 30 & 31 Vict., c. 3, s. 91(25) grants the federal government power over "Naturalization and Aliens." In *Morgan v. Prince Edward Island (Attorney General)*, [1976] 2 S.C.R. 349, it was agreed by all parties and accepted by the court that power over citizenship was conferred on the federal government either by implication of s. 91(25) or under the general power to make laws for the peace, order and good government of Canada.

that, given that an individual is legally entitled to reside in Ontario, while the length of residence or intended residence might be relevant to a valid provincial purpose, immigration status could not be.

It might also be argued that it is within the power of the province to determine who qualifies as a “resident” or an “ordinary resident”, and that one aspect of this definition might refer to immigration status. My argument is simply that whether the definition is contained in the *Health Insurance Act* or some statute of general application, a definition of “resident” which discriminates against Convention refugee claimants would violate s. 15, and would have to be justified under s. 1 with reference to some valid purpose.

The second criterion for a valid justificatory purpose is that it be consistent with *Charter* values. As Dickson C.J. commented in *Oakes*:

[A]ny s. 1 inquiry must be premised on an understanding that the impugned limit violates constitutional rights and freedoms — rights and freedoms which are part of the supreme law of Canada ...

The court must be guided by the values and principles essential to a free and democratic society which I believe embody, to name but a few, respect for the inherent dignity of the human person, respect for cultural and group identity, and faith in social and political institutions which enhance the participation of individuals and groups in society. The underlying values and principles of a free and democratic society are the genesis of the rights and freedoms guaranteed by the Charter and the ultimate standard against which a limit on a right or freedom must be shown, despite its effect, to be reasonable and demonstrably justified.⁵⁷

If it meets this test, the objective must also be of sufficient importance:

It is necessary, at a minimum, that an objective relate to concerns which are pressing and substantial in a free and democratic society before it can be characterized as sufficiently important.⁵⁸

It could be argued that even if “fulfilling a budget promise” promotes “faith in social and political institutions which enhance the participation of individuals and groups in society,” it is not a sufficiently important purpose to justify overriding a constitutional right. Furthermore, fulfilling a budget promise to restrict health care benefits in a discriminatory way is an invalid purpose. The analysis of Iacobucci J. in *Egan* provides an appropriate analogy:

57. *Supra*, note 49 at 135–36 [emphasis added].

58. *Ibid.* at 138–39.

The importance of providing relief to some elderly couples does not justify an infringement of the equality rights of the elderly couples who do not benefit for constitutionally irrelevant reasons. ...

The only way that, at a conceptual level, this aspect of the *Oakes* test might be satisfied in the appeal at bar is if the purpose of the legislation would be construed as ameliorating the situation and fostering the existence of elderly heterosexual couples only. ... It is clear that, were this to be the goal of the legislation, such a goal would itself be discriminatory. The law in this area is unequivocal: a constitutionally impermissible purpose will not save a law under s. 1 of the Charter: *R. v. Big M*.⁵⁹

The circularity of justifying a s. 15 breach with a discriminatory purpose can be illustrated with a slightly different example. Suppose the provincial government had declared its intention to preserve health care for all residents of Ontario, and defined “resident” to mean “all males who make their home in Ontario”. It is clear that if it would be discriminatory for the government to refuse to grant OHIP to women, it would not become more valid because of the (arbitrary) definition of “resident” adopted. Similarly, the government cannot define “resident” in such a way as to discriminate against any other group, such as refugee claimants, and then use this definition to justify refusing to grant OHIP coverage. In any case, I will argue below that this objective fails on a proportionality analysis.

Whether controlling cost can ever justify the violation of a *Charter* right is a matter of some debate. Writing for the three members of the court who decided *Singh* on *Charter* grounds, Wilson J. rejected the administrative convenience and cost arguments put forward by the Attorney General of Canada:

... I have considerable doubt that the type of utilitarian consideration brought forward by Mr. Bowie can constitute a justification for a limitation on the rights set out in the Charter. Certainly the guarantees of the Charter would be illusory if they could be ignored because it was administratively convenient to do so. No doubt considerable time and money can be saved by adopting administrative procedures which ignore the principles of fundamental justice but such an argument, in my view, misses the point of the exercise under s. 1.⁶⁰

Even if the cost of compliance with fundamental justice is a factor to which the courts would give considerable weight, I am not satisfied that the Minister has demonstrated that this cost would be so prohibitive as to constitute a justification within the meaning of s. 1.⁶¹

59. *Supra*, note 43 at 615–16 [emphasis in original].

60. *Supra*, note 42 at 218–19.

In *Retail, Wholesale & Department Store Union, Local 580 et al. v. Dolphin Delivery Ltd.*⁶² and *RWDSU v. Saskatchewan*,⁶³ the court held that avoidance of economic cost to a third party could justify limitations on the right to strike which violates s. 2(b). However, in those cases the *Charter* right itself was being invoked to advance the economic interests of the applicants:

It would be strange, indeed, if our society were to give constitutional protection for the freedom of employees to advance economic, as well as non-economic, interests by striking, while insisting that the state remain idle and indifferent to the infliction on others of serious economic harm.⁶⁴

In *R. v. Lee*⁶⁵ and *R. v. Chaulk*,⁶⁶ the court held that the cost of empanelling a jury a second time or the cost of having the Crown prove the sanity of the accused could justify violation of a s. 11(f) or s. 7 right, respectively. However in *Lee*, Lamer J. notes for the majority that the “cost” of empanelling successive juries is more than merely an economic cost:

The rationale for the section lies in the “cost” to potential jurors and to the criminal justice system in terms of economic loss and of the disaffection created in the community for the system of criminal justice. ... The expense, it should be noted, is not only to the system. ...

I do not believe that the importance of the objective can be measured solely by reference to the amount of money lost as a result of the non-appearance of accused persons, and the cost of empanelling a second jury. Rather the cost, and by implication the importance of the objective, must be measured in terms of the overall “cost”, both in the sense of economic loss and disruption to lives, and in the sense of confidence and respect for the system, to the individuals selected for jury duty and to society as a whole.⁶⁷

In *Schachter v. Canada*, Lamer C.J. writing for five members of the court made an *obiter* comment which suggests that economic cost to government could never justify a *Charter* violation: “This court has held, and rightly so, that budgetary considerations cannot be used to justify a violation under s. 1.”⁶⁸

61. *Ibid.* at 220.

62. [1986] 2 S.C.R. 573, 33 D.L.R. (4th) 174 [hereinafter *Dolphin Delivery* cited to S.C.R.].

63. [1987] 1 S.C.R. 460.

64. *Ibid.* at 476.

65. [1989] 2 S.C.R. 1384 [hereinafter *Lee*].

66. [1990] 3 S.C.R. 1303 [hereinafter *Chaulk*].

67. *Supra*, note 65 at 1390–91.

In *Egan*, Sopinka J.'s comments⁶⁹ may signal a retreat from this position, but L'Heureux-Dube J. noted the court's position in *Schachter* with approval.⁷⁰ The other decisions did not address the issue of budgetary cost.

I conclude from this review of the Supreme Court of Canada's decisions that budgetary cost alone cannot justify a violation of a *Charter* right. However, if the objective is framed in terms of maintaining an acceptable standard of health care in Ontario, budgetary considerations may enter into the proportionality analysis.

(B) *Proportionality Test*

First, the measures adopted must be carefully designed to achieve the objective in question. They must not be arbitrary, unfair or based on irrational considerations. In short, they must be rationally connected to the objective. Secondly, the means, even if rationally connected to the objective in this first sense, should impair "as little as possible" the right or freedom in question. Thirdly, there must be a proportionality between the effects of the measures which are responsible for limiting the Charter right or freedom, and the objective which has been identified as of "sufficient importance."⁷¹

The third branch of the proportionality test was modified by the Supreme Court of Canada in *Dagenais v. Canadian Broadcasting Corp.* to encompass a weighing of the effect of the impugned measure on the right in question against not only the objective to be achieved, but the effect the impugned measure has on the achievement of that objective:

... At other times, however, the measure at issue, while rationally connected to an important objective, will result in only the partial achievement of this object. In such cases, I believe that the third step of the second branch of the *Oakes* test requires both that the underlying objective of a measure and the salutary effects that actually result from its implementation be proportional to the deleterious effects the measure has on fundamental rights and freedoms.⁷²

I would, therefore, rephrase the third part of the *Oakes* test as follows: there must be a proportionality between the deleterious effects of the measures which are responsible for limiting the rights or freedoms in question and the

68. [1992] 2 S.C.R. 679 at 709, 93 D.L.R. (4th) 1 [hereinafter *Schachter* cited to S.C.R.]. For the context of this remark, see text accompanying *infra*, note 85.

69. Quoted in the text accompanying *supra*, note 52.

70. *Supra*, note 43 at 571.

71. *Oakes*, *supra*, note 49 at 139 [emphasis in original, references omitted].

72. [1994] 3 S.C.R. 835 at 887, 120 D.L.R. (4th) 12, Lamer C.J. [emphasis in original].

objective, and there must be a proportionality between the deleterious and the salutary effects of the measures.⁷³

(a) Salutary Effects – The Election Promise

It was argued above that preserving public confidence in the electoral system might be an important objective. By a stretch, “fulfilling an electoral promise” to contain health care costs might be rationally connected to that objective. But the scheme enacted by the Ontario government would fail the minimal impairment test, as it is possible to devise a scheme to reduce health care costs in a non-discriminatory fashion. Thus the present scheme does not impair the equality right as little as possible. Finally, whatever small effect fulfilling this single election promise might have on public faith in democratic institutions would certainly be outweighed by the deleterious effect on the equality rights of refugee claimants.

(b) Deleterious Effects

The deleterious effects on the health of refugee claimants are lower because of the existence of IFH, but the Ontario government might not be permitted to rely on that program in a s. 1 justification. In *Egan*, the four members of the court who discussed the issue were:

... uncomfortable with basing the constitutionality of federal legislation upon the actions of a provincial legislature over which Parliament has no control. ... Although there might be cases in which provincial legislation or law could be relied upon in preserving the constitutionality of federal legislation, this would only be in a situation where all of the provinces have specifically ensured that the discriminatory effect of federal legislation be eliminated through provincial enactments or law.⁷⁴

There are significant differences between OHIP and IFH coverage in terms of services available. In addition, whereas OHIP coverage is universal, IFH recipients must demonstrate that they have insufficient funds to pay for their own health care in order to qualify. Therefore, the Ontario government might not be able to rely on IFH to demonstrate minimal impairment or proportionality.

Even with the existence of IFH, loss of OHIP coverage has had and will have deleterious effects on the health of refugee claimants, although the extent of these effects is difficult to quantify. Although Ontario hospitals and CHCs have a policy of not turning away anyone in need of treatment whether or not they have medical coverage, this policy is not shared by doctors in private practice. Significant delays in receiving treatment can result if an individual is turned

73. *Ibid.* at 889 [emphasis in original].

74. *Supra*, note 43 at 614, Iacobucci J.

away by a practitioner (or a receptionist) who is unfamiliar with IFH. If medical practitioners and staff do not understand the program, it is reasonable to conclude that many refugee claimants will be unsure what services are covered, or where they can go to receive treatment. Many new immigrants, unfamiliar with the Canadian medical system, who are refused treatment or erroneously billed for treatment that is provided, will be reluctant to engage the medical system again. Many simple health problems, if left untreated, can result in serious complications requiring expensive intervention.

Individuals who become aware of the existence of CHCs and are close enough to one to receive health services there, are less likely to encounter problems than those who must seek out an accommodating doctor on their own. Community Health Centres are equipped to provide many basic medical services, and the staff are generally familiar with IFH. When the patient must be referred out, there are sometimes complications.

In order to determine the experience that refugee claimants have had with IFH, I spoke with several staff workers at CHCs in Toronto about problems which they have experienced. These interviews were conducted over the telephone during a one-week period in April, 1996. Although the experiences reported here may not reflect the sum of the clinics' engagement with IFH, the comments are at least illustrative of the concerns which the program raises.

The Davenport Perth Neighbourhood Centre has found that some specialists refuse to accept patients with IFH coverage, but since St. Joseph's Hospital does, they now routinely send their clients there. The medical lab to which they send clients and samples for testing simply asks for the list of services covered by IFH before they will do any work. After an initial period of adjustment, they have not experienced any major problems.

Access Alliance has found that many specialists will not accept referrals of patients covered by IFH as they are unwilling to go through the paperwork required to bill the federal government for services provided. Lawrence Heights CHC reported that one specialist who does accept referrals had been calling the CHC repeatedly because he was not being paid. Apparently there is a backlog of IFH bills, and it takes at least six months to receive payment after the bill is submitted.

Rexdale CHC reported that many local labs are not aware of the existence of IFH, and ask clients referred from Rexdale for payment. To address this problem, Rexdale often sends their clients to the lab with a letter certifying that the CHC will pay for the service. They have found it more expedient to pay for lab services for refugee claimants out of the CHC's general budget, rather than trying to convince the labs to bill IFH. Since they refer many patients to the

Etobicoke General Hospital for emergency treatment, they have attempted to educate the hospital staff about IFH. They encountered serious barriers, as the hospital initially acted as if IFH did not exist, and staff would ask patients who produced IFH documents for money in advance of treatment. Rexdale has maintained a constant dialogue with the hospital on the issue, and although they have raised the awareness and acceptance of IFH among the hospital staff they have been unable to reach everyone, and clients they refer to the hospital still occasionally get turned away.

4 Villages CHC seems to have had the most success dealing with specialists and hospitals. It seems that rather than turn patients away, specialists to whom they refer clients covered by IFH send the bills to 4 Villages. 4 Villages ignores the bills, and explains the IFH billing procedure to anyone who calls asking for payment.

By contrast, East End Health Services has given up. In their experience, most specialists in Toronto refuse to accept patients covered by IFH. The most common complaint seems to be the length of time it takes to receive payment from the federal government. East End generally treats individuals with IFH coverage as uninsured, and pays specialists from their general funds.

PCLS has one client, named Mariah, who has had serious problems proving that she is eligible for IFH coverage. The generally accepted proof of coverage (where coverage is accepted) is an Immigration form IMM 1442 B AQ (Acknowledgement of Convention Refugee Claim) accompanied by a schedule of benefits covered by the program. However, claimants such as Mariah who are being landed as part of the backlog program do not have this form. Instead, they are told to produce the letter from Immigration which confirms that there is a credible basis to their refugee claim and that they will therefore be landed on humanitarian and compassionate grounds. However even those practitioners and administrators who are familiar with IFH are not generally aware that this exception for backlog claimants exist.

Mariah is 55 years old and has a serious heart condition. She has been to several doctors who have refused to treat her. Finally, in January 1996 she was experiencing serious chest pains, and called an ambulance which took her to Humber Memorial Hospital for emergency treatment. Again, the hospital refused to accept that she was eligible for IFH, and has sent her at least three bills demanding payment for the hospital visit and the ambulance ride. A student at PCLS called Immigration to confirm that Mariah is eligible for IFH and to determine what documents she must produce to prove her status. He then began telephoning the hospital to sort out the problem. After several phone calls he managed to convince a person in the hospital billing office that Mariah was

eligible, and the person agreed to explain this to the person in charge of IFH administration for the hospital. Several weeks later, Mariah received her third bill. The PCLS student finally spoke to the person in charge of IFH administration on April 11, and it was expected that the matter would end there, three months after Mariah's hospital visit. Two weeks later, at the time of this writing, the PCLS student was again negotiating with the hospital billing staff on the same issue.

Mariah is unable to work because of her medical condition, and is receiving welfare. The extended battle with private practitioners and hospital staff, and the constant worry of how she would pay the hospital bill, has cost her a great deal of time and energy, and cannot have improved her health. It has certainly made her reluctant to visit a hospital or call an ambulance in the future.

The staff at CHCs and Community Legal Clinics (CLCs) have had some time to gain experience with IFH, and are more comfortable than many newcomers negotiating with specialists and hospital billing staff. Despite these advantages, their experience with IFH has often been frustrating. Mariah's experience demonstrates that, with the proper assistance, it is (we still hope) possible to get adequate medical treatment free of charge. A refugee claimant who does not perceive lack of access to health care as a legal issue, or whose lawyer will only assist under the strict terms of the client's legal aid certificate, may give up after being refused treatment the first time.

Denial of OHIP coverage may have substantial effects on the health or the economic situation of refugee claimants. Perhaps the most severe effect is the perpetuation of alienation and disadvantage that stems from the Ontario government's validation of a discriminatory distinction, and the use of that distinction to deny one of the basic rights extended to virtually everyone else living in Canada. L'Heureux-Dube J.'s comments about the effects of government discrimination against homosexuals in *Egan* are applicable:

[T]he Charter breach (i.e. the discriminatory effect) is quite severe. The discrimination ... arises on the face of the legislation. ... In addition, the impugned distinction is in an Act that plays an important role in a very important Canadian social institution. The interest at issue is a fundamental one ... and the non-recognition is complete, rather than partial. Although the claimants are not necessarily economically worse off as a result of their exclusion ... the complete exclusion from the program ... has a significant discriminatory impact in terms of perpetuating prejudice, stereotyping, and marginalization ...⁷⁵

75. *Supra*, note 43 at 570.

Thus even if IFH provided, in theory or in practice, equivalent health care coverage, which it does not, the very fact that refugee claimants are singled out for different treatment is exclusionary and differentiating, and would violate s. 15 for that reason alone. The psychological effects of being treated differently, and of virtually being accused by the Minister of Health of having come to Canada to defraud Ontario's health care system, are deleterious effects to be considered in s. 1.

(c) Salutory Effects – Cost Control And Preserving Health Care

Denying health care coverage to refugee claimants would free up resources to provide additional coverage to other Ontario residents. But it fails the rational connection test if, as I have argued above, immigration status is an impermissible criterion for the Ontario government. Even if I am wrong and the measure passes the rational connection and minimal impairment tests, I would argue that the deleterious effects of violating the equality guarantee are far out of proportion to the salutary effect of reduced cost to the public purse.

The government of Ontario estimates that restricting eligibility for health care will save \$30 million per year. By the government's own calculation this amounts to \$1,071 per refugee claimant. In 1992–93, the Ontario government spent over \$19 billion on health care.⁷⁶ Thus the \$30 million savings represents less than one fifth of one percent of health care expenditures in the province, or \$2.77 per resident.⁷⁷

While the court has suggested it might be willing to consider cost in a s. 1 analysis, it has been quite clear that the cost must be significant, or even "prohibitive."⁷⁸ In *RWDSU v. Saskatchewan*, in which the right itself was invoked to further an economic interest, and so the standard for justification was lower than it would be otherwise, the violation was saved by s. 1 because "the economic harm threatened by a total work stoppage in the dairy processing industry was so immediate, of such a high degree and of such an intense focus ..."⁷⁹

76. Health Canada, *Green Book Tables: Provincial Government Health Expenditures and Related Federal Contributions 1974–75 to 1992–93* (Ottawa, July 1994) at 9.

77. In 1993 there were 10,813,000 people living in Ontario: Statistics Canada, *Annual Demographic Statistics 1994* (Ottawa, 1994). Again, if the expected savings announced by the Minister are based on accurate figures, this means that on a per capita basis, a refugee claimant uses only 61% of the health care resources of an average Ontario resident.

78. *Singh, supra*, note 42 at 220.

79. *Supra*, note 63 at 480, Dickson C.J. [emphasis added].

In this case, the economic cost is not focused on any segment of society, it is distributed broadly through the tax system. It is such a small proportion of total health care expenditures in Ontario that it can hardly be considered prohibitive. Therefore, the burden which the government claims Convention refugee claimants place on the health care system cannot justify terminating their health care benefits.

Moreover, the government's calculations are open to dispute. To begin with, the bulk of refugee claimants' health care costs are simply being transferred to the IFH and the federal government, and do not constitute a saving at all. The only savings come from services which are not offered under IFH and are no longer available to refugee claimants. In calculating the salutary effect of the measure, a better approximation would be the difference between actual expenditures under IFH and expected expenditures under OHIP.

Even this figure would be too high, for two reasons. First, some refugee claimants will receive services not covered by IFH by attending Community Health Clinics (CHCs). CHCs routinely provide services for people who cannot provide proof of OHIP coverage for a variety of reasons, including having lost their card, or having neglected to apply. Although CHCs are expected by the government to establish that the patients they treat are eligible to receive OHIP coverage, in practice they bill the Ontario government for a number of patients who are not.⁸⁰

Second, the acceptance rate for refugee claimants in Canada is approximately 60%.⁸¹ The vast majority of successful claimants become permanent residents of Canada, and therefore eligible for OHIP under the current regulations. Any increased medical costs for successful claimants resulting from the deferral of treatment which is not covered by IFH but would have been covered by OHIP must be deducted from the calculated cost savings.

Even if this remaining cost is of sufficient importance to justify a s. 15 violation, the measure adopted by the Ontario government is not minimally impairing. The same savings could be had by requiring refugee claimants to pay for services not covered by IFH, as is the case now, but refunding these payments to successful refugees who become eligible for OHIP. In my opinion this would still fail the s. 1 test, but if I am wrong, it nonetheless demonstrates that a measure could have been enacted which impairs the equality right less than the current regulation.

80. This information was provided by a staff worker at a CHC in Toronto.

81. From 1990 to 1994, the acceptance rates, defined as the number of claims upheld divided by the sum of the number heard and the number withdrawn or abandoned, were 70%, 64%, 57%, 46% and 61% respectively. *Refugee Update* (1994) No. 22, Jesuit Refugee Service at 2; Immigration and Refugee Board *Annual Report* (1994) at 10.

V. REMEDY

A detailed discussion of remedies is beyond the scope of this paper, but a few notes are in order. Section 52 of the *Charter* asserts that any law that is inconsistent with the *Charter* is, "to the extent of the inconsistency, of no force and effect."⁸² However s. 24(1) provides:

Anyone whose rights or freedoms, as guaranteed by this Charter, have been infringed or denied may apply to a court of competent jurisdiction to obtain such remedy as the court considers appropriate and just in the circumstances.⁸³

In *Osborne v. Canada (Treasury Board)*,⁸⁴ the court held that the primary concern in selecting a remedy is to apply the measures that will best vindicate the values expressed in the *Charter* and to provide the form of remedy to those whose rights have been violated that best achieves that objective. Remedies include, but are not restricted to, a declaration that the law is of no force or effect under s. 52(1), reading down the law or conferring a constitutional exemption.

A declaration that the *Health Insurance Act* is invalid would not further the equality value of the *Charter*, since in that case refugee claimants covered by IFH would have greater health care access than other Ontario residents. Some group disadvantaged relative to refugee claimants (if one exists) would have a valid *Charter* challenge. A declaration of invalidity would arguably violate s. 7 since deprivation of a minimum level of health care impacts on the right to life. Substantively, a declaration of invalidity would be of no benefit to refugee claimants, and have a substantial adverse impact on the general population.

A less intrusive remedy, more in keeping with the legislative objective, would be to read Convention refugee claimants in to the *Health Insurance Act*. Once again, as noted in *Schachter*, this raises the issue of cost:

Even where extension by way of reading in can be used to further the legislative objective through the very means the legislature has chosen, to do so may, in some cases, involve an intrusion into budgetary decisions which cannot be supported. This court has held, and rightly so, that budgetary considerations cannot be used to justify a violation under s. 1. However, such considerations are clearly relevant once a violation which does not survive s. 1 has been established, s. 52 is determined to have been engaged and the court turns its attention to what action should be taken thereunder.

82. *Supra*, note 7.

83. *Charter*, *supra*, note 7.

84. [1991] 2 S.C.R. 70.

Any remedy granted by a court will have some budgetary repercussions whether it be a saving of money or an expenditure of money. Striking down or severance may well lead to an expenditure of money. ... In determining whether reading in is appropriate then, the question is not whether courts can make decisions that impact on budgetary policy, it is to what degree they can appropriately do so. A remedy which entails an intrusion into this sphere so substantial as to change the nature of the legislative scheme in question is clearly inappropriate.⁸⁵

The appropriate consideration is whether striking down or reading in resolves the *Charter* violation in a manner least intrusive to the legislative sphere. I would argue that if budgetary considerations have entered into the proportionality analysis, and the budgetary impact has been found to be minimal, the analysis need not be repeated here. In the case at bar, reading in refugee claimants to the list of persons eligible for OHIP coverage is the remedy which vindicates the equality rights of refugee claimants and least impacts the legislative sphere.

Of course, if the ground of distinction identified in the s. 15 analysis was national origin, reading in refugee claimants would not suffice. A complete solution would be to strike the definition of resident in s. 1.1 of the Reg. 552, and either revert to the definition previously contained in the Act, or to a common law definition of resident. This would be a more intrusive remedy, and a court might be reluctant to impose it, particularly if reading in refugee claimants would satisfy the equality rights of the claimant(s) before the court. To achieve this remedy, it might be necessary to co-ordinate a number of simultaneous actions, so that the pool of applicants before the court would be sufficiently diverse to make reading in a new clause for each of them equally uncomfortable.

Regardless of the remedy, the three-month waiting period will still apply. It should also be noted that if instead of striking the section refugee claimants are read in, they would still be subject to the requirements of s. 1.1(2)(b). The “presence” requirement in s. 1.1(2)(b)(ii) could be used to delay approval until the applicant had lived in Ontario for 6 months, at which time coverage would be granted retroactive to the end of the three-month waiting period.

A potentially more difficult issue is whether a refugee claimant can satisfy the requirement of s. 1.1(2)(b)(i) that he or she “intends to make his or her permanent and principle home in Ontario”. The government might argue that since a refugee claimant does not (yet) have the right to remain in Ontario “permanently”, he or she is not capable of forming the intention to do so. Of

85. *Supra*, note 68 at 709–10.

course, one can intend to do that which is not legally permissible. Since most refugee claims are successful, many claimants probably expect that their claim will succeed, and expect and intend to remain in Ontario permanently. A court, or the Health Services Appeal Board, should simply examine the circumstances of the refugee claimant the same way they determine the place of residence of any other applicant — based on the amount of time they spend away from the province, whether they have a domicile or other assets abroad, and other indicia of intent to build a life in Ontario. The vast majority of refugee claimants would have no difficulty satisfying this type of analysis, particularly if the Board were sensitive to the reasons a person fleeing persecution might leave assets behind.

VI. PRACTICAL CONSIDERATIONS – CAN A *CHARTER* ACTION SUCCEED?

I often wonder whether we do not rest our hopes too much upon constitutions, upon laws and upon courts. These are false hopes; believe me, these are false hopes. Liberty lies in the hearts of men and women; when it dies there, no constitution, no law, no court can save it; no constitution, no law, no court can even do much to help it. While it lies there it needs no constitution, no law, no court to save it.⁸⁶

There are a number of barriers to *Charter* litigation which must be considered in any discussion of whether a particular action will succeed on its merits. One barrier of particular importance to a poverty law clinic is, of course, cost. Evidently, any refugee claimant to whom the cost of health care is an issue will not have the resources to mount a *Charter* challenge.

A newspaper report in 1985 estimated that the cost of taking a criminal [*Charter*] case to the Supreme Court of Canada 'can be more than \$34,500', while those bringing non-criminal cases under the Charter 'should be prepared to spend at least \$200,000'. The operative words are 'at least'. A woman from Ontario recently reported spending \$200,000 on a Charter case that had not yet reached the Ontario Court of Appeal. A challenge brought by college instructor Merv Lavigne against the use of union dues for political causes cost the National Citizens Coalition, the right-wing lobby funding the case, \$400,000 before the trial judge ever rendered a decision.⁸⁷

86. L. Hand, "The Spirit of Liberty", in I. Dillard, ed., *The Spirit of Liberty – Papers and Addresses of Learned Hand* (New York: Vintage Books, Inc., 1959) 143 at 144.

87. A. Petter, "Canada's Charter Flight: Soaring Backwards into the Future" (1989) 16 *J.L. & Soc.* 151 at 155–56.

If this barrier can be overcome, which is no small feat, some commentators have argued that two factors make poverty law claims less likely to succeed than other *Charter* challenges. First, the interpretation of *Charter* guarantees is shaped by previous challenges, which will have been brought by the economically powerful and will reflect their concerns. Second, judges will, given their socio-economic backgrounds, be ill-disposed to consider that an economic benefit conferred by the state (necessitating a reallocation of resources) is a right worthy of the same protection as a positive liberty of individual action.⁸⁸

Some characteristics of the OHIP issue make a challenge more likely to receive a favourable ruling than other social benefit cases. First, the legislation discriminates on its face against refugee claimants, so it is not necessary to demonstrate an adverse impact. Second, while courts have been reluctant to use s. 15 to expand a government program to include a new class of beneficiaries, perhaps out of fear of imposing substantial and ever-increasing burdens on the public purse, this is a case where a benefit had been conferred on a disadvantaged group, and has subsequently been taken away. This is precisely the sort of case where the discriminatory treatment is easy to see, and easy to remedy.

As for the issue of cost, while public interest advocacy groups will continue to have funds available to litigate significant issues, there are more such issues than funds. It is worth noting that at the time of this writing (April 1996), four Community Legal Clinics are involved in the preliminary stages of a *Charter* challenge to the three-month residency requirement which was introduced concurrently with the changed definition of resident. Perhaps at some time in the near future, this issue will rise to the top of some organization's list of litigation priorities.

Equality is a value to which all Community Legal Clinics should and do ascribe importance. Moreover, as indicated above, the procedural and economic barriers which are raised by the substitution of IFH for OHIP can have profound effects on the lives of our clients, impairing their ability to put forward a successful refugee claim, and to remain in Canada pending its final determination. Health care should not be thought of as an issue peripheral to Immigration law, but as a core interest of our clients.

IV. CONCLUSIONS

In summary, Convention refugee claimants in Canada are a disadvantaged group subject to the protection of the equality guarantees of s. 15 of the *Charter*. The

88. See for instance *ibid.* at 156-7; I. Morrison, "Poverty Law and the Charter: The Year in Review" (1990) 6 *J.L. & Social Pol'y* 1 at 17 and following.

Health Insurance Act constitutes a *prima facie* violation of this provision. There are four objectives of the legislation which can be postulated: (1) discouraging individuals from coming to Canada for the purpose of obtaining health care; (2) fulfilling a budget promise; (3) controlling government expenditures; (4) maintaining adequate health coverage for Ontarians. The first objective is *ultra vires* the province of Ontario. The second objective would probably not be raised by the province, but if it were, it is a discriminatory and therefore invalid purpose. Furthermore, the recent changes to the *Health Insurance Act* have only tenuous effects on the objective, which are outweighed by the deleterious effects of the *Charter* violation. The third objective is arguably invalid as well, and more properly considered as an aspect of the fourth. The fourth objective is valid, but the Act does not minimally impair the equality right since an across the board cut in health care expenditures would achieve the same object, and in any case the cost savings are out of proportion to the severe deleterious effects the changes to the Act have on the equality which the *Charter* guarantees to every individual in Canada, including Convention refugee claimants.

The most appropriate remedy would be to amend the definition of resident in the *Health Insurance Act*, to include refugee claimants (at a minimum) or to remove all references to immigration status and returning to the prior definition. If the purpose of the statute is to provide health care to residents of Ontario, then it should do so, regardless of the reasons they became residents.

How we treat the most disadvantaged members of our society is a measure of our compassion and our humanity. As a signatory to the United Nations *Convention Relating to the Status of Refugees*,⁸⁹ Canada has undertaken to provide refuge and protection to individuals fleeing life-threatening persecution in their country of origin. This protection must extend to equal access to health care while they await the determination of their claims. Anything less will have serious repercussions on our international reputation, the health of our future citizens, and the moral fibre of our society.

89. 28 July 1951, Can. T.S. 1969 No. 6.