Court File No. [redacted]

FEDERAL COURT

BETWEEN:

[redacted]

HIV LEGAL NETWORK

Applicants

- and -

THE MINISTER OF CITIZENSHIP AND IMMIGRATION

Respondent

AFFIDAVIT OF [redacted]

I, [redacted] of the city of Toronto, in the province of Ontario, MAKE OATH AND SAY AS FOLLOWS:

1. I am an Applicant in this matter and therefore I have knowledge of the matters herein deposed to in this Affidavit.
2. I am a [redacted] citizen born on [redacted] in [redacted] in [redacted]
3. I am HIV positive but very healthy. I was diagnosed with HIV in June 2021 in [redacted] I currently manage my HIV status through HIV medication which is effective in keeping me healthy. My medication is paid for by the company that manufactures the medication I am taking. I previously had additional insurance through the educational institution I was studying at using my study permit, but I can no longer access those benefits.

Background

4. I first came to Canada with a study permit, issued on March 31, 2022. My study permit allowed me to begin a diploma program at [redacted] a designated learning institution in Ontario.

5. I attach as **Exhibit "A"** to this Affidavit a copy of my study permit, issued on March 31, 2022, and valid until August 2, 2023.

6. I did not hire a lawyer to help me with my initial application for a study permit when I applied for it in 2021. When I completed the study permit application, I did the Immigration Medical Exam as instructed in June 2021. The panel physician who completed my Immigration Medical Exam is the one who first diagnosed me with HIV. The panel physician then instructed me to find a family doctor to begin treatment and complete the medical certificate process.

7. I did as I was instructed and provided the IRCC with a medical certificate from my family doctor in [redacted] dated July 6, 2021, indicating that my prognosis for the next five years was good as long as I continued to take my medication.

8. On June 6, 2023, I applied to extend my study permit, which was set to expire on August 2, 2023. I once again did not hire a lawyer to help me with the extension application. I attach as **Exhibit "B"** to this Affidavit the June 7, 2023, correspondence from Immigration, Refugees and Citizenship Canada confirming my application to renew my study permit was received.

9. On July 7, 2023, I received correspondence from Immigration, Refugees and Citizenship Canada informing me that my application had been transferred to the Canada Immigration Centre located in Etobicoke for processing. I attach as **Exhibit "C"** to this Affidavit the July 7, 2023, correspondence from Immigration, Refugees and Citizenship Canada confirming the transfer of my file.

10. On September 11, 2023, I received correspondence from Immigration, Refugees and Citizenship Canada informing me that my biometric information had been received and was valid through to April 21, 2031. I attach as **Exhibit "D"** to this Affidavit the September 11, 2023, correspondence from Immigration, Refugees and Citizenship Canada about my biometrics validity.

11. On September 11, 2023, I received a negative decision on my study permit extension application. In the decision letter, the officer indicated that the reason for refusing my application was because my health condition was expected to cause excessive demands on the social and health services of Canada.
12. I attach as **Exhibit "E"** to this Affidavit the September 11, 2023, correspondence from Immigration, Refugees and Citizenship Canada rejecting my study permit extension.
13. The refusal letter also laid out my options to re-apply, indicating that any new applications would be assessed on its merits. The letter indicated that this new application may also be refused unless it was supported by new or different information.
14. At no point in the processing of my study permit extension application was I asked for information about my health or the cost of my treatment.

Impacts of the refusal

15. Ever since I was diagnosed with HIV, I have tried to avoid societal discrimination and stigma. In [redacted] people living with HIV are judged harshly and are often seen as morally blameworthy, sexually irresponsible, dirty, and unwelcome. If people learn you are HIV positive in [redacted] it can negatively impact your ability to work, maintain relationships, and even find housing. Some healthcare providers will even refuse to provide treatment if they know you are HIV positive. For this reason, I have never revealed my HIV status to my friends or family in [redacted]
16. This was one of the reasons I wanted to come to Canada to study. After doing online research, I learned that Canadian society values non-discrimination, and is open and accepting of people with HIV. I also learned that Canada accepts applications for study permits from people who are HIV

positive, as long as they are healthy. This gave me hope that in Canada, I would not be discriminated against based on my HIV status. I wanted a chance to prove myself and show that my HIV status does not in reality hinder me or my ability to learn and work. I wanted the chance to show that as a person, I am more than just my diagnosis and I have much more to contribute to society.

17. The approval of my initial study permit application gave me hope. I was hopeful that I would find acceptance in Canada, and finally get a chance to learn in an environment free from discrimination based on my HIV status.

18. This changed when I received the refusal letter. Immediately, I felt as if I was once again being pre-judged based on my HIV status alone. It felt like my chance to prove my abilities beyond my HIV status was taken away arbitrarily, even though I was healthy and had already been accepted to study in Canada. I was hurt, because it felt like Canada was judging me and stripping me of my dignity. It felt like I was no longer a whole person with many characteristics and abilities. Instead, Canada had prejudged me on one characteristic alone, my HIV status. And because of my HIV status, I was losing an important opportunity to study and improve myself. I was devastated.

19. The consequences of this refusal have been difficult for me. Without my study permit, I cannot continue my education, and I cannot work. With my study permit, I was able to work part time at a pharmacy in Toronto. This income helped me pay for my tuition and living expenses while living in Toronto. Without this income, I was thrown into financial uncertainty and am completely reliant on the money my parents gave to me to help me pay for my education. However, there is a limit to the support my parents can provide. I have a finite amount of savings, and without authorization to study and work, I will eventually run out of money and be unable to support

myself. In addition, my academic future has been indefinitely postponed and thrown into uncertainty.

20. The refusal has also impacted my mental health. The whole process has been torturous for me. Being judged solely on the basis of the virus I carry has significantly deteriorated my self-confidence and self-worth. Ever since the refusal letter, I have struggled to sleep, my appetite has disappeared, and I am constantly overthinking things and worrying about what will happen next. I feel anxious and depressed and have started to isolate myself more. Before the refusal, I was hopeful that I could exist in Canadian society free from discrimination based on my HIV status. Ever since the refusal the old feelings of stigma that I had in [redacted] have returned. I feel like I need to hide, and that I cannot disclose my HIV status to anyone for fear of being judged or denied services – just as I have been denied the ability to study.

Extension of time

21. I was informed of the negative decision on my application for a study permit on September 11th, 2023. Because I had never used legal counsel in applying for study permit previously, I didn't know who to consult about this decision. It took me a few days to be referred to the HIV Legal Clinic in Toronto, HALCO.
22. I contacted HALCO for an appointment to speak about the refusal on September 13, 2023. However, they did not have an available appointment for me to meet with a lawyer until September 18, 2023.
23. I accepted the appointment with HALCO, not knowing that I only had 15 days to apply for judicial review of the decision on my study permit application. Nowhere on the refusal letter does it state that I only had 15 days to apply for judicial review of the decision.

24. After meeting with HALCO on September 18, 2023, I was advised that they did not have the capacity to take on my case due to staffing issues. They referred me to Battista Migration Law Group. I met with counsel at Battista Migration Law Group on September 29th, 2023. After being advised by counsel of my right to apply for judicial review of the decision, I immediately instructed them to do so.
25. Since receiving the decision, I have always had a continuing intention to challenge the refusal. My delay in starting the legal challenge was related solely to the delay in my ability to consult legal counsel with an expertise in HIV and medical inadmissibility.

Request for anonymity

26. On October 3, 2023 my counsel submitted an anonymity order notice.
27. I requested that my identity be kept anonymous because of my HIV diagnosis. HIV is highly stigmatized here in Canada, and abroad. I have made the request to keep my identity a secret, because I am fearful that if my name is made public, I will face even greater levels of discrimination in Canada, and back home in [redacted] I am worried that this could include threats, or limit my ability to study, work, live where I choose in [redacted]
28. It would be especially difficult for me if my parents and friends were to find out about my HIV diagnosis. As I already noted, I have not told my parents or my friends back home in [redacted] that I am HIV positive. If public court record reveals my name, I will face incredible stigma and shame in my own home. The refusal has created a great deal of uncertainty in my life, so I want to be able to fight for my rights without the added fear that my HIV status will be discovered by my friends and family.

Additional evidence

29. I attach as **Exhibit "F"** to this Affidavit the response from IRCC Department Officials to questions posed by the Parliamentary Subcommittee on Citizenship and Immigration.

30. I attach as **Exhibit "G"** to this Affidavit a copy of the results of several Access to Information and Privacy requests.

31. I make this affidavit in support of my Application for Leave and for Judicial Review and for no other, or improper, purpose.

DECLARED remotely by)
[redacted]
Province of Ontario, before me)
on this 1st day of February,)
2024, in accordance with O. Reg.)
431/20, Administering Oath)
or Declaration Remotely.)

Michael Battista

A COMMISSIONER, ETC.

[redacted]

DEPONENT

This is Exhibit ‘F’ referred to in the affidavit of

[redacted]

sworn before me, this 1st

day of February 2024

A COMMISSIONER FOR TAKING AFFIDAVITS

IRCC's response to requests for information made by the Standing Committee on Citizenship and Immigration on October 24, 2017

Question 1: Medically Inadmissible Applicants

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?

Response:

For this question, IRCC has made the assumption that "deemed inadmissible" means a finding of inadmissibility by a medical officer. This may differ from a "decision", which means a final decision by the visa/immigration officer.

Table: Number of inadmissible Immigration Medical Examinations (danger to public health (M4), danger to public safety (M6), excessive demand (M5)) by year of assessment, broken down by immigration application type

Immigration application type	2013	2014	2015	2016	Total
PR*	1,042	887	524	628	3,081
TR**	137	119	97	87	440
Unknown	58	54	47	280	439
Grand Total	**1,237**	**1,060**	**668**	**995**	**3,960**

*PR = permanent residents
**TR= temporary residents
***Most applications with a coding of "unknown" are "up front medical examinations." This occurs when individuals present for an immigration medical examination before they have made an immigration application.
****Data obtained from GCMS as of Oct. 27, 2017.
*****Please note that the data is subject to change based on several factors due to the dynamic process of the immigration process, including changes in medical assessments, updates in final immigration decisions and changes in immigration categories that applicants apply to.
******Gradual deployment of the Global Case Management System (GCMS) began in 2010 and was not completed until 2014. As a result, health information was not consistently captured in IRCC's data systems prior to 2014.

IRCC's response to requests for information made by the Standing Committee on Citizenship and Immigration on October 24, 2017

Question 2: Diagnosis of Medically Inadmissible Cases

Question:

Hon. Michelle Rempel: 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 case.

Response:

The primary medical diagnosis is listed; however, applicants often have multiple medical diagnoses. There is no specific medical diagnosis that automatically renders a case as medically inadmissible. Medical decisions are made on a case-by-case assessment.

In the table, when there are two dashes (--), it means that there are less than five cases.

Table: Number of inadmissible Immigration Medical Examinations (danger to public health (M4), danger to public safety (M6), excessive demand (M5)) by year of assessment, broken down by primary medical diagnosis.

Count of inadmissible IMEs (M4, M5, M6)	**Year of IME assessment**				
Primary medical diagnosis	**2013**	**2014**	**2015**	**2016**	**Total**
AIDS: Acquired Immunodeficiency Syndrome - with or without Other Conditions	--	0	0	--	--
Alzheimer's Disease	10	10	5	15	40
Aneurysm	--	--	0	0	--
Aortic Valve Disease	14	--	0	--	21
Behaviour Disorder	--	--	--	--	8
Bipolar Disorder - Manic-Depressive Psychosis	--	0	0	--	--
Blood, and Blood-Forming Organ, Disease	5	8	--	--	19
Cardiomyopathy	30	22	5	18	75
Cerebrovascular Disease - Ill-Defined	31	19	8	13	71
Colon - Malignant Neoplasm	6	--	--	--	15
Congenital Anomaly	18	29	16	38	101
Congestive Heart Failure	5	7	--	--	17
Connective Tissue Disorder	13	11	10	13	47
COPD: Chronic Obstructive Pulmonary Disease	15	16	--	--	36
Depression	--	--	0	0	--

Osteoarthritis	15	22	--	--	48
Parkinson's Disease	17	--	--	9	34
Peripheral Vascular Disease	--	0	0	--	--
Personality Disorder	--	0	--	0	--
Pulmonary Fibrosis - Postinflammatory	--	0	0	--	5
Pulmonary Tuberculosis- Inactive	--	--	--	0	8
Pulmonary Tuberculosis Inactive – Previously Active	0	0	--	0	--
Pulmonary Tuberculosis: Active	14	9	9	17	49
Rectum, Rectosigmoid Junction and Anus - Malignant Neoplasm	5	--	--	--	12
Renal Failure - Chronic	150	120	81	149	500
Renal Function Impairment Disorder	0	0	0	5	5
Schizoaffective Psychosis	--	--	--	5	12
Schizophrenia	14	9	9	8	40
Senile Dementia	78	45	13	22	158
Small Intestine - Malignant Neoplasm	0	--	--	0	--
Stomach - Malignant Neoplasm	5	--	0	--	9
Trachea, Bronchus and Lung - Malignant Neoplasm	41	24	--	--	79
Unspecified	31	7	0	0	38
Total	**1,237**	**1,060**	**668**	**995**	**3,960**

*Data obtained from the Global Case Management System (GCMS) as of Oct. 27, 2017

** Please note that the data is subject to change based on several factors due to the dynamic process of the immigration process, including changes in medical assessments, updates in final immigration decisions and changes in immigration categories that applicants apply to.

***For confidentiality reasons, cell suppression was required when less than 5 cases were identified in a cell. As such, numbers may not add up to the total. As well, in rows where only one number was suppressed, a second number was also removed so that calculations could not be made to determine the suppressed number.

**** Gradual deployment of GCMS began in 2010 and was not completed until 2014. As a result, health information was not consistently captured in IRCC's data systems prior to 2014.

IRCC's response to requests for information made by the Standing Committee on Citizenship and Immigration on October 24, 2017

Question 3: Avoided Costs

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

Response:

A. *How did you arrive at the figure* (*annual cost savings*)?
Each finding by a medical officer involves identifying the estimated costs from the health and social services related to an individual's medical diagnosis, generally for the five years following the medical examination.

We used findings, rather than final decisions by visa officers, because applicants take decisions on their applications once they are informed of the assessment – if they abandon their application or submit an acceptable mitigation plan, there are still savings to the province of destination. An analyst examined the case files for applicants with excessive demand findings from 2014 and totaled up these estimated costs as the expected savings for provinces.

This is how we arrived at the estimate of $135M over five years for the expected savings from 2014 findings. Since the health conditions of applicants and the projected health and social services varies widely each year, the Department has not estimated or assigned an annual amount of savings. Findings from 2014 produce cost avoidance over five years. In 2015, and for each subsequent year, an additional estimate of $120M - $150M in avoided costs would overlap the previous years' savings.

B. *What is your projection if this policy continues*?
We have not gone beyond this one year of detailed estimates, however, we would expect that each subsequent year of findings would generate approximately $120M-150 M per year in expected savings, which, when added together, would provide the overall expected net benefit for provinces.

IRCC's response to requests for information made by the Standing Committee on Citizenship and Immigration on October 24, 2017

Question 7: Inadmissible cases close to cost threshold

Ms. Jenny Kwan: What about applicants who have been denied in previous years for amounts very near to this threshold? We have heard the number of people who are being assessed in these contracts. How many people were denied and for those who have been denied, and 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?

(...)

I want to clarify on the question around collecting data and providing the data back to the committee for the people who don't qualify based on the amount to which they exceeded the acceptable government rate of excessive demand. Could we have that number broken down by increments of $500? So rather than get the information to say within $50,000 they exceeded this amount and so they don't qualify, provide the smaller amounts so that we get a fuller sense of who's being rejected in smaller increments. I know of one case where an immigration lawyer came forward to say that her client was rejected because they exceeded the amount by $400. So I would like to see by how much people are being rejected and how much they did exceed the amount.

Response:

The attached table and bar graph provides the number of Immigration Medical Examinations assessed in 2014 as medically inadmissible for excessive demand that had a final immigration decision of refused, by estimated cost above the 2014 threshold of $31,635 over five years (shown in increments of $500).

Every application is considered on its merits. Before finalizing the decision, a departmental immigration or visa officer issues a procedural fairness letter outlining the reasons for the recommendation of medical inadmissibility. The applicant then has the opportunity to challenge the medical recommendation and submit further information as well as a mitigation plan. The officer takes this into consideration before making a decision. Applicants can apply for Humanitarian and Compassionate consideration of their application. They also can apply for leave for judicial review, and some applicants (sponsorship) can appeal the decision to the Immigration Appeals Division.

As to the inquiry regarding whether the Department intends to launch a proactive review of refusal decisions where the estimated costs were close to the threshold, the Department does not intend to review cases that have been previously determined inadmissible for excessive demand.

IRCC's response to requests for information made by the Standing Committee on Citizenship and Immigration on October 24, 2017

Question 8: Processing of Medically Inadmissible Cases

Ms. Jenny Kwan: 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?

Has IRCC's review of medical inadmissibility included a review of these inconsistencies? If yes, what efforts has IRCC taken 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 and, if yes, what is being done to make this happen. If not, why not?

Response:

An evaluation of IRCC's Health Screening and Notification (HSN) Program was conducted between November 2013 and December 2014. The evaluation noted that medical assessments were decentralized in several Regional Medical Offices across the world and recommended streamlining the assessments of excessive demand cases to ensure that decision-making is more straightforward, consistent and timely. In response, IRCC created a Centralized Medical Admissibility Unit (CMAU) in May 2015, which is located in Ottawa, with the mandate to assess all potentially medically inadmissible cases. The centralization of complex cases allows for the development and maintenance of a centre of expertise on the procedures and content necessary for such cases. It ensures that the same medical processing procedures are applied to all complex cases regardless of where the applicant resides, which is important for standardization.

The Department has also begun the process of centralizing the immigration officer components of the process for all new Permanent Resident Applications. Beginning later this year, all new permanent resident cases where an initial excessive demand determination has been made will be handled centrally by a dedicated team of subject matter experts in Ottawa. It is anticipated that, through centralization, the Department will be able to provide more timely and consistent decision-making to its clients.

IRCC's response to requests for information made by the Standing Committee on Citizenship and Immigration on October 24, 2017

Question 9: Exempt Groups Expansion

Ms. Jenny Kwan: 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, Mr. Chair. Is this true? If yes, what groups is the government considering to make exemptions from medical inadmissibility in excessive demand provisions?

Response:

IRCC has consulted with the provinces as part of its review of the excessive demand provision. Because this is a fundamental review, the Department informed them that it needed to examine the full range of possible changes. However, because the ultimate framing of detailed options rests with the Minister, and a final decision on the direction of the provision would fall to Cabinet, IRCC has not provided provincial officials with specifics.

IRCC's response to requests for information made by the Standing Committee on Citizenship and Immigration on October 24, 2017

Question 10: Persons with Disability – Exemption

Ms. Jenny Kwan: 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 able-bodied persons do not have to. Do officials or does the government acknowledge 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 being made. 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?

Response:

As noted at the Committee hearing, it is the Government's position that the excessive demand provision does not discriminate against persons with disabilities, as confirmed through current jurisprudence. IRCC would note that all applicants for permanent residency have to go through the process of health admissibility screening, including those who are currently exempted from the excessive demand provision. A decision on any changes to these exemptions would fall to Cabinet, and would in turn require legislative amendments to be introduced in Parliament.

IRCC's response to requests for information made by the Standing Committee on Citizenship and Immigration on October 24, 2017

Question 12: Negative Decisions Overturned

Ms. Salma Zahid: I would like to know, over the last few years what percentage of the negative decisions due to excessive demand were overturned by either a ministerial intervention, or the federal court, or the IRB?

Response:

The Department does not track the number of applicants for which ministerial intervention was used to overturn a decision to reject an applicant due to excessive demand. Related to the question, in 2016, 21 temporary resident permits were issued to overcome inadmissibility on health grounds (danger to public health or public safety, excessive burden), but the Department does not track how many were issued on the opinion of a departmental official versus on the Minister's instructions. In addition, the Minister may grant an applicant permanent resident status or an exemption from the excessive demand provision based on humanitarian and compassionate considerations. The Department does not track how many times the Minister did this for applicants who were inadmissible for excessive demand.

Federal Court

The following table identifies the number of cases of litigation received by the Federal Court for A38(1)c, broken down by year received. In the table:

- Dismissed refers to cases where the officer's refusal decision was upheld by the Federal Court.
- Consent/Allowed refers to cases returned to the processing office either, by the Court or due to consent by the Department, for re-determination as a result of some weakness or error in the decision; this error could have been procedural and not necessarily related to the medical assessment.
- Outstanding refers to cases that are currently before the Federal Court and no outcome has been reached.

Number of cases of litigation*	2012	2013	2014	2015	2016	2017**	Total
Dismissed	12	12	25	18	9	6	82
Consent/Allowed	4	15	15	15	14	10	73
Outstanding						5	5
Total	**16**	**27**	**40**	**33**	**23**	**21**	**160**

*The data from the Federal Court was not linked to immigration data and, therefore, includes applicants for permanent residence who submitted an appeal for health grounds.
**data is valid until September 2017.

VS. IAD

The following table identifies the number of cases of appeal received from the Immigration Appeals Division of the Immigration and Refugee Board of Canada since 2014 on health grounds, broken down by year received.

Number of appeals received by the Immigration Appeals Division of the Immigration and Refugee Board of Canada, by year

Year	Number of cases of appeal received*
2014	112
2015	83
2016	34
2017**	19
Grand Total	**248**

*The Immigration Appeals Division data was not linked to immigration data.
**Data is valid until September 2017.

The following table identifies the number of appeals received and overturned by the Immigration Appeals Division of the Immigration and Refugee Board of Canada since 2014 on health grounds, broken down by year received. It is important to note that new evidence may have been introduced to make the final Immigration and Refugee Board decision.

Number of cases of appeal received and overturned by the IAD, by year.

Year	Number of cases of appeal received and overturned
2014	40
2015	17
2016	2
Grand Total	**59**

*data is valid until September 2017.

IRCC's response to requests for information made by the Standing Committee on Citizenship and Immigration on October 24, 2017

Question 13: Mitigation Plans Accepted

Ms. Salma Zahid: My next question is, 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? (...) Would you have any numbers that how many of these plans have been accepted over the last two or three years?

Response:

Once an Immigration Medical Examination is completed, a medical officer assesses it for medical inadmissibility and shares the findings with a visa/immigration officer, who makes the final decision on admissibility. From 2013-2016, the number of cases found medically inadmissible on grounds of excessive demand but that had a final immigration decision approved was 706 (see table below for a breakdown by year). It is assumed that these cases were approved due to a viable mitigation plan; however, a case by case review would be required to determine if the approval was due to a mitigation plan or for other reasons, such as humanitarian and compassionate grounds.

WRONG ASSESSMENT

Table: Number of medically inadmissible (excessive demand - M5) Immigration Medical Examinations (IME) that had a final immigration decision approved, most likely due to a viable mitigation plan, by year of medical assessment.

	Year of IME assessment				
	2013	2014	2015	2016	Total
Count of M5* IMEs	262	224	104	116	706

*M5 medically inadmissible cases due to excessive demand on health care and social services.
**Data obtained from Global Case Management System (GCMS) as of October 27, 2017.
***Please note that the data is subject to change based on several factors due to the dynamic process of the immigration process, including changes in medical assessments, updates in final immigration decisions and changes in immigration categories that applicants apply to.
**** Gradual deployment of GCMS began in 2010 and was not completed until 2014. As a result, health information was not consistently captured in IRCC's data systems prior to 2014.

IRCC's response to requests for information made by the Standing Committee on Citizenship and Immigration on October 24, 2017

Question 14: IRPA Interpretation and Medical Instructions

Ms. Salma Zahid: How much scope do officers have with regard to the interpretation of Section 38.1 of the IRPA? When were the most recent ministry instructions issued and have officers been told to interpret the act strictly or they do have some more flexibility while making their decisions?

Response:

Medical and Visa Officers are mandated to apply the provisions of IRPA. They are guided by policy instructions when determining medical admissibility and are required to consider all the information, medical and non-medical, presented to them by the applicants. They exercise their decision-making authority objectively with fairness, consistency and in a transparent manner while making their assessments. IRPA is aligned with the Government of Canada's priorities to protect health, safety, and security of Canadians and the sustainability of publicly funded Canadian health and social services.

Excessive demand on health and social services Instructions to Medical and Visa Officers were updated as of December 30, 2016 and can be found online. The website address is: http://www.cic.gc.ca/english/resources/tools/medic/admiss/excessive.asp. A copy has been included for ease of reference.

IRCC's response to requests for information made by the Standing Committee on Citizenship and Immigration on October 24, 2017

Question 15: Humanitarian and Compassionate Considerations

Mr. Randeep Sarai: How many applications applied for that (medical) discretion, annually?

Response:

The following table provides the number of applicants that had a medical finding of excessive demand and a final immigration decision of approved or refused based on Humanitarian and Compassionate (H&C) grounds. It should be noted that the numbers represent only those cases where final decisions have been made; other final decisions may still be outstanding.

Table: Number of medically inadmissible (for excessive demand) Immigration Medical Examinations (IME) that had Humanitarian and Compassionate considerations, by final immigration decision and year of medical assessment.

Count of IMEs with a medical finding of excessive demand with a Humanitarian and Compassionate Decision					
	Year of IME assessment				
Final Immigration Decision	**2013**	**2014**	**2015**	**2016**	**Total**
Approved	42	69	51	41	203
Refused	5	9	3	4	21
Total	**47**	**78**	**54**	**45**	**224**

* Medically inadmissible cases due to excessive demand on health care and social services.
**Data obtained from GCMS as of Oct. 27, 2017.
***Please note that the data is subject to change based on several factors due to the dynamic process of the immigration process, including changes in medical assessments, updates in final immigration decisions and changes in immigration categories that applicants apply to.
**** Gradual deployment of the Global Case Management System (GCMS) began in 2010 and was not completed until 2014. As a result, health information was not consistently captured in IRCC's data systems prior to 2014.

IRCC's response to requests for information made by the Standing Committee on Citizenship and Immigration on October 24, 2017

Question 16: International Mitigation Guidelines

Mr. Randeep Sarai: Are there other countries that have a bond or mitigation guidelines that have been considered successful, specifically in western or developed countries? Or Australia?

Response:

Australia and New Zealand have provisions comparable to Canada's excessive demand provision. There are no mechanisms to mitigate inadmissibility in New Zealand. In Australia, applicants generally cannot offer to mitigate anticipated costs. The exception to this is under the skilled workers class, where the sponsoring employer provides an undertaking to meet the health costs.

IRCC's response to requests for information made by the Standing Committee on Citizenship and Immigration on October 24, 2017

Question 17: Active Tuberculosis and Syphilis

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

Response:

Active Tuberculosis in Immigration Processing

- Active infectious pulmonary tuberculosis poses a risk to airline passengers, and infected clients cannot travel to Canada using commercial transport.
- Individuals with active pulmonary tuberculosis are not medically admissible to Canada.
- An individual found to have active pulmonary tuberculosis during an Immigration Medical Examination must, therefore, undergo treatment prior to arriving in Canada. Most clients who have active infectious pulmonary tuberculosis undergo a six-month course of treatment. After beginning treatment, it can take up to four months to determine if the client is no longer infectious to others.
- In most cases, immigration medical decisions are delayed until the clients complete their course of treatment.
- Once the treatment has been successfully completed, individuals can then be admitted to Canada and are required to undergo medical surveillance by provincial or local public health officials after landing/arrival in Canada.
- Individuals can still be refused should they decline appropriate treatment for tuberculosis; withdraw their application rather than keep their application open (e.g. students who will miss their start dates at university); deliberately submit fraudulent documentation; or are discovered attempting to travel to Canada on a visa not normally requiring an immigration medical examination (e.g. a visitor visa). These clients can be assessed as being inadmissible.
- Appropriate treatment for difficult-to-treat tuberculosis can last two years or longer, and some of these clients have their applications refused but then submit a new application and can be considered for admission to Canada, although these cases are unusual.

Table: Number of medically inadmissible (M4 – danger to public health) Immigration Medical Examinations that had a final immigration decision of refused due to threat to public health, by year of medical assessment.

	Year of IME assessment				
	2013	**2014**	**2015**	**2016**	**Total**
Count of M4* IMEs	**8**	**4**	**5**	**6**	**23**

*M4 medically inadmissible cases due to threat to public health for active pulmonary tuberculosis.
** Data obtained from GCMS on Oct. 27, 2017.
***Please note that the data is subject to change based on several factors due to the dynamic process of the immigration process, including changes in medical assessments, updates in final immigration decisions and changes in immigration categories that applicants apply to.
****Gradual deployment of the Global Case Management System (GCMS) began in 2010 and was not completed until 2014. As a result, health information was not consistently captured in IRCC's data systems prior to 2014.

Table: Number of Immigration Medical Examinations (IME) with a medical diagnosis of treated inactive pulmonary tuberculosis, by year of medical assessment 2014 to September 2017

	Year of IME assessment				
	2014	**2015**	**2016**	**2017**	**Total**
Count of IMEs with treated inactive pulmonary tuberculosis**	**434**	**614**	**494**	**392**	**1,934**

*Active pulmonary tuberculosis identified at the time of the IME and successfully treated during the assessment process.
** Data obtained from GCMS ANSWERs on Nov 1, 2017.
***Please note that the data is subject to change based on several factors due to the dynamic process of the immigration process, including changes in medical assessments, updates in final immigration decisions and changes in immigration categories that applicants apply to.
****Gradual deployment of the Global Case Management System (GCMS) began in 2010 and was not completed until 2014. As a result, health information was not consistently captured in IRCC's data systems prior to 2014.

Active Tuberculosis in Canada

Number of Active Tuberculosis Cases in Canada as reported by the Public Health Agency of Canada					
Year	2012	2013	2014	2015	2016
Number of Active Cases	1685	1640	1568	1639	n/a

Syphilis in Immigration Processing

- Syphilis is an infection that responds well to antibiotic treatment, which usually consists of three visits to a clinic taken over a two-week period.
- If untreated syphilis is detected during the immigration medical examination, treatment is automatically offered to the client; the two-week delay does not have an adverse effect on the visa application and it is extremely rare for applicants to refuse treatment, once diagnosed.
- Over the last seven years, there has been only one case of a 40 year old client who initially declined treatment; however, after consultation with a local specialist he consented to receive appropriate treatment.
- Over this period of time, no client has been rejected for immigration due to 'untreated syphilis'.
- In view of the fact that all applicants who test positive for syphilis are treated and cured prior to finalization of their application, surveillance by provincial or local public health officials for syphilis is no longer required.

Syphilis in Canada

- Syphilis is the least common reportable sexually transmitted infection in Canada.
- There were 4,551 new infectious syphilis diagnoses in 2015 in Canada, according to the Public Health Agency of Canada.

- Syphilis outbreaks have been reported across Canada, including in Vancouver, Edmonton, Calgary, Winnipeg, Toronto, Ottawa, Montreal and the Yukon, with the highest reported rates of infectious syphilis diagnoses among Canadians aged 25 to 29.
- There are no reliable statistics in Canada of the number of untreated cases of syphilis, or the number of individuals who refuse treatment once diagnosed; once it is diagnosed, it is unusual for clients not to accept appropriate treatment.

IRCC's response to requests for information made by the Standing Committee on Citizenship and Immigration on October 24, 2017

Question 18: Tuberculosis Cases on Hold

Mr. Nick Whalen: When you were quoting these numbers back to us, I know we had been asking for rejections. Maybe you can also include the numbers of on holds as well so we have a sense of how much the application and the timelines are being impacted by these types of screening rather than them coming to Canada and being treated in Canada.

Response :

There are a total of 435 tuberculosis (TB) cases that are currently on hold due to TB treatment.

(Data obtained from the Global Case Management System (GCMS) as of October 27, 2017 and Migration Health Branch Regional Medical Offices databases on October 31, 2017.)

IRCC's response to requests for information made by the Standing Committee on Citizenship and Immigration on October 24, 2017

Question 19: Average Processing Time

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

Response:

The Department does not enter systematically into its Global Case Management System (GCMS) coded information that would allow it to search the processing times, by category of applicants found inadmissible for excessive demand. This analysis would require a case-by-case chart review.

As every case is unique, the time period from application to decision can vary widely. Looking strictly at the number of days between the date that an application is received and the final decision date would not provide data on processing times, as it may not account for the time period when applications are on hold for applicants to respond to furtherance letters that request additional medical testing. While the Department recognizes that, from a client perspective, this still contributes to the time it takes for the applicant to receive a final decision, there are also many reasons why an applicant may choose to delay their response to furtherance letters, or their application. Accounting for this time would provide a clearer picture of the time that a file is being processed. However, undertaking a comprehensive analysis to account for this time would require significant effort, given the need to review individual cases.

Furthermore, for some of the more complex cases, there exist data/system limitations (e.g., if a file is cancelled and re-submitted at a later date, the original received date may not be updated in GCMS).

With respect to applicants who have to undergo more than one Immigration Medical Examination (IME), although IRCC can provide the number of clients with two or more IMEs, the Department cannot specify which ones or how many were due to IRCC processing times because there could be various reasons for a second IME. Some of these other reasons could include, but are not limited to, clients doing up front medicals but taking a long time to submit their immigration application resulting in the expiry of the initial medical examination; some procedural fairness outcomes requiring a new medical examination; or clients taking long periods of time to respond to furtherance requests.

Table: Number of applicants that had more than one IME performed under the same application, with one of those medicals having been deemed medically inadmissible on the basis of excessive demand, by year of medical assessment.

	2013	2014	2015	2016	Total
Number of times where more than one IMEs were performed	**271**	**279**	**183**	**153**	**886**

* Data obtained from GCMS as of Oct. 27, 2017.

**Please note that the data is subject to change based on several factors due to the dynamic process of the immigration process, including changes in medical assessments, updates in final immigration decisions and changes in immigration categories that applicants apply to.

***Gradual deployment of the Global Case Management System (GCMS) began in 2010 and was not completed until 2014. As a result, health information was not consistently captured in IRCC's data systems prior to 2014.

IRCC's response to requests for information made by the Standing Committee on Citizenship and Immigration on October 24, 2017

Question 20: Autism Cases

Gary Anandasangaree: Would you be able to provide how many of the 84 (Autism cases) were able to go through the fairness process and were admitted to Canada?

Response:

It should first be clarified that the 84 autism cases referred to in the question are actually cases that were refused by an immigration/visa officer, following all steps in the process, including procedural fairness. Further details on number of cases are provided below.

It should be noted that no specific health condition will result in an automatic rejection of an applicant. Each applicant is assessed on an individual basis. As such, not all autism cases are refused. From 2014 to 2017, a total number of 460 cases had a primary medical diagnosis of infantile autism. Of this number:

- 336 were medically admissible;
- 40 had a medical inadmissibility finding of excessive demand but were then found admissible by a visa/immigration officer, who makes the final decision on admissibility; and
- 84 were refused, four of which have had their cases re-opened under Judicial Review as of November 11, 2017 (this is the number referred to in the question asked at the Parliamentary Committee meeting).

The table below provides the breakdown by year of the number of permanent resident applicants with a primary medical diagnosis of infantile autism that had a final immigration decision of "Refused".

Table: Number of medically inadmissible applicants for Permanent Residence with a Primary Medical Diagnosis of Infantile Autism that had final immigration decision of refused, 2014-March 2017*

Primary Medical Diagnosis	2014	2015	2016	2017	Total
Infantile Autism	37	16	23	8	84

* Due to changes in the systems used by the Medical Unit, data for years prior to 2014 is not available, as not all medicals were being processed in the Global Case Management System (GCMS).

**The classification of medical conditions is based in part on the International and Statistical Classification of Diseases (ICD) 9/10.

***Please note that the data is subject to change based on several factors due to the dynamic process of the immigration process, including changes in medical assessments, updates in final immigration decisions and changes in immigration categories that applicants apply to.

IRCC's response to requests for information made by the Standing Committee on Citizenship and Immigration on October 24, 2017

Question 21: Inadmissibility Based on Costs versus Wait Times

Hon. Michelle Rempel: I'm wondering if you could provide the committee with a breakdown of how many people let's say over the last five years have been deemed inadmissible on the first category as opposed to the second category *(costs and wait times)*, broken down by those two?

Response:

Under the *Immigration and Refugee Protection Act* (subsection 38(1) of the *Act*), foreign nationals are inadmissible if their health condition is likely to pose a danger to the public health or public safety, or might reasonably be expected to cause excessive demand on health or social services. Departmental medical officers assess the results of applicants' immigration medical examinations, taking into consideration the current state of their health condition(s), the likely prognosis, and the cost of anticipated health and social services required over the next five to ten years and the potential impact on wait lists.

Applicants are inadmissible if the predicted five-year cost of the health and social services required to treat their health condition, or that of an accompanying dependant, would likely exceed the average Canadian per capita cost ("the cost threshold"). The 2017 cost threshold is $33,275 over five years.

Applicants are inadmissible if the services required to treat their health condition, or that of an accompanying dependant, are expected to add to existing waiting lists and would increase the rate of mortality and morbidity for Canadian residents. The wait lists consideration is applied to services where IRCC has evidence that there are wait lists that are significant enough that admitting a foreign national who needs the service would be expected increase the rate of mortality and morbidity for Canadian residents. Presently, departmental medical officers have evidence of such wait lists only for dialysis and some transplantation services.

The Department does not enter systematically into its Global Case Management System coded information that would allow it to search the number of people deemed inadmissible based on the cost threshold versus wait times. This analysis would require a case-by-case chart review of all cases. In general, however, most findings based on wait times also exceed the cost threshold.

IRCC's response to requests for information made by the Standing Committee on Citizenship and Immigration on October 24, 2017

Question 23: Excessive Demand cases refused by medical diagnoses, immigration category and amount over the cost threshold

Ms. Jenny Kwan: (...) if the committee could be provided with a complete list of medical diagnoses used to deny applicants, so the number of applicants denied for, I think, the last 10 years so that we can actually get a sense of what that looks like for each of the categories.

When I say each of the categories, their live-in caregivers, the economic class, and so on and so forth. That's what I mean by that. Then for those numbers, can we get the reasons why they were denied. I'm not asking for information for particular cases, but in a group, so that there's no breach of confidentiality. (...) I would be very interested in looking at the information that's being provided on the reasons why people were denied. Do you also collect this data on the basis of those who were denied, how much did they exceed the figure of excessive demand which the government uses? (...)

Could we have that number broken down by increments of $500? So rather than get the information to say within $50,000 they exceeded this amount and so they don't qualify, provide the smaller amounts so that we get a fuller sense of who's being rejected in smaller increments. I know of one case where an immigration lawyer came forward to say that her client was rejected because they exceeded the amount by $400. So I would like to see by how much people are being rejected and how much they did exceed the amount.

Response:

To clarify, findings of excessive demand are all based on an individual assessment of the results of the applicant's Immigration Medical Exam, plus any supporting tests, documents, information or reports. There are no specific medical diagnoses that automatically renders an applicant medically inadmissible. Medical assessments for each individual applicant is done on a case-by-case basis.

Applicants are inadmissible to Canada if the predicted five-year cost of the health and social services required to treat their health condition, or that of an accompanying dependent, would likely exceed average Canadian per capita costs.

Please refer to the table in the response to Question 7 for the number of Immigration Medical Examinations assessed in 2014 as medically inadmissible for excessive demand that had a final immigration decision of refused, by estimated cost above the 2014 cost threshold of $31,635 over five years (shown in increments of $500).

Please see the table attached, which provides a breakdown by immigration application category and the primary medical diagnosis. As with the table below, it shows the number of Immigration

Medical Examinations assessed as inadmissible on health grounds between 2013 and 2016 that had a final immigration decision of "refused".

The following table shows the number of Immigration Medical Examinations assessed as inadmissible on health grounds due to excessive demand for Permanent Resident applicants (Temporary Resident applicants are not included in this table) who had a final immigration decision of refused, by year of medical assessment and primary medical diagnosis.

Primary Diagnosis	2013	2014	2015	2016	Total
Renal Failure - Chronic	81	65	36	42	224
Intellectual Disability	76	59	10	18	163
HIV Positivity - Asymptomatic	47	34	35	17	133
Developmental Delay	41	46	6	31	124
Infantile Autism	52	35	19	12	118
Senile Dementia	38	19	*	*	68
Nervous System Disorder	16	14	5	16	51
Ischaemic Heart Disease - Chronic	18	15	*	*	39
Trachea, Bronchus and Lung - Malignant Neoplasm	20	9	*	*	35
Congenital Anomaly	11	16	*	*	34
Hepatitis - Chronic	12	*	10	*	31
Hepatitis 'B'	12	*	15	*	30
Osteoarthritis	10	14	*	*	27
Cardiomyopathy	12	11	*	*	26
Cerebrovascular Disease - Ill-Defined	10	6	*	*	22
Impaired Hearing or Deafness	7	11	*	*	22
Female Breast - Malignant Neoplasm	6	11	*	*	21
Other	15	5	*	*	20
Parkinson's Disease	11	*	*	*	18
Genitourinary Organs- Malignant Neoplasm	6	9	*	*	17
Alzheimer's Disease	*	5	*	6	16
COPD: Chronic Obstructive Pulmonary Disease	6	7	*	*	14
Impaired Vision or Blindness	*	5	*	*	13
Heart Failure	9	*	*	*	13
Organ or Tissue Transplant	*	*	*	*	11
Hypertension	*	*	8	*	11
Mitral Valve Disease	5	*	*	*	10
Multiple Sclerosis	*	5	*	*	10
Liver - Cirrhosis: Chronic Liver Disease	*	*	*	*	9
Heart - Congenital Anomaly	5	*	*	*	9
Lymphoid and Histiocytic Tissue - Malignant Neoplasm	*	*	*	*	8
Aortic Valve Disease	6	*	*	*	7

Rectum, Rectosigmoid Junction and Anus - Malignant Neoplasm	*	*	*	*	7
Connective Tissue Disorder	*	*	*	*	7
Blood, and Blood-Forming Organ, Disease	*	*	*	*	7
Nonspecific Abnormal Findings	*	*	*	*	6
Colon - Malignant Neoplasm	*	*	*	*	5
Schizophrenia	*	*	*	*	5
Congestive Heart Failure	*	*	*	*	5
Nonspecific Abnormal Results of Function Studies	*	*	*	*	*
Liver and Intrahepatic Bile Ducts - Malignant Neoplasm	*	*	*	*	*
Pulmonary Tuberculosis- Inactive	*	*	*	*	*
Endocrine Gland - Malignant Neoplasm	*	*	*	*	*
Stomach - Malignant Neoplasm	*	*	*	*	*
Haemophilia: Congenital Factor VIII Disorder	*	*	*	*	*
AIDS: Acquired Immunodeficiency Syndrome - with or without Other Conditions	*	*	*	*	*
Neoplasm of Unspecified Nature	*	*	*	*	*
Leukaemia - Unspecified Cell Type	*	*	*	*	*
Nonspecific Abnormal Findings on Radiological and Other Examination of Body Structure	*	*	*	*	*
Malignant Melanoma - Skin	*	*	*	*	*
Multiple Myeloma	*	*	*	*	*
Personality Disorder	*	*	*	*	*
Aneurysm	*	*	*	*	*
Muscular Dystrophies and Other Myopathies	*	*	*	*	*
Small Intestine - Malignant Neoplasm	*	*	*	*	*
Nervous System - Malignant Neoplasm	*	*	*	*	*
Peripheral Vascular Disease	*	*	*	*	*
Inactive TB- Pulmonary Tuberculosis Inactive - Latent TB Identified during IME and treated	*	*	*	*	*
Renal Function Impairment Disorder	*	*	*	*	*
Pulmonary Fibrosis – Post-inflammatory	*	*	*	*	*
Diabetes Mellitus	*	*	*	*	*
Total	**593**	**455**	**206**	**190**	**1444**

*Data obtained from GCMS as of Oct. 27, 2017.
**Primary medical diagnosis is listed. Some applicants have multiple medical diagnoses. There is no specific medical diagnosis that automatically renders a case as medically inadmissible. Medical decisions are made on a case-by-case assessment.
***To protect privacy, counts of less than five cases have not been reported. As such, numbers may not add up to the total.

IRCC's response to requests for information made by the Standing Committee on Citizenship and Immigration on October 24, 2017

Question 24: Applicants impacted by this test

Mr. Nick Whalen: Ms. Kwan asked for a lot of information, but I'd like to make sure that in there it's not just rejections, that we're getting information on the people who are impacted by this test. Of all the 360,000 or 550,000 medical exams you look at, what percentage of them do they 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 does this become 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.

Response:

Among people who were not inadmissible on medical grounds, those who have a medical condition are assessed as M2 (medically admissible cases with a condition of public health concern that requires surveillance), M3 (medically admissible cases with a medical condition) or M2/3 (medically admissible cases with a condition of public health concern that requires surveillance and another medical condition)

A medical finding of M2 means a potential risk to public health (e.g. inactive tuberculosis). The majority of these individuals require additional testing (e.g. to verify the effectiveness of treatment) or treatment of their condition (e.g. for active tuberculosis) prior to a final decision being made. The vast majority of these individuals require medical surveillance by provincial or local public health officials after landing/arrival in Canada.

A medical finding of M3 means a health condition(s) is present but is not expected to place an excessive demand on health or social services. The majority of these individuals do not require any additional testing or treatment beyond the standard immigration medical examination because the severity of their disease is rated as low and uncomplicated, meaning they would require few health or social services.

Sometimes, in order to determine if a person would have an M2 or M3 finding, further testing is needed. Without conducting a case-by-case chart review, which would not be possible to complete in the timeframe available for the Committee's study, it is not possible to identify the number of individuals assessed as M2 or M3 who were required to undergo further testing or treatment.

With respect to the portion of the question concerning the assessment of impact on wait times that would increase the rate of mortality and morbidity for Canadian residents, please see the Department's answer to question 21.

Table: Percentage of Immigration Medical Examinations assessed as M2 (medically admissible cases with a condition of public health concern that requires surveillance) or M3 (medically admissible cases with a medical condition), 2014 – September, 2017

* Data obtained from GCMS as of November 3, 2017.

Immigration Medical Exam Assessment Result - Medical Code	**2014 (%)**	**2015 (%)**	**2016 (%)**	**2017 (up to Sept. 30, 2017) (%)**
M2 (medically admissible cases with a condition of public health concern that requires surveillance)	1.41	1.38	1.25	1.25
M2/3 (medically admissible cases with a condition of public health concern that requires surveillance and another medical condition)	0.45	0.43	0.43	0.41
M3 (medically admissible cases with a medical condition)	8.93	9.54	10.57	7.70

IRCC's response to requests for information made by the Standing Committee on Citizenship and Immigration on October 24, 2017

Question 25: Syrian Initiative – IFHP Utilization

Hon. Michelle Rempel: Do you think it would be possible to provide the committee with some sort of estimate or some sort of analysis on the estimated increase in cost past year one for, let's say, the Syrian refugee cohort? (...) Maybe just for lack of that data, could you provide us with the data that you do have for the utilization and top-up around the year one?

Response:

The following table provides information on Interim Federal Health Program (IFHP) utilization as of September 30, 2017, for the first cohort of Syrian refugees who arrived in Canada between November 4, 2015 and February 29, 2016.

Table: IFHP utilization by category of care for Syrian refugees who arrived between November 4, 2015 and February 29, 2016

Category of Care	Number of users*	Number of Claims Reimbursed	Value of Claims Reimbursed	% of Total Value of Claims Reimbursed
Assistive Devices	438	1,189	$823,935	3.7%
Counselling	27	112	$19,435	0.1%
Dental Care	14,441	76,905	$9,029,512	40.4%
Drugs	18,320	232,893	$6,285,277	28.1%
Home Visits-Nursing Homes	6	264	$41,414	0.2%
Hospital Care	2,348	5,434	$747,479	3.3%
Medical Care	8,195	73,193	$2,500,893	11.2%
Other Professional Services**	3,776	9,971	$731,940	3.3%
Transportation	711	837	$158,298	0.7%
Vision Care	10,152	30,959	$1,989,703	8.9%
Total	**23,122**	**431,757**	**$22,327,885**	**100.0%**

*The users may have made claims in a different category of care or a different province/territory. The sum of users by category of care or province/territory is therefore not equal to the total number of users.
**Includes services such as post-arrival health assessment, translation, and physiotherapy.

IRCC's response to requests for information made by the Standing Committee on Citizenship and Immigration on October 24, 2017

Question 26: Processing Costs

What is the cost to process excessive demand cases?

Response:

Using readily available information from the departmental analysis discussed during IRCC officials' testimony during CIMM hearings, the cost of processing excessive demand cases are estimated at between $800,000 and $1,100,000 per year.

This includes the assessment, litigation of cases, and policy work related to the provision, but does not include visa officer costs given the relatively small volume of cases these represent relative to overall file volumes.

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IRCC's response to requests for information made by the Standing Committee on Citizenship and Immigration on October 24, 2017

Context and definitions to explain IRCC data and responses

The responses to questions from members of the CIMM are based on:

- Data pulled from the Global Case Management System (GCMS),
- An in depth case-by-case analysis of 2014 medically inadmissible files, and
- Data pulled from the Interim Federal Health Program database on claims.

The responses provide the numbers based on applicants, meaning individuals, rather than on applications, which can include multiple applicants (individuals) in a family group.

The majority of the data provided comes from the Department's Global Case Management System (GCMS). There were limitations in obtaining historic data as the gradual deployment of GCMS began in 2010 and was not completed until 2014. As a result, health information was not consistently captured in the Department's data systems prior to 2014. Where possible, partial results are reported for 2013 to 2017.

The date that the data was accessed is specified. Data obtained on other dates may differ due to several factors related to the dynamic process of the immigration process, including changes in medical assessments, updates in final immigration decisions and changes in immigration categories to which applicants apply.

For some questions, responses provide numbers based on immigration medical assessments conducted in 2014 only. This is because some health information, such as the predicted cost of services, is captured in the Department's data systems in note form only (e.g. notes between the medical officer and the visa/immigration officer). In order to analyze this information to provide numbers, it was necessary to first conduct an in-depth case-by-case analysis. Because in-depth case-by-case analyses are very time consuming, (for example, it took several months for one analyst to review the 2014 cases), the analysis was limited to one year, 2014. Analysis of additional years was not possible for this request. 2014 was chosen as a representative year because all cases were fully entered into the new GCMS system and most cases would have been finalized, including through the procedural fairness stage.

For the responses, "deemed inadmissible" was understood to mean a finding of inadmissibility by a departmental medical officer. The term "decision" was understood to mean a final decision by the visa/immigration officer. The Department reports on both stages in the process. The number of cases deemed inadmissible is always larger than the number ultimately refused at the decision stage. The number diminishes between the stage of a finding of excessive demand by a medical officer and a decision by a visa/immigration officer to refuse an application. For example, an applicant may withdraw their application or provide a credible plan to mitigate the costs (e.g., by committing to pay out of pocket or seek private services) or the visa/immigration officer may approve the applicant on humanitarian and compassionate considerations or may refuse them on non-health grounds.

Additionally, some cases that receive a finding of inadmissibility by the medical officer are not finalized before the end of a given calendar year. This may be because the Department is waiting for the applicant to prepare a response at the procedural fairness stage (which precedes the visa/immigration officer's decision) or because the medical assessment was done close to the end

of the calendar year (i.e., such that a final decision by the visa/immigration officer does not occur until the next calendar year).

For questions regarding diagnosis, the primary medical diagnosis has been reported. Some applicants have multiple medical diagnoses. There is no specific medical diagnosis that automatically renders a case as medically inadmissible. Medical recommendations to visa/immigration officers are made on a case-by-case basis.

To protect privacy, counts of less than five cases have not been reported. As such, numbers may not add up to the total.

IRCC's response to requests for information made by the Standing Committee on Citizenship and Immigration on October 24, 2017

ANNEX – Question 7: Inadmissible cases close to cost threshold

Table: Number of Immigration Medical Examinations (IMEs) assessed in 2014 as inadmissible on health grounds due to excessive demand who had a final immigration decision of refused, by estimated cost above the 2014 cost threshold of $31,635 over five years (shown in increments of $500).

Note that results less than 5 have not been suppressed for this table, because doing so would have made nearly all of the table unreadable.

Estimated cost (over five years) in increments of $500, that is over the 2014 threshold	Count of IMEs
3,001-3,500	1
8,001-8,500	2
9,501-10,000	2
12,501-13,000	1
13,000-13,500	1
14,000-14,500	7
16,001-16,500	1
17,501-18,000	1
19,501-20,000	1
21,001-21,500	10
22,001-22,500	1
22,501-23,000	1
23,001-23,501	7
25,501-26,000	1
25,501-26,001	1
25,501-26,002	1

25,501-26,003	1
31,001-31,500	9
33,001-33,500	14
36,001-36,500	1
36,501-37,000	1
37,501-38,000	2
38,001-38,500	6
39,001-39,500	2
39,501-40,000	1
40,501-41,000	3
41,001-41,500	1
41,501-42,000	1
42,001-42,500	2
43,001-43,500	5
43,501-44,000	2
46,001-46,500	1
46,501-47,000	7
47,001-47,500	1
47,501-48,000	1
50,501-51,000	1
52,501-53,000	1
53,001-53,500	1
55,501-56,000	13
57,501-58,000	4
59,501-60,000	1
62,001-62,500	1
63,501-64,000	2

64,001-64,500	1
65,001-65,500	1
68,001-68,500	7
71,001-71,500	2
73,501-74,000	4
74,001-74,500	1
76,501-77,000	2
80,001-80,500	2
81,501-82,000	1
86,501-87,000	3
88,001-88,500	2
88,501-89,000	1
93,001-93,500	3
95,001-95,500	1
97,001-97,500	1
98,001-98,500	1
99,001-99,500	3
103,001-103,500	1
108,001-108,500	3
111,501-112,000	1
112,001-112,500	1
114,001-114,500	1
118,001-118,500	3
119,501-120,000	2
129,001-129,500	1
131,001-131,500	10
138,501-139,000	1

139,001-139,500	1
139,501-140,000	1
140,001-140,500	1
141,001-141,500	1
143,001-143,500	3
144,501-145,000	1
145,001-145,500	2
145,501-146,000	3
148,001-148,500	1
148,501-149,000	1
149,001-149,500	3
151,001-151,500	3
155,001-155,500	1
155,501-156,000	1
156,001-156,500	2
158,001-158,500	4
160,001-160,500	1
161,501-162,000	1
163,001-163,500	1
166,001-166,500	1
168,001-168,500	1
168,501-169,000	1
169,501-170,000	2
170,001-170,500	2
171,501-172,000	1
173,501-174,000	1
177,501-178,000	4

178,001-178,500	2
180,001-180,500	1
183,501-184,000	1
193,001-193,500	7
195,501-196,000	1
198,001-198,500	1
199,501-200,000	4
202,501-203,000	1
203,001-203,500	4
204,001-204,500	1
204,501-205,000	1
205,501-206,000	1
209,001-209,500	3
210,501-211,000	1
213,501-214,000	1
215,001-215,500	2
215,501-216,000	1
217,501-218,000	1
221,001-221,500	1
223,501-224,000	1
226,501-227,000	2
233,001-233,500	7
236,501-237,000	6
240,501-241,000	1
243,001-243,500	2
244,001-244,500	2
247,001-247,500	6

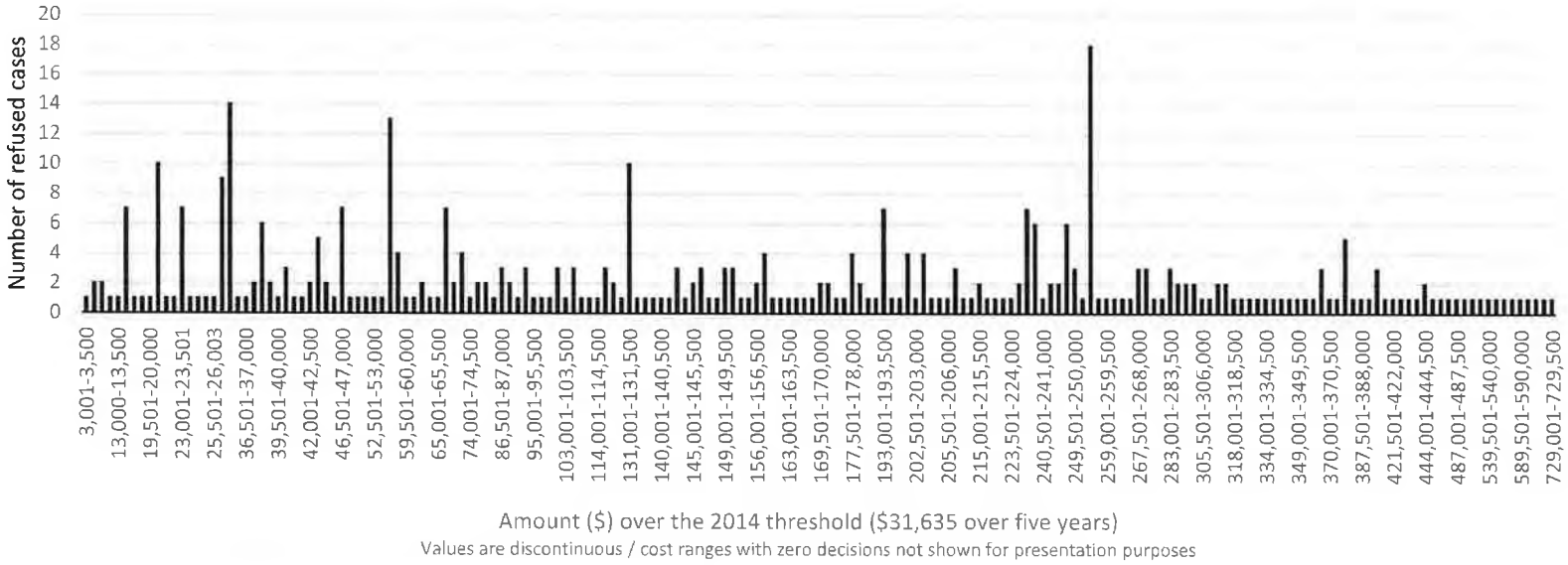
249,501-250,000	3
250,001-250,500	1
253,001-253,500	18
255,001-255,500	1
259,001-259,500	1
260,501-261,000	1
261,501-262,000	1
262,501-263,000	1
267,501-268,000	3
268,001-268,501	3
276,001-276,500	1
279,501-280,000	1
283,001-283,500	3
284,501-285,000	2
290,501-291,000	2
291,001-291,500	2
305,501-306,000	1
306,001-306,500	1
309,001-309,500	2
317,501-318,000	2
318,001-318,500	1
318,501-319,000	1
321,001-321,500	1
331,501-332,000	1
334,001-334,500	1
343,001-343,500	1
346,501-347,000	1

347,001-347,500	1
349,001-349,500	1
353,501-354,000	1
361,501-362,000	1
362,501-363,000	3
370,001-370,500	1
371,501-372,000	1
383,001-383,500	5
386,501-387,000	1
387,501-388,000	1
406,501-407,000	1
417,501-418,000	3
418,001-418,500	1
421,501-422,000	1
423,001-423,500	1
428,001-428,500	1
436,501-437,000	1
444,001-444,500	2
452,001-452,500	1
483,001-483,500	1
486,501-487,000	1
487,001-487,500	1
499,001-499,500	1
504,001-504,500	1
504,501-505,000	1
539,501-540,000	1
559,001-559,500	1

563,501-564,000	1
568,001-568,500	1
589,501-590,000	1
597,001-597,500	1
605,501-606,000	1
718,001-718,500	1
729,001-729,500	1
Grand Total	**391**

*Data obtained from GCMS as of Oct. 27, 2017.
**Results obtained from merging the 2014 excessive demand findings among immigration medical assessments with the results of an in-depth case-by-case analysis conducted by the Department for cases in 2014. The estimated cost ($) above the 2014 cost threshold of $31,635 over five years is shown for cases with a final immigration decision of refused. The cost is shown in increments of $500. Increments not shown indicate no cases for that value.
***Please note that the data is subject to change based on several factors due to the dynamic process of the immigration process, including changes in medical assessments, updates in final immigration decisions and changes in immigration categories to which applicants apply.
****Values are discontinuous; cost ranges with zero decisions not shown for presentational purposes.

Graph 7. Frequency distribution of the number of Immigration Medical Examinations (IME) assessed in 2014 as medically inadmissible for excessive demand that had a final immigration decision of refused, by estimated cost above the 2014 cost threshold



This is Exhibit ‘G’ referred to in the affidavit

of [redacted]

sworn before me, this 1st

day of February 2024

A COMMISSIONER FOR TAKING AFFIDAVITS

ACCESS TO INFORMATION AND PRIVACY (ATIP) RESULTS INDEX

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A Cost-Benefit Analysis on the Excessive Demand provision in the Canadian Immigration Processing System

Ye Tao

September 9, 2016

Any comments or requests for information may be transmitted to:

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Table of Contents

Executive summary

Introduction The excessive demand (XSD) provision is used to prevent applicants who may require health and social services in excess of the Canadian average in coming to Canada. However, debates about whether this provision truly protects our health care system frequently arise. This analysis attempts to quantify the costs and benefits of the XSD provision.

Methodology We report costs and benefits of the XSD provision in three categories, using a Treasury Board Secretariat template: costs and benefits quantified in monetary terms, costs and benefits quantified in non-monetary terms, and costs and benefits described qualitatively. To reflect the uncertainty of estimation of cost and benefit, a level of uncertainty that is determined by data relevancy, complexity of the cost and benefit determination, and assumption plausibility is attached to each estimate.

Data Sources The data for the cost-benefit analysis of the XSD provision are mainly collected from Global Case Management System (GCMS), IRCC's regional medical offices (RMO) and other branches. Other sources include Statistics Canada, Canada Institute for Health Information (CIHI), and research and analysis on immigration health and labour data.

Estimation and main findings Table 1 in the follow page briefly summarizes the costs and benefits brought to Canadian society by the XSD provision and presents their estimates or results. The two main findings based on these estimation are:

- The health care and social services preserved from the XSD cases in 2014 is $135 million projected over the first 5 years after the immigrant's potential arrival to Canada. This is 279 times the processing cost of running the XSD program in 2014.
- It is possible to estimate that the XSD provision deterred more than 800 people with HIV, renal failure, hepatitis B, and developmental delay (the top four prevalent conditions leading to an XSD assessment) from sending an economic class immigration application in 2014 which otherwise would increase processing of XSD cases by 36%.

Conclusion The XSD provision constitutes an important part of Canada's immigration system. It preserves substantial resources for Canada with relatively small input.

Table 1: Summary of estimation and results

Cost	Benefit
Cost in monetary term - direct **1. Processing cost:** expenditures on identifying, assessing and reassessing XSD cases (M5) ***Estimation*:** convert MOFs, case and adjudicators' time spending on identifying, assessing and reassessing M5 cases into dollar values ***Estimation result*:** $ 483,166 ***Level of uncertainty*:** low **2. Deportation cost**: inland XSD applicants ***Estimation*:** Ignoring deportation cost ***Level of uncertainty***: low **3. Litigation cost** ***Estimation*:** sum of litigation cost of all appeals due to disagreement with MOF's XSD assessments ***Estimation result***: $270,000 - $550,000 ***Level of uncertainty***: is low for overseas appeals but may be high for inland appeals **Cost in monetary term - indirect** **Cost of other work relevant to XSD :** policy analyst at MHB whose work is indirectly related to XSD ***Estimation*:** convert policy analysts' time spending on M5 cases into dollar values ***Results***: $57,289 ***Level of uncertainty***: low **Cost in non-monetary term** **Rejection of people without XSD problem:** the whole family will be denied if one of their family members has XSD problem ***Estimation***: no estimation involved ***Results*:** In 2014, 3068 of those people were rejected, 403 among them aged 15 to 54 with a bachelor or higher degree. ***Level of uncertainty***: no uncertainty issue **Cost described qualitatively** **Media critiques and poor country image** ***Estimation*:** no estimation involved ***Results***: Canada's immigration system was often described as short-sighted and selfish – a system cares only Canada's current interests, and Canada's country image was disproportionally damaged by the public outrage of several XSD cases ***Level of uncertainty***: no uncertainty issue	**Benefit in monetary term - direct** **Saved XSD cost:** health care and social services saved by denying applicants assessed as excessive demand from coming to Canada **Estimation**: sum of cost estimate of all M5 cases in 2014 **Estimation result**: $135 million over 5 years. Health care and social services saved in 5 years is 279 times the processing cost. **Level of uncertainty:** low **Benefit in monetary term - indirect** **Production gains:** due to the replacements of M5 applicants **Estimation**: earning difference between replacements and M5 applicants **Results:** $0.7-$0.9 million per year six months after landing, $1.1-$1.3 million 2 years after landing, and $1.4-$1.6 million 5 years after landing **Level of uncertainty**: high **Benefit in non-monetary term** **1. Prevent people with severe health condition** (HC) from submitting an application ***Estimation*:** the number of economic class applicants with HIV and 3 other health conditions who were prevented by the XSD provision in 2014 ***Results*:** in 2014, the XSD provision prevented 838 economic applicants with these four health conditions from submitting applications, which otherwise would bring additional 335 M5 cases in 2014. ***Level of uncertainty*:** medium or high **2. Avoid to add new cases** to existing waiting lists and avoid to increase the rate of mortality and morbidity in Canada as a result of an inability to provide timely treatment ***Estimation*:** no estimation involved ***Results*:** Between 250-300 cases per year are assessed as excessive demand for this reason alone. ***Level of uncertainty*:** no uncertainty issue **Benefit described qualitatively** **Contribution** to (1) the healthy immigrant effect; (2) quick settlement and integration ***Estimation***: no estimation involved **Results**: (1) the XSD provision is one of the main contributors to the healthy immigrant effect; (2) It reduces the number of immigrants who have difficulties in their initial settlement and long-term integration. **Level of uncertainty**: no uncertainty issue

1. Introduction

Paragraph 38(1) (c)[1] of the Immigration and Refugee Protection Act (IRPA) states that a foreign national is inadmissible on health grounds if he or she is expected to cause excessive demand (XSD) on health or social services. The aim of the XSD provision is to prevent immigration to Canada by applicants who may require health and social services in excess of the Canadian average; however, debates about whether this provision truly protects our health care system frequently arise.

First, very few people have been denied entry into Canada on the grounds of excessive demand since it was introduced in the 1976 Immigration Act. This has always raised questions concerning the value of this provision. In fact, excessive demand cases ranged from only 0.31 to 0.96 percent of the total immigration applications between 1993 and 2002. After IRPA exempted all family-class sponsored spouses, common-law and conjugal partners and their dependent children, and convention refugees and persons in need of protection and their dependents from XSD determination, the proportion became even smaller, to a level around 0.2 percent (see Annex A). Second, the XSD provision has been frequently challenged in court which often implies a significant amount of litigation cost, as different interpretations of the provision have been the basis for appeals. Third, the immigration medical examination (IME) heavily relies on applicants' self-reported health information, and only a limited number of diseases are screened for using objective medical tests. Given that applicants are not always aware of their health problems or in rare cases may even conceal them, applicants who were assessed as medically admissible may start to require excessive health and social services soon after they enter Canada. The XSD provision would fail to screen these people out. This failure could be worsened by emerging or re-emerging diseases worldwide and panel physicians' lesser familiarity with diseases that are not common in their geographic areas.

Cost-benefit analysis (CBA) is widely used to assess medical treatments, programs, and government policies. It values the costs and benefits of an intervention and compares them with that of alternatives, particularly, the alternative of no intervention. To respond to the concerns and doubts on the XSD provision, and more importantly, to ensure effective and efficient use of public

[1] In this analysis, we refer to this clause as the Excessive Demand (XSD) provision.

resources, a cost-benefit analysis on the XSD provision is essential. This analysis compares the costs and benefits of the XSD provision with that of no intervention to the XSD cases. It reports costs and benefits through three categories, costs and benefits quantified in monetary terms, costs and benefits quantified in non-monetary terms, and costs and benefits described qualitatively, as suggested by the Treasury Board Secretariat. To reflect the estimation uncertainty of these costs and benefits, a level of uncertainty is attached to each of these estimates. The levels of uncertainty are classified as low, medium and high depending on the data used in the estimation, the complexity of the cost and benefit determination mechanism, and assumption plausibility.

This analysis only focuses on the cost and benefit that the XSD provision has brought to Canadian society, and does not discuss the cost and benefit that the provision has imposed on others, particularly, on the immigration applicants. Finally, as we shall see, data availability limits the range of the proposed analysis. Nonetheless, this study proposes to take advantage of the available data to make a reasonable cost-benefit analysis on excessive demands.

2. Assumptions

There are two types of assumptions in this analysis. The first type includes assumptions that hold for all permanent residence and temporary residence (PR and TR) applicants – the studied population. The second-type of assumptions are those that only hold for certain PR and TR applicants. These assumptions will be discussed in each section relevant to specific groups of applicants. In this section, we only list the broad, first-type assumptions:

(i) The PR and TR target levels are independent of the XSD provision. The denial of excessive demand cases does not change the number of immigrants to Canada and the denied applicants are replaced by applicants without excessive demand conditions.

(ii) Applicants may not be aware of the details of the XSD provision when applying for immigration to Canada; however, it is assumed that all applicants know that one or more severe medical condition(s) will likely result in rejection of their application.

(iii) People will not apply for immigration if they believe their application is very likely to be rejected. A failed application is costly and time consuming and may impact an applicant's life trajectory and aspirations.

3. Methodology

3.1 Types of cost and benefit

This cost-benefit analysis (CBA) on the XSD provision compares results of the implementation of the provision with a scenario in which no intervention screens for excessive demands. In general, the CBA requires that both the cost and benefit of the intervention be translated into monetary terms. However, some costs and benefits resulting from the XSD provision are hard to quantify in monetary terms. For example, criticisms that the XSD provision discriminates against people with disabilities have often appeared on media. But it is nearly impossible to quantify this cost in monetary terms. On the other hand, the main purported benefit brought by the XSD provision is that it prevents people with severe medical conditions from applying to immigrate to Canada. These people might have intended to apply but may have relented. However, because we only attempt to estimate this deterrence effect for economic applicants with certain health conditions, it is hard to translate this into a total dollar figure. In order to reflect the whole picture of costs and benefits resulting from the XSD provision, we adopt the strategy recommended by the Treasury Board Secretariat (TBS). The method reports costs and benefits through three categories, namely, costs and benefits quantified in monetary terms, costs and benefits quantified in non-monetary terms, and costs and benefits described qualitatively.

3.2 Uncertainty of cost and benefit estimations

In this analysis, the estimation of some costs and benefits uses data from external sources such as research publications which are not directly relevant to PR and TR applicants. The indirect relevancy of these data is likely to create a significant bias in the estimation. Therefore, the uncertainty of these estimates is higher than those that depend only on internal data - data reflecting

applicants themselves or directly relating to processing them. Moreover, some cost or benefit is a combined effect of the XSD provision and other factors. Isolating the pure effect due to the XSD provision is close to impossible; this also adds uncertainty to the cost and benefit estimation. To reflect the uncertainty of estimation, in this analysis, a level of uncertainty is attached to each cost and benefit estimate, using three levels of uncertainty—low, medium and high.

The level of uncertainty is determined by: the data used for the estimation, the complexity of the cost or benefit determination mechanism, and the plausibility of estimation assumptions[2]. A low level of uncertainty corresponds to the use of internal-data and a direct and one-factor-determined (the XSD provision) cost or benefit, while a high level of uncertainty is due to either the use of external data or an indirect and multiple-factor-determined (including the XSD provision) cost or benefit. To estimate cost and benefit brought by the XSD provision, we have to make assumptions. Estimation with a low-level uncertainty is based on strong assumptions, while estimation with a high level of uncertainty is normally related to weak assumptions. Table 2 attempts to describe these levels of uncertainty of the estimation.

Table 2: Levels of uncertainty of estimations

Level of uncertainty	Data sources	Data relevance	Determining factor	Assumption
Low	internal	direct	single factor	strong assumption
Medium	mixture of internal and external	external data highly relevant	single factor	weak or medium assumption
High	mixture of internal and external	external data and somewhat relevant	multiple factors	weak assumption

Attaching a level of uncertainty to estimations enables us to obtain a strict and reliable estimate if we only wish to consider costs and benefits at the low level of uncertainty. It also allows us to look into different types of costs and benefits brought by the XSD provision when costs and benefits at medium and high uncertainty levels are also considered.

[2] In economics, a strong assumption is far from the reality while a weak assumption closer to the reality. It contradicts the sense of English language. In this analysis, we use "strong" and 'weak" assumptions in the sense of common English usage.

4 Data Sources

The data for the cost-benefit analysis of excessive demand are collected from: (1) the Global Case Management System (GCMS); (2) IRCC's regional medical offices (RMOs); (3) statistics of national and international sources such as Statistic Canada, Canada Institute for Health Information (CIHI), and World Health Organization (WHO), and (4) research and analysis on immigration health and labour. Some important data for this analysis were provided by work units at different branches of IRCC such as OPS Statistics and Reporting Unit (OPS-Stats), Litigation Management Division (BCL) and Department Legal Service Unit (DLSU), and other government department such as Department of Justice (DOJ). To correspond to the methodology used in the analysis, these data are also classified into three categories: data used for estimating costs and benefits quantified in monetary term, data used for estimating costs and benefits quantified in non- monetary term, and data used for describing costs and benefits qualitatively. Table 3 below lists these data and their sources.

Table 3: Data for cost benefit analysis on the excessive demand provision

Data		Data content	Data source
Quantified in monetary term	Cost	Work contributing to the identification, assessment and reassessment of XSD cases	Migration Health Branch (MHB), Regional Medical Office (RMO)
		Litigation cost from XSD appeals	provided by Case Management Branch & Department of Justice
		Deportation cost of XSD cases	provided by OPS-Stats team of OPMB-PMU
	Benefit	Cost estimate of health care and social services related to XSD cases	GCMS, medical officers' narrative
		Labour market participation rate, employment rate of immigrants, and employment earnings	statistics from IRCC and STC
Quantified in non-monetary term	Cost	Information on family members of applicants who were assessed as excessive demand	provided by OPS-Stats team of OPMB-PMU
	Benefit	Immigration applications by immigration class, sex, age, and country of origin	Medical-HB subject area of GCMS Answers
		Applicant's health information /XSD cases by immigration class, sex, age, and country of origin and medical condition(s)	Medical-HB subject area of GCMS Answers
Described qualitatively	Cost	News and critics on XSD assessments and appeals; the XSD threshold in recent years	Media, MHB
		The health spending of Canadians by age, sex provinces and territories in recent years	Statistics and researches from HC and CIHI
		Work by visa officers contributing to the identification, assessment and reassessment of XSD cases	R&E survey
	Benefit	Statistics on health immigrant effect and integration	Immigration research

5. Estimation and results

5.1 Cost

5.1.1 Cost quantified in monetary term

The costs incurred by the XSD provision that can be quantified in monetary term include: (1) processing cost resulting from identifying, assessing and reassessing excessive demands cases, these expenditures are used to pay the salary of MOFs, medical doctors (RMOs overseas), and case and health adjudicators; (2) litigation fees resulting from excessive demand appeals, these fees are spent on external legal consultation and services; (3) deportation expenses for removing

landed foreign nationals handed a removal order due to excessive demand. Processing expenditures, litigation fees, and deportation expense are direct cost that are quantified in monetary terms.

5.1.1.1 Direct cost 1 - Processing cost

Estimation Expenditures resulting from identifying, assessing and reassessing excessive demands cases all contribute to processing costs and include the following:

- Medical Opinion: identifying potential excessive demands cases based on Immigration Medical Examination (IME).
- Fairness Procedure: filing an excessive demands judgment, medical opinion, notifying applicants of the judgment, and requiring more information about the medical condition or self-supporting plan. For example, in the Social Service Procedural Fairness letter that is sent to applicants assessed as XSD, all social services required in relation to the medical condition and the corresponding expenses are listed[3].
- Medical Profile: assessing potential excessive demands cases based on new information provided by applicants and making an evaluation of medical admissibility or medical inadmissibility.
- Assessment of financial ability: assessing the self-support ability of the applicants who have been identified as excessive service demanders but who claim responsibility to provide or pay the excessive demands on social services through a mitigation plan, and then reassessing the application.

MOFs in NHQ, and MOFs and local medical personnel in RMOs overseas, and case and health adjudicators are responsible for the above tasks. However, as identifying, assessing, and reassessing XSD cases is only a part of their work, we need to evaluate the percentage of their working time spent on these activities to estimate the processing cost. Since May 2014, medical officers (MOF) in regional medical office (RMO) at Ottawa have been required to record their time spent on XSD assessments. Based on the records from May 2nd to July 16th, 2014, 23.3% of MOFs' time at RMO Ottawa was spent on XSD assessments. Case adjudicators process both electronic and paper IME forms. They spend much less time on electronic form than paper form[4]. However, when they process the same type of forms, they spend almost the same amount of time

[3] See page 68 of *OP15 Medical Procedures*, Appendix U: Declaration of Ability and Willingness, 2012-08-02.
[4] According to case adjudicators' estimation, they approximately spend 2 minutes on processing an electronic form while they spend 10 minutes for a paper form because they need to input the information digitally first.

on each case no matter whether it is a potential XSD case or not. Based on the number and types of electronic and paper forms processed by case adjudicators between July 1st, 2013 and January 1st, 2014, they spent a half percent (0.5%) of their working time on XSD cases. Health adjudicators or nurses also spend a similar length of time on each case including potential XSD cases. According to the cases they processed in 2013, health adjudicators spend 8.4 percent of their working time on cases with XSD concerns[5]. See these estimates in Table 4.

Table 4: MOFs and Case and Health Adjudicators' time on XSD cases (RMO Ottawa)

Medical Officers (MOF)	2014/05/02-2014/07/16
Total time for diagnosis (minutes)	21450
M5 time	3825
Time on Procedural Fairness	1175
Percent of time on XSD cases	23.3%
Case Adjudicator (CA)	2013/07/01 - 2014//01/01
Total IME from processed (minutes)	107436
IME form for M5 concern	512
Proportion of time on XSD cases	0. 5%
Health Adjudicator (HA)	2013/01-2013/12
Total IME forms processed	112750
IME form for M1-M3 concerns	103283
IME form for M4-M6 concerns	9467
Proportion of time on XSD cases	8.4%

MOFs who work at RMOs overseas have not recorded their time spent on XSD assessments as their colleagues have done in RMO Ottawa. However, we know the number of MOFs working in RMOs, and can make an estimation based on the proportion of time MOFs at RMO Ottawa spent on XSD cases. The estimated percentages of time MOFs at each RMO spent on XSD cases are listed in Table 5.

Table 5: Medical Officers' time (%) on XSD cases

Office	# of M5 cases	# of MOFs	percent
Ottawa	188	2.6	23.3%
London	328	3.5	30.2%
Manila	323	4	26.0%
New Delhi	93	2	15.0%

*: The number of MOFs and medical doctors at each RMO was provided between August 7 and 10, 2014.

[5] Health adjudicators reported excessive demand (M5), risk to public health (M4), and risk to public safety (M6) cases as an aggregate number and did not report them separately. However, given only one percent of these cases are M4 and M6, here we ignore the trivial difference made by M4 and M6 cases.

We also know the number of case and health adjudicators working in RMOs[6]. They follow the same procedure as case and health adjudicators at RMO Ottawa to process XSD cases; hence we assume they spent the same proportion of their working time on XSD cases.

> *Assumption*: case and health adjudicators who work at RMOs overseas spent the same proportion of their working time on XSD cases as those at RMO Ottawa.

When acquiring the above data, we also requested the staff and salary information of all RMOs[7]. The local employees at RMOs overseas are paid in their national currencies, while the IRCC's MOFs overseas are paid in Canadian dollars. Based on the time proportion they spent on XSD cases and staff and salary information of all RMOs, we obtain the processing cost of XSD cases.

Result Using salary information, the portion of time that MOFs, medical doctors, and case and health adjudicators spend on excessive demand cases, as well as Bank of Canada's exchange rates between foreign currencies and Canadian dollar on August13, 2014, the total processing cost resulting from identifying, assessing and reassessing excessive demands cases is $ 483,166.

Uncertainty of the estimation When estimating the processing cost of XSD cases, we only use the data collected from each RMO. Although the percent of time that staff overseas spent on XSD cases are estimated based on their counterparts at RMO Ottawa, the processes are similar and we account for RMO-specific proportions of M5 cases. Therefore, these estimates should be reliable and at a low level of uncertainty.

Critically, visa officers also spend significant time on processing XSD cases. We currently have no way of precisely estimating this input. However, according to an open-ended survey to visa officer performed by the Health Screening and Notification evaluation in 2014, visa officers found the process involved in reviewing and finalizing XSD cases is time consuming as a result of the multiple steps: the procedure fairness letters (PFL) process, consultation with the RMO, and communication with the client. Throughout these steps, they have to review all of the information thoroughly, and carefully document each step to ensure that the decision is based in facts and law.

[6] For impact on visa officer time, please see further below.
[7] This information is available upon request.

Typically, when applicants dispute the MOF's diagnosis, they often provide volumes of medical information and reports that come in dribs and drabs to support their finding. Because visa officers have limited medical knowledge / expertise to fully understand and evaluate these documents, it takes them extra time to process them.

5.1.1.2 Direct cost 2 - Litigation fees

When an applicant thinks a decision or an assessment made to his/her immigration application was based on an error or ignored evidence or violated legal process, he /she may question the decision or assessment, and file an appeal. If the simple appeal is unsuccessful, then they may apply for a judicial review[8]. There are two major steps in the judicial review process: application for leave (paper review) and judicial review (full hearing). Both processes generate expense for the government. According to data provided by Litigation Management (BCL) of IRCC and National Litigation Coordination Team (NLCT) of Department of Justice (DOJ), from 2010 to 2014, there were around 20 to 30 overseas cases each year requesting Application for Leave and Judicial Review (ALJR) due to excessive demand assessment. The leave was granted for more than half of these cases in 2010, 2011, and 2012, and their appeals thus reached to the Federal Court for judicial review. In 2013, the leave was granted for 9 out of 26 requests. In 2014, of 33 applicants who requested ALJR, 5 were granted leave, 8 were denied, and 12 were outstanding. The litigation cost of these appeals in these years is listed in Table 6.

Table 6: Litigation Cost of Overseas XSD Appeals from 2010 to 2014

Year	# of Cases	ALJR Amount	JR Amount	Appeal Amount	Total
2010	22	$109,286.75	$129,000.69	$35,451.16	$ 275,748.60
2011	19	$85,106.77	$49,621.06		$ 136,738.83
2012	15	$37,439.24	$53,304.40	$ 43,367.63	$ 136,123.27
2013	26	$114,910.63	$25,566.28		$ 142,489.91
2014	33	$94,550.38	$38,458.43		$ 135,022.81

Litigation cost data are provided by DOJ

[8] Subsection 72(1) of IPAR provides that any matter, decision, determination or order made, measure taken or question may be judicially reviewed by the Federal Court to ensure that the law, as intended by Parliament, is applied correctly by departmental officials.

The amounts provided in the table are an estimate of the total cost of legal services on file. The estimation was made by searching each individual file and running a detailed statement of account report. The cost is calculated as the number of hours on file being multiplied by the hourly rate of each counsel and paralegal. Since there are some cases were in an outstanding status at application for leave or judicial review stages in 2013 and 2014, the litigation cost listed in the table is not complete for these two years.

To estimate the litigation cost related to XSD appeals, we face two limitations: (i) only overseas litigation cost data are available and we, at time of writing, are still waiting for these data inland appeals; (ii) a few appeals in 2013 and 2014 were still outstanding, and hence litigation cost in these two years was still incomplete. According to suggestions made by a senior analyst in the Department Legal Service Unit (DLSU), we make the following assumption to overcome the current limitations.

> *Assumption*: There are a similar number of inland and overseas appeals each year and their litigation costs are in the same range.

Result Based on the above assumption and the highest and lowest litigation cost overseas from 2010 to 2012, a low and high litigation cost are set for appeals in 2014. The low cost is $270,000 while the high cost is $550,000.

Uncertainty of the estimation The litigation cost is estimated using only historical data overseas under a weak assumption. Therefore, the estimate of this cost is at high level of uncertainty.

5.1.1.3 Direct cost 3 - Deportation expense

Deportation may happen if an inland applicant who was assessed as XSD and did not appeal or lost his/her appeal insists on staying in Canada. Information extracted from GCMS shows that there have been only two deportations of inland foreign nationals due to the Removal Cause Act

Paragraph 38(1) (c) since 1993[9]. In this analysis, we ignore the cost from deportation since it makes a trivial effect on the overall cost.

5.1.1.4 Indirect cost – IRCC employees indirectly contribute to XSD assessments

Several policy analysts who work at the Migration Health Branch indirectly involve in the XSD assessments. They provide policy support to MOFs on processing XSD cases. Based on the descriptions and allocation of their work for performance measurement, $ 57,289 of their salary was paid for their time spent on XSD related work. This estimation is directly based on their regular work and salary information, therefore at a low level of uncertainty.

5.1.2 Costs quantified in non-monetary term

Some applicants are denied immigration because they have a family member assessed as excessive demand. In this situation, no matter whether the family member is a principal applicant or a dependent, the whole family will be rejected for immigration even if the rest of the family members are healthy and have skills that are highly desired by Canada. We lose some valuable applicants in this way. For example, in the beginning of 2015, a physician in South Africa and her architect husband's application for permanent residents under the skilled-worker category was rejected because of her autistic son (*Jan 12, 2015, National Post)* [10].

Using the Unique Client Identifier (UCI) number of PR and TR applicants who received an IME in 2014 and were assessed as an excessive demand case, the OPS-Stats team of OPMB-PMU extracted the records of their family members in the same applications. Based on these records, the total number of those affected family members can be obtained. Their age, gender, and

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[9] OPMB-PMU-2015-2005 Removals for EXC. Demand.xlsx
http://gcdocs2.ci.gc.ca/otcs/llisapi.dll?func=ll&objaction=overview&objid=62715748)

[10]. http://news.nationalpost.com/news/canada/judge-upholds-decision-denying-entry-to-south-african-doctor-because-her-autistic-child-would-cost-taxpayers-too-much

education attainment, and their client type (principal or dependent) and immigration class are reported below.

Result In 2014, the 930 applicants assessed as XSD had 3,068 family members applying for immigration along with them. 75 percent of these family members, or 2,305, were under 55; less than 16 percent of them, or 490, were 65 or older. Among family members who were aged between 18 and 54, 403 had a bachelor or higher degree with 9 holding a PhD degree and 79 holding a master's degree. In addition, among them, 242 had postsecondary education with 134 holding a diploma or certificate. 52 percent of these family members, or 1,587, were principal applicants. 76 percent or 2,338, were permanent resident applicants.

Uncertainty of the estimation The statistics and distributions we report here directly reflect people who were affected by their family members' XSD assessments. There is no estimation involved in the calculation of this cost and hence no uncertainty issue.

5.1.3 Costs described qualitatively

Media reports on the rejection of applicants assessed as XSD can hurt Canada's image. Typically, stories on the rejection of the immigration of families with a mentally or physically disabled child have often attracted public attention and received criticism.

5.1.3.1 Media critiques and bad country images

The followings are comments and statements cited from some of these recent stories.

Story 1: Jazmine, a 14-year-old Philippine girl was assessed as XSD due to her hearing disability. Karen Talosig, Jazmine's mother, has been working as a live-in caregiver since 2008 and applied for permanent residency for herself and Jazmine in 2010.

- *Facing public outrage, Ottawa has reversed an earlier decision and will now let a deaf girl it deemed "medically inadmissible" join her Filipino caregiver mother in Canada (June 25, 2015, The Toronto Star)*
- *Helene Whitfield, one of Talosig's former employers said she would be embarrassed as a Canadian if the application were rejected on these grounds (May 29, 2014 5:50 PM PT, CBC News)*
- *Susan Masters, executive director at the Western Institute for the Deaf and Hard of Hearing, says it is a short-sighted approach and Canada could be losing a lot when they don't look beyond a person's disability (May 29, 2014 5:50 PM PT, CBC News)*
- *Hedy Fry, the Liberal MP for Vancouver Centre, said: "The B.C. School for the Deaf says the child is proficient in American Sign Language and it is no more cost to educate her than any other child. So is this the government's new discriminatory immigration policy? That deaf persons need not apply (May 27, 2015 2:00 am Global News)*

Story 2: Nicolas Montoya, a 13-year-old boy with Down syndrome. Nicolas's father, Felipe Montoya, is a tenured professor of York University. He applied for permanent residency for his family three years ago but was denied recently in March 2016.

- *The IRCC letter references reports that Nicolas functions at the level of a three-year-old. It goes on to estimate that special education supports for Nicolas would cost between $20,000 and $25,000 a year, a finding Montoya questions. (Michelle McQuigge, The Canadian Press, Published on Sun Mar 20 2016)*
- *Toronto immigration and refugee lawyer Mary Keyork feels the "Canadian goal of uniting more families" should take precedence in the law. (Gilbert Ngabo, Metro Published on Sun Mar 20 2016)*
- *"There were no extra provisions for him. He joined a classroom just like my daughter did," Montoya said. "My daughter is not deemed inadmissible because of her use of state services, yet Nico is." (Michelle McQuigge, The Canadian Press, Published on Sun Mar 20 2016)*
- *"Bhaskar Thiagarajan, the president of the Down Syndrome Association of Toronto, said the Montoya family is in an unfortunate situation that many others have gone through. Each year, several families contact his office seeking advice, but he said it's so difficult he*

can't even bring his own sister who has Down syndrome to Canada from India."(CBC News Posted: Mar 15, 2016 7:55 PM ET)

Story 3: Taehoon, a 15-year-old boy who have been living Canada since he was 3 years old, was facing deportation with his family because of his autism. Sungsoo Kim, Taehoon's father, applied for permanent residency for his family in 2006 but was denied in 2012.

- *"The problem I have is he's been here 12 years now. He's* (Sungsoo Kim) *had a full-time job since the day he was done college and he owns a house and pays taxes ... He's an honest-to-God standup citizen — unfortunately not of Canada." (Feb 27, 2015, Hamilton Spectator)*
- *Trish Simons, president of the Hamilton chapter of Autism Ontario said: "I think it's terrible someone should be denied (permanent residency in Canada) because a person has autism ... but they (Immigration Canada) do kind of have a point because it is an expensive disorder." (Mar 15, 2012, Mississauga News)*
- *Family of autistic child not wanted as citizens (March 19, 2012 11:05:04 PM, CHCH)*

Story 4*:* Rachel, a seven-year-old girl whose family was emigrated from France in 2005, was denied residency due to her cerebral palsy in 2010. David Barlagne, Rachel's father applied for permanent status for his family in 2008, he, his wife and elder daughter were accepted. Rachel was denied.

- *But lawyer Stéphane Minson said the system discriminates against disabled children, and the law must change. "A child should not be reduced to a financial figure," Mr. Minson said. "But it's clear this is becoming a political debate, and it's less a question of law than morality." (Feb 24, 2010, The Globe and Mail)*
- *"Cases like this are always difficult to deal with, particularly when they involve a young girl who is intelligent and endearing, if not exceptional, according to those who know her," Federal Court judge Johanne Gauthier wrote. However, "judicial review is subject to specific rules that apply to all cases, even those where strong sympathy for the applicant and his family would favour a different outcome." (May 18, 2010, 8:19 PM ET, CBC News)*

When discussing XSD cases, the historical Hilewitz and de Jongs cases also need to be reviewed[11]. They are the first two XSD cases that reached the Supreme Court of Canada (SCC) and still have a fundamental influence on medical admissibility decisions. Since then, all applicants are entitled to an individualized assessment of the likely demand their disability or impairment might place on social services. Immigration officers must also consider the intentions and ability of these applicants to provide the required social services without availing themselves of publicly funded social services. Here are some comments from *the Globe and Mail* on these two cases.

- *The case has attracted two legal interveners -- the Canadian Association for Community Living and the Ethno-Racial People with Disabilities Coalition of Ontario -- who argue that the "excessive demands" provision devalues those who have disabilities."; ... heavy smokers and unsafe drivers should be barred as well. It says that the rejection of those with defects is part a lingering attitude that denies the opportunities and services to a vulnerable group. (Feb 7, 2005)*
- *A majority of the Supreme Court judges who heard the case said it seemed "somewhat incongruous" that the wealth that allowed these families to qualify for entry into Canada was then ignored in determining the admissibility of their children. (Oct 21, 2005)*

<u>Result</u> In general, discussions in the media focus on the potential discrimination against people with health conditions while ignoring the humanitarian and companionate effort Canada has made in other cases (including refugees) and the potential financial burden Canada may face in the future. Canada's immigration system in this situation has often been described as short-sighted and selfish – a system that cares only about Canada's current interests. This ignores the fact that refugees and the majority of family applicants are exempted from the XSD provision, and about 10 percent of immigrants Canada accepts every year have various health conditions. Canada's country image is damaged by the public outrage against certain XSD decisions. The negative influence of these media stories on the Canada's image is certain. However, the magnitude of the influence is hard to measure.

[11] These two individuals are the adult son and teenage daughter of independent businessmen who had applied to enter Canada with their families. Both children were denied visas because they are developmentally disabled and would place an excessive demand on Canadian social services.

5.1.3.2 Inequality implied by the unique XSD threshold

In the current XSD provision, a unique Excessive Demand threshold is applied to all applicants to determine whether they require excessive demand without considering their age, gender, and intended destination. Thus, the unique excessive demand threshold places senior applicants at a disadvantaged position. In general, seniors require more health care and social services[12]. Senior applicants who were medically inadmissible under the current threshold might be admissible if an XSD threshold based on the health spending for their Canadian age-matched counterpart was applied to them. On the other hand, young applicants who were medically admissible might become inadmissible if an age-matched threshold was applied in their case. Furthermore, Canadian provinces and territories (P/Ts) have different costs of health care and social services, hence the unique XSD threshold is in favour of applicants who choose P/Ts with a low cost of health care and social services as their destination–because projected health costs are estimated based on provincial data, an applicant who was medically inadmissible in one P/T might be medically admissible in another province. A favourable assessment due to choice of destination is likely to drive more applicants with severe health conditions to provinces with low health cost which may lead to maldistribution of costs and waiting lists for medical procedures between provinces. It may also discourage immigration to more remote provinces and territories.

The XSD threshold is used by medical officers to determine whether an applicant is likely to require more health and social services than the average Canadian over a period of time. It is based on the CIHI aggregate data that represented the average Canadian per capita health expenditure, and adds a supplement for certain social services[13] that the CIHI figure does not completely cover. This XSD threshold is updated every year. In 2014, the threshold was $6,327 per year. The threshold is usually multiplied by five unless the anticipated length of stay is shorter than five years or there is evidence that significant costs are likely to be incurred beyond that period, in which case the period is no more than 10 consecutive years. Annex B lists the excessive demand

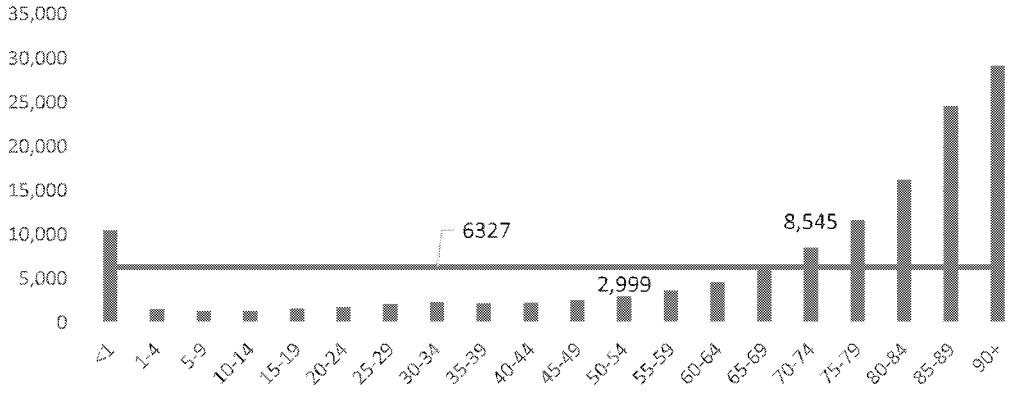
[12] According to *National Health Expenditure Trends, 1975 to 2015*, in 2013, Canadian seniors who were 65 or older accounted for 15.3 percent of population but generated 45.4 percent of national health expenditures.

[13] For the definition and amount information of social services included in the threshold, please see the report on excessive demand threshold written by CMAU team of Migration Health Branch.

threshold in the past 7 years. The average health spending of Canadians by age, sex, and certain health conditions in all provinces and territories can be obtained from CIHI[14].

Results According to CIHI's estimate of Provincial and Territorial Government Health Expenditures in 2012, the average health expenditure of Canadian seniors who are 70 or older is at least $ 8545, while the average expenditure of Canadians who are younger than 55 is at most $3000. Figure 1 shows the health expenditure of each age group. It implies that, under the XSD threshold in 2014 ($6327), for a senior applicant who was 70 or older, even if his/her demand on health care was $2200 less than the average level of his/her Canadian counterpart, his/her application would still be assessed as an XSD case. On the other hand, for an applicant who is younger than 55, even if his demand on health care is $3300 more than the average level of his/her Canadian counterpart, he/she is still assessed as medical admissible.

Figure 1: Estimate of average government health expenditures by age



The unique threshold may be viewed as unfair by some as it sets a criterion that is tougher for senior applicants to meet while easier for younger applicants.

CIHI's estimate of the Total Provincial and Territorial Government Health Expenditures in 2012 lists the health spending of each province or territory by age and sex. Except for Newfoundland and Labrador, the per capita spending of Eastern provinces is 20 percent lower than that of western

[14] http://www.cihi.ca/CIHI-ext-portal/internet/en/documentfull/spending+and+health+workforce/spending/nhex_product_2014

provinces for most age groups. Furthermore, health spending is extremely high in the Territories. The per capita health spending of Northwest Territory and Nunavut is double or even triple that of the provinces for all age groups except infants. Although the per capita health spending of Yukon is lower than the two other territories, it is still significantly higher than the per capita spending of the provinces, particularly for those who are younger than 24, or older than 70. Using CIHI's Patient Cost Estimator [15], we compare the health cost of renal failure in different provinces/territories for different age groups.

Table 7 : Estimated Average Cost ($) – Renal Failure

	NU	NT	YT	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	CA
All	-	-	8330	7501	10260	8134	8820	7702	7578	6520	7015	7870	8611	7988
1-7	-	-	-	8562	13049	22263	5205	13085	8990	5817	-	-	-	10824
8-17	-	-	-	**5863**	7547	10496	24884	7969	**4580**	**4068**	**4538**	-	-	8020
18-59	-	-	5917	7670	9991	8322	9022	7826	6906	6063	7697	10392	8786	7912
60-79	-	-	9504	7755	10438	8308	8602	7621	7733	6673	6897	5824	9127	8040
80 +	-	-	8462	6993	10267	7704	7709	7689	7802	6669	6864	8836	7566	7931

The estimation is based on more than 84% of all inpatient cases submitted by acute care hospitals to CIHI IN 2012-2013. –: No estimate available

Table 7 shows that the estimated average cost for renal failure is lower in Quebec and eastern provinces (except Newfoundland and Labrador) than that in other provinces for almost all age groups. For each individual refused based on XSD, his or her health and social service cost is estimated using the prices of the intended province or territory. Given the unique excessive demand threshold, $6,327, being applied to all PR/TR applicants, the regional difference in health cost would lead to different assessments on XSD if an applicant changes his/her intended destination. For example, according to Table 7, a 14 year old applicant with renal failure may be assessed as medical admissible if his/her family chooses Quebec, British Colombia, New Brunswick, or Nova Scotia as their intended destination but may be assessed as XSD if they choose other P/Ts as their destination.

Uncertainty of the estimation There is no estimation involved in the above analysis.

[15] https://www.cihi.ca/en/spending-and-health-workforce/spending/patient-cost-estimator

5.2 Benefits

5.2.1 Benefits quantified in monetary term

Health care and social services preserved due to the denial of XSD cases are the *direct benefits* from the application of the XSD provision. They can be estimated in dollars. Production gains from the replacement of medically inadmissible applicants with medically admissible applicants are *indirect benefits* of the XSD provision and can also be quantified in monetary terms.

5.2.1.1 Direct benefit - saved health care and social services

Based on an applicant's health condition(s) and the cost of medicine, health care, and social services he/she may need in his/her intended province/territory, MOFs estimate the cost of health care and social services the applicant may require. This information is contained in the MOFs' narratives stored in GCMS. However, MOFs were strictly required to estimate the cost of each XSD case only since May 2014. Therefore, a precise estimate was not available for most XSD cases before this date. Thus, the cost and benefit analysis in monetary term will be based on medical assessments in 2014.

Estimation In 2014, 930 cases were assessed as XSD. Among them, 778 cases had been estimated by medical officers with respect to health care and social services cost. The cost for the remaining 152 cases, more than 16 percent of all XSD cases, were not estimated. Undoubtedly, these 152 cases could account for a significant portion of the total cost. In this analysis, these missing estimates are imputed. The method behind the imputation is to use the average of all available estimates for a health condition to measure the cost of the estimate for missing cases.

> *Assumption*: the cost of health care and social services for a missing XSD case can be represented by the average cost of all estimate-available XSD cases caused by the same health condition.

If an applicant is assessed as XSD, he/she will be notified of the result and receive a letter to ask for his/her response. If the applicant thinks the assessment does not reflect his/her true health status or he/she has a plan to mitigate his/her needs in health care and social services, he/she can file a formal request for procedural fairness within 60 days, and the applicant's medical file will be reassessed. If the applicant disagrees with the result of procedural fairness or reassessment, he/she can further file an appeal. The process may take several years. Up to June 6, 2016, 428 of the 930 XSD cases either did not respond to the procedural fairness letter or remained XSD status after procedural fairness. 207 passed an immigration medical assessment (IMA) or had their file closed, 23 passed an IMA but it expired before they arrived in Canada, and 30 transferred to humanitarian and compassionate (H&C) category. There were 195 cases in progress, 24 were in procedural fairness and 23 were waiting to be reassessed.

When looking into the reasons of 207 cases that passed IMA or were closed, 128 cases either had a reasonable mitigation plan or a stable health status after a new treatment, or were closed because of a cancellation or withdrawal of application, or the death of the applicant who was assessed as XSD. Although these XSD cases passed IMA, the XSD provision still saved health and social services for Canada in these cases (assuming mitigation plans were followed—which is currently not enforced by the provinces in most instances). We do not know how many cases of those that were still in progress, in procedural fairness or ready to be assessed, or cases that passed IMA but with an expired IME, which in total are 265 cases, would also have saved health and social services costs. However, it is reasonable to assume that it is the same proportion as the 207 IMA-passed or closed cases.

Results According to the status of the 930 cases on June 6, 2016, 109 cases were either assessed as not XSD, re-categorized as Excessive Demand Exempt (EDE), or were furthered as part of an application for H&C considerations. Based on the cost estimate given by MOFs and the imputed cost of the estimate-missing cases, the total value of the saved health care and social services of the remaining 821 cases is $134,925,790 in five years[16]. This estimate is based on the price of health care and social services in 2014 and does not consider the health care cost inflation in the future. This potential spending was the direct benefit quantified in monetary term preserved by the

[16] According to paragraph 38(1)(c) of IRPA, an excessive demand assessment also implies the health care and social services required will last for at least five years.

XSD provision. It is 279 times the processing cost spent on identifying, assessing, and reassessing excessive demand cases in 2014.

Uncertainty of the estimation When estimating the total cost saved by the XSD provision, for cases whose estimate is an interval rather than a number, the lower range is used to calculate the average cost, implying a conservative estimate of the saved cost. Therefore, the probability of overstating the saved cost is low.

5.2.1.2 Indirect benefit – production gains

The indirect benefit of the implementation of excessive demand provision is production gains from the replacement of the XSD applicants with medically admissible applicants. A person with a medical condition that leads to excessive demand is likely to face more constraints for work. Even if he/she is employed, the person tends to have more absenteeism than others because of his/her health status. In general, applicants without the XSD problem are more productive than those who were assessed as XSD, and there are production gains resulting from the replacement of the XSD applicants.

Estimation In this analysis, we use earning differences between XSD applicants and their replacements to represent production gains. To estimate earning differences between them, we first project the increase in employed males and females resulting from the replacements. Then we multiply these increases in employment with employment earnings of recent male and female immigrants.

Xue (2007) compared immigrants' employment rate 6 months, 2 years and 5 years after their arrival to Canada using data from the three waves of the Longitudinal Survey of Immigrants to Canada (LSIC) [17]. Among the 930 excessive demand applicants, 739 applicants were 15 or older. Specifically, 119, 247 and 373 of them are in 15-24, 25-44 and 45 or older age groups, respectively. By applying the employment rates in Xue's study to males and females in these three age groups, we calculate the number of male and female applicants who would be employed 6 months, 2 years

[17] http://www.IRCC.gc.ca/english/resources/research/integration/9-appendix.asp

and 5 years after their arrival to Canada if these excessive demand applicants were replaced by applicants without the XSD issues. Our estimation of employment is conservative because we do not include 289 applicants who were 55 or older while Xue's employment estimation included these people.

No study compares labour market performance between applicants with and without XSD issues. However, a study conducted by Turcotte (2014) that compares employment rate between Canadians with and without disabilities may shed some light on the scale of employment increment resulting from the replacement of the XSD applicants. Turcotte (2014) found that persons with disabilities were less likely to be employed than persons without a disability, and disabilities with greater severity are associated with lower employment rates. From this study, for people aged 25 to 64, the employment rate was 68%, 54%, and 42% among those with a mild, moderate, and severe disability respectively, compared with 79% for Canadians without a disability. The ratio between employment rates of Canadians with a moderate disability and without a disability is 0.68. Thus, if we assume that conditions leading to XSD affect employment as moderate disabilities do, then the employment increment resulting from the replacement of the XSD applicants is about 30 percent.

Statistics Canada (2008) investigated earnings and incomes of Canadians over the past quarter century using data from the 1981, 1991, 2001 and 2006 Census, in which median employment earning of recent immigrants and the Canadian-born between the age of 15 and 54 were compared[18] in two education groups, e.g., with or without a bachelor degree. These employment earnings of male and female immigrants can be used to calculate the total earning of the applicants who replaced XSD applicants.

The followings are two assumptions we use to estimate the production gains:

> *Assumption1*: the gender and age distribution remain unchanged when the applicants assessed as XSD were replaced with medically admissible applicants;
>
> *Assumption2*: health conditions that lead to XSD affect employment at the same rate as moderate disabilities do.

[18] http://www12.statcan.ca/census-recensement/2006/as-sa/97-563/table/t8-eng.cfm

Results Based on the median earnings from Statistics Canada of recent male and female immigrants aged 15 to 54 with or without a university degree[19], we calculated the production gains due to the replacements in two scenarios. One scenario assumes none of these replacements have a university degree, while another assumes that 30 percent of these replacements have a university degree to reflect typical proportion of new immigrants who possess a university degree. The first scenario provides a lower bound of production gains while the second scenario shows higher potential gains. Table 9 lists the projected increase in employment and production gains at six months, two years, and five years after the replacements landing in Canada, respectively. The 20-year-period total production gain is sum of gains over four periods: first two years in Canada, 3rd and 4th year in Canada, 5th to 10th year in Canada, and the 11th to 20th in Canada. In the first period, the employment earning at six months after the replacements landing in Canada is applied; in the second period, the employment earning in two years after the replacements landing in Canada is applied; in the third period, the employment earning in five years after the replacements landing in Canada is applied, and in the last period, the employment earning in five years after the replacements landing in Canada is applied to those who were between 15 to 44 years of age in 2014.

Table 9: Projected production gains from the replacements of XSD applicants

	6 months after landing	2 years after landing	5 years after landing	20-year-period total
Δ Employment	37	56	68	
Production gains - Scenario 1	763,545	1,162,733	1,421,918	24,720,039
Production gains - Scenario 2	823,552	1,254,175	1,533,896	28,944,448

Uncertainty of the estimation The estimation of production gain uses both internal data (applicants who were assessed as excessive demand in 2014 from GCMS) and external data (employment rate and earning of recent immigrants and employment rate of Canadians with and without disabilities). The level of uncertainty of the estimation is high because of the following reasons: (1) earnings of replacements are based on recent immigrants' earnings which are indirectly related to permanent residency applicants in 2014; (2) only immigrants between 15 and 54 years of age old are

[19] http://www12.statcan.ca/census-recensement/2006/as-sa/97-563/table/t8-eng.cfm

considered in the first the second 5-year period; in the second 10-year period, only those who were between 15 and 44 years old in 2014 are considered; (3) the employment rate of Canadians with and without disabilities is not highly relevant to that of PR/TR applicants who were assessed and not assessed as XSD because health conditions that lead to XSD may affect employment rate differently than moderate disabilities do. Although the level of uncertainty of this estimate is high, the estimate is conservative because we do not include the earnings of people who were older than 55 in 2014 and the employment rate and salary level are held at the level when immigrants were in their fifth year in Canada when calculating their earnings from the 6th to 20th year after landing.

5.2.2 Benefits quantified in non-monetary term

5.2.2.1 Deterring people with serious medical conditions from application

An important but often ignored benefit that the XSD provision has brought to Canadian society is that it deters people with serious medical conditions from submitting an immigration application. Canada is recognized for its health care systems and social assistance programs. It provides free health care to all Canadians and its permanent residents. Without the XSD provision or a similar provision, we would expect to observe more people with more severe medical conditions making immigration applications. Currently, these people know that their physical or mental conditions may not allow them to pass an immigration medical assessment. They know that they are likely to waste their money by making an immigration application, such as the costs spent on the IME and travel related to the application process. To most people in developing countries, these expenses are significant.

To estimate the number of people who were deterred from submitting an application due to the XSD provision, we face two main difficulties. First, during the implementation of the current point-based immigration system, we cannot find a period in which there is no XSD or similar provision. Second, there are many types of diseases that can lead to an XSD assessment, and it is hard to consider all conditions in one analysis.

Although we cannot observe the prevalence of a health condition for all applicants in our immigration system in which there was no XSD or similar provision, the excessive demand

exemption (EDE) gives us a chance to look into it in a special group of applicants. As per provision A38(2) of IRPA and R24, R117(g) and R139(4) of IRPR, refugees, spouses/partners and dependent children of family class applicants are exempted from the XSD provision. Because refugees are not comparable to other applicants in many aspects, we only consider the exempted individuals in the family class. Many might also argue that the family-class exempted individuals are different from economic applicants in their characteristics, and hence in their health profiles as well. However, according to *Evaluation of the Family Reunification Program* conducted by Research and Evaluation Branch (2014) [20], Spouse/Partner immigrants (S&P), who account for more than 80% of exempted individuals in family class, have higher average earnings than spouses of principal applicants of economic immigrants at each year since landing. This implies that most exempted individuals in family class and economic applicants are likely to have similar socioeconomic backgrounds. Furthermore, table 10 provides the age distribution of the exempted individuals in family class and of economic applicants in 2014. We can see that, exempted individuals in family class and economic applicants have a similar percent of members in each of age groups that are older than 24.

Table 10: Age distribution of two groups

Age	Family EDE	Economic
0-14	14.9	26.38
15-24	21.4	14.04
25-44	55.8	51.16
45-64	7.4	8.3
65 or older	0.5	0.13

Based on data of TR/PR applicants who received IME in 2014

Age and socioeconomic status are major health determinants. The similar age structure in three oldest age groups and similar socioeconomic backgrounds imply that family EDEs and economic applicants are likely to have a relatively similar health profile, and hence a similar prevalence of particular health conditions. Therefore, for this analysis, we used the prevalence of a health condition among exempted individuals in family class and compared this to the prevalence of this condition amongst economic applicants to try and estimate the magnitude of the deterrence effect

[20] http://www.IRCC.gc.ca/english/resources/evaluation/frp/index.asp

of the XSD provision. In this analysis, we only analyze the four most prevalent health conditions which account for 36% of the total XSD cases in 2014. This allows us to project how many potential applicants with these conditions were prevented from submitting their applications.

Estimation The number of potential economic applicants who were deterred by the XSD provision from submitting an application who had HIV, renal failure, hepatitis B, or developmental delay, which are the most prevalent conditions that lead to an XSD assessment.

Based on applicants who received their IME in 2014, Table 11 lists the number of economic applicants with these four conditions, and the number of XSD cases brought by each of these conditions in this class, as well as the percentage of these conditions being assessed as XSD cases[21].

Table 11: Four top health conditions causing an XSD assessment in Economic class

Health condition	Economic applicants with conditions	Corresponding M5 cases	Percent of being M5
HIV Positivity - Asymptomatic	53	39	73.6%
Renal failure	29	18	62.1%
Hepatitis 'B'	778	36	4.6%
Developmental delay	118	44	37.3%

Based on data of TR/PR applicants who received IME in 2014.

Because exempted individuals in family class are exempted from the XSD provision, we should expect to observe a higher prevalence of these four health conditions in them than in economic applicants. Table 12 compares the prevalence of these four health conditions between economic applicants and family EDEs.

[21] Because all excessive demand cases (M5) are from non-EDE applicants, the percentage of people with a health condition who were assessed as a M5 case is the ratio of the number of M5 cases with the health condition compared to all non-EDE applicants with the condition.

Table 12: Prevalence of the top 4 conditions causing XSD assessments

Condition	Family EDE	Economic	Family EDE /Economic
HIV Positivity - Asymptomatic	0.00236	0.00028	8.5
Renal failure	0.00022	0.00015	1.5
Hepatitis 'B'	0.00608	0.00409	1.5
Developmental delay	0.00088	0.00062	1.4

Based on data of TR/PR applicants who received IME in 2014.

Table 12 shows that, the prevalence of HIV positivity – asymptomatic among exempted individuals in family class is more than eight times that of economic applicants, and the prevalence of other three conditions of exempted individuals in family class is also 40 to 50 percent higher than that of economic applicants. It implies applicants with these health conditions would be multiplied if the XSD provision did not exist for the economic class. Using the prevalence of exempted individuals in family class and the number of economic applicants in 2014, we project the potential number of economic applicants with these health conditions. Based on these projections and the percentages of the XSD cases assessed among people with these health conditions (Table 11) we also project the number of the XSD cases implied by these potential economic applicants. The followings are assumptions we make for these projections.

Assumption1: without the XSD provision, the level of economic class applicants will stay unchanged;

Assumption2: without the XSD provision, the prevalence of the above mentioned four health conditions for economic applicants is similar to that of exempted individuals in family class in the current immigration system.

Results Table 13 lists the main results of these projections. It shows that, if the XSD provision did not exist, there would have been 1,816 people with these four health conditions among economic applicants in 2014 - an 85 percent increase from the actual level (978). These 1,816 applicants would have brought 472 people who would have required health care and social services costing more than the excessive demand cost threshold of $6,327. This would have been 3.4 times the actual number of excessive demand cases found in 2014 among economic class applicants related to these four health conditions. The sharp increase in the number of cases in our projections results mainly from HIV. Economic applicants with this condition would increase from 53 to 449

without an XSD provision. Furthermore, given more than 70 percent of economic applicants with HIV were assessed as XSD in 2014, the increase in economic applicants would have led to an 87 percent increase in the number of cases in the projection that would have had costs above the excessive demand threshold, if the XSD provision did not exist. The numbers in Table 13 reflect the potential economic applicants with the four most common XSD health conditions and the number of cases implied by our projection.

Table 13: Economic applicants (E-apps) with 4 health conditions and M5 cases

	E-apps with conditions - 2014	projected E-apps with conditions	M5 cases in E-apps - 2014	projected M5 cases in E-apps	Δ M5 cases
HIV Positivity - Asymptomatic	53	449	39	330	291
Renal failure	29	42	18	26	8
Hepatitis 'B'	778	1158	36	54	18
Developmental delay	118	167	44	62	18
total	978	1816	137	472	335

Projection based on applicants who received IME in 2014

Undoubtedly, if there was no XSD provision, the number of TR applicants with these conditions would have also increased. Applying the prevalence of HIV of family EDEs to TR applicants would have made TR applicants with this condition quintuple, from 77 to 404, and the corresponding number of cases with costs exceeding the excessive demand threshold among TR applicants would have increased from 47 to 247. The difference in age structure and country of residence of TR applicants from family EDEs are likely to make true differences different from these predictions; however, this basic projection sheds light on how the potential volume of TR applicants with HIV, for example, could have changed if the XSD provision did not exist. Moreover, if other health conditions that result in XSD assessments were also considered, even more economic and TR applicants with health conditions would be projected, and hence even more cases with costs expected to exceed the excessive demand threshold.

Uncertainty of the estimation To project the number of potential economic applicants who were deterred from applying immigration by the XSD provision, we only used internal data from GCMS. Although family EDEs and economic applicants are close to each other socioeconomically

and have a relatively similar age structure, the difference in their distribution by country of residence may somewhat violate the assumptions we made for our projection. In this sense, the estimation is between medium and high level of uncertainty.

5.2.2.2 Avoid increase in waiting lists of some serious diseases

Applicants assessed as XSD would lengthen waiting lists for some important tests (such as MRIs and other diagnostic imaging) and procedures (such as kidney and liver transplants) if they were allowed to come to Canada, and therefore might prevent or delay the treatment of Canadian patients. The denial of these applicants removes the direct impact of immigration on these waiting lists. From June 24, 2011 to May 31, 2014, 750 cases (or approximately 250-300 per year) were assessed as XSD cases merely because they would be added to existing waiting lists and would increase the rate of mortality and morbidity in Canada. There is no estimation involved in the calculation of this benefit and hence no uncertainty issue.

5.2.3 Benefits described qualitatively

5.2.3.1 Healthy immigrant effect

It is widely known that, on average, recent immigrants are healthier than their Canadian-born counterparts. This is referred to as the "*healthy immigrant effect*". Ng et al (2005) state that this is partially due to pre-arrival health screening of immigrants. Given that more than 95 percent medically inadmissible cases in PR/TR applications were XSD cases and that 70 percent of IME questions fully or partially ask information related to XSD, the XSD provision is one of the main contributors to the healthy immigrant effect in Canada. The following table shows the number of questions in IMM 5419 (07-2013) E, the form for Immigration Medical Examination (IME), for different screening purposes.

Table 14: Questions in IME Form and their purposes

	Medical History	Physical Examination	Laboratory Requisition	Chest X-Ray Requisition	Total
Total number of questions	15	22	8	7	52
Excessive Demand questions	10	19	5.5		34.5
Public Health questions	2		2.5	7	11.5
Public Safety questions	1	1			2
Other	2	2			4

Based on IMM 5419 (07-2013) E

From Table 14, you can see that, except the Chest X-Ray Requisition and Report section, most questions in IMM 5419 (07-2013) E are for the purpose of excessive demand screening. Of all 52 questions, 34.5 questions ask for information related to excessive demand. (There are 3 questions that are used for both excessive demand and public health screening purposes. We count half of these 3 questions for each purpose. That is the reason for the appearance of 0.5 questions.)

5.2.3.2 Quick settlement and integration

The XSD provision reduces the number of immigrants with serious health issues. Therefore, it may indirectly contribute to quicker settlement and integration of new immigrants. Housing might be the first thing most new comers facing in their initial settlement in Canada. For newcomers with severe health conditions, the availability of medical care in their neighborhood or city is likely to contribute to their selection of living arrangements. If the medical care they need was unavailable in a community they may not consider it. If they find that it is difficult to access medical care in their initial settled neighbourhood/city, then they may move. Once they find a family doctor and specialist that satisfies their needs in their neighborhood or city, then they and their families may tend to stay there and would be reluctant to relocate. On the other hand, newcomers without a health condition or with a milder health condition would depend less on health care services. Their house selection might depend more on job opportunities and schooling opportunities for kids, as for other Canadians.

Certainly, good health is an important labour market advantage. Job-oriented house selection may enhance this labour market advantage. Although there is no direct comparison on labour market performance between immigrants with and without severe health conditions, Turcotte's study

(2014) on employment of Canadians with disabilities reveals that, Canadians without a disability have a much higher employment rate and a better earning than Canadians with disabilities, and that they tend to find a job that matches their skills.

Compared to immigrants with severe health conditions, immigrants without a health condition or with mild health conditions also may have more channels to get involve in Canadian communities. It likely facilitates their integration to Canadian society, whereas immigrants with severe health conditions may be more likely to experience more challenges and difficulties in their integration process. Thus, they are likely to have a low labour market participation and employment rate, and their mobility level might restrict them to participate in community activities. These disadvantages could impede their integration to Canadian society. More importantly, it might exacerbate their health conditions if no proper measures are taken. In extreme cases, some immigrants may return to their home countries to seek integration, and social and emotional support[22,23].

5.3 Cost-benefit ratio

We have seen the substantial net benefit brought by the XSD provision from the result of each type of cost and benefit. However, a cost-benefit ratio communicates a direct picture of the contribution of the provision, for each category. With the uncertainty level attached to each estimate that was quantified in monetary and non-monetary term, we can calculate this ratio at different levels of uncertainty. A ratio involving only benefit and cost estimates at a low level of uncertainty provides us with a reliable scale which directly displays the effectiveness of the XSD provision, while a ratio involving benefit and cost estimates at medium and high levels of uncertainty enables us to compare costs and benefits in a broad range. Given our benefit estimates at medium and high level of uncertainty are more likely to be underestimated rather than overestimated, benefit to cost ratios at these levels are conservative. Table 15 lists these ratios. Detailed explanations of these ratios will be seen in section 5.3.1 and section 5.3.2 follows.

[22] See difficulties experienced by a disabled immigrant from Penner (2012), page 36. Struggling in settlement, the person said, "Certainly my future would have been far more, you could say, far better than it is, provided I had not immigrated."

[23] Murphy (2010) identified social and emotional support as one of the nine key immigrant settlement needs.

Table 15: Benefit to cost ratios

	Benefit	Cost	Ratio	Level of uncertainty
saved XSD cost/processing cost	$134,925,790	$ 483,166	279	Low
saved XSD cost^2/processing cost^2	$237,943,751	$ 753,166 - $ 1,033,166	230 - 316	Medium to high
Benefit_M/Cost_M	$266,888,199	$ 810,455 - $ 1,090,455	245 - 329	Medium to high
Benefit_nM/Cost_nM	$34,977,333	$8147	4279	Medium but conservative

saved XSD cost is an estimate of health care and socil services saved in a 5 – year period while saved XSD cost^2 is an estimate of health care and social services saved in a 20-year period. processing cost^2 also includes litigation fees. Benefit_M is the sum of saved XSD cost^{2}and production gains, while Cost_M is sum of processing cost^2 and policy analysts' salaries paid for the XSD related work. Benefit_nM and Cost_nM are estimates of benefits and costs quantified in non-monetary term.

5.3.1 Costs and benefits quantified in monetary term

The health care and social services preserved from the XSD cases in 2014 is $135 million in the first 5 years. It is 279 times the processing cost in 2014 without considering inflation of health care and social services costs. However, it is not the final ratio. In fact, people who have chronic diseases are likely to keep requiring health care and social services for the entire span of their lives. They will likely require more health care and social services as they age. In the next several paragraphs, we describe how we project the cost of health care and social services these people may need in the next 15 years following their first 5 years in Canada. (Thus, we will only consider the demand of PR applicants.)

After procedural fairness, 109 of the 930 cases that were previously assessed as XSD were no longer found to be inadmissible based on excessive demand. For the other 821 cases, 714 applicants were suffering from chronic diseases. Among them, 376 PR applicants were under 45 years old in 2014, and 96 PR applicants were between 45 and 64 years old. According to the life expectancy of Canadians with chronic diseases[24], we make the following assumptions for PR applicants who have a chronic condition and were assessed as XSD if they were allowed to come Canada. These assumptions are conservative.

[24]For example, a study conducted by the Canadian Observational Cohort Collaboration, indicated the overall life expectancy of Canadians undergoing antiretroviral treatment for the AIDS-causing virus had climbed to 65 years. http://www.ctvnews.ca/health/life-expectancy-of-hiv-positive-canadians-rises-to-65-years-study-1.2505690

Assumption1: In the second 5 years in Canada, 75% of those who were under 45 in 2014 will require the same amount health care or/and social services as they would request in their first 5 years. Similarly, for the second 5 years in Canada, 50% of those who were between 45 and 64 in 2014 will require the same amount health care or/and social services as they would request in their first 5 years;

Assumption2: In the second 10 years in Canada, 50% of those who were under 45 in 2014 will require the same amount health care or/and social services as they would request in their first 5 years.

Under the two assumptions and the consideration of applicants whose medical assessment was still uncompleted, the health care and social services that people assessed as XSD in 2014 would cost Canada 238 million dollars in a 20-year period if they had been allowed to come to Canada. This projection does not consider price increases for health care and social services.

Although we do not have litigation cost for all XSD appeals in 2014, based on the highest and lowest litigation cost of appeals overseas from 2010 to 2012, i.e., $275,748 for 2010 and $136,123 for 2012, if we assume that the number of inland and overseas appeals in 2014 are the same [25], we can set a low and a high litigation cost for appeals in 2014. The low cost is set as $270,000 while the high cost is set as $550,000. Adding the litigation cost to the processing cost, the direct cost quantified in monetary term is between $753,166 and $1,033,166. The cost-benefit ratio of the XSD provision projected over 20 years is thus between 230 and 316. The cost-benefit ratio reveals not only reveal the dramatic difference between benefit and cost, but also the fact that most costs of the program are one-time costs.

By adding the production gains obtained from the replacement of XSD applicants to the saved XSD cost in the 20-year period, we obtain the total benefit quantified in monetary term: 267 million dollars without considering price increases in health care and social services. On the other hand, the total cost quantified in monetary term including indirect program management costs (i.e. the salaries of policy specialists) is between $810,455 and $1,090,455. The ratio of the total benefit to the total cost quantified in monetary term in a 20-year period is 245 to 329.

[25] As mentioned earlier, this assumption was suggested by a senior analyst from Departmental Legal Service Unit (DLSU).

5.3.2 Costs and benefits quantified in non-monetary term

In 2014, 3,068 people were denied for PR or TR applications because one of their family members was assessed as XSD. Without the XSD provision, they would come to Canada if they satisfied other requirements of PR/TR applications. Some of these applicants might even be desired by Canada. However, given there are so many people who want to come to Canada and a huge inventory of applicants waiting at each stage of immigration process, almost none of these rejected people was irreplaceable. Using this consideration, the cost of the rejection of these people for Canada is the processing time spent on their applications. However, because these people did not themselves have XSD problems (only their family member did), MOFs did not touch their IME files, and they took less than one percent of case and health adjudicators' processing time[26]. On the other hand, 838 applicants with HIV and the other top three conditions, which could bring 335 XSD cases, were deterred from submitting an application in 2014 because of the XSD provision. Therefore, MOFs and case and health adjudicators' processing time was saved. Although these deterred applications did not save case and health adjudicators a considerable amount of time, they might have reduced a quarter of MOFs' time on processing XSD cases in 2014[27]. When evaluating the deterrence effect of the XSD provision, we confined our analysis to economic class and considered only four health conditions. Family non-EDEs and TR applicants with health conditions, and economic applicants with other health conditions who were prevented by the XSD provision were not considered. However, the estimated deterrence of applications from economic applicants with those four health conditions is strong enough to show the power of the XSD provision. In this analysis, using TBS guidelines, we express this type cost and benefit in non-monetary term not because they cannot be quantified in monetary terms but because of the incompleteness of the cost and benefit.

To calculate the ratio between benefits and costs quantified in non- monetary term, we first translate these incomplete benefits and costs into dollar values under the following assumptions.

> *Assumption1*: the processing time that case and adjudicators spent on the 3,068 rejected applicants is assumed to be 1% of their total processing time;

[26] There are about half million applicants each year receive IME. These 3068 rejected people accounted for less 1% of those who received IME.
[27] If these 838 applications were not prevented from application, it is reasonable to assume that MOFs would have had to spend 1.26 times [=(930+335)/930] the amount of time they actually spent on processing XSD cases in 2014.

Assumption2: the saved processing time due to the prevention of potential economic applicants with the four health conditions includes MOF time only; the time of case and health adjudicators is ignored;

Assumption3: potential applicants with health conditions who are deterred by the XSD provision is estimated to be 335/year.

The translation of costs and benefits from non-monetary to monetary terms makes the calculation of the cost-benefit ratio far from precise in this case; however, it is indeed a conservative ratio because we overstate the cost but understate the benefits. Therefore, the ratio is a lower bound of estimates of the ratio. Based on case and health adjudicators' salaries in 2014, 1% of their processing time costs $8,000. Deterring applications from the 838 applicants who would have been expected to result in 335 XSD cases saved MOF compensation by $123,000, based on MOF salaries in 2014. Finally, by using the average cost of the XSD cases caused by the four health conditions in 2014, the deterred XSD cases saved almost 35 million dollars in a 5-year period. The non-monetary benefit is thus at least 4,200 times the non-monetary cost.

6. Limitations and future work

To reflect relevant costs and benefits of the XSD provision, this analysis includes three types of costs and benefits depending on whether they are measurable and how they are measured. However, it is hard to collate costs and benefits measured in different units. Therefore, we are unable to use a single number to measure the ratio of all benefits over all costs, although this ratio is preferred by most cost-benefit analyses.

To estimate processing cost, we calculated the proportion of work time that MOFs, case and health adjudicators at RMO Ottawa spent on identifying, assessing, and reassessing XSD cases in a period of time (65 days for MOFs for example) and apply these proportions to corresponding employees at RMOs overseas. However, cases varies in complexity and locally hired doctors and nurses at RMOs overseas may be different from their colleagues at RMO Ottawa in both knowledge and

experience. Thus, our estimation of processing cost may not properly reflect the processing cost overseas. We know that visa officers also spend significant time with XSD cases; however, we currently do not have the precise time break-down to estimate these costs, and therefore give a qualitative impression instead.

For this analysis, litigation costs resulting from XSD appeals were only available for overseas cases. We estimated total litigation costs in 2014 by assuming that the inland and overseas appeals generate a similar amount of cost, based on the advice of senior legal counsel. The true cost could be updated if litigation costs for inland appeals becomes available. Similarly, 152 XSD cases did not have MOF's estimation for health and social services cost. We imputed the health care cost for these cases. However, for a health condition that caused only a few XSD cases, the imputation may not reflect the level of severity of the disease and hence the difference in health care cost.

To estimate product gains resulting from the replacement of XSD applicants, we used the ratio between employment rate of Canadians with a moderate disability and Canadians without a disability to project the employment increase due to the replacement of XSD applicants; however, health conditions that lead to XSD may affect employment rate differently than moderate disabilities do. To project the number of people prevented from application for economic class by the XSD provision, we used exempted individuals in family class to project an immigration system in which no XSD provision exists. Besides the obvious weakness – having to ignore differences between exempted individuals in family class and economic applicants, this approach has two other limitations. First, only XSD cases resulting from the top four health conditions were projected; second, family non-EDEs and temporary resident applicants prevented by the XSD provision were not considered.

Ultimately, not all human capital can be easily quantified. However, Canada is in the enviable position of having many potential applicants for immigration, and our current processes continue to propagate a healthy immigrant effect.

7. Conclusion

The objective of the IRCC policy on excessive demand for health and social services is to reduce cost pressures on P/T health and social services budgets. In 2014, the rejection of XSD cases saved Canada $135 million for the coming 5 years. This is 279 times the processing cost that was used for identifying, assessing and reassessing XSD cases in 2014. Given the majority of the XSD cases resulted from chronic diseases, the rejection of these applicants save more health and social service resources over an even longer period. If the deterrence effect of the XSD provision and product gains resulting from the replacement of XSD economic applicants are also considered, the benefits are even more significant. Based on the results of this cost benefit analysis, we conclude that the XSD provision preserves substantial resources for Canada with a relatively small input.

Annexes

Annex A: Excessive Demand Statistics

Year	Total medical assessments	Total XSD cases	Percent of XSD cases
1993	324921	1008	0.31
1994	283297	1438	0.51
1995	312013	2991	0.96
1996	346417	2973	0.86
1997	296735	2623	0.88
1998	262297	1684	0.64
1999	321605	1322	0.41
2000	385887	1482	0.38
2001	401578	1732	0.43
2002	348974	1723	0.49
2003	439075	1086	0.25
2004	458839	993	0.22
2005	410321	942	0.23
2006	410555	1061	0.26
2007	499571	1055	0.21
2008	519830	1093	0.21
2009	545012	1295	0.24
2010	545746	1202	0.22
2011	500911	815	0.16
2012	540354	940	0.17
2013	482398	1135	0.24
2014	531236	930	0.17

1. Numbers for 1993-2004 are cited from Annex B: Excessive Demand Statistics, Chapter 7, Excessive Demand and Medical Inadmissibility: The Need for Policy Renewal, p20. Improving the Management of Migration Health: An Action Plan for the 21st Century, the Migration Health Task Force. May 2005.
2. Numbers for 2005 and 2006 are extracted from Cognos of Enterprise Data Warehouse (EDW).
3. Numbers for 2007-2012 are cited from Health branch Dashboard -2012 Year End Report
4. Numbers for 2013 and 2014 based on date extracted from GCMS Answers

Annex B: Excessive Demand Threshold 2009 -2014

	2009	2010	2011	2012	2013	2014	2015
CIHI aggregate	4,867	5,211	5,614	5,811	5,948	5,988	6,045
CIHI aggregate growth rate	7.01	7.07	7.73	3.51	2.36	0.67	0.96
Supplementary amount adjusted*	276	294	321	330	337	339	342
Excessive Demand Threshold	5,143	5,505	5,935	6,141	6,285	6,327	6,387

* Supplementary amount reflecting cost related to certain social services

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Immigration, Refugees and Citizenship Canada | Immigration, Réfugiés et Citoyenneté Canada

Deputy Minister | Sous-ministre

Ottawa K1A 1L1

s.14(a)
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F-898473

MEMORANDUM TO THE MINISTER

EXCESSIVE DEMAND RECENT DEVELOPMENTS

FOR INFORMATION

SUMMARY

- The purpose of this memorandum is to provide you with information on recent developments related to the fundamental policy review of excessive demand, in preparation for the October 11-12, 2016, meeting of Federal/Provincial/Territorial Ministers Responsible for Immigration.
- At this meeting you will introduce the review and the provincial/territorial engagement.

BACKGROUND:

- In order to protect the health and safety of Canadians and to protect the publicly-funded health and social services that Canadians rely on, the *Immigration and Refugee Protection Act* and its associated regulations require Immigration, Refugee and Citizenship Canada medical officers to assess whether all applicants for permanent residence and many applicants for temporary residence are medically inadmissible. There are three distinct health grounds of medical inadmissibility: public health, public safety, and excessive demand.
- A foreign national may be found inadmissible if their health condition might reasonably be expected to cause excessive demand on health or social services, with some exemptions to balance the objectives of protecting publicly-funded services with that of promoting family reunification and refugee protection.
- A number of issues related to the excessive demand provision have been flagged. Many of these issues are not within the control of the Department or the Government. They include:

Canada

- A 2015 evaluation highlighted many of these issues. In particular, the evaluation noted that the majority of provinces and territories declined to participate in providing feedback on excessive demand. It also identified a lack of formal mechanisms to facilitate engagement on excessive demand between the Department and provincial/territorial ministries of health.

- Given these issues, in March 2016, the then Deputy Minister agreed to undertake a fundamental review of the excessive demand policy.

CURRENT STATUS:

- Since that time, there has been increasing pressure from various advocacy groups on the excessive demand provision:
  - raised concerns that the excessive demand provision is discriminatory against persons with disabilities.
  - raised the issue that many permanent resident applications from live-in caregivers are rejected based on the grounds of medical inadmissibility.
  - There is an online petition asking for the elimination of the provision.
  - In early September, wrote to you and all provincial/territorial ministers responsible for immigration asking for the removal of this provision

- Departmental officials have been working with the Office of Disability Issues to explore how they may help to frame the options developed while striking a balance between increased levels of immigration and protection of the health care system. The Department is also exploring how the Office of Disability Issues may help in brokering the proposed meeting

- The Department has been working on possible options as part of the policy review. The analysis shows that: provinces/territories request reversal of decisions; courts are turning excessive demand cases back for re-decision; refusals are seen as discriminatory against immigrants with disabilities; and the current provision saves provinces and territories $135M over five years, representing only 0.1% of provincial/territorial health spending (which was $144B in 2015).

- The Department recognizes the importance of consulting with provinces and territories as part of this fundamental policy review.

- In September 2016, Federal/Provincial/Territorial Deputy Ministers Responsible for Immigration agreed to establish a working group to discuss excessive demand as part of the Department's policy review. At the first working group teleconference on October 6, the attached deck (see Annex B) was presented to inform provinces and territories of the main option under review: Provinces and territories will then have an opportunity to consult with their respective health and education sectors and provide feedback. Should there be support for this approach, If there are concerns, alternative options will be presented.

- At the October meeting of Federal/Provincial/Territorial Ministers Responsible for Immigration, you will be formally informing provincial/territorial ministers of the launch of the Department's excessive demand policy review and consultations. The Department has been working with Health Canada to align the excessive demand issue with their discussions with provinces and territories on the Health Accord.

COMMUNICATIONS IMPLICATIONS:

- Cases involving inadmissibility due to excessive demand often receive significant media attention that is negative towards the Department.
- A review of the policy is welcome from the public communications point of view and has already been acknowledged publicly. When concrete policy changes are developed, a new communications approach will be developed at that time.

NEXT STEPS:

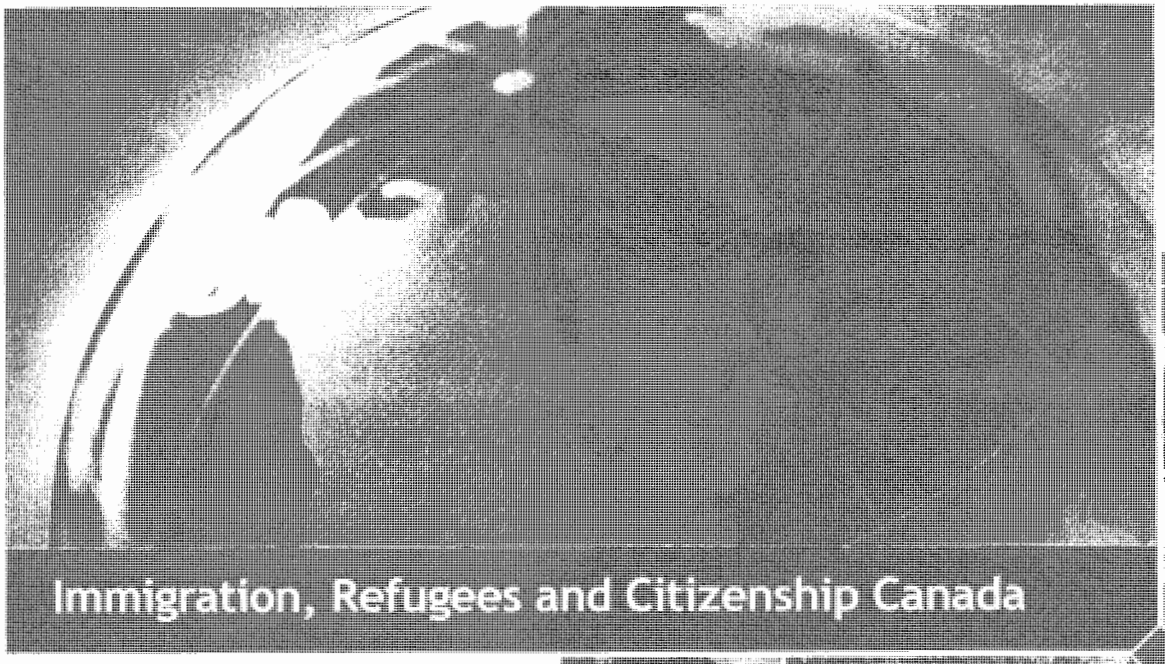
Marta Morgan

Annexes:

B: Excessive Demand Fundamental Review F/P/T Working Group Presentation

B

Immigration, Refugees and Citizenship Canada
Immigration, Réfugiés et Citoyenneté Canada



Excessive Demand Fundamental Review

F/P/T Immigration Working Group

Date TBD

Canada

Objectives

- To explain IRCC's reasons for launching a review of the law on excessive demand on health and social services
- To inform you of the option under review by IRCC for changing the legislative provisions

Excessive demand

- Under the *Immigration and Refugee Protection Act*, three grounds for medical inadmissibility:
  - Danger to public health
  - Danger to public safety
  - **Excessive demand on health and social services**
- Excessive demand applies to permanent resident applicants and some temporary resident applicants, with exemptions for Convention refugees, protected persons and some members of the family class

See Annex 1 for legislative provisions

The approach has evolved over time

- Tests of medical conditions have historically been a feature of immigration admissibility, back to the 19th Century
  - Initial inflammatory terms like "mentally defective" and "deaf and dumb" were tied to the eugenics ideas of the era.
  - With the advent of medicare in the 1960s, legislators refocused their consideration to the impact of ill immigrants on medical and social services
  - Use of the term excessive demand was introduced in 1976 to shift the intent from denying entry to people with disabilities per se to avoiding above-average costs of providing services
  - As of 2002, family-class spouses and dependent children, and resettled refugees became exempted from the policy (asylum seekers were already exempted)

Excessive demand appears to have lost its relevance

- Observations of a changing landscape:
  - P/Ts are requesting decisions be reversed, agreeing to absorb costs
    - Placing priority on recruitment of highly skilled immigrants over impacts on health and social services
  - Some P/Ts have integrated funding and delivery of special education into regular services
  - Only 0.2% of applicants are refused for excessive demand (see Annex 2 for most costly health conditions and services)
  - Courts are turning excessive demand cases back for re-decision
  - Refusals no longer seen as protecting services, but as discriminating against immigrants with disabilities
  - IRCC is reviewing possible changes,

Annex 1: Legislative provisions

Immigration and Refugee Protection Act

38. (1) A foreign national is inadmissible on health grounds if their health condition

(*a*) is likely to be a danger to public health;

(*b*) is likely to be a danger to public safety; or

(*c*) might reasonably be expected to cause excessive demand on health or social services.

(2) Paragraph (1)(*c*) does not apply in the case of a foreign national who

(*a*) has been determined to be a member of the family class and to be the spouse, common-law partner or child of a sponsor within the meaning of the regulations;

(*b*) has applied for a permanent resident visa as a Convention refugee or a person in similar circumstances;

(*c*) is a protected person; or

(*d*) is, where prescribed by the regulations, the spouse, common-law partner, child or other family member of a foreign national referred to in any of paragraphs (*a*) to (*c*).

Immigration and Refugee Protection Regulations

34. Before concluding whether a foreign national's health condition might reasonably be expected to cause excessive demand, an officer who is assessing the foreign national's health condition shall consider

(a) any reports made by a health practitioner or medical laboratory with respect to the foreign national; and

(b) any condition identified by the medical examination.

Annex 1 cont.: Legislative provisions

Immigration and Refugee Protection Regulations - Definitions

excessive demand means

(a) a demand on health services or social services for which the anticipated costs would likely exceed average Canadian per capita health services and social services costs over a period of five consecutive years immediately following the most recent medical examination required under paragraph 16(2)(b) of the Act, unless there is evidence that significant costs are likely to be incurred beyond that period, in which case the period is no more than 10 consecutive years; or

(b) a demand on health services or social services that would add to existing waiting lists and would increase the rate of mortality and morbidity in Canada as a result of an inability to provide timely services to Canadian citizens or permanent residents.

health services means any health services for which the majority of the funds are contributed by governments, including the services of family physicians, medical specialists, nurses, chiropractors and physiotherapists, laboratory services and the supply of pharmaceutical or hospital care.

social services means 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 physically, emotionally, socially, psychologically or vocationally; and

(b) for which the majority of the funding, including funding that provides direct or indirect financial support to an assisted person, is contributed by governments, either directly or through publicly-funded agencies.

Centralized Medical Admissibility Unit (CMAU)

Migration Health Branch

IMPN Director Conference

November 16, 2016

Dr. Arshad Saeed

s.19(1)

CMAU Team

- **Dr. Arshad Saeed, Director**
- **Dr. Stephanie Minorgan**
- **Joanne Watier**
- **Mary Voisey**
- **Emily Escaravage (Mat lve)**

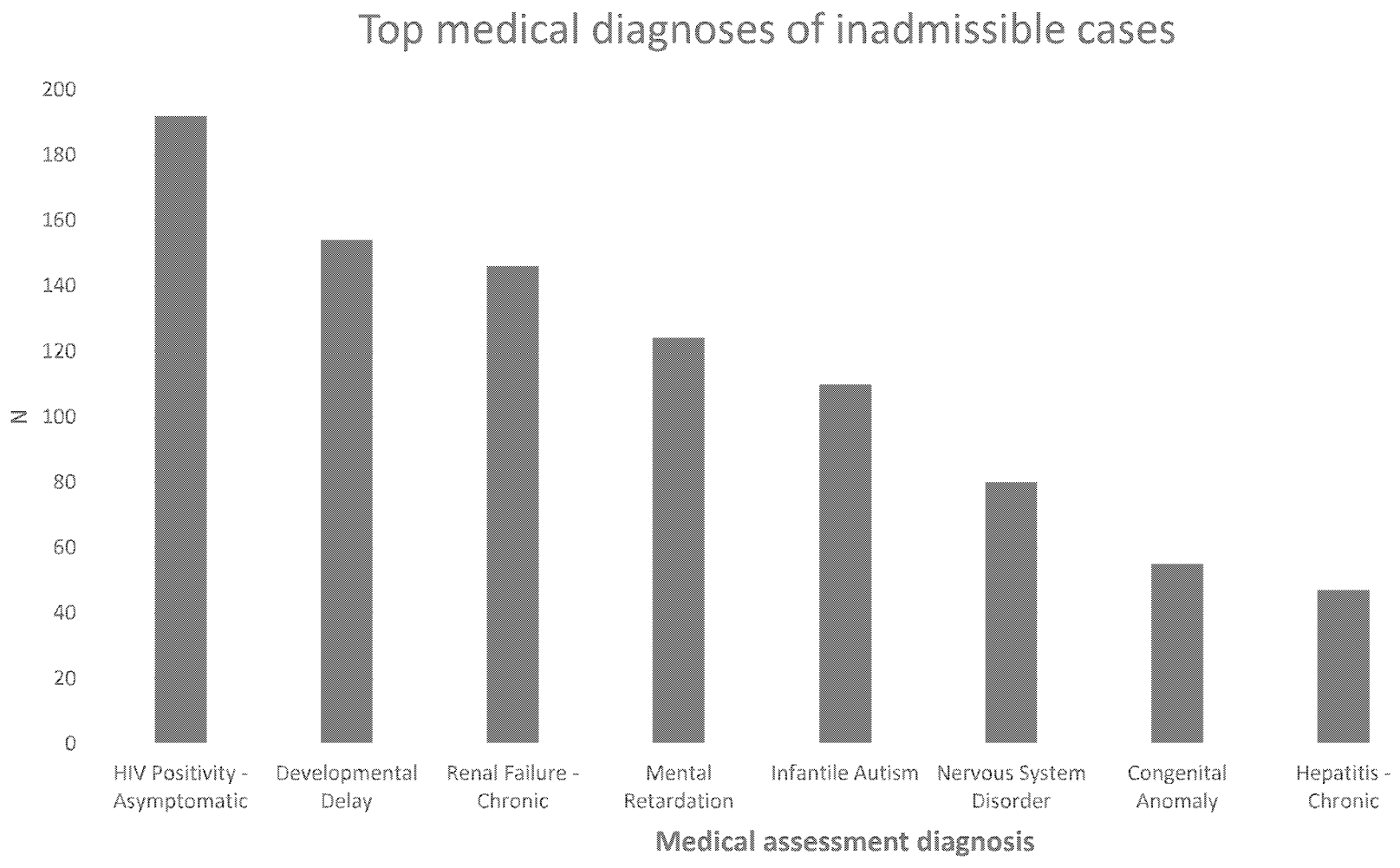
Files Assessed and in Progress since CMAU Inception

- CMAU files based on the following Paper File Location:

Sum of # of Medicals

Paper File Location	Assessed	Cancelled	In Progress	Grand Total
Admissibility Review	908	5	215	1128
Admissibility Review - Education	139	10	47	196
Admissibility Review Qualitative - Education	190	3	125	318
Grand Total	**1237**	**18**	**387**	**1642**

Trends by Type of Diagnoses



Breakdown of IMEs Assessed
Granted and Not Granted

Assessed = 1221

- 827 (68%) were inadmissible (Medical Assessment Status = Not Granted)
    - M4 8
    - M5 812
    - M6 2
    - M5/6 4
    - M4/5 1
- 394 (32%)were admissible (Medical Assessment Status = Granted)
    - M3 376
    - M2 2
    - M1 2
    - M2/3 14

CMAU Furthered* Files

50 IMEs were furthered

- 1 Furtherance requested
- 27 Received by eMed
- 13 Review Ongoing
- 2 Review Required
- 7 Sent

18 were Cancelled

*These numbers do not represent furtherances that are complete and may have been furthered by CMAU or by RMO.

Challenges in Costing Special Ed Services

- Individualized costing is no longer possible
  - Most P/T have changed their funding allocation process for special education and do not report costs
  - Alternate approach was required
- In 2015, special education files represented 37% of all incoming inadmissible files*
- Special education files were put on hold in May 2015
  - Currently, ~172 special education files await assessment

*Source: Centralized Medical Admissibility Unit, Presentation to BOC, June 29, 2015, slide 7, Phase 1: Outcome

The Special Education Pilot Project

- Question: Can a ***qualitative*** approach replace costing as evidence supporting inadmissible medical assessments requiring special education services?

- Pilot, designed in consultation with Case Management Branch and Legal Services, started in January 2016
  - Detailed list of applicant special education requirements (type of services, number, frequency) vs. average student education requirements
  - No costing provided in medical officer rationale
  - **Results and Recommendation**: Based on the finalized cases MOF and Immigration Officer were able to process cases using the qualitative narrative.
  - Given the success of the pilot project, IRCC is using the qualitative narrative to assess sp ed services.

Example of Complete PF Sent to CMAU

Subject: IME: xxxxxxx UCI: xxxxxxx Application #: xxxxxxxxx

Dear officer,

The above applicant was found medically inadmissible (M5) due to Chronic Hepatitis B infection (070.3). We sent a PF letter on 2016/08/30 and we have received additional information. I'm sending you by email an electronic version of all documents received (please see attached).

List of documents (copies):

1. Two page statutory declaration of (SP) dated October 19, 2016;
2. One page later from xxxxxx(PA) dated 2016/10/17;
3. One page of pregnancy/family photos (2), undated;
4. One page LOE for PA dated Sept 22, 2016;
5. One page LOE from SP dated Sept 23, 2016;
6. Two pages of tax assessment for year not stated;
7. One page property tax bill;
8. One page certificate of balance from dated Sept 8, 2016;
9. One page Summary of Application for dated Aug 30, 2016;
10. Five page Application for dated October 8, 2016;
11. One page translator's affidavit from dated Sept 26, 2016;
12. Nine pages of insurance contract from undated. Effective date 1998/06/08;
13. One page letter from dated Oct 14, 2016.

Process Improvements

- PFs to be sent with a list of documents
- All RMOs to transfer files once a week (Fridays)
- Transfers to CMAU need appropriate codes for furtherance
- When furtherance is requested, ensure type of info is indicated in Other Medical
- When potential M5 is an M3 should CMAU be returning to responsible officer?

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Excessive Demand Provision under the *Immigration and Refugee Protection Act*

Issue: Growing calls for the review or elimination of the excessive demand provision under the *Immigration and Refugee Protection Act*.

Summary

- Under the *Immigration and Refugee Protection Act*, a foreign national can be considered inadmissible to Canada on health grounds if the applicant could reasonably be expected to place an excessive demand on Canada's publicly funded health or social services. No health condition automatically leads to inadmissibility. Each case is assessed by an officer on an individual basis.

- Many disability, HIV, immigration and refugee advocates are calling for the review or elimination of the excessive demand inadmissibility provision. Their position is that the provision contravenes the *Canadian Charter of Rights and Freedoms* and the United Nations Convention on the Rights of Persons with Disabilities.

- Immigration, Refugees and Citizenship Canada (IRCC) is undertaking a fundamental review of the excessive demand provision. Provinces and territories, as well as key stakeholder groups, are providing input to this review for departmental consideration in developing policy options, which will be presented to senior departmental officials in the spring of 2017.

Background:

- Paragraph 16(2)(b) of the *Immigration and Refugee Protection Act* (*IRPA*) and associated regulations require applicants for permanent residence and some applicants for temporary residence to submit to medical examination in order for IRCC to assess whether an applicant is admissible on health grounds. Pursuant to subsection 38(1), there are three grounds of possible health inadmissibility: danger to public health, danger to public safety and excessive demand on health or social services.

- Under subsection 38(1)(c) of the *IRPA*, a foreign national may be found inadmissible if his/her health condition might reasonably be expected to cause excessive demand on health or social services. However, subsection 38(2) of the Act and subsection 30(1) of the *Immigration and Refugee Protection Regulations* (*IRPR*) exempt certain individuals from the excessive demand provision such as Convention refugees applying for resettlement to Canada, protected persons and some persons being sponsored as members of the family class. As well, most temporary resident applicants are not assessed to determine if they would be inadmissible for excessive demand.

- The objectives of the excessive demand policy are two-fold:
  - to reduce the cost burden on publicly funded provincial/territorial health and social services, thereby protecting the services that Canadians rely on; and
  - through the exemptions under the excessive demand provision, to balance protecting publicly funded services with promoting family reunification and refugee protection.

- An applicant may be found inadmissible if the services required to treat his/her health condition or that of an accompanying dependent is anticipated to cost more than the annual cost threshold, $6,450 for 2016, which is based on the average Canadian per capita costs for health and social services reported annually by the Canadian Institute of Health Information; or if the services required to treat a certain health condition could be expected to add to provincial/territorial wait lists.

- No health condition automatically leads to inadmissibility. Each case is assessed by an officer on an individual basis, taking into consideration the applicant's Immigration Medical Examination (conducted by third-party physicians in the country of residence of the applicant).

- If it is determined that an applicant's condition might reasonably be expected to cause excessive demand on publicly funded social services, an applicant may propose a mitigation plan for consideration by immigration officers to demonstrate his/her ability and willingness to mitigate any cost impact on social services in Canada. However, no mitigation plan can be considered for health services which are required to be covered by the provincial/territorial insurance plans pursuant to the *Canada Health Act* (e.g. hospital services, physician care and surgical-dental services).

- Approximately 900-1,000 applicants per year (0.2% of all applicants) are found inadmissible to Canada for excessive demand, including about 200-300 cases related to special education needs. A recent IRCC cost-benefit analysis shows that the excessive demand provision saves provincial/territorial health and social services about $135 million over five years for each year of decisions, which is about 0.1% of all PT health spending (approximately $144 billion in 2015).

- A recent (2015) evaluation found that IRCC officers often lack data on services publicly funded by provinces/territories, including wait times, cost information and availability of anticipated social services needs for certain health conditions, which impedes their ability to fully assess the feasibility of an applicant's mitigation plans to overcome social services costs. The lack of data and information has resulted in longer processing times.

- There has been increasing pressure from advocacy groups and an online petition to review or eliminate the excessive demand provision. Their position is that the provision contravenes the *Canadian Charter of Rights and Freedoms* and the United Nations Convention on the Rights of Persons with Disabilities. In addition, there was an intervention about the excessive demand provision with the Prime Minister during his town hall meeting in Kingston.

- Inadmissibility findings with respect to excessive demand on social services can result in negative media attention. Typically, a case would involve an economic immigrant applicant who has a child requiring special social services supports, such as special education. If the child is found to be inadmissible, the entire family is inadmissible.

Legal Considerations:

Current Status:

- In recognition of these challenges and in response to the evaluation findings, IRCC has been conducting a fundamental review of the excessive demand provision over the past several months.

- Since October 2016, IRCC has been consulting provinces and territories on the excessive demand provision and is expecting responses on the impact of potential changes to the provision. Of the responses received as of February 2, 2017, smaller jurisdictions have said that the provision has limited impacts for them

- Concurrently, the Department is assessing position papers from advocacy groups, such as the Canadian Association of the Deaf, HIV and AIDS Legal Clinic Ontario, and the Canadian Association for Community Living. The Canadian Bar Association is also preparing a brief. In collaboration with Employment and Social Development Canada's Office of Disability Issues, IRCC anticipates meeting with the Council for Canadians with Disabilities within the next month to formally consult with this key stakeholder group.

- As part of the United Nations Committee on the Rights of Persons with Disabilities, in April 2017, the Government of Canada will be participating in the review of Canada's First Report on the United Nations Convention on the Rights of Persons with Disabilities. It is expected that this issue will be raised at that forum. Preparations are under way to present Canada's position on various issues, including immigrants and refugees with disabilities.

Next Steps:

- IRCC will develop policy options for consideration by senior officials in the spring of 2017.

Assessment of these options will consider provincial responses, input from advocacy groups and public concerns for protecting Canadian health and social service in a context of continued high levels of immigration. All input will be used to inform the policy options.

Approved by: Dawn Edlund, Associate Assistant Deputy Minister
Director General: André Valotaire
Originator: Barbara Perron
Branch: Migration Health Branch
Date: February 3, 2017
GCDOCS- 127440353

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Immigration, Refugees and Citizenship Canada
Immigration, Réfugiés et Citoyenneté Canada

Cost-Benefit Analysis on Excessive Demand - Findings, Challenges & Lessons Learned

Policy Committee

March 1, 2017

Canada

PURPOSE OF PRESENTATION

- To provide an overview of the cost-benefit analysis (CBA) on the policy of excessive demand (XSD) on health and social services.
- To share practical insights and challenges encountered in conducting CBA in the IRCC/immigration context.
- To learn from your experiences in applying CBA in the context of policy reviews and/or program evaluations.

s.14(a)
s.21(1)(a)
s.21(1)(b)

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CONTEXT OF STUDY

Policy Issues & Challenges

- An HSN Evaluation found a lack of formal mechanisms to facilitate engagement and sustained input from P/Ts on migration health issues.
- It was recommended that IRCC engage more constructively with P/Ts on questions related to XSD.

MRAP & P/T Engagement

- In response, IRCC committed in its Management Response Action Plan to develop a strategy to consult P/Ts on XSD.
- A key step in engaging ministries of health, immigration, education and social services in discussion on the XSD provision would involve consideration of the policy's relevance and sustained benefits for P/T health-care systems.

Cost-Benefit Analysis

- A cost-benefit analysis of XSD was conducted to inform IRCC's fundamental reassessment of the provision and to act as a key discussion tool to engage P/Ts and to inform their input into the overall policy review.

s.14(a)

s.21(1)(a)
s.21(1)(b)

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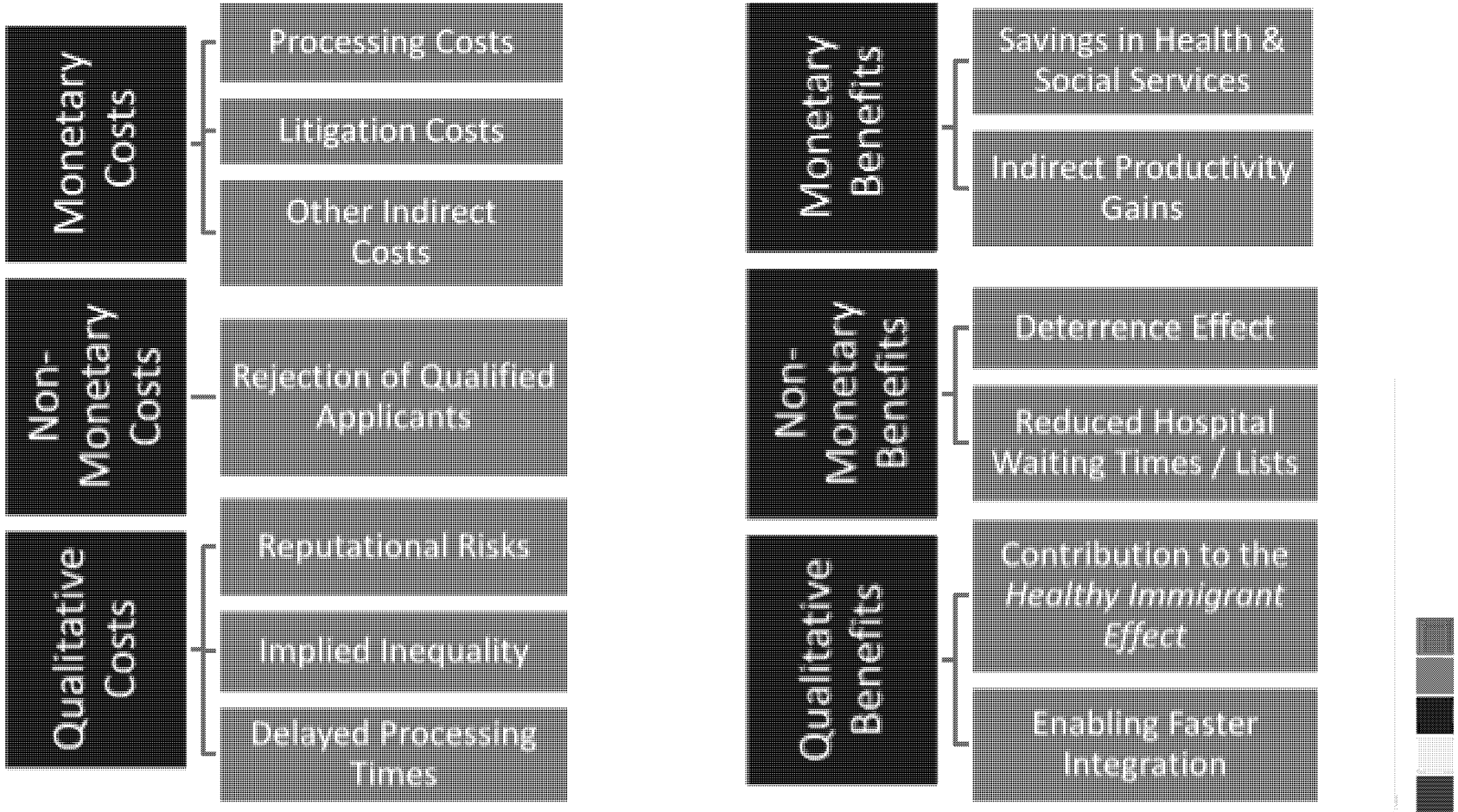
MAIN FINDINGS

- The projected health care & social services costs saved over five years on account of rejected XSD cases in 2014 are $135 million.
  - This is 279 times the cost of running the XSD program over the year.

In purely economic terms, the XSD provision saves substantial resources for provinces and territories.

- Unfortunately, these findings do not adequately reflect many real, yet difficult to measure costs to IRCC.
  - E.g., negative media coverage leading to poor country image, lost human capital, delayed processing times, weakened public confidence, etc.

EXCESSIVE DEMAND COSTS & BENEFITS



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s.21(1)(b)

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CHALLENGE #1: IDENTIFYING COSTS & BENEFITS

Considering a Possible Deterrence Effect

- A potential benefit of the XSD provision is that it may deter persons with serious medical conditions from immigrating to Canada.
- This analysis provided some evidence that XSD may have deterred more than 800 people from pursuing immigration.
- The challenge is that the deterrence effect is highly difficult to assess in order to determine the provision's existence and/or exact impact.
- In estimating the deterrence effect, several proxies were used and assumptions made in order to fulfill the analysis, thus creating a high degree of uncertainty in our results.
- While some have argued that deterrence is an important component of CBA, others question the strength of the finding given this uncertainty.

→ Consequently, we struggled with how to reconcile these opposing views.

CHALLENGE #2: VALUING COSTS & BENEFITS

Accounting for Qualitative Costs & Benefits

- CBA tends to favour costs & benefits that are expressed in quantitative, monetary terms.
- Yet, some values may not be easily quantified.
  - **Negative Media Coverage Leading to Poor Country Image:** A family was denied permanent residency and faced deportation after 12 years in Canada due to their son's autism diagnosis.
  - **Lost Human Capital:** A York University professor applied for permanent residency for his family but was initially denied because his son has Down syndrome.
  - **Pressure from Stakeholders:** There is a growing number of disability, HIV, immigration and refugee advocacy groups calling for the review or elimination of XSD, claiming that it contravenes the *Canadian Charter of Rights and Freedoms* and the UN Convention on the Rights of Persons with Disabilities.
  - **Internal Perception of XSD:** Comments in evaluation from departmental officials ranged from long-standing irritant to insufficient coverage given exemptions.

How do you factor qualitative costs & benefits into your decision?

PUTTING THE FINDINGS INTO PERSPECTIVE

- Relative to total health-care spending, a savings of $135 million is just 0.1% of all P/T health outlays.
- Only 0.2% of all applicants are deemed inadmissible to Canada on grounds of excessive demand.
-

Excessive Demand Policy: Document for Discussion with Provinces and Territories

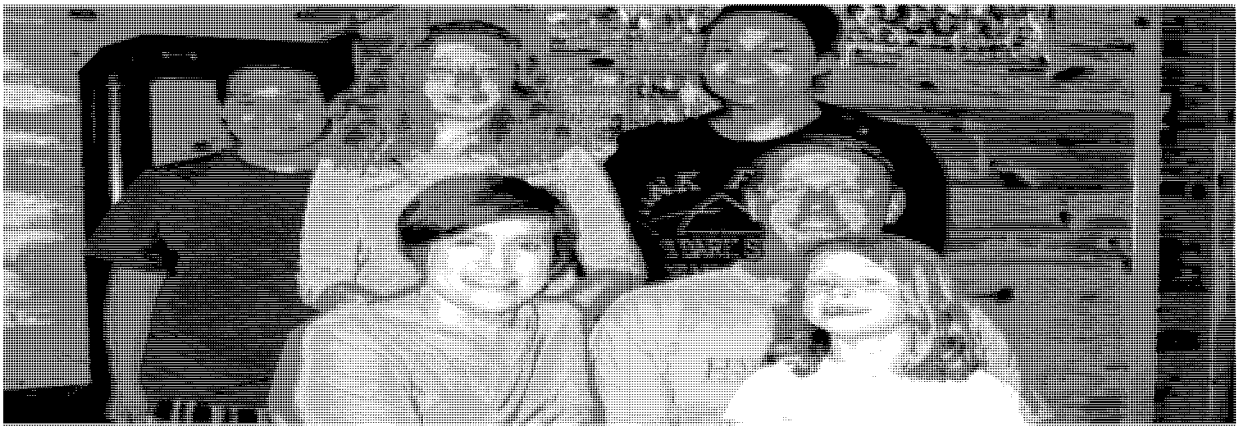
Illustrative Media Article

The following July 26, 2017 CBC media article illustrates a number of the issues related to the current excessive demand policy:

Americans denied permanent residency because of daughter's special needs

Family here since 2013, invested $600K in business, but denied status because of 6-year-old's health needs

By Erin Brohman, CBC News Posted: Jul 26, 2017 7:15 AM CT Last Updated: Jul 26, 2017 3:51 PM CT



The Warkentin family is fighting to stay in Canada after they were denied permanent residency by immigration officials because of six-year-old Karalynn's health. (Submitted by Karissa Warkentin)

A U.S. family of six who have built a business in Canada want to stay here but have been denied permanent residency because of the potential costs of treating the youngest child's health problems. The Warkentin family came to Canada from Colorado in 2013 to operate an outfitting business in Waterhen, 275 kilometres northwest of Winnipeg. Their work permits to run their hunting and fishing lodge will expire in November. When they came to Canada, Jon and Karissa

Warkentin didn't know that their daughter Karalynn, then two, had special needs. She was diagnosed in 2014 with epilepsy and global developmental delay. Their letter of rejection from Immigration, Refugees and Citizenship Canada (IRCC), which arrived in April, said Karalynn's health condition might cause "excessive demand" on health or social services in Canada. "It's hard because we have one person in our family who has a disability out of all six of us. It makes us feel like we're second class. Canada doesn't want you. You feel put down," said Jon Warkentin.

Karalynn loves to jump on the trampoline, play with Lego and greet the customers at her parents' hunting and fishing lodge, the Warkentins say. (Submitted by Karissa Warkentin)

Karalynn was deemed inadmissible to Canada on health grounds stemming from her global developmental delay and ADHD, the letter said. As a result, all family members were deemed inadmissible to Canada. "We were mystified, because she doesn't require daily nursing care," said Karissa Warkentin. "She doesn't go to speech therapy, she doesn't go to occupational therapy, she doesn't require physical therapy. She's not in the hospital because she has chronic health conditions." Karalynn loves to jump on the trampoline, play with Lego and watch the movie *Frozen*. She's been seizure-free for two years, does not take any medications, and a psychologist's report submitted to IRCC suggested only the possibility that she had ADHD, Warkentin said. She behaves at the cognitive level of a three- or four-year-old and needs to be supervised, her mom said. "Global developmental delay is a very broad, sort of not really well-understood diagnosis," she said. "We think this policy is outdated and unfair, and not just for us, not just for our family, but for other families, too. It's basing a human being's worth in dollars and cents."

'Excessive demand' on health service

Annual health care spending for the average Canadian is $6,655, federal officials say, and that's the price used to determine whether a newcomer will place "excessive demand" on health services. "Its role is to prevent individuals with a severe medical condition from coming to Canada," said Kenneth Zaifman, an immigration lawyer. "I know that government is sometimes run like a business, and it has to be, and that's why they're doing that, but we were never given the exact figures," said Warkentin, who would have liked to see a breakdown of how projected costs for her daughter would exceed $6,655. Under their work permits, Jon, Karissa, Karalynn and her siblings Shataya, 18, Grace, 17, and Gabe, 14, were granted Manitoba health cards along with social insurance numbers. They did not have to purchase any private insurance except for when they travelled outside of Canada. Jon Warkentin said it's going to be tough for them to leave, particularly given that the children are all enrolled in school. "Emotionally, it would be hard to leave our friends, and it would be hard for the kids to leave their friends and their school

and all that they know here." The federal official handling the Warkentins' file had asked them to explain how Karalynn would not be a burden on the health care system, and to submit relevant documentation, before the final decision was reached. The family sent a notarized letter saying they would handle all of their daughter's health care costs going forward. They also sent testimonials from school and community officials on their contributions, and information about how block funding from Frontier School Division covers in-classroom support to all students who need it, regardless of whether Karalynn is there. On Wednesday, IRCC sent an emailed statement to CBC News stating that with no additional information sent, the "decision to refuse the PR [permanent resident] application was maintained." "Such decisions are not arrived at lightly," the agency said in the email. "However, IRCC must maintain a balance between welcoming new members into Canadian society while also protecting our publicly funded health and social services."

Looking ahead

The Warkentins entered the residency application process through the provincial nominee program. Now they're looking at selling their business, which will mean a financial loss, and leaving a community they've come to love. They're willing to cover any of Karalynn's costs to stay. "Long term, we would love to set up a disability savings account if there needs to be a long-term plan into her adulthood, if she's unable to live on her own, if the gap widens in her delay, or nothing really changes. But we can't do that until we're residents of Canada," said Karissa Warkentin. Jon Warkentin said there's more value in keeping them in Canada than sending them away because of Karalynn's needs. They've invested nearly $600,000 in their growing business and have paid "in excess of $20,000" to government in taxes and fees, he said. The Warkentins have hired a lawyer who is appealing the decision at the federal level. Karissa Warkentin believes it will all work out, one way or another. "I'm one of the blessed few that has the opportunity to go back to the United States of America and rebuild a future there. I know there are other people that are in this situation that don't have that luxury," she said.

With files from Danelle Cloutier

http://www.cbc.ca/news/canada/manitoba/permanent-resident-health-care-costs-immigration-1.4221930

DRAFT

FMRI

FORUM OF MINISTERS RESPONSIBLE FOR IMMIGRATION

EXCESSIVE DEMAND POLICY

FPT Ministers Meeting
September 14-15, 2017
Toronto, Ontario

Purpose

- To explain IRCC's reasons for launching a review of the law on excessive demand on health and social services

- To inform you of the option under review by IRCC for changing the legislative provisions

Excessive Demand

- Under the *Immigration and Refugee Protection Act*, three grounds for medical inadmissibility:
  - Danger to public health
  - Danger to public safety
  - **Excessive demand on health and social services**

- Excessive demand applies to permanent resident applicants and some temporary resident applicants, with exemptions for Convention refugees, protected persons and some members of the family class

Long-standing Challenges

Operational and Policy

- Lack of cost information and data leads to:
  - inability to fully assess mitigation plans
  - longer processing times
- Unenforceability of mitigation plans
-
- Duplication in visa and medical officer roles
- Exemptions may reduce policy effectiveness

Legal

Excessive Demand

Provincial/Territorial Engagement

-

- Complex consultations involving ministries responsible for immigration, health care, education and social services

Media/Public Perception

- Negative media attention around some inadmissible cases (often sympathetic cases involving children needing social services)
- Public calls for review and elimination of the provision (e.g., online petition, Council of Canadians with Disabilities, Canadian Council for Refugees, Caregivers' Action Centre, HIV and Aids Legal Clinic Ontario)

s.21(1)(a)
s.21(1)(b)

Option 1 : Cost Threshold

- **Policy**: applicants are inadmissible if their health condition might reasonably be expected to cause excessive demand on health or social services. Applicants are inadmissible if the predicted five-year cost of the health and social services required to treat their health condition, or that of an accompanying dependant, would likely exceed average Canadian per capita costs. The 2017 cost threshold is $33,275/5 years.
- **Challenges**: credibility - Media and stakeholders criticize the threshold as too low overall, under-estimating social services costs (and therefore finding too many applicants as inadmissible), not accounting for economic and social benefits that refused applicants would bring.

s.21(1)(a)
s.21(1)(b)

Option 2: Consideration of Wait Lists

Policy: applicants are inadmissible if the services required to treat their health condition, or that of an accompanying dependant, are expected to add to existing waiting lists and would increase the rate of mortality and morbidity for Canadian residents.

Challenges: effectiveness – the wait lists consideration is applied to services where IRCC has evidence of existing wait lists. Presently, wait lists are considered only for dialysis and some transplantation services.

000113

s.21(1)(a)
s.21(1)(b)

Option 3: Definition of the Services under the Provision

Policy: The definition of social services includes special education services and related services, such as vocational rehabilitation services. These services are frequently required by applicants' accompanying dependants who have intellectual disabilities, blindness, deafness, etc. Applicants are inadmissible if the predicted five-year cost of the health and social services required to treat the health condition would likely exceed the cost threshold.

Challenges: litigation and processing delays – since most provinces and territories moved to integrate students needing special education services into mainstream educational services, IRCC has had difficulty finding data to support assessments of excessive demand for applicants needing special education and related services. This has created processing delays for these applications. Additionally, IRCC faces difficulties in defending these decisions and many are returned by appeal bodies to IRCC for redetermination. To the extent that applicants are succeeding with their appeals, the effectiveness of the policy is diminished. Additionally, media, applicants, and disability advocates view the consideration of special education services as discriminatory and contravening the *Canadian Charter of Rights and Freedoms* and the United Nations Convention on the Rights of Persons with Disabilities.

Option 4: Exempted Immigration Groups

Policy: Foreign nationals are inadmissible to Canada on health grounds if they pose an excessive demand on health or social services. However, the *Act* exempts certain individuals from the excessive demand provision such as Convention refugees applying for resettlement to Canada, protected persons and some persons being sponsored as members of the family class.

Challenges: fairness and efficiency – concerns about fairness expressed that large segments of permanent resident admissions (e.g., resettled refugees, family-class sponsored spouses and dependent children) are not subject to the policy, while those selected for their future economic and social benefits (e.g., economic class applicants, temporary workers) are subject to the policy. Secondly, the need to monitor and consider the eligibility of temporary residents for provincial/territorial health insurance, which is the prerogative of provinces and territories and varies across jurisdictions and across temporary resident categories, introduces inefficiencies for IRCC in the processing of applicants for temporary residency.

Overview of the Centralized Medical Processing Unit (CMAU)

Dr. Arshad Saeed
Director, CMAU
October 21, 2019

Statistics: Medicals assessed by CMAU

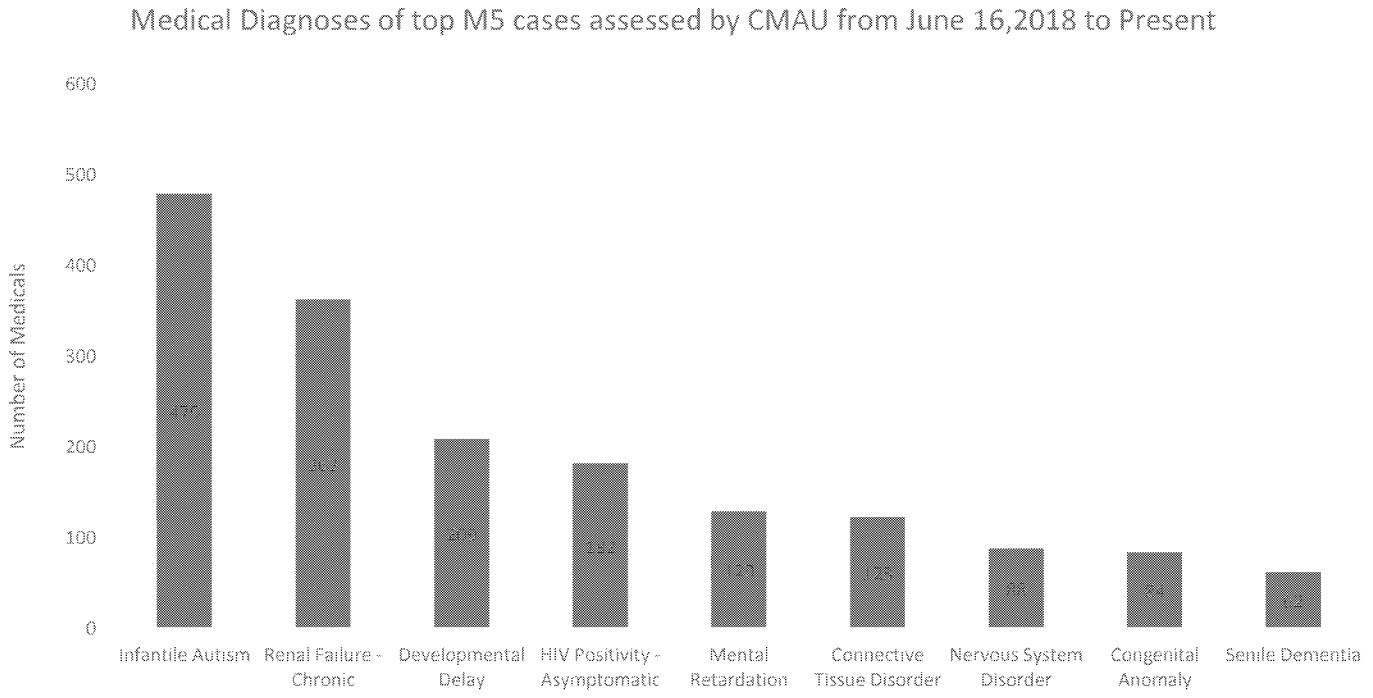
Table 1: Number of medicals assessed by CMAU between June 16, 2018 and June 16, 2019

Medical Code	Number IMEs
Admissible	
M 2/3	42
M3	389
Sub-Total Admissible	431
Inadmissible	
M4	80
M5	1384
M 5/6	3
M6	4
Sub-Total Inadmissible	1471
Grand Total Assessed	1902

Table 2: Number of medicals assessed by CMAU before June 16, 2018

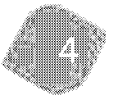
Medical Code	Number of IMEs
Admissible	
M 2/3	88
M3	1099
Sub-Total Admissible	1187
Inadmissible	
M4	121
M 4/5	1
M5	2499
M 5/6	11
M6	30
Sub-Total Inadmissible	2662
Grand Total Assessed	3849

Statistics – Top Medical Diagnoses for CMAU M5s



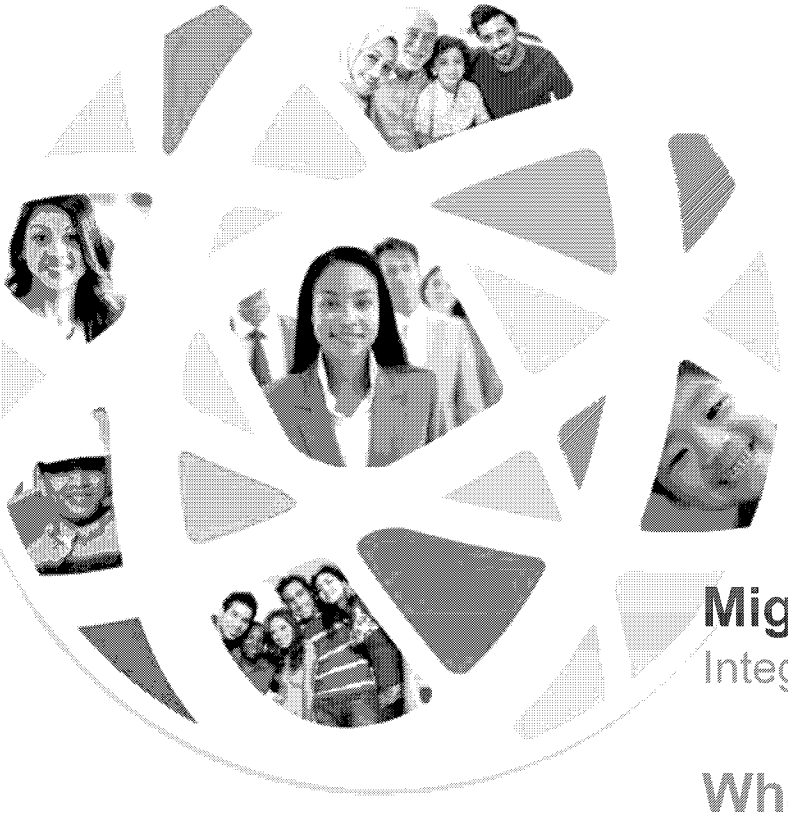
Contributions

- All files previously on hold for Excessive Demand were reviewed and assessed by MOFs and sent to Niagara Falls for processing
- Review of cases and training was provided to Niagara Falls HM
- Costing provided for Implementation Costs of Excessive Demand
- Creation of a cost field for cases in GCMS
- New contract initiated and completed for Taking Care Inc. for costing of long term care
- All CMAU paper files on floor (M4, M5, M6) sent to the Transformation and Digital Solutions Sector (TDSS) for destruction or to hold for retention period.



Challenges

- **When RMO MOFs not available to assist CMAU with cases, risk of a backlog which can then lead to issues with program integrity / service standard timeframe not being met**
- **Still receiving questions and clarifications from NF on an ongoing basis**
- **Have received PFs from overseas when TPP could have been applied**
- **2nd MOF required for CMAU**



Migration Health Branch

Integrated Medical Processing Network

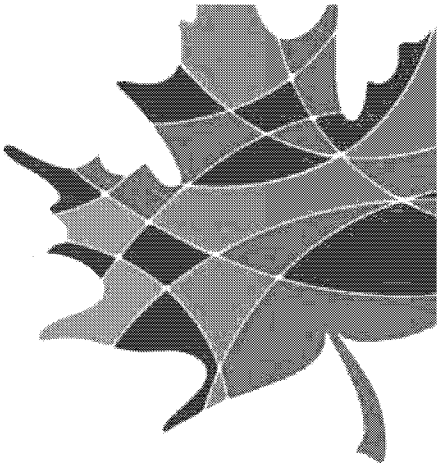
What Keeps Us Up at Night?

Elaine Barrett-Cramer, MD, MPH
a/Senior Medical Director & RMO Medical Directors
October 22nd 2019

Immigration, Refugees and Citizenship Canada | Immigration, Réfugiés et Citoyenneté Canada

Canada

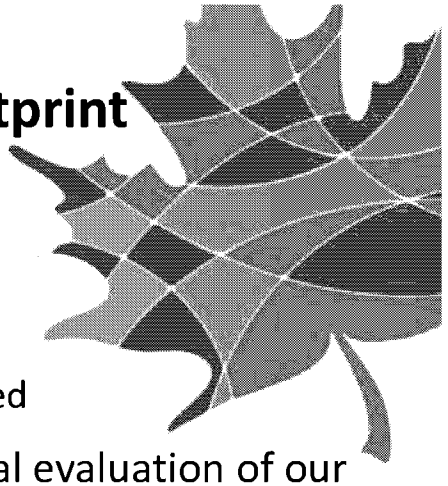
Integrated Medical Processing Network Challenges:



What keeps us up at night?

1. Profound growth in IME processing volumes and physician network footprint
2. Immigration Medical Exam selection criteria do not fully target at-risk population
3. Abandoned Immigration Medical Exams are often associated with tuberculosis
4. Inability to effect timely GCMS change requests is impacting case processing

Growth in processing volumes and network footprint



- Between 2011-2013, the RMO's were reduced from 10 to 4
  - eMedical and GCMS functionalities and efficiencies expected
- Redistribution of workloads and resources based on a global evaluation of our worldwide activities
- Increase in migration levels requiring additional panel sites
- Some countries very dense in panel sites (Canada)
- Large territories that some RMO's are unable to visit
- Loss of dialogue with panel physicians in larger regions

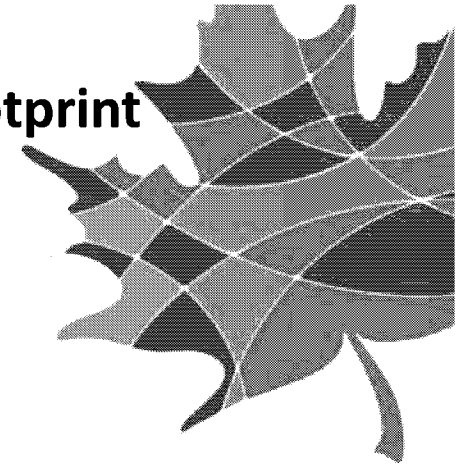
Quick facts about the Regional Medical Offices 2018

Total IME volume Jan 1st to Sept 30th, 2019: 667,114

Growth in processing volumes and network footprint

	# of Countries		# of Panel Physicians		# of IME's	
	2013	**2019 (%↑)**	2013	**2019 (%↑)**	2013	**2018 (%↑)**
London	72	**101 (40%)**	206	**375 (82%)**	59,763	**123,285 (106%)**
Manila	18	**22 (22%)**	152	**332 (118%)**	80,672	**152,702 (89%)**
New Delhi	5	**14 (180%)**	72	**133 (84%)**	81,694	**238,738 (247%)**
Ottawa	41	**56 (36%)**	237	**341 (43%)**	181,614	**302,247 (66%)**
Paris	39	**N/A**	122	**N/A**	57,876	**N/A**
Beijing	3	**N/A**	83	**N/A**	71,941	**N/A**

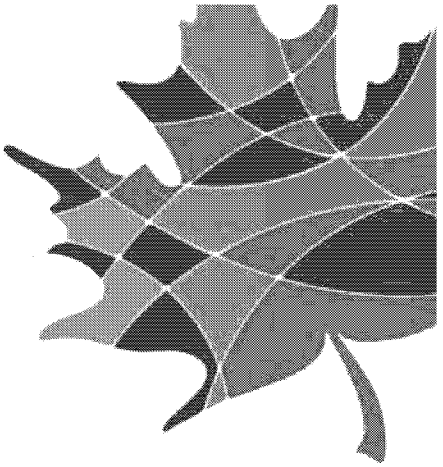
Growth in processing volumes and network footprint



Discussion points:

- Review the adequacy of the MHB footprint
- Consider an increase in staff within RMOs to address processing volume increases
- Create and fund recruitment and retention strategy to develop MOFs and Assistant Directors
- Enhance collaboration with IN and IPM
- Evaluate the efficiency of site visits vs. desk top audits
- Develop a physician management framework with M5 partners

Integrated Medical Processing Network Challenges:



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Immigration Medical Exam selection criteria

- Total of 21,776/1,474,243 (1.5%) Immigration Medical Exams assessed with a diagnosis of active, inactive or latent tuberculosis (TB) over 21 month period

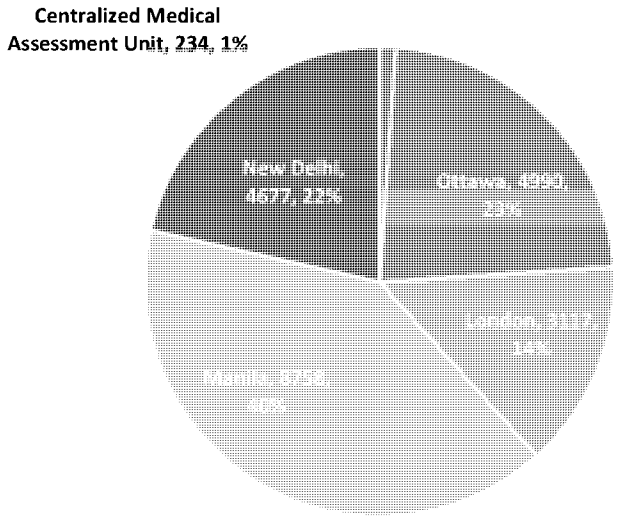


Figure 1: Number and percentage of IMEs with a TB diagnosis by RMO from January 1, 2018 to September 30, 2019

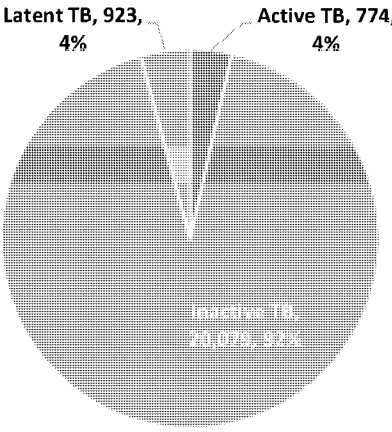
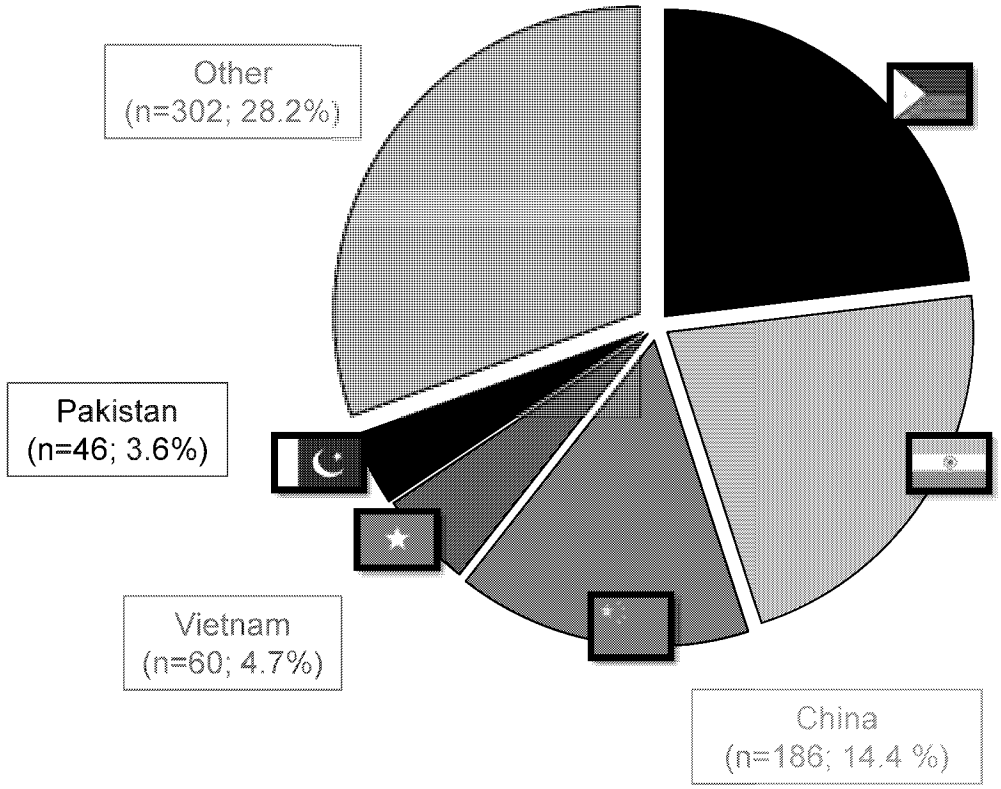


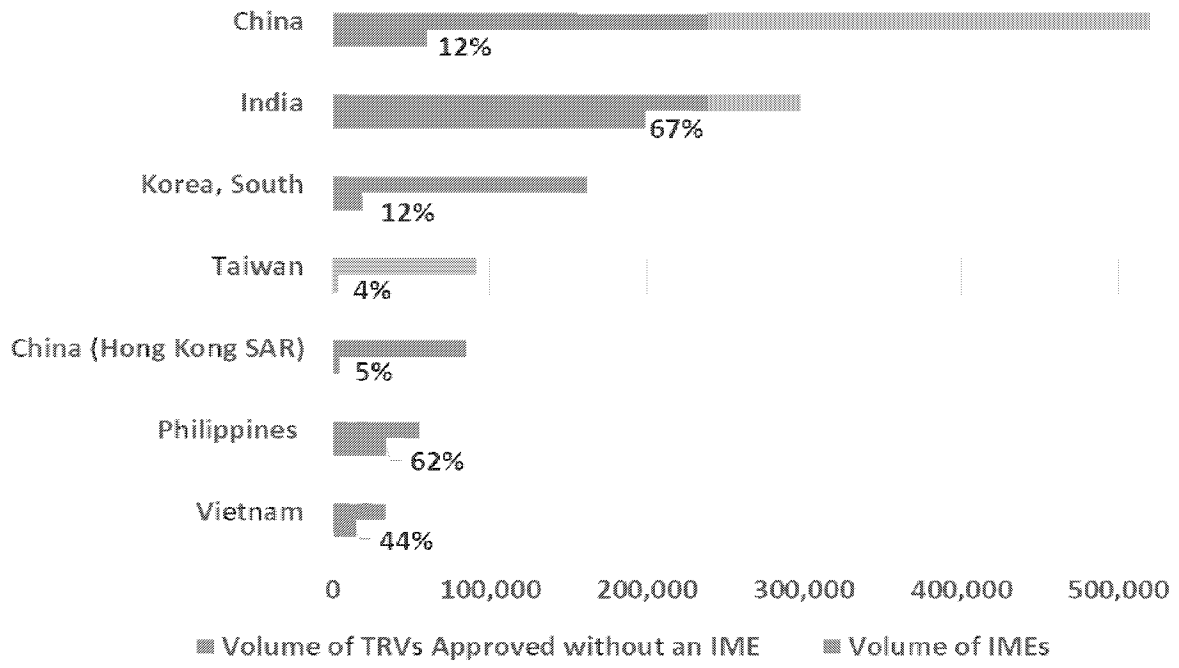
Figure 2: Number and percentage of IMEs with a TB diagnosis by TB type from January 1, 2018 to September 30, 2019

Immigration Medical Exam selection criteria

Top Countries of Origin for In-Canada active TB diagnosis



Immigration Medical Exam selection criteria



- Large portions of high TB-risk applicants missed with current screening criteria
- Screening emphasis on category and duration of stay

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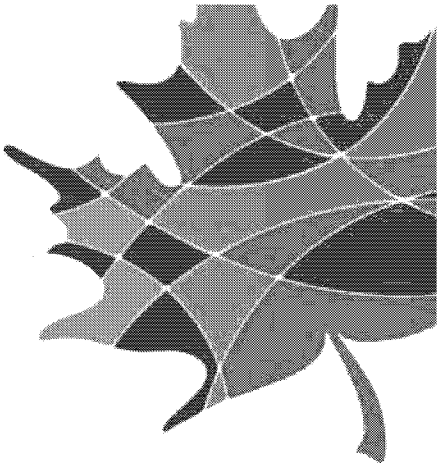
Immigration Medical Exam selection criteria

Discussion points:

- Revise tuberculosis screening criteria based upon risk associated with country or residence of origin, not application category
- Restrict long-term and multiple entry TRVs to low tuberculosis incidence countries
- Require IMEs for TRVs in high tuberculosis incidence countries
- Extend IME validity period to 2 years for low-risk countries and those compliant wit surveillance
- Consider integrating with VACs: Chest x-rays, biometrics, teleradiology centres
- Focus screening on risks such as age and other specific cohorts (China, Korea, Taiwan, Australia)

Integrated Medical Processing Network Challenges:



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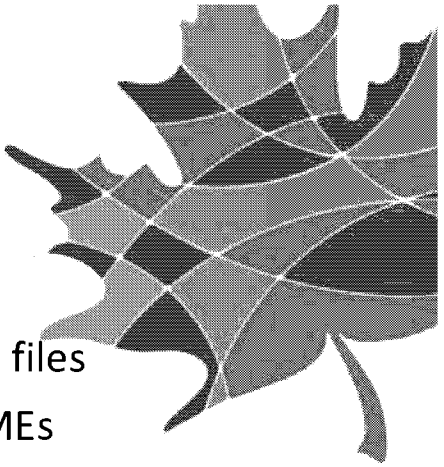
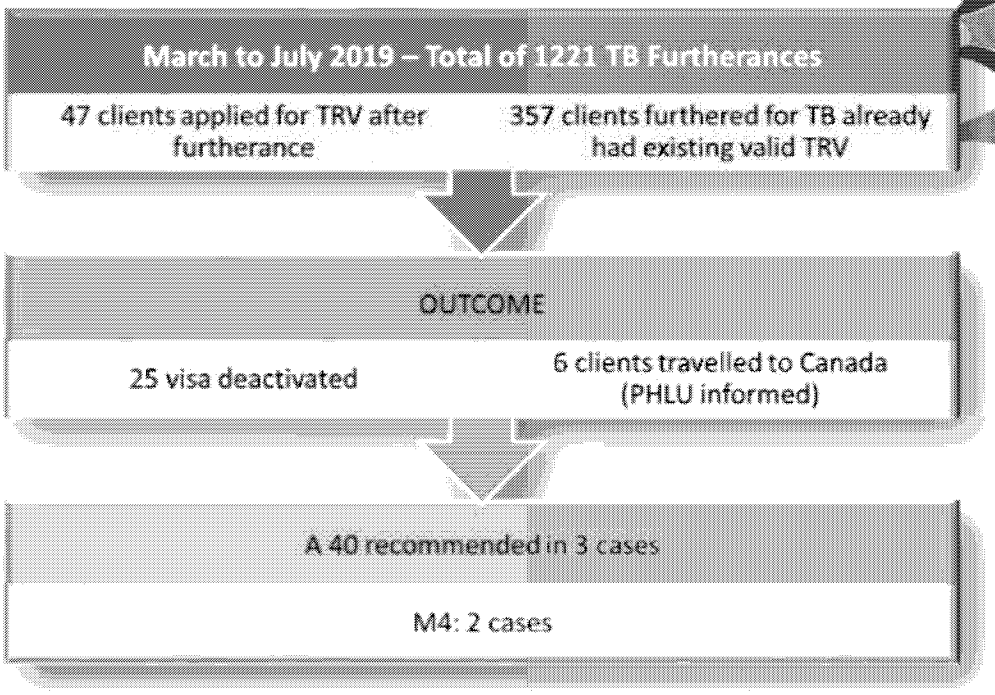
Abandoned Immigration Medical Exams



- Since 2016, TR Program Delivery favors multi-entry visas
- Wide use of Upfront Medical Exams leading to unlinked TB files
- TRV requirements allow clients to "visa-shop" and avoid IMEs
- Significant portion of at-risk clients travel to Canada avoiding IME
- Challenge for MHB to stop at-risk clients from travelling once identified
- Difficult to prove misrepresentation
- IME issuance is the decision of migration officers with no medical background

Abandoned Immigration Medical Exams



- Current QA protocol resource intensive in time and staff
- Reduced from monthly to weekly reviews
- Requires Info Alerts and for migration officers to contact the RMO for all withdrawals

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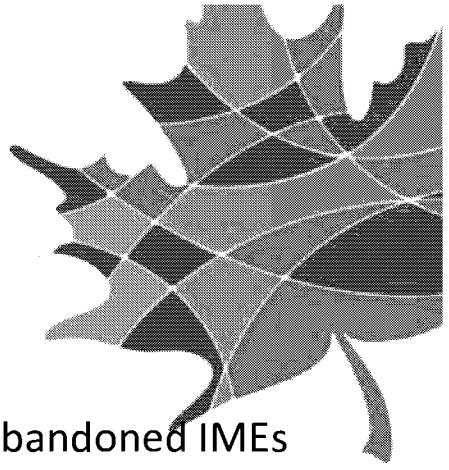
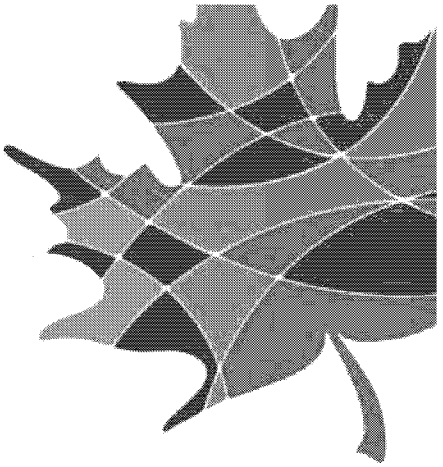
Abandoned Immigration Medical Exams



Discussion points:

- Consider discontinuing Upfront Medical Exams entirely
- Consider wider use of (and training for) A40 in relation to abandoned IMEs
- Create system changes to identify high risk cases and to prevent visa issuance for in-progress IMEs
- Develop an info alert for MHB use
- Develop guidelines, with IN, for visa deactivation where appropriate
- Develop criteria for when to deactivate visas, when to use A40 misrepresentation, when to make an M4 decision
- Consider biometrics and/or facial recognition in association with the IME

Integrated Medical Processing Network Challenges:



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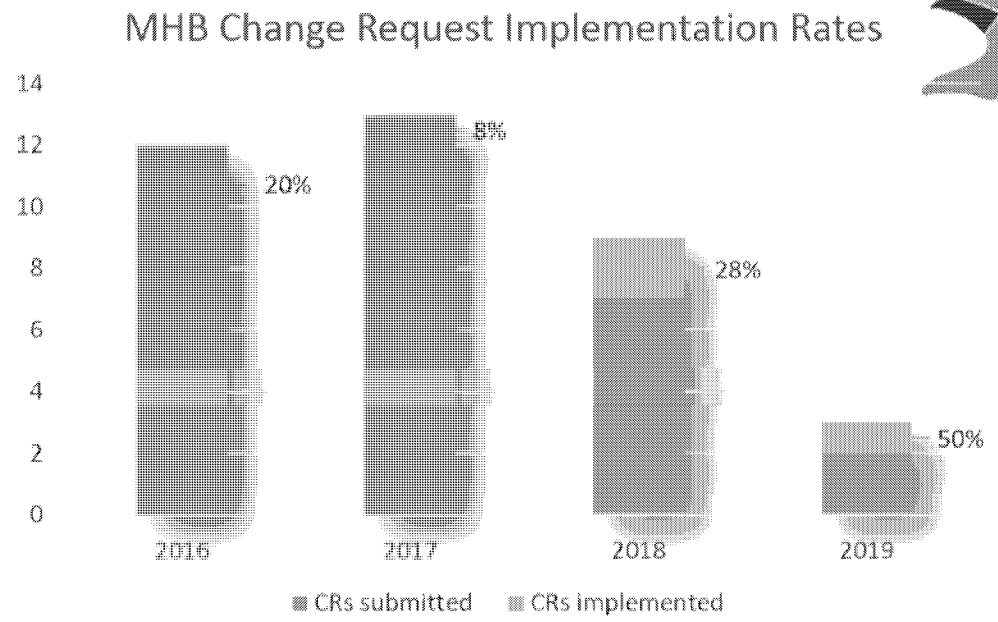
Inability to effect GCMS change requests



- Change requests labelled as low or medium priority
- MHB early adopter of automation and is very dependent on the system
- MHB change requests often given a delay of 24 to 36 months before completion

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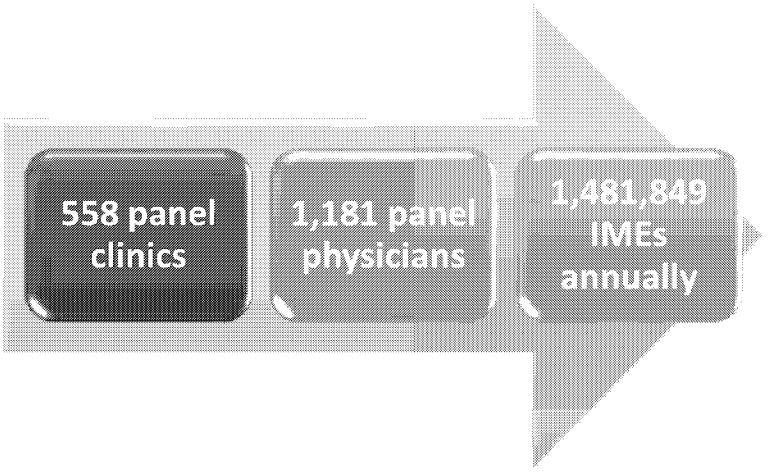
Inability to effect GCMS change requests



All dependent on GCMS to flow into the migration process

- eMedical depends on GCMS
- Clients and physicians negatively affected by system misalignment
- Challenges identified could be managed with change requests

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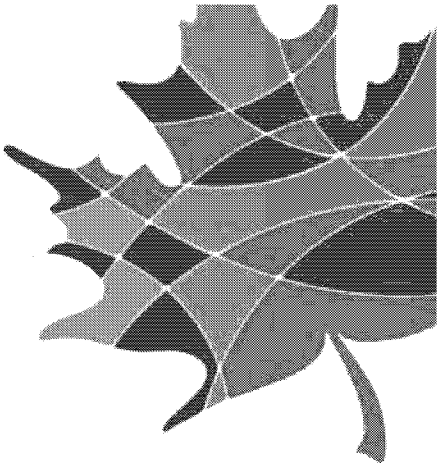
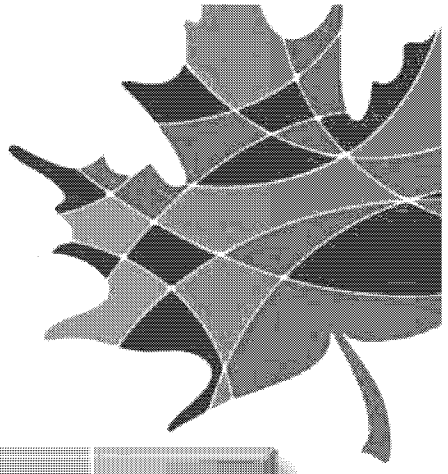
Inability to effect GCMS change requests



Discussion points:

- Embed a dedicated MHB GCMS officer
- Prioritize MHB GCMS for change requests that impact eMedical functionality
- Advancements in program integrity, quality assurance and innovation hinge on system changes

Case processing snapshot

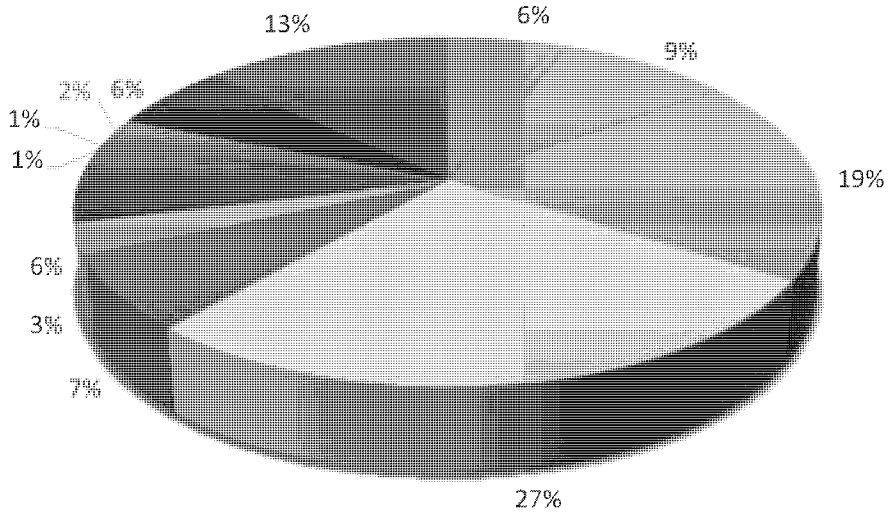


Jan 1st 2018-Sep 30th 2019	London	Manila	New Delhi	Ottawa	Total
IMEs Received	229,010	267,627	444,076	539,169	1,482,294
IMAs	227,686	266,809	441,283	535,268	1,474,243
Reassessments	9,032	1,723	4,123	39,526	54,430
Furtherances	6,629	13,520	12,307	11,778	45,655

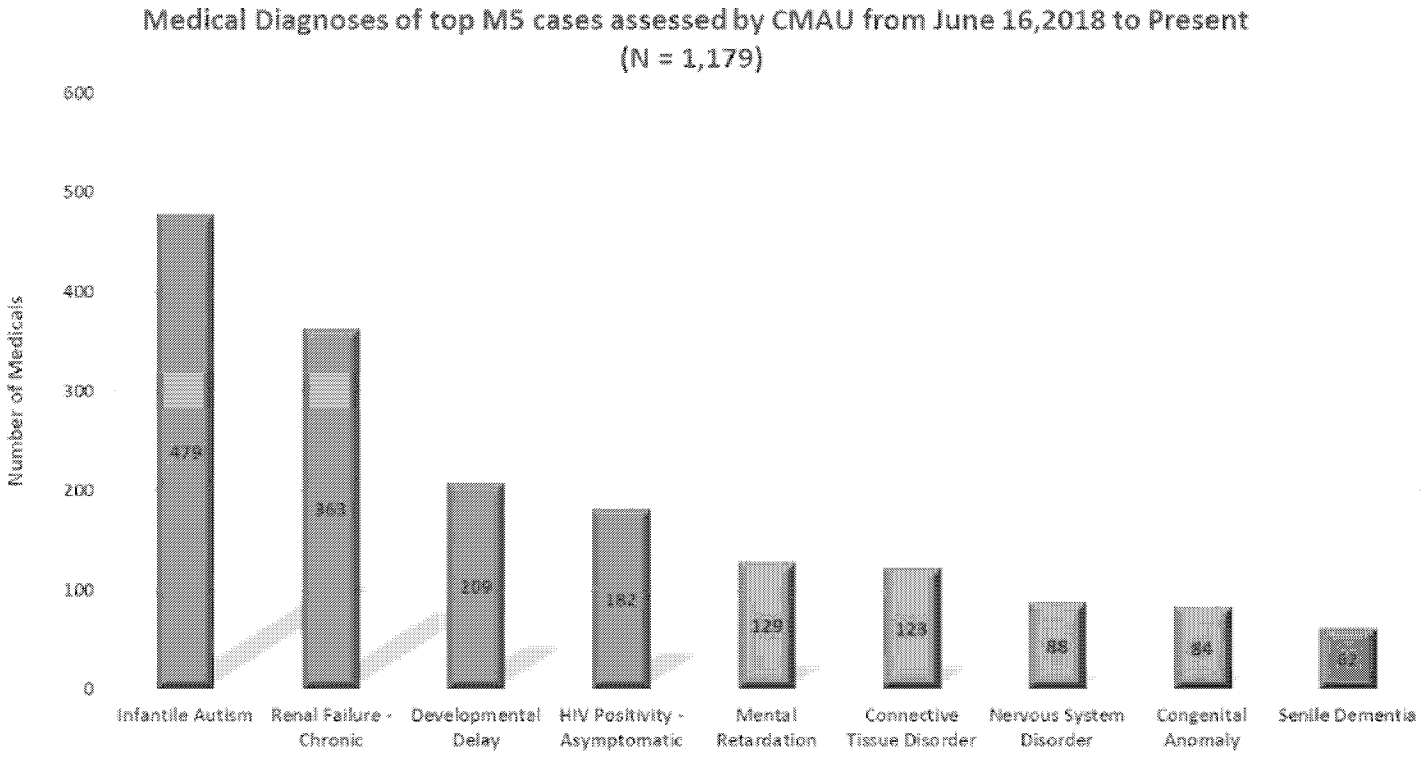
Case processing snapshot

Percentage of Medical Diagnoses for In-Canada IMEs by Diagnostic Category

(N=30,827 diagnoses; 22,228 individual IMEs; 0.9% of total IME volume)



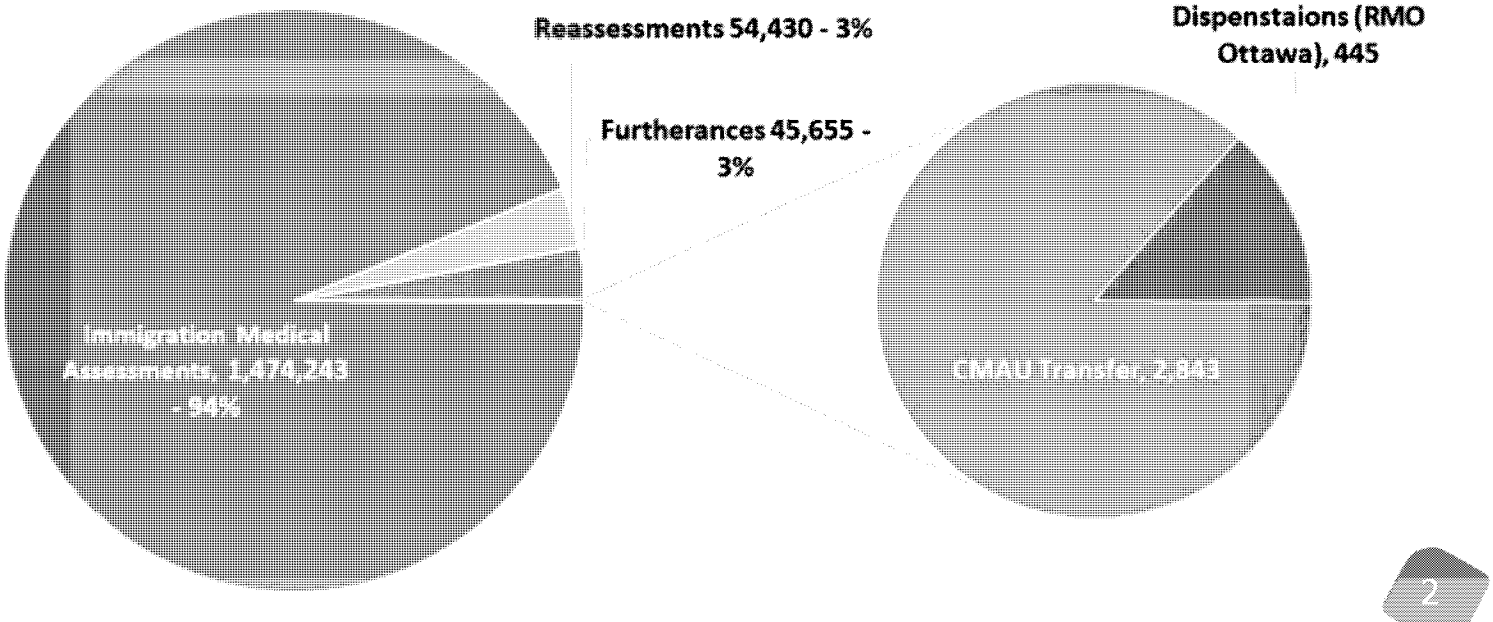
- Tuberculosis
- Infectious Diseases
- Diabetes
- Heart & Circulatory Diseases
- Kidney & Liver Diseases
- Cancer
- Mental Illness
- Degenerative Conditions
- Pulmonary Conditions
- Congenital & Developmental Conditions
- Other
- Non-Specific Findings



Case processing snapshot

- Total of **1,482,294** Immigration Medical Exams received from January 01, 2018 to September 30, 2019.

Processing volume for January 2018 – September 30, 2019



Presentation to the IRCC Excessive Demand Working Group

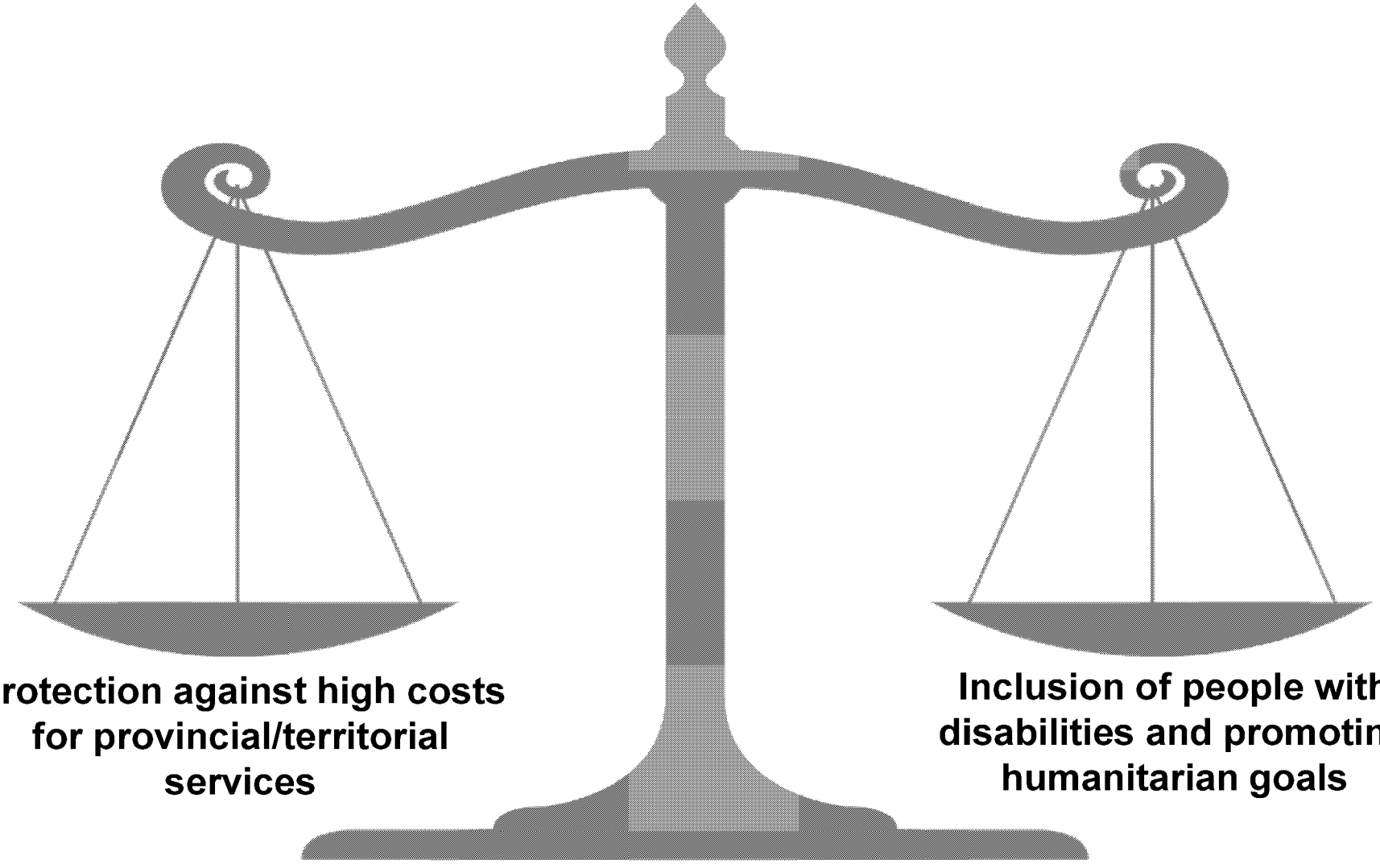
Internal Discussion

Research & Partnerships Unit (MHPP)

July 9th, 2021

Migration Health Branch

Amended Regulations – Striking the appropriate balance between protecting health services and promoting inclusion



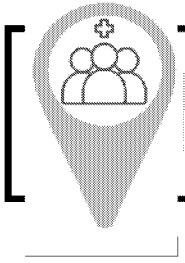
Protection against high costs for provincial/territorial services

Inclusion of people with disabilities and promoting humanitarian goals

Continued public support for immigration

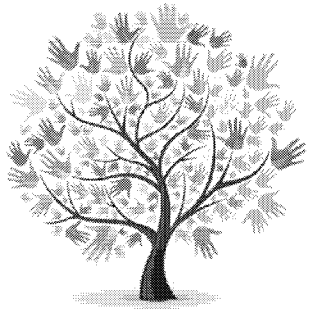
Why do we need an Excessive Demand policy?

- Facilitates immigration while protecting health and social services
  - Although cost savings are relatively small in the context of overall health spending, individual high-cost cases can have **significant impacts** on local hospitals, in particular in smaller centres or provinces
- Supports federal investments in provincial/territorial health-care systems
- But very few applicants with a medical diagnosis are refused
  - Applicants have opportunity to present mitigation plans to offset decisions
  - From 2013-2016, out of more than **3.6 million** medical exams, only **1,772** individuals (0.05%) found inadmissible for reasons of excessive demand
  - For example, among applicants diagnosed as HIV+
    - 2,000 applicants diagnosed with HIV over a 3-year period
    - Only 29% initially assessed as potential excessive demand
    - Less than 7% refused



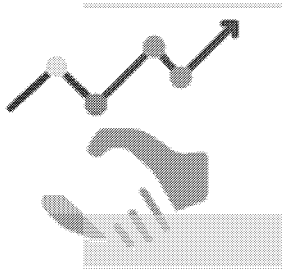
Fundamental to ensuring social license for higher immigration levels

Challenges with the Policy & Government Response

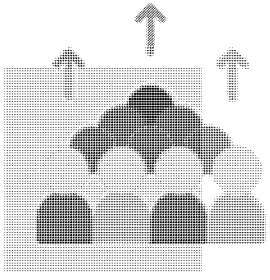


Canadian Values
Diversity & Inclusion

Contributions to Canadian Society
Economic & Social



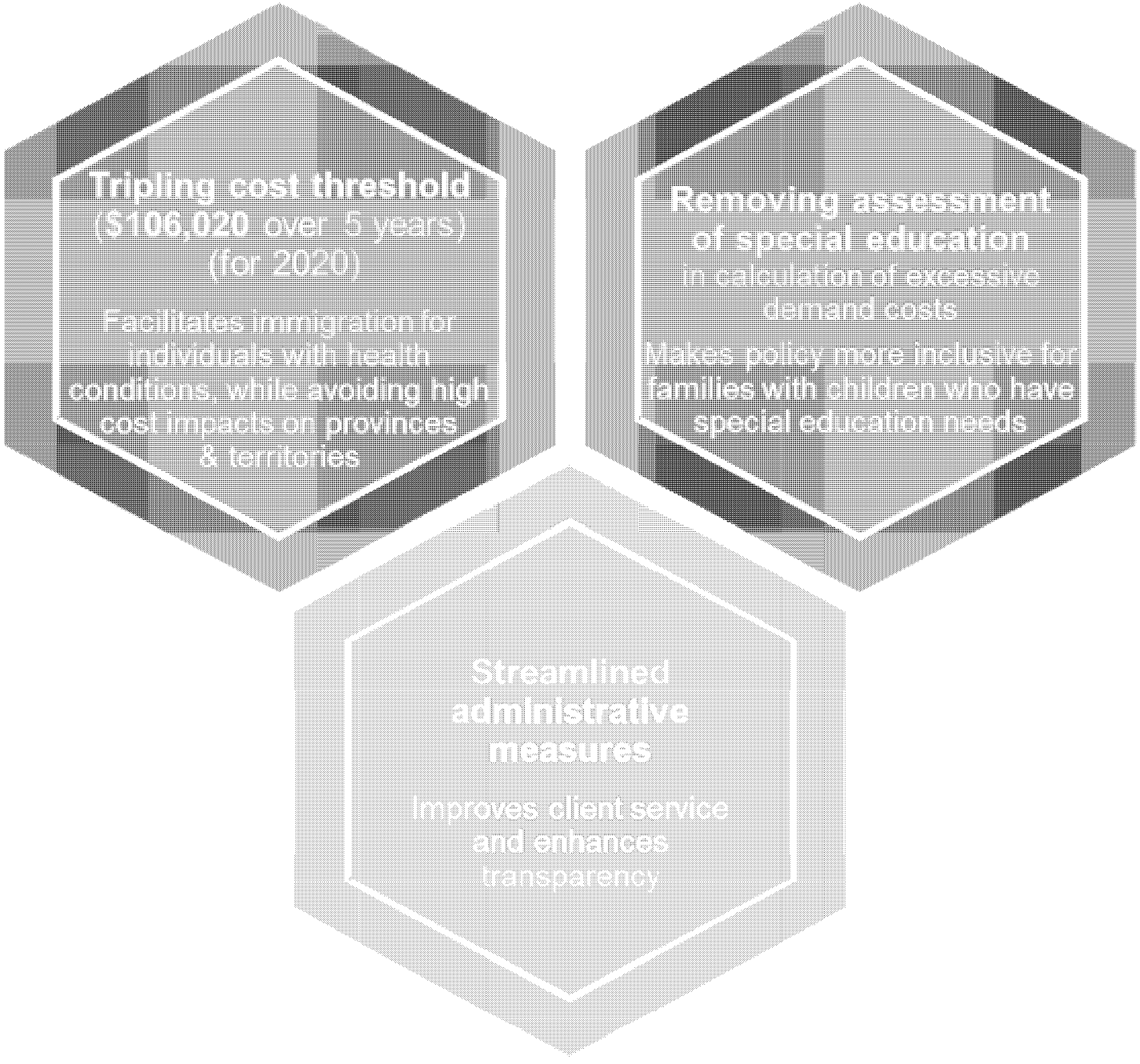
Difficult Applications to Process



Negative Media Coverage and Portrayal
Unfair & Discriminatory

- **House of Commons Committee on Citizenship and Immigration studied the issue in 2017 and called for the elimination of the policy.**
-
  - More time to collect additional data and explore with P/Ts.
- **In response, the Government decided to change the policy by implementing a Temporary Public Policy as an interim step.**

The Temporary Public Policy (TPP): Policy Amendments



Background – monitoring TPP outcomes

First year of TPP implementation (2018-2019)

Canada wide report: High-level outcomes and costing data (incurred vs. avoided) for P/Ts.

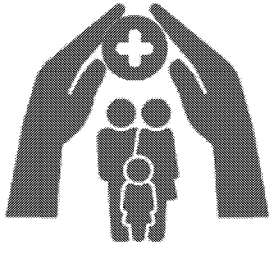
- Shared with P/Ts in 2019.
- Most applicants & family members (87%) examined for possible excessive demand were admitted to Canada.

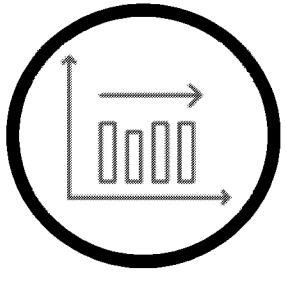
Second year of TPP implementation (2019-2020)

Canada wide report shared with P/Ts in March 2021

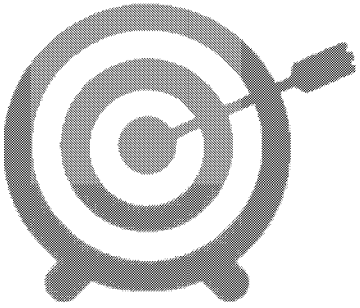
Supplementary year 2 analyses shown in this presentation

- Objective is to describe the cohort of individuals affected by the TPP in terms of demographic characteristics, region of origin, immigration category and health conditions.





Methods – Establishing the Cohort

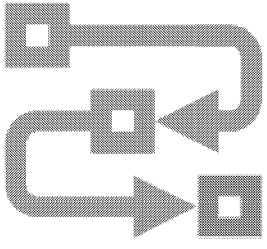


Application Final Assessment

- Application finalized between **June 1st, 2019** to **May 31st, 2020**
  - **Approved**
  - **Refused**
  - **Withdrawn**

Finding Excessive Demand Applicants in GCMS

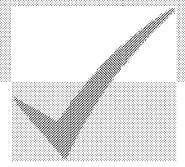
- **As per Program Delivery Instructions (PDI):**
  - Application special program code = XSD
  - Medical Assessment = M5
  - Appropriate Organization IDs (outcomes)



Medical Assessment

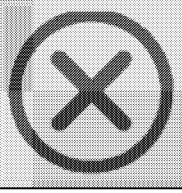
- **Primary Medical Diagnosis**
- **Inadmissibility Reason**
  - *Health Services 38(1)(c)*
  - *Social Services 38(1)(c)*
  - *Displacement of a Canadian on waiting list*
- **Cost Over 5 Years**

Overview of Final Outcomes



Approved

- **Under the Temporary Public Policy (TPP)**
- **Feasible Mitigation Plan**
- **Humanitarian and Compassionate (H&C) grounds**

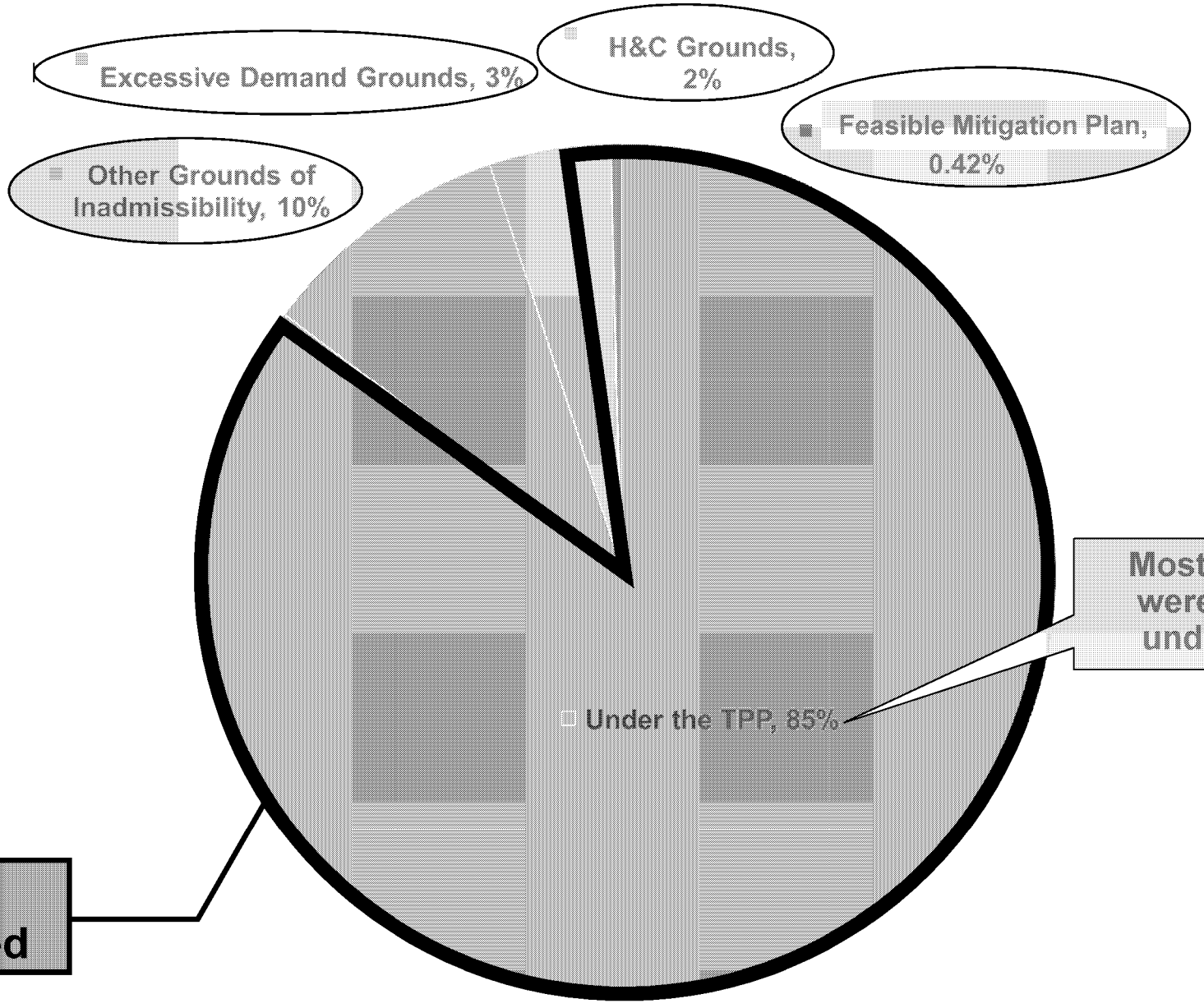


Refused

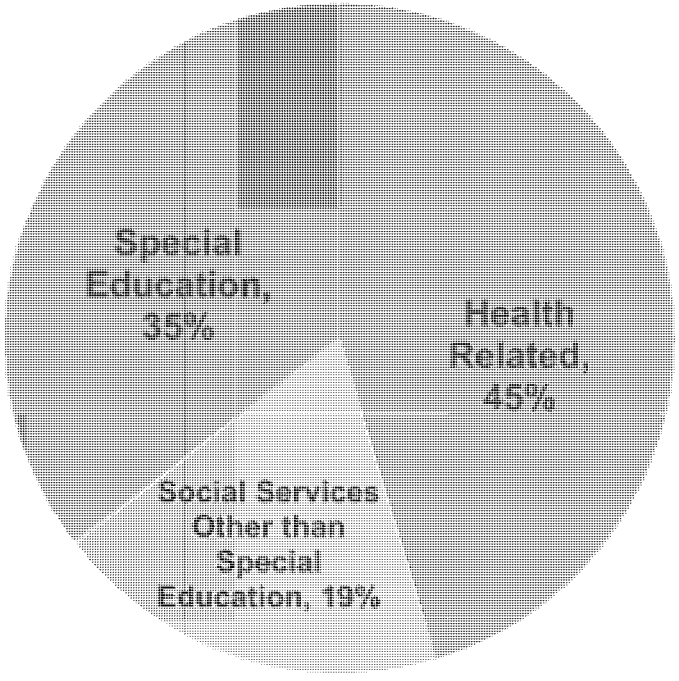
- **Excessive Demand Grounds**
- **Other Grounds of Inadmissibility**
  - The Immigration and Refugee Protection Act (IRPA), S.C. 2001, c. 27.

Final Outcomes – Year 2 TPP

Total of **475** M5 applicants that had a final assessment



M5 Applicant Findings: Health and Social Services



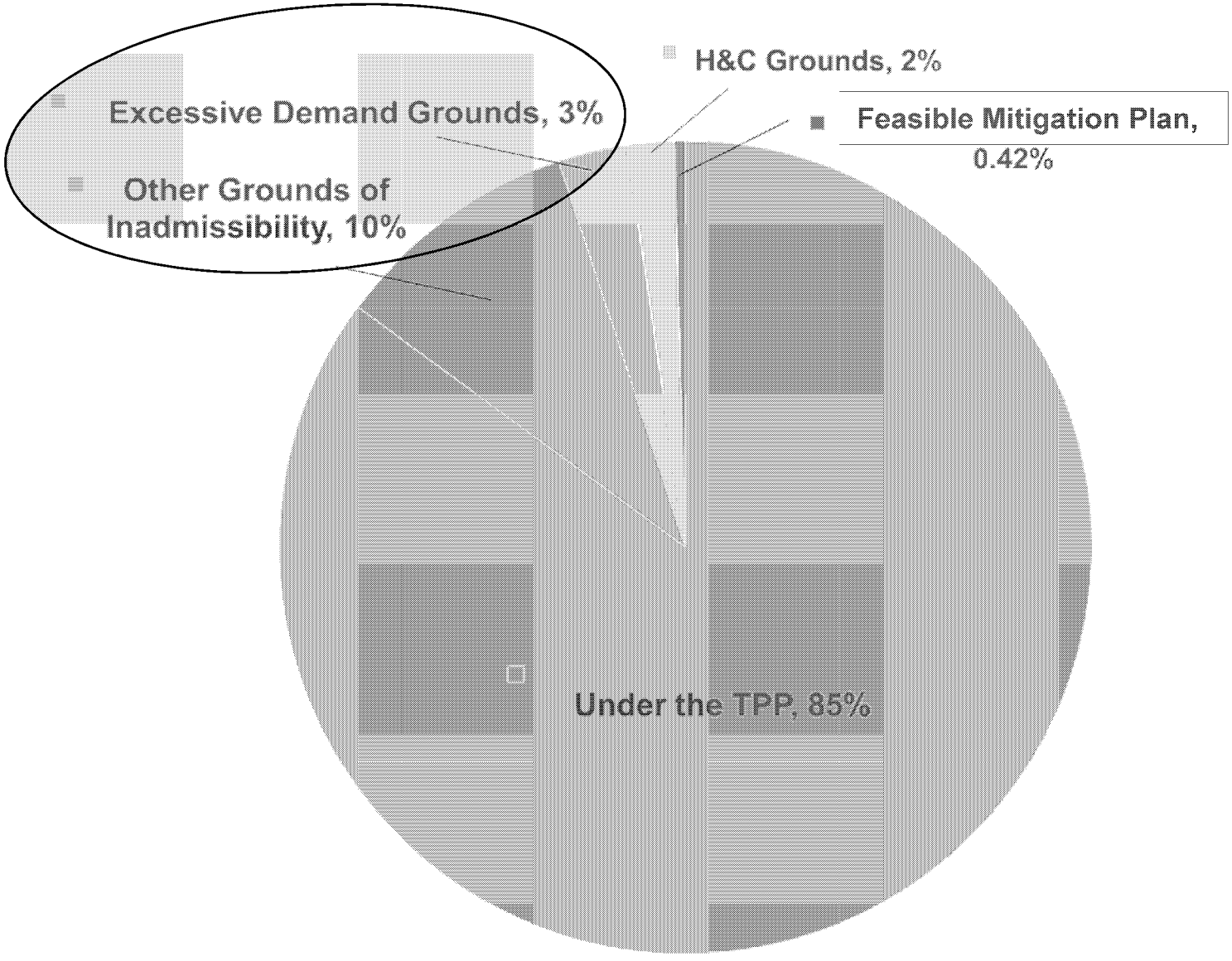
Social Services

- Any social services;
- 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.

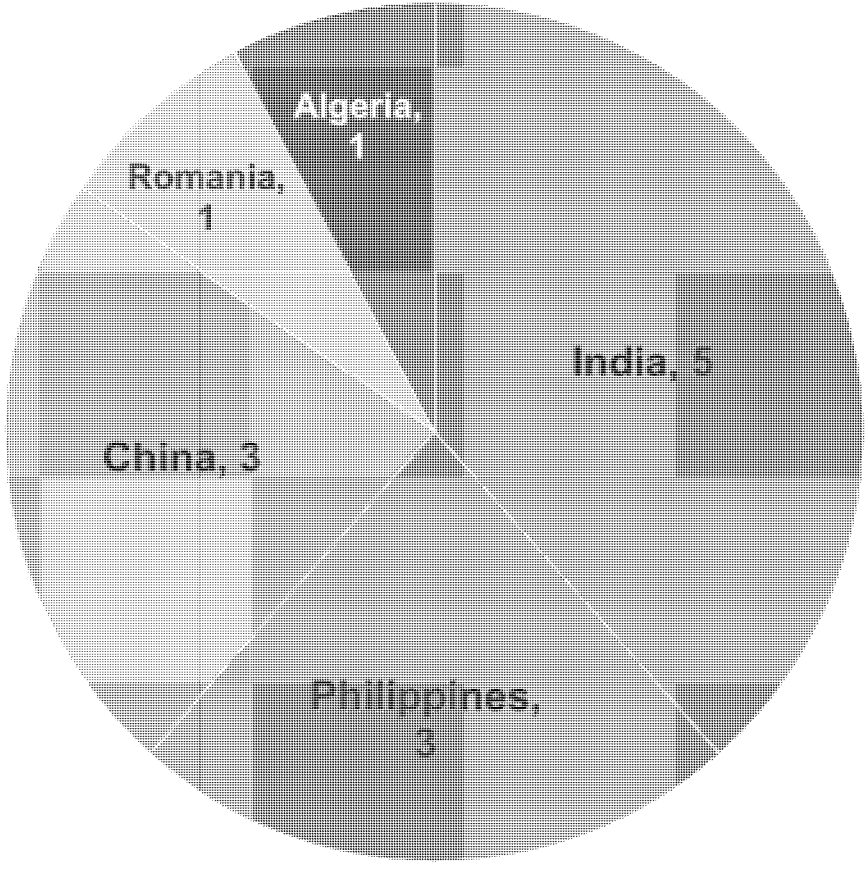
Health Services

- Physician services;
- Nursing services;
- Laboratory and diagnostic services;
- Pharmaceuticals and pharmaceutical services hospital services;
- Chemotherapy and radiotherapy;
- Dialysis;
- Psychiatric services;
- Supplies related to these services.

What do we know about the refused M5 applicants?



Refused on Excessive Demand Grounds: Who are affected?



M5 Applicants Country of Citizenship

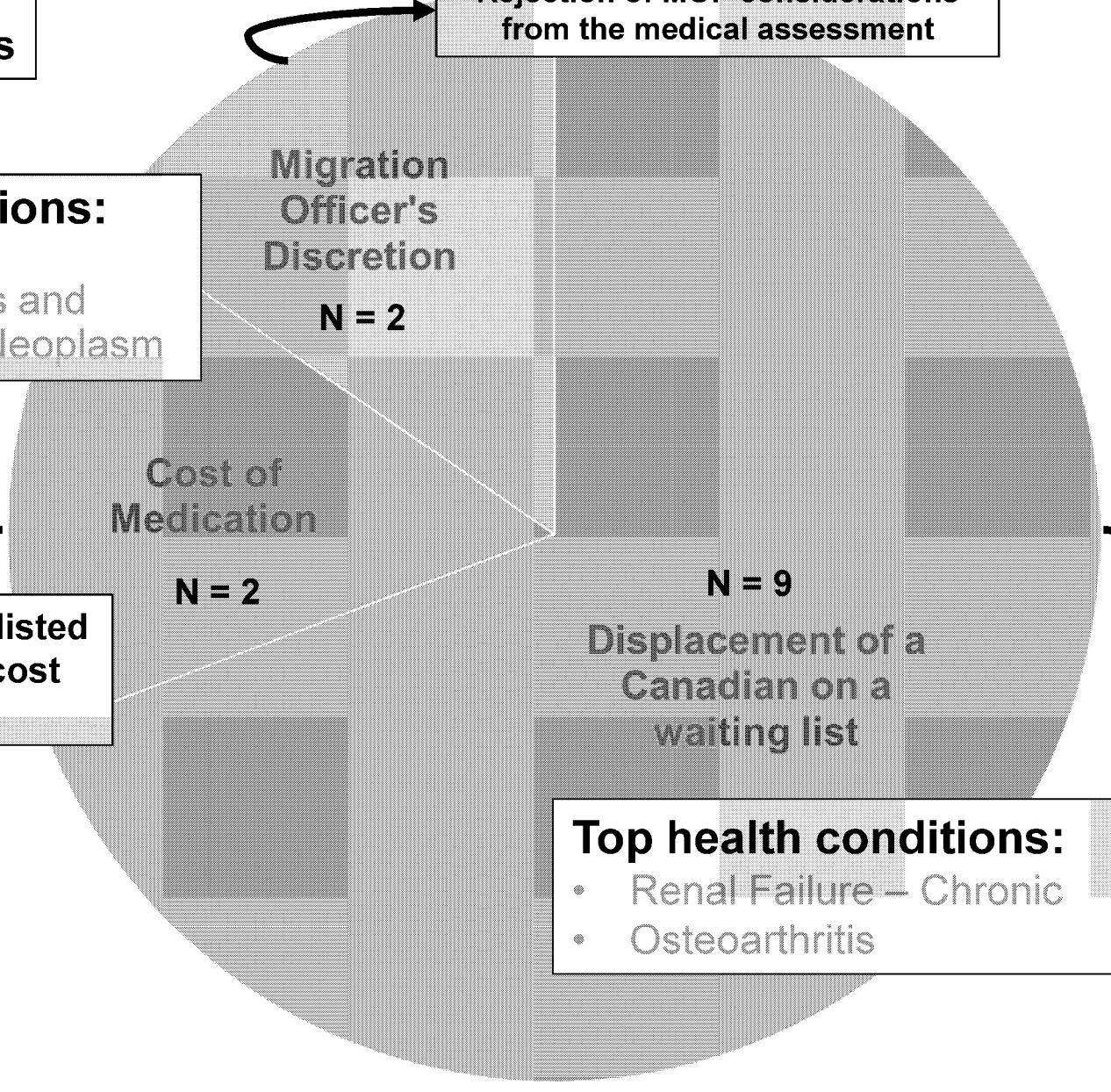
A total of 13 M5 applicants (3%) in the cohort were refused on excessive demand grounds

- Most applicants are **men** (70%).
- Half are in the **65+ age group**.
- Half of applicants were applying for a **TRV.** Most applicants had **health related findings**.

Main Reasons for Refusals (ED)

N=13
M5 Applicants

Rejection of MOF considerations from the medical assessment



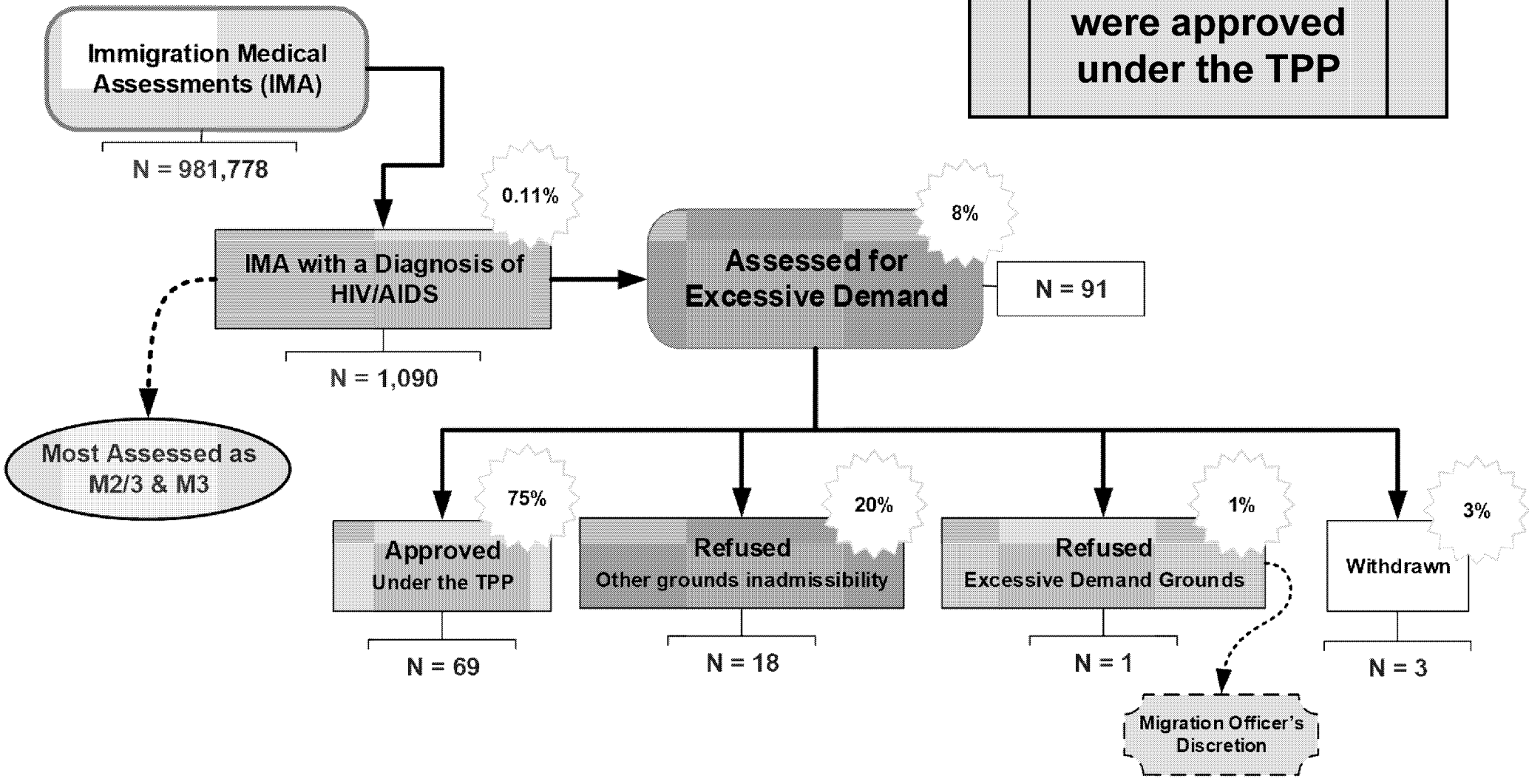
Top health conditions:
- Multiple Myeloma
- Trachea, Bronchus and Lung - Malignant Neoplasm

Costs over 5 years listed above 2019/2020 cost threshold

Top health conditions:
- Renal Failure – Chronic
- Osteoarthritis

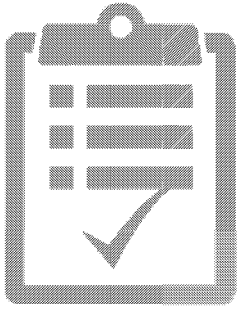
Case Study: Impacts on applicants living with HIV/AIDS

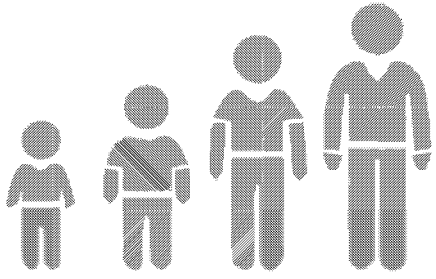
Most applicants were approved under the TPP



Between June 1st, 2019 to May 31st, 2020.

Summary

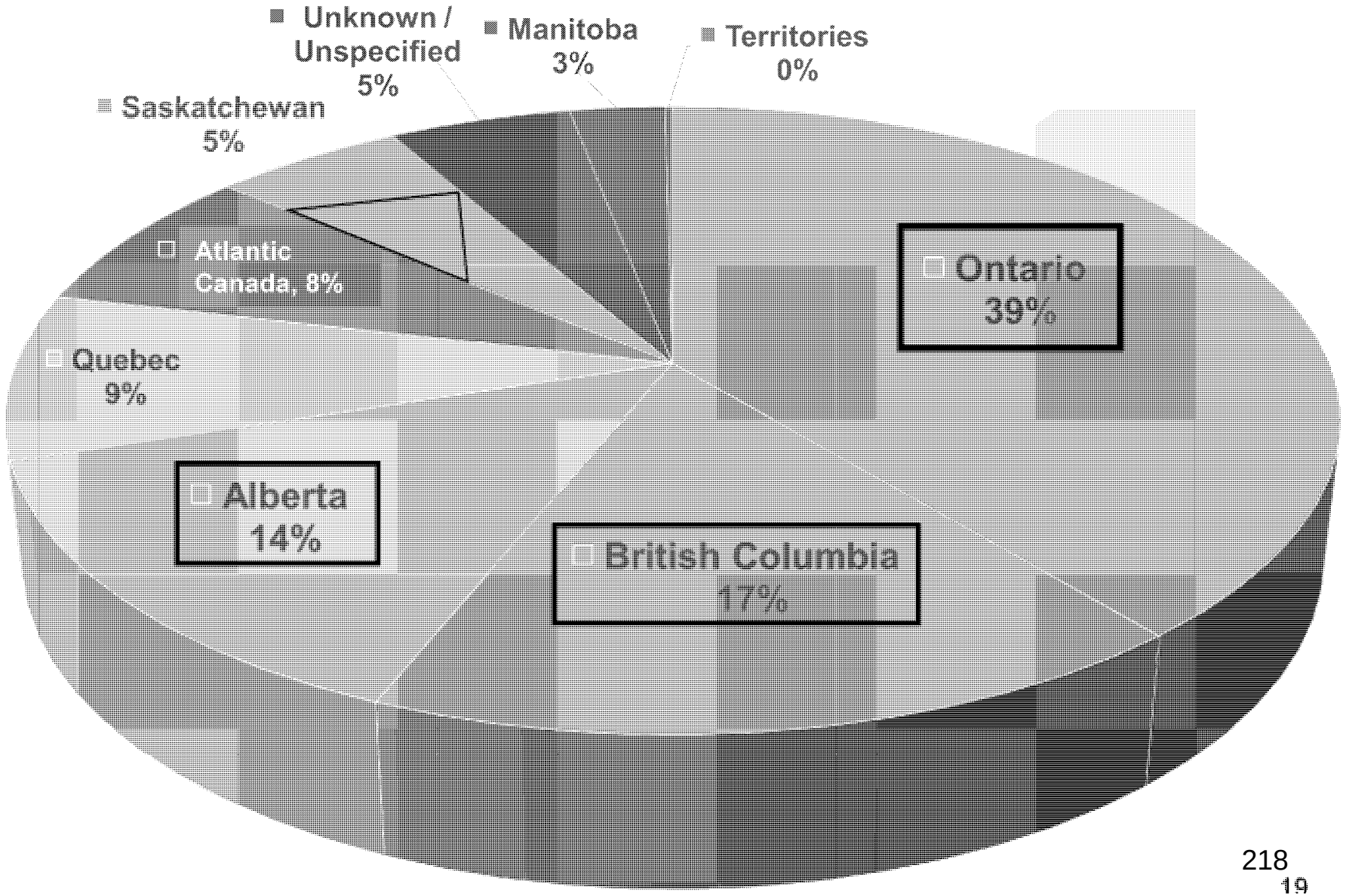




- Almost all M5 applicants (**85%**) were approved under the TPP.
  - Would have previously been refused under the old definition of excessive demand.
- There has been a limited increase in costs for health and social services related to migration, which P/Ts have absorbed
- The TPP has helped remove barriers for many individuals with health conditions that are manageable, including persons with disabilities
- The TPP on excessive demand on health and social services is aligned with Canadian values on the inclusion of persons with disabilities, and recognizes the ability of persons with disabilities (or with manageable health conditions) to integrate into Canadian society and make economic contributions
- These successes support our decision to codify the TPP changes in the amended regulation

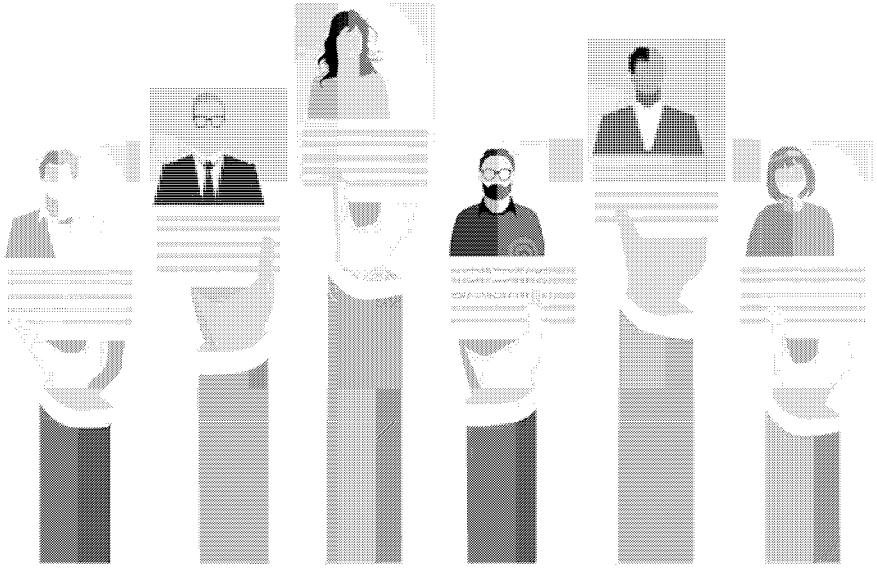
Annexes

M5 Applicants approved under the TPP: P/T Destination

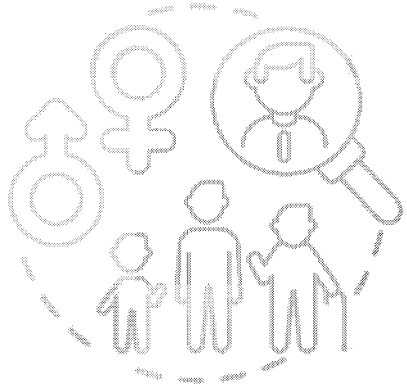


Atlantic Canada: New Brunswick, Nova Scotia, Newfoundland & Labrador, Prince Edward Island

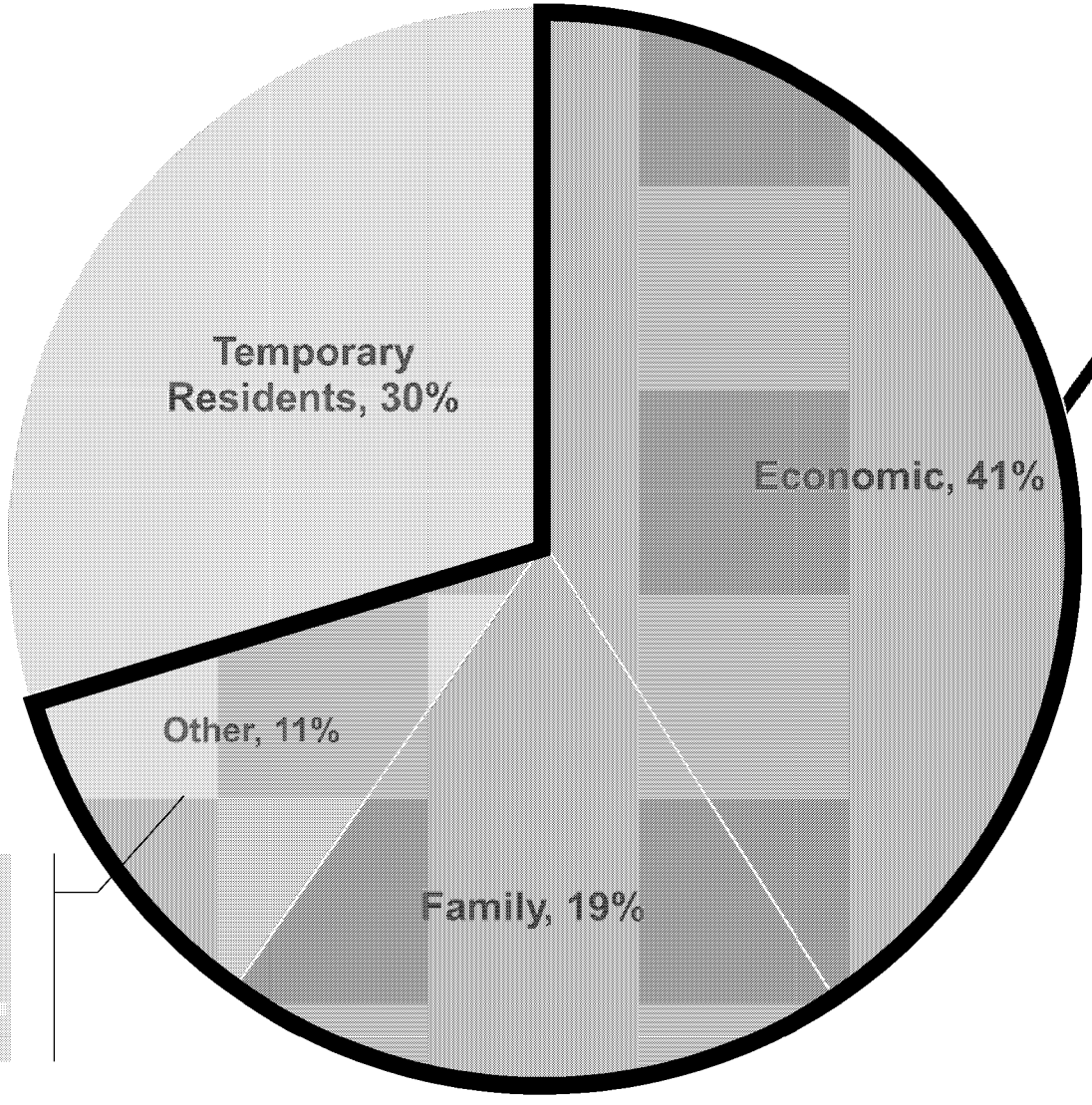
What do we know about the M5 applicants of the Year 2 TPP cohort?



Applicants Age Groups and Gender



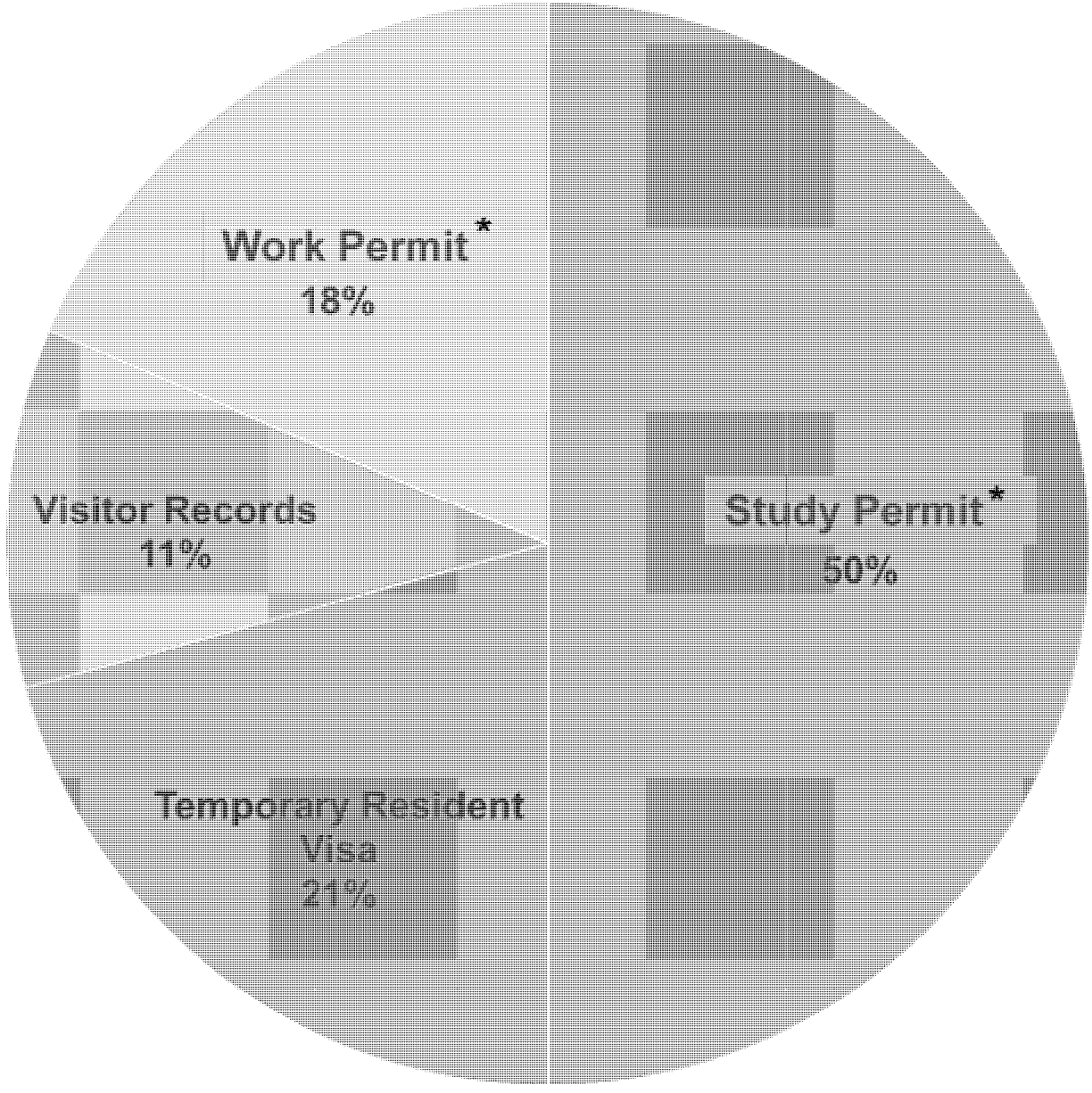
Immigration Type & Class (n = 475)

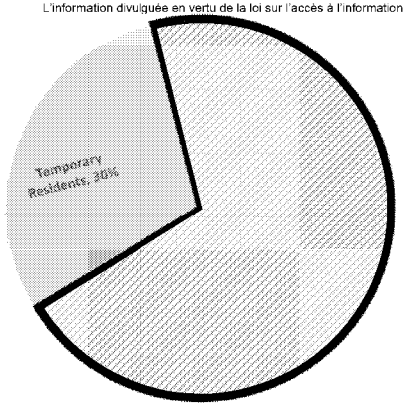


Permanent Residents

- In-Canada Humanitarian and Compassionate Case
- Permit Holders

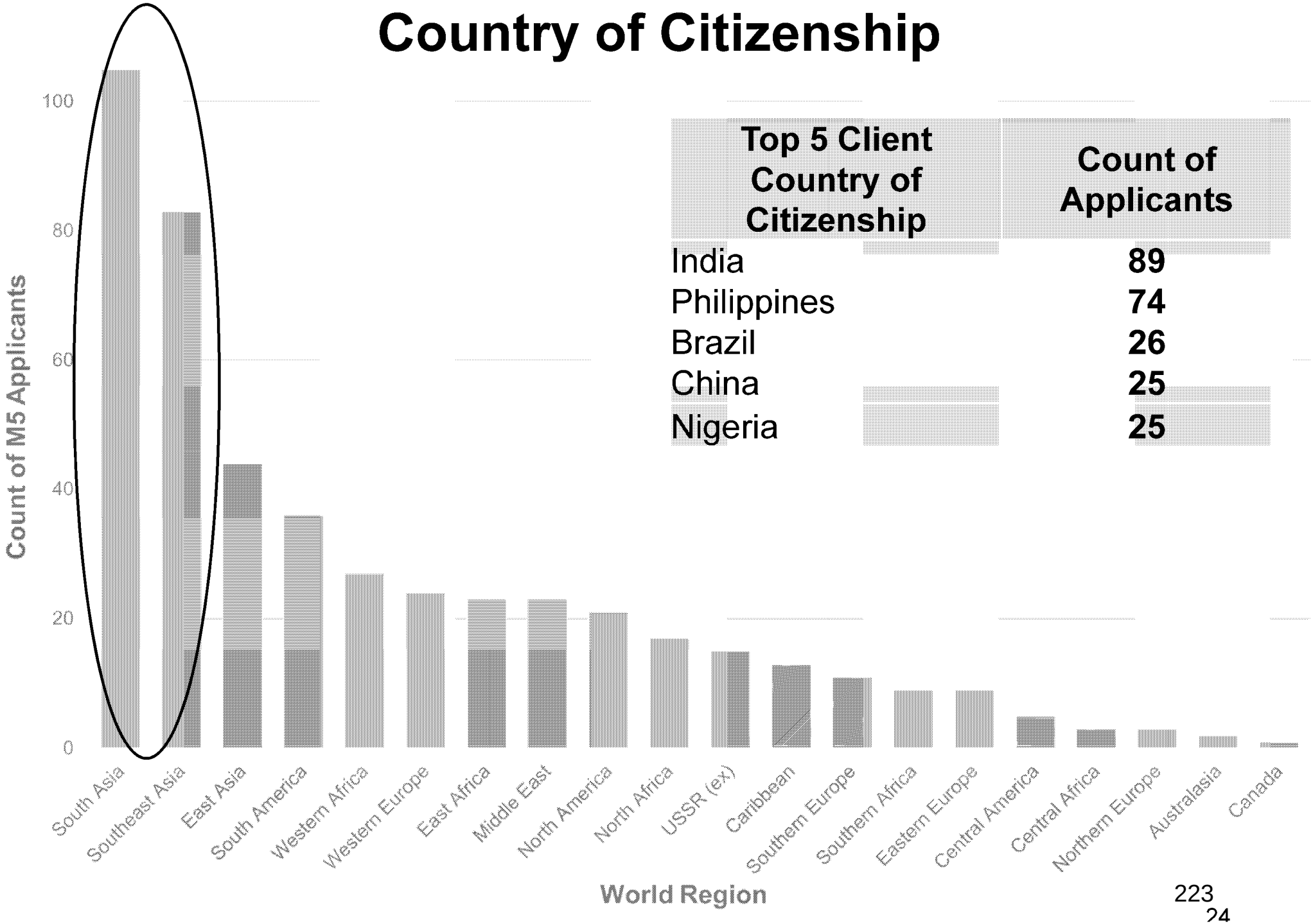
Temporary Residents (n = 140)





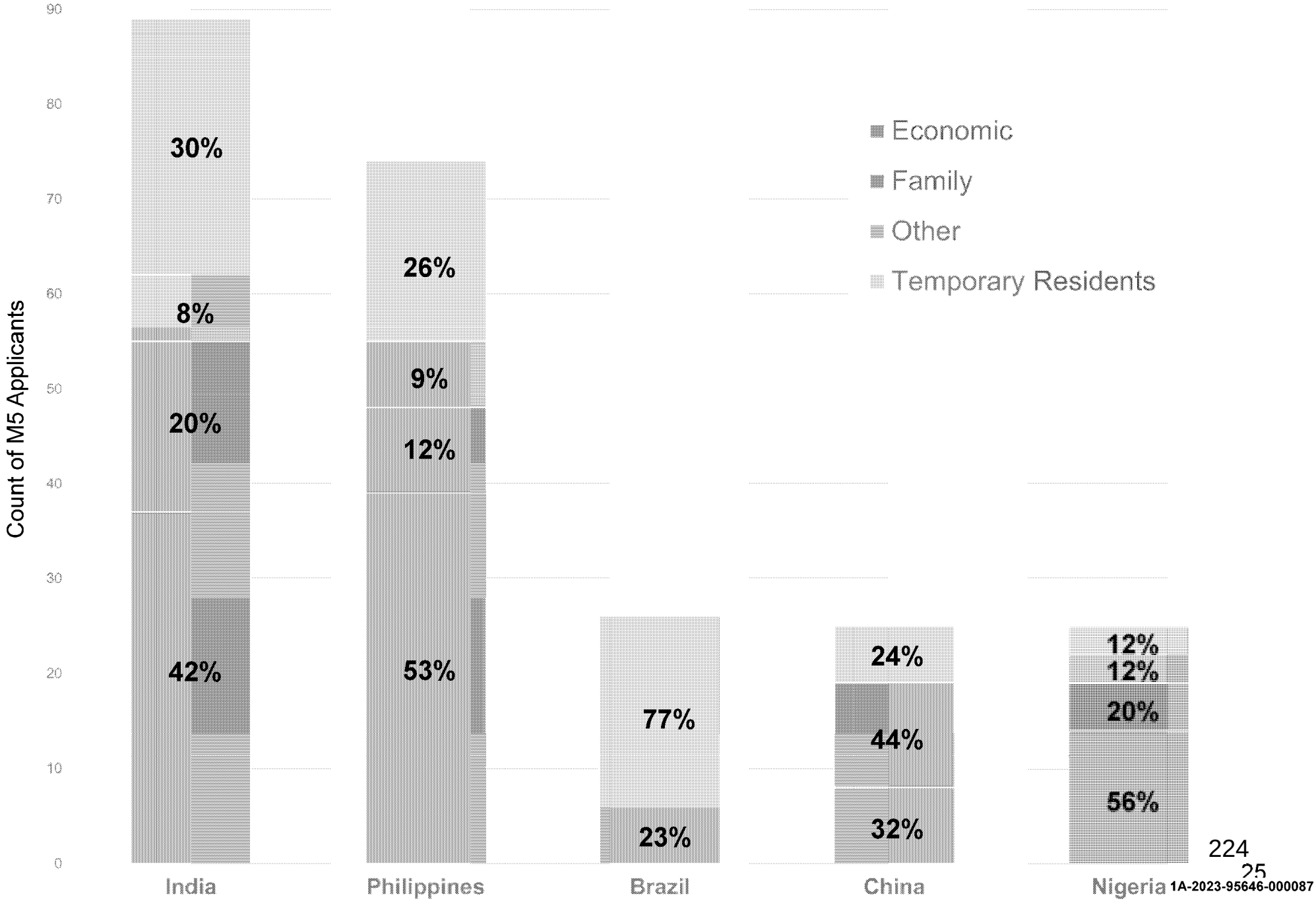
*Including permit extensions.

Country of Citizenship

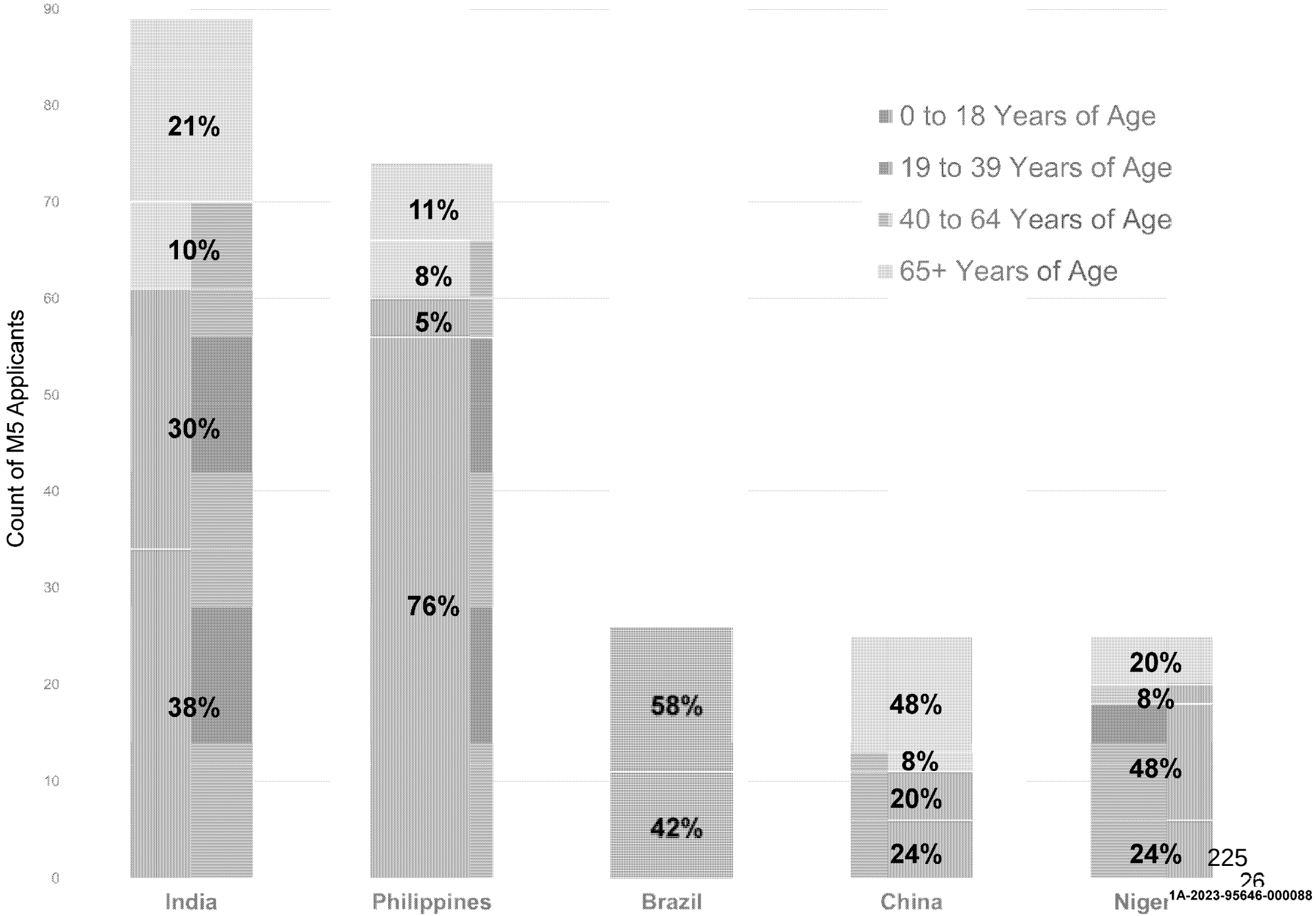


Top 5 Client Country of Citizenship	Count of Applicants
India	89
Philippines	74
Brazil	26
China	25
Nigeria	25

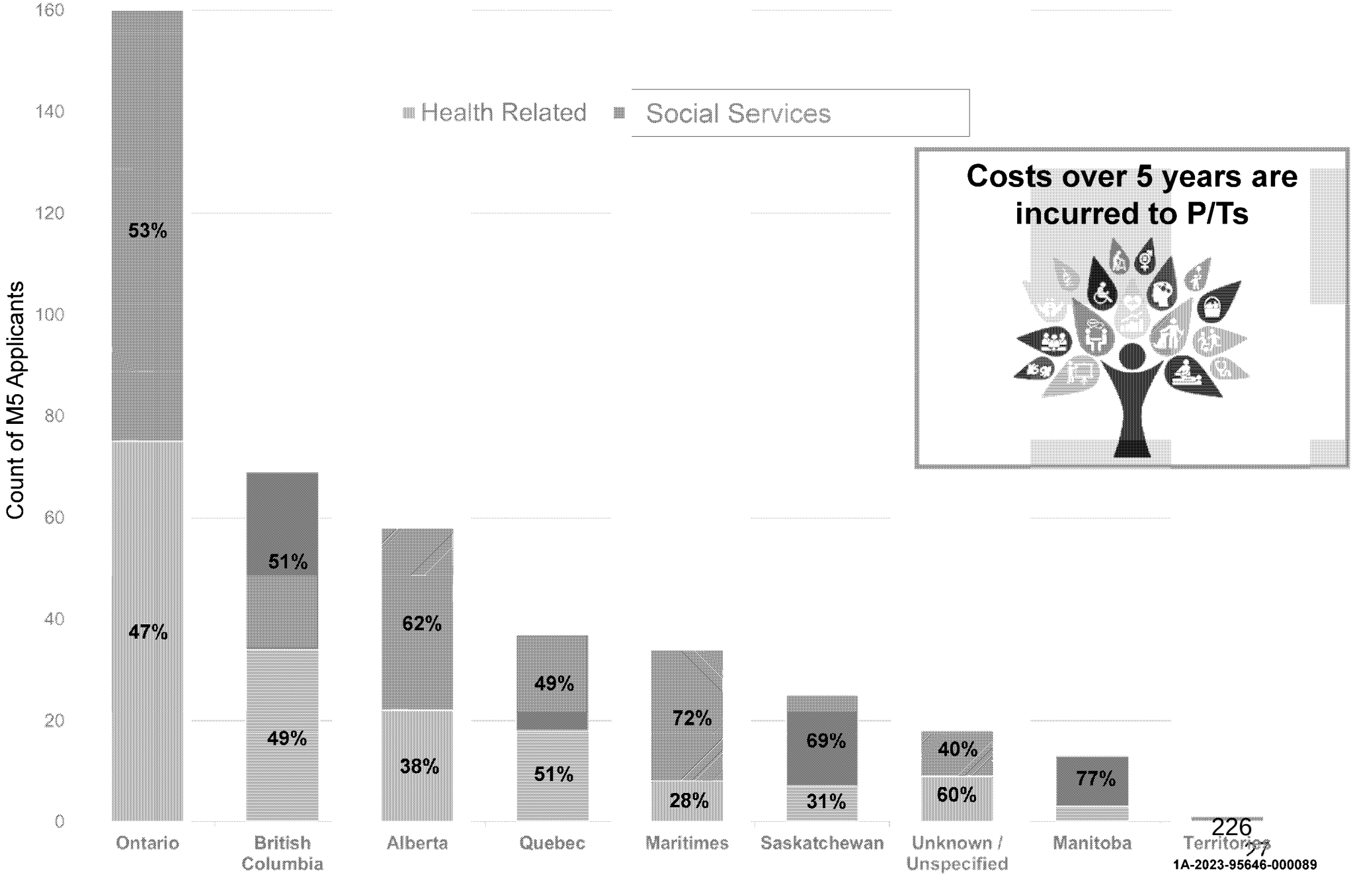
Immigration Class by Top 5 Countries of Origin



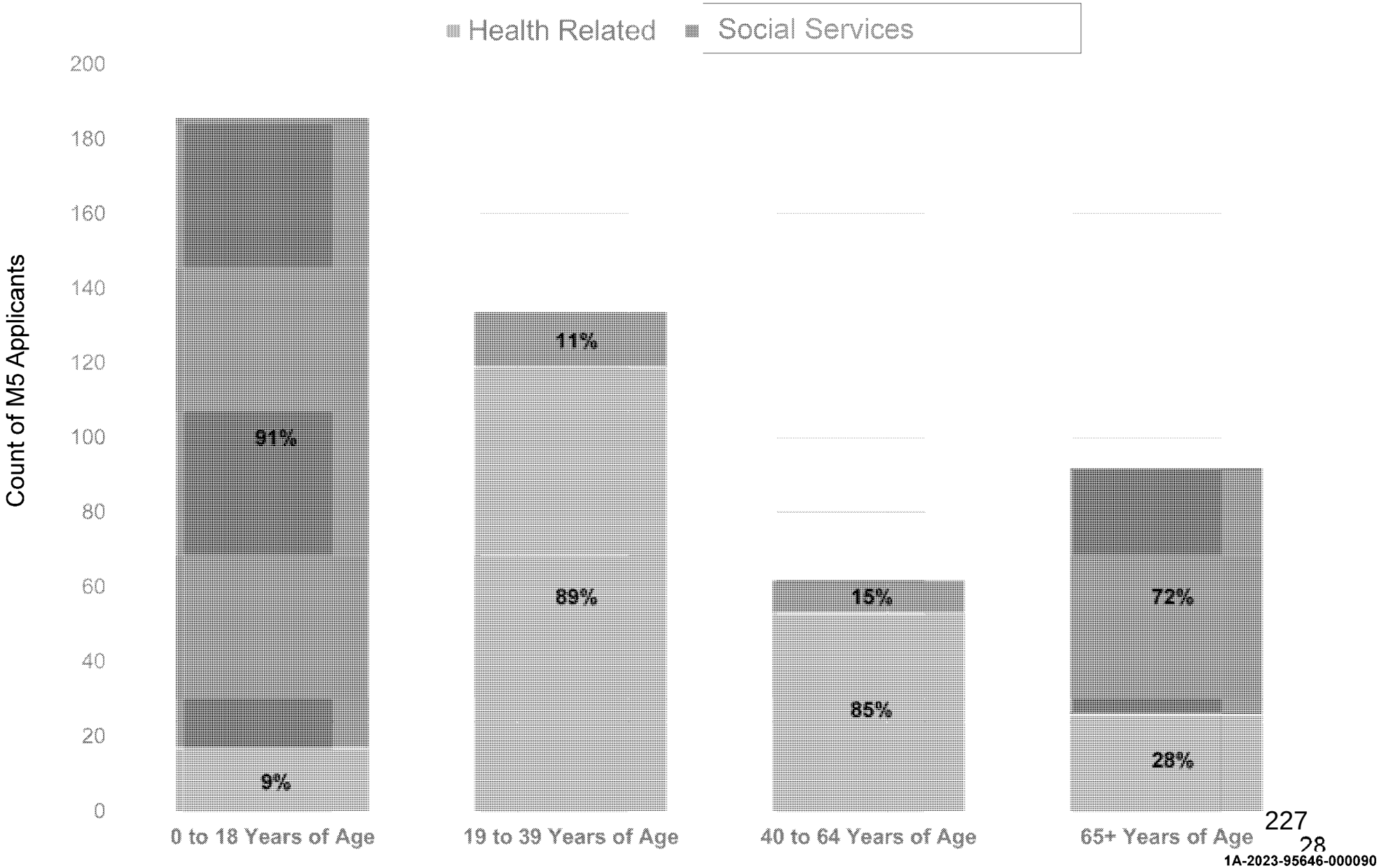
Age Groups by Top 5 Countries of Origin



Approved Applicants: P/T Destination & Excessive Demand Findings



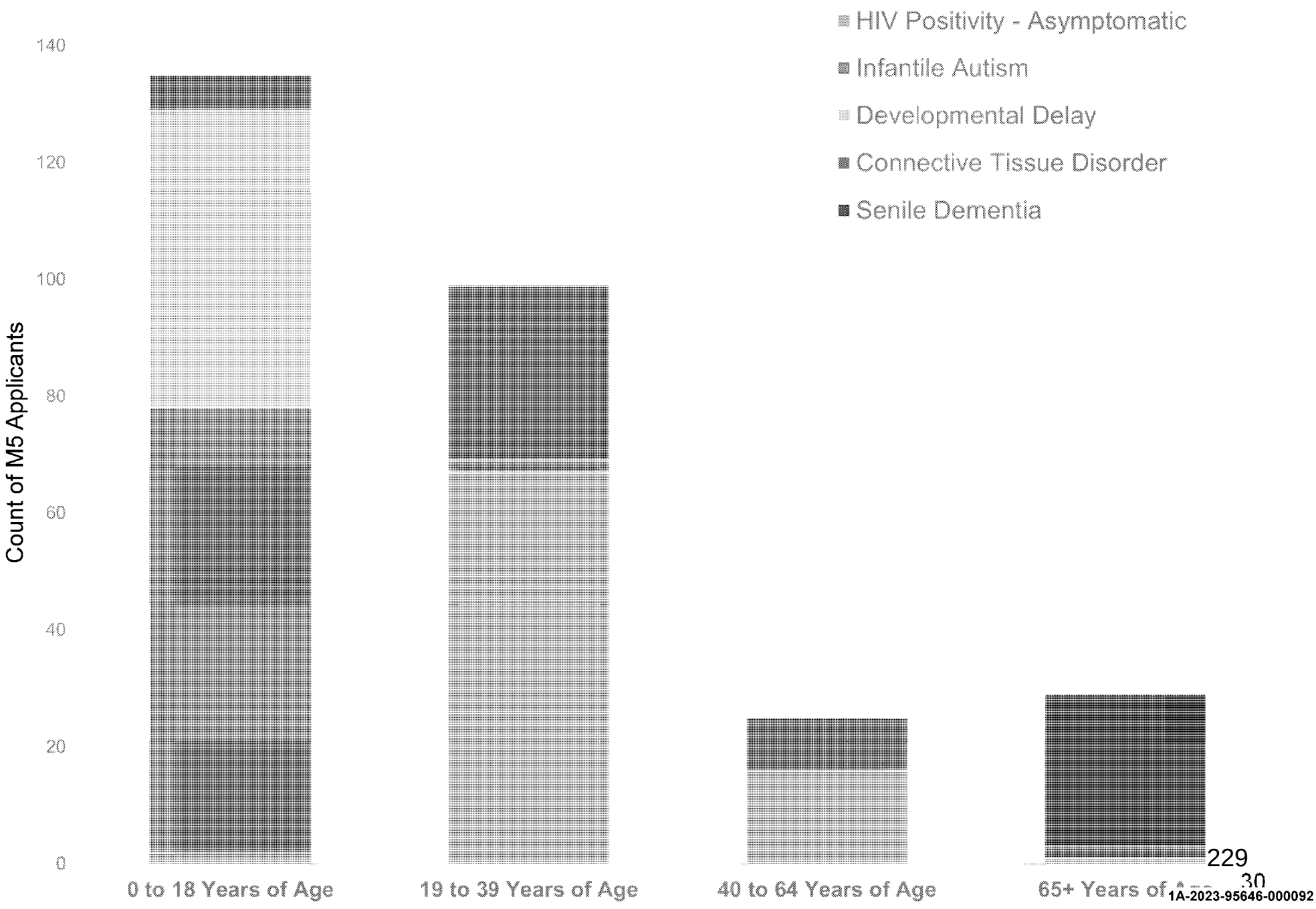
Excessive Demand Findings by Age Group



Health Conditions

Primary Medical Diagnosis	Application Final Assessment		TOTAL
	Approved	Refused	
HIV Positive – Asymptomatic (795.8)	68	19	87
Infantile Autism (299)	68	10	78
Developmental Delay (315)	45	6	51
Connective Tissue Disorder (710)	45	2	47
Senile Dementia (290)	26	0	26
Congenital Anomaly (759)	23	0	**23**
Intellectual Disability (318)	20	1	**21**
Cancer*	18	2	**20**
Nervous System Disorder (349)	17	0	**17**
Multiple Sclerosis (340)	14	1	**15**
Cardiovascular Disease**	12	1	**13**
Renal Failure – Chronic (585)	3	10	**13**
Osteoarthritis (715)	8	1	**9**
Alzheimer's Disease (331)	8	0	**8**
Cerebrovascular Disease - Ill-Defined (437)	8	0	**8**
Hepatitis – Chronic (571.4)	6	1	**7**
Parkinson's Disease (332)	5	0	**5**
Cognitive and behavioral disorders***	4	1	**5**
Other Conditions****	17	5	**22**
TOTAL	**415**	**60**	**475**

Top 5 Health Conditions distributed across Age Groups

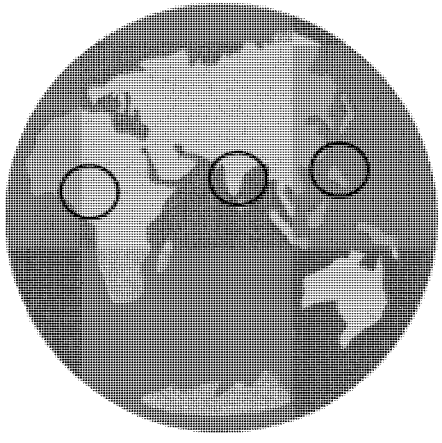


Refused on Other Grounds of Inadmissibility: Who are affected?

A total of 47 M5 applicants (10%) in the cohort were refused on other grounds of inadmissibility

- Most applicants are **men** (75%).
- Most applicants (85%) were **under 40** years of age
- Almost **half** of the 47 applicants were applying for a **Study Permit**.
- All applicants were eligible for the TPP.

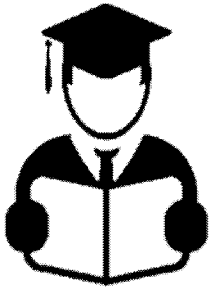
Top 3 Client Country of Citizenship
Philippines
Nigeria
India



Main Reasons for Refusals (Other Grounds)

As per IRPA…

Temporary Residents



- **Study Permits -** R216 (1) b
  - *Foreign National will leave Canada by the end of the period authorized for their stay under Division 2 of Part 9* […]
  - Eligibility Failed.

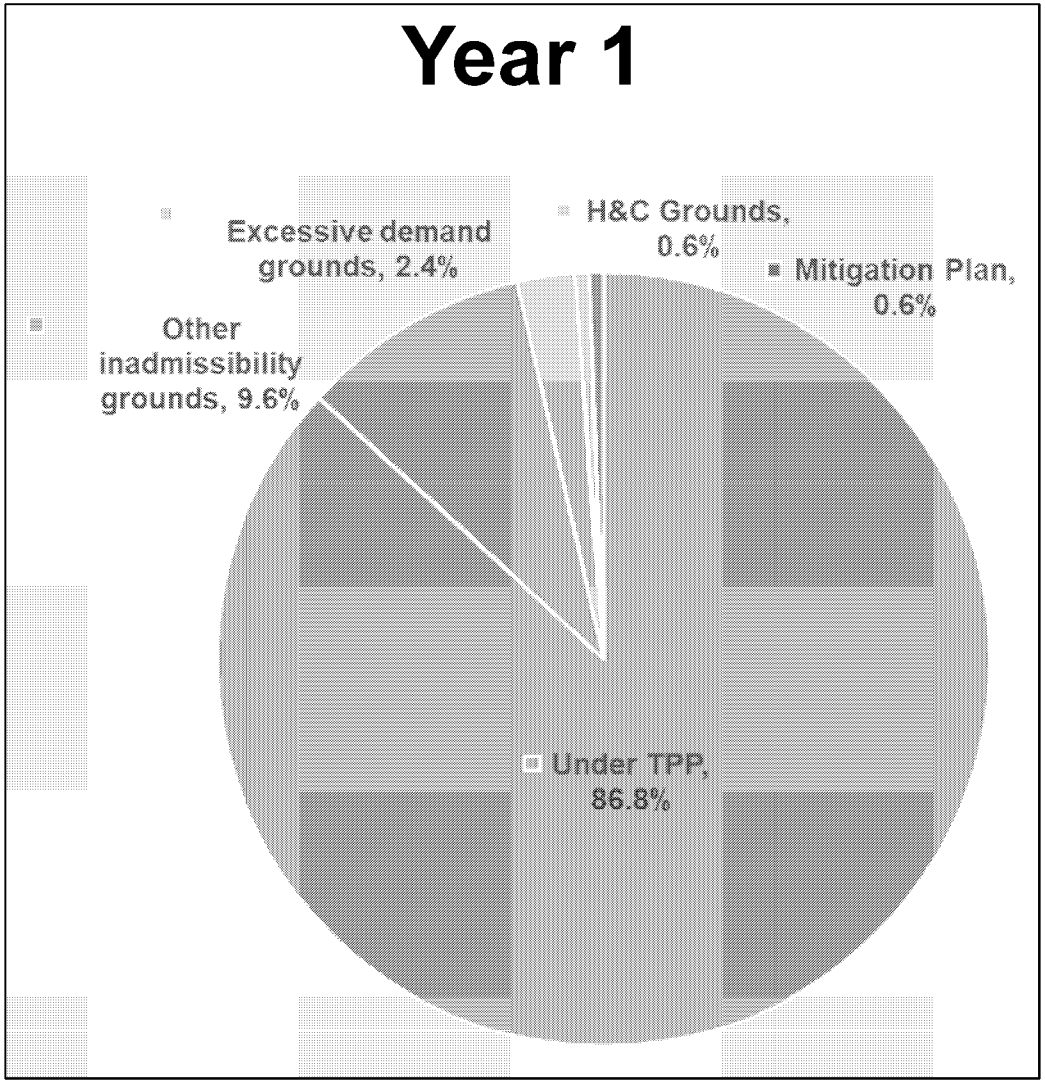
Permanent Residents

- **Skilled Workers (Federal)** - A11.2
  - *Foreign National did not meet criteria set out in an instruction given.*

Comparisons

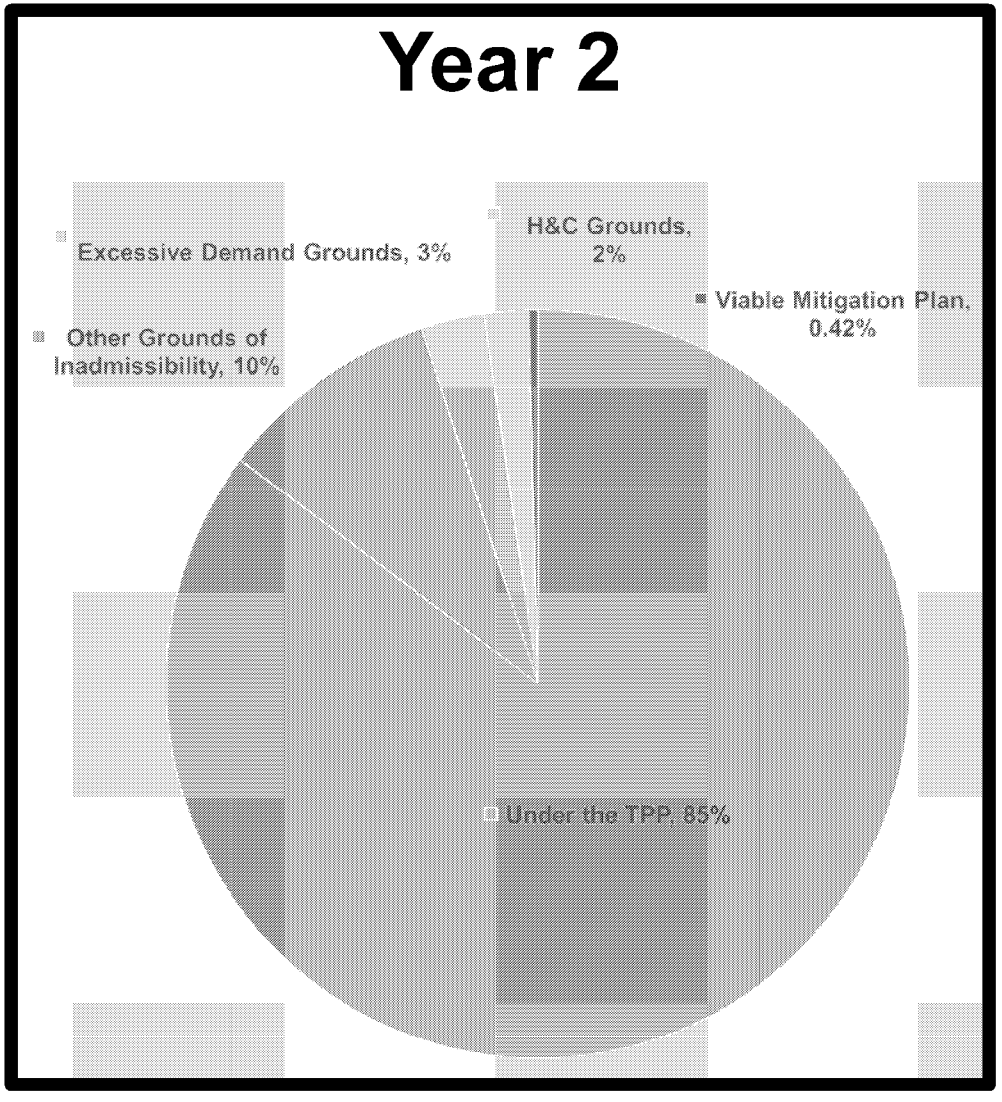
N=167

Year 1



N=475

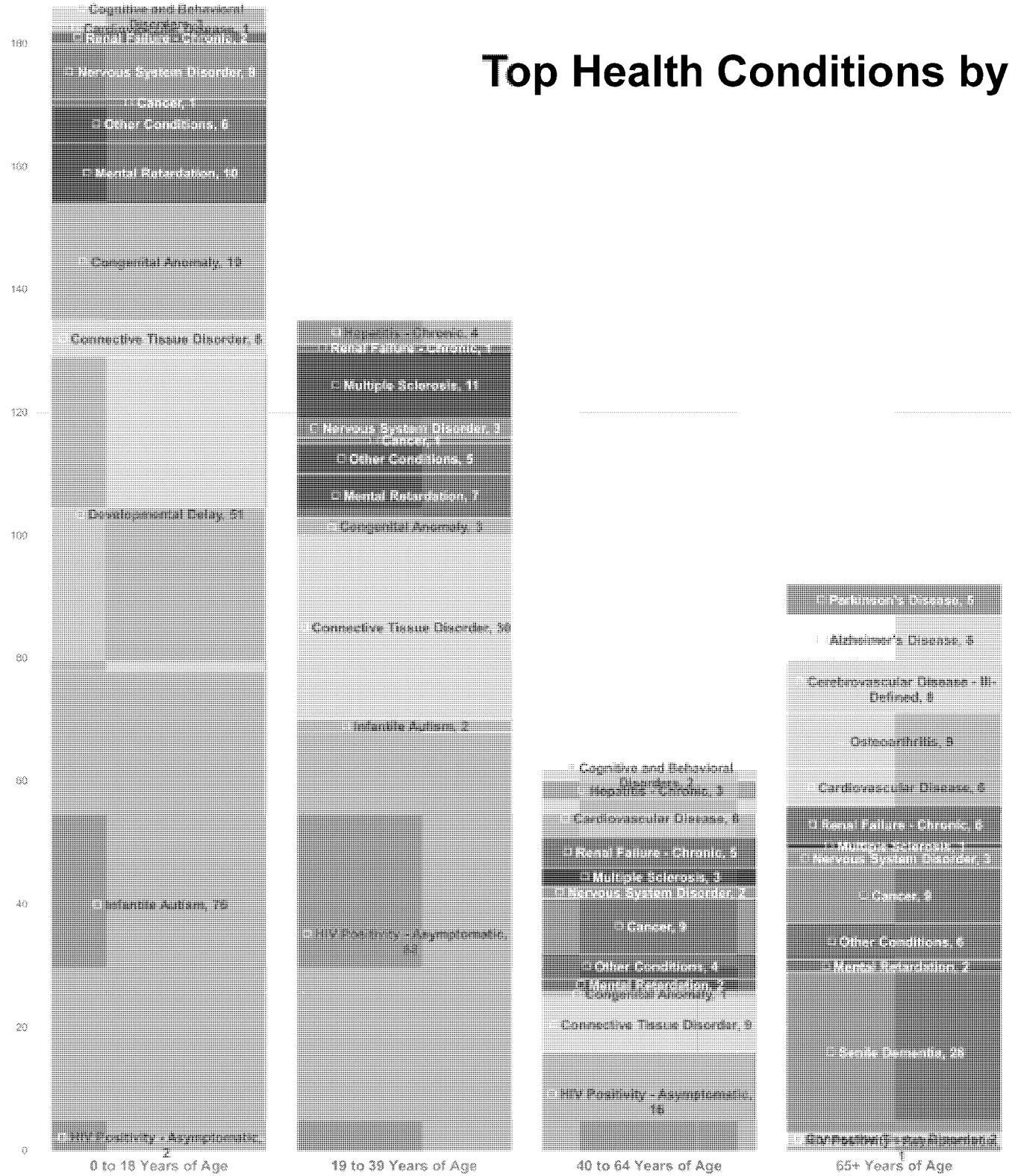
Year 2



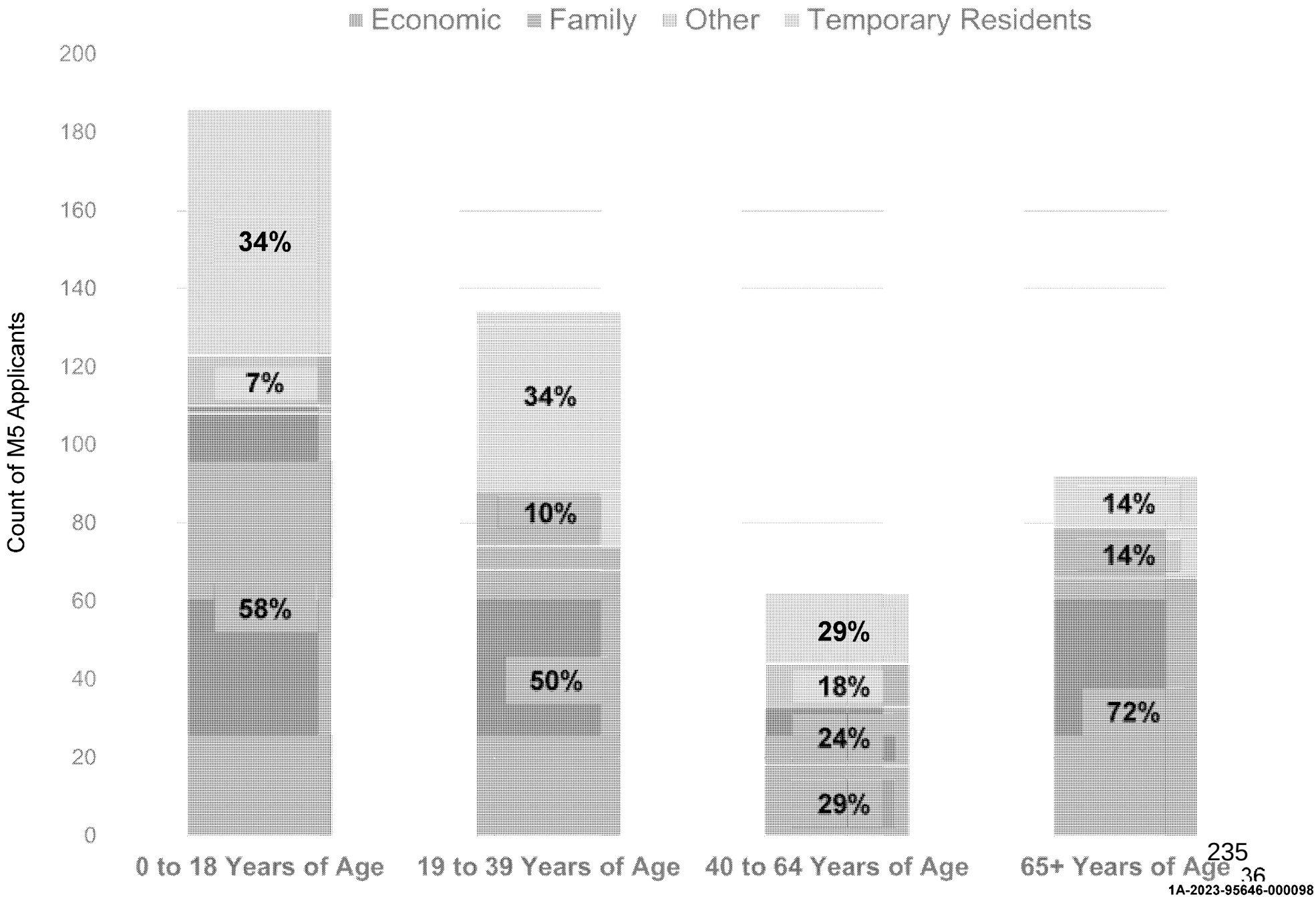
Top Health Conditions by Age Groups

Count of Client UCI	Age Groups (Years of Age)				Grand Total
Row Labels	0 to 18	19 to 39	40 to 64	65+	
HIV Positivity - Asymptomatic	2	68	16	1	87
Infantile Autism	76	2			78
Developmental Delay	51				51
Connective Tissue Disorder	6	30	9	2	47
Senile Dementia				26	26
Congenital Anomaly	19	3	1		23
Intellectual Disability	10	7	2	2	21
Other Conditions	6	5	4	6	21
Cancer	1	1	9	9	20
Nervous System Disorder	9	3	2	3	17
Multiple Sclerosis		11	3	1	15
Renal Failure - Chronic	2	1	5	6	14
Cardiovascular Disease	1		6	6	13
Osteoarthritis				9	9
Cerebrovascular Disease - Ill-Defined				8	8
Alzheimer's Disease				8	8
Hepatitis - Chronic		4	3		7
Cognitive and Behavioral Disorders	3		2		5
Parkinson's Disease				5	5
Grand Total	**186**	**135**	**62**	**92**	**475**

Top Health Conditions by Age Groups



Immigration Class by Age Groups



Looking back: The Implementation of the TPP on Excessive Demand (2018-2021)

Internal Discussion

Research & Partnerships Unit (MHPP)

Migration Health Branch

What is the Excessive Demand Policy?

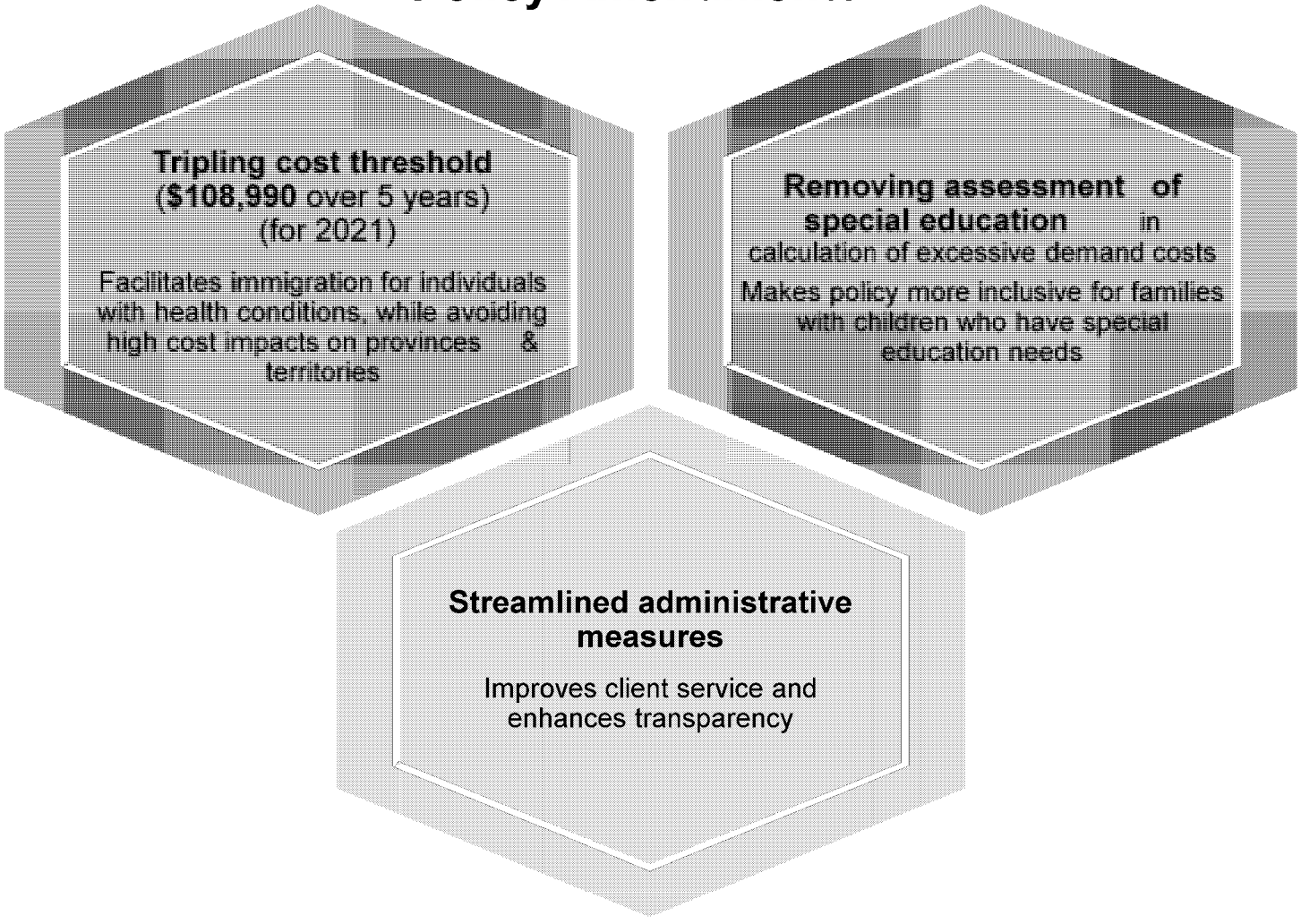
Excessive Demand on Health and Social Services

- Applicants must not be inadmissible under 38(1)(c) of the Act. Regulations allow refusal where:
  - Health or social services costs will exceed the **excessive demand cost threshold** (i.e., average Canadian health-care expenditures)
  - The need for services will affect **waiting lists** for key services

Excessive Demand Exemption

- Subsection 38(2) of the Act provides a **policy exemption** for refugees, protected persons and family class sponsored children, spouses and dependent children

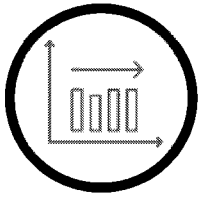
The Temporary Public Policy (TPP): Policy Amendments



Background – Monitoring TPP Outcomes

1st year of TPP implementation (2018-2019)

- Canada wide report: High-level outcomes and costing data (incurred vs. avoided) for P/Ts
  - Shared with P/Ts in 2019 & updated version in 2020
  - Most applicants & family members (87%) examined for possible excessive demand were admitted to Canada



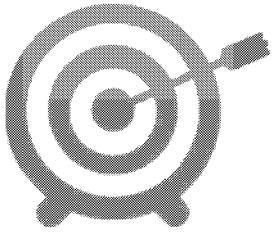
2nd year of TPP implementation (2019-2020)

- Canada wide report shared with P/Ts in March 2020
- Supplementary analyses (internal) presented to the IRCC Excessive Demand Working Group

3rd year of TPP implementation (2020-2021)

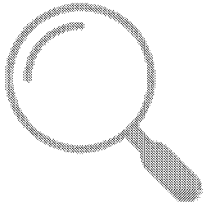
- No Canada wide report for P/Ts
- Internal analysis

Methods – Establishing the Cohorts



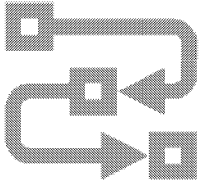
Application Final Assessment

- Application finalized & closed between **June 1st, 2018** to **May 31st, 2021**
  - **Approved**
  - **Refused**
  - **Withdrawn**



Finding Excessive Demand Applicants in GCMS

- **As per Program Delivery Instructions (PDI):**
  - Application special program code = XSD
  - Medical Assessment = M5
  - Appropriate Organization IDs (outcomes)



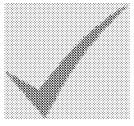
Medical Assessment

- **Primary Medical Diagnosis**
- **Inadmissibility Reason**
  - *Health Services 38(1)(c)*
  - *Social Services 38(1)(c)*
  - *Displacement of a Canadian on waiting list*
- **Cost Over 5 Years**

Client & Application Characteristics

Gender	Country of Citizenship
Age	Application Type, Class & Category

Overview of Final Outcomes



Approved

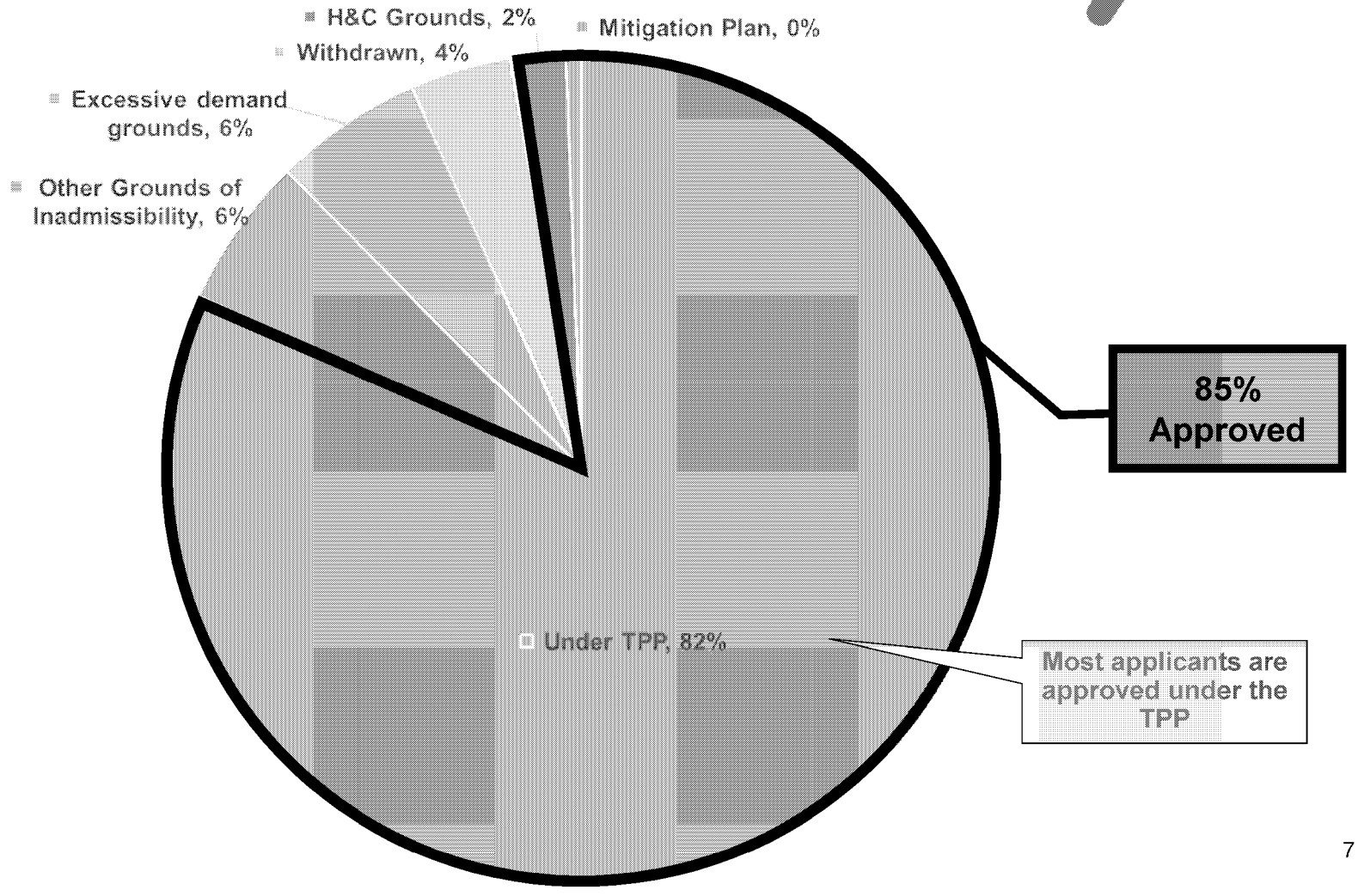
- **Under the Temporary Public Policy (TPP)**
- **Viable Mitigation Plan**
- **Humanitarian and Compassionate (H&C) grounds**

Refused

- **Excessive Demand Grounds**
- **Other Grounds of Inadmissibility**
  - The Immigration and Refugee Protection Act (IRPA), S.C. 2001, c. 27.

Final Outcomes (2018-2021)

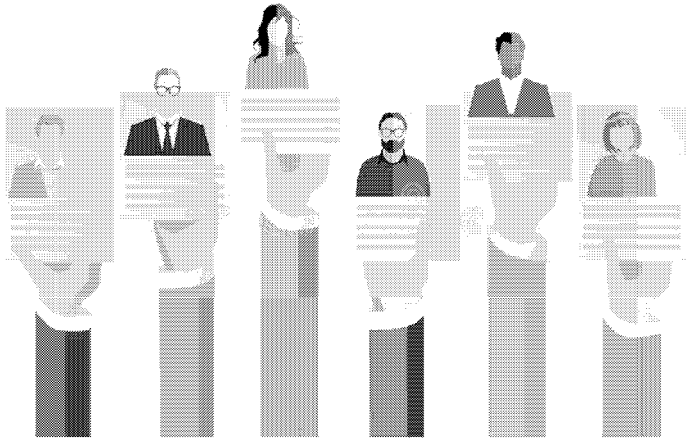
N = 1,182



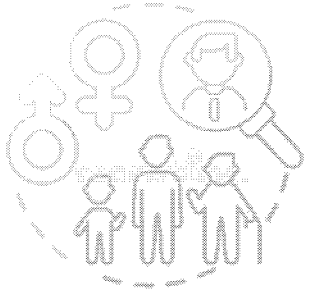
Final Outcomes (2018-2021)

	Approved									Refused						Total			Withdrawn		
	Under the TPP			Acceptable Mitigation Plan			H&C Grounds			Excessive Demand Grounds			Other Grounds of Inadmissibility								
	Year 1	Year 2	Year 3	Y1	Y2	Y3	Y1	Y2	Y3	Y1	Y2	Y3	Y1	Y2	Y3	Y1	Y2	Y3	Y1	Y2	Y3
Special Education & Related Services	70	236	265	0	1	1	0	2	3	0	1	1	5	19	1	**77**	**259**	**274**	2	6	3
Health Related	75	168	153	1	1	3	1	7	12	4	12	50	11	28	6	**98**	**216**	**236**	6	17	12
Total	**145**	**404**	**418**	**1**	**2**	**4**	**1**	**9**	**15**	**4**	**13**	**51**	**16**	**47**	**7**	**175**	**475**	**510**	**8**	**23**	**15**
	(Average) 322			2			8			23			23								
	Total Approved: 999									Total Refused: 137									Total Withdrawn: 46		

What do we know about the M5 applicants over the years?



Applicants Age Groups and Gender



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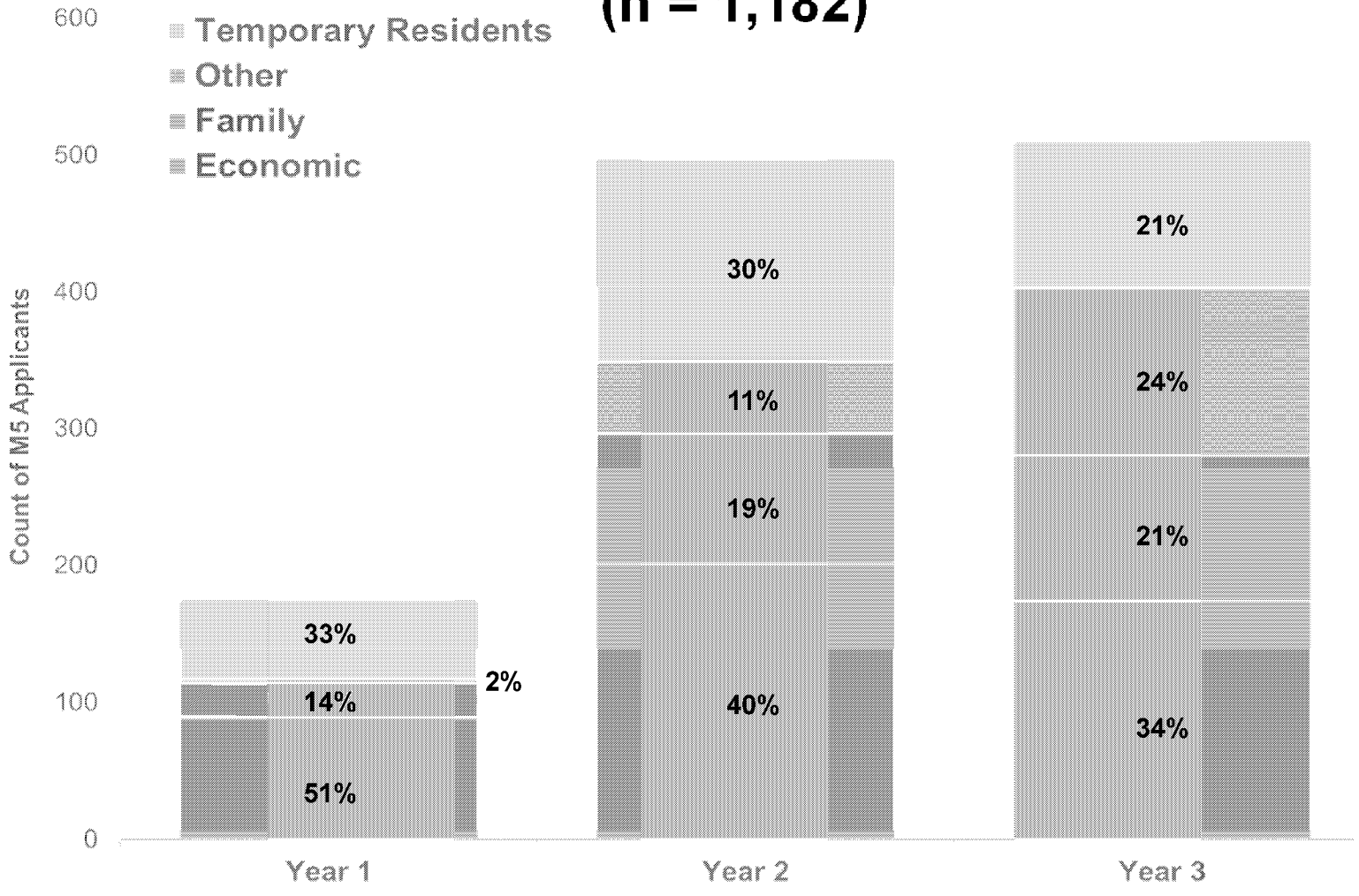
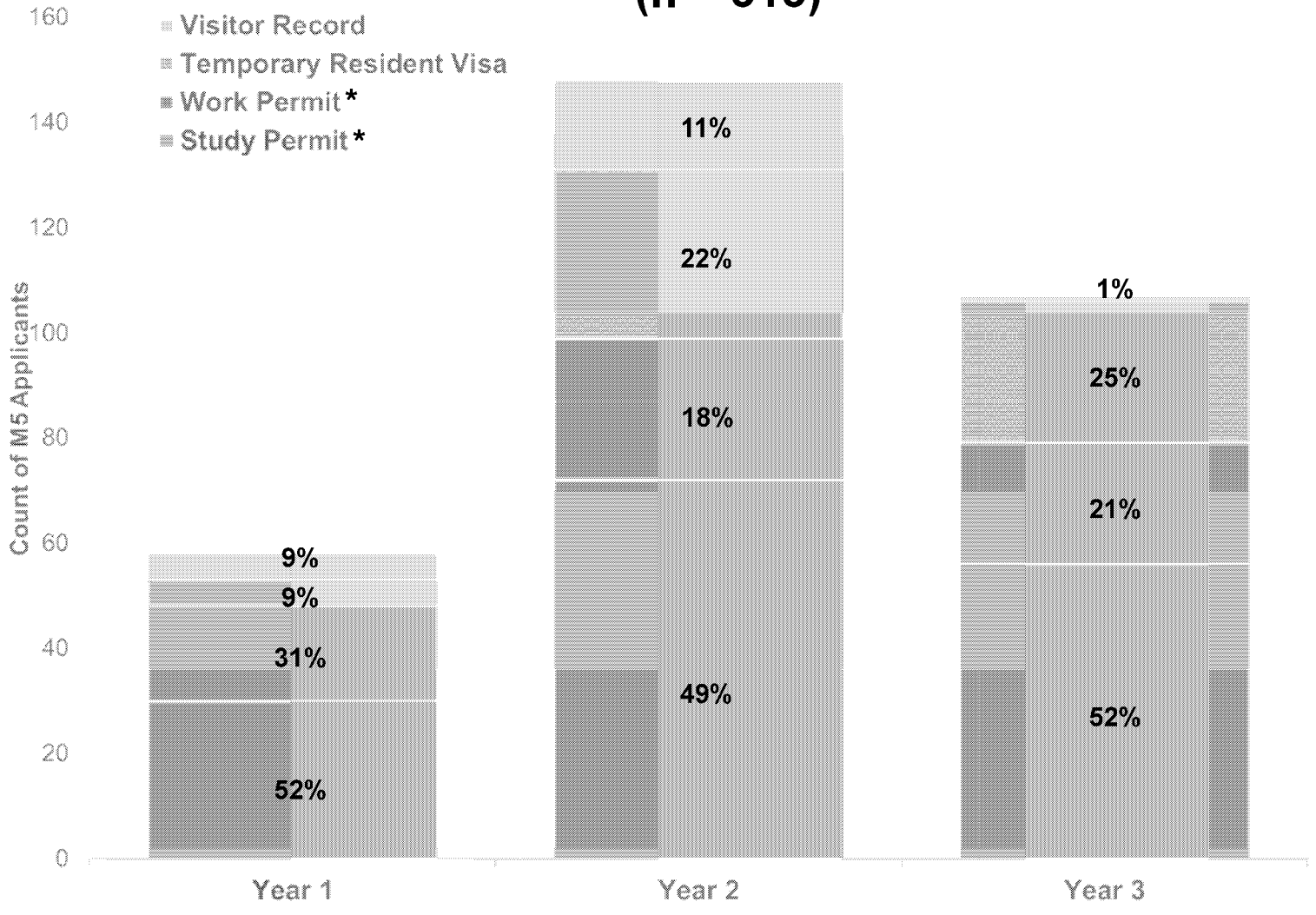
Immigration Type & Class (n = 1,182)

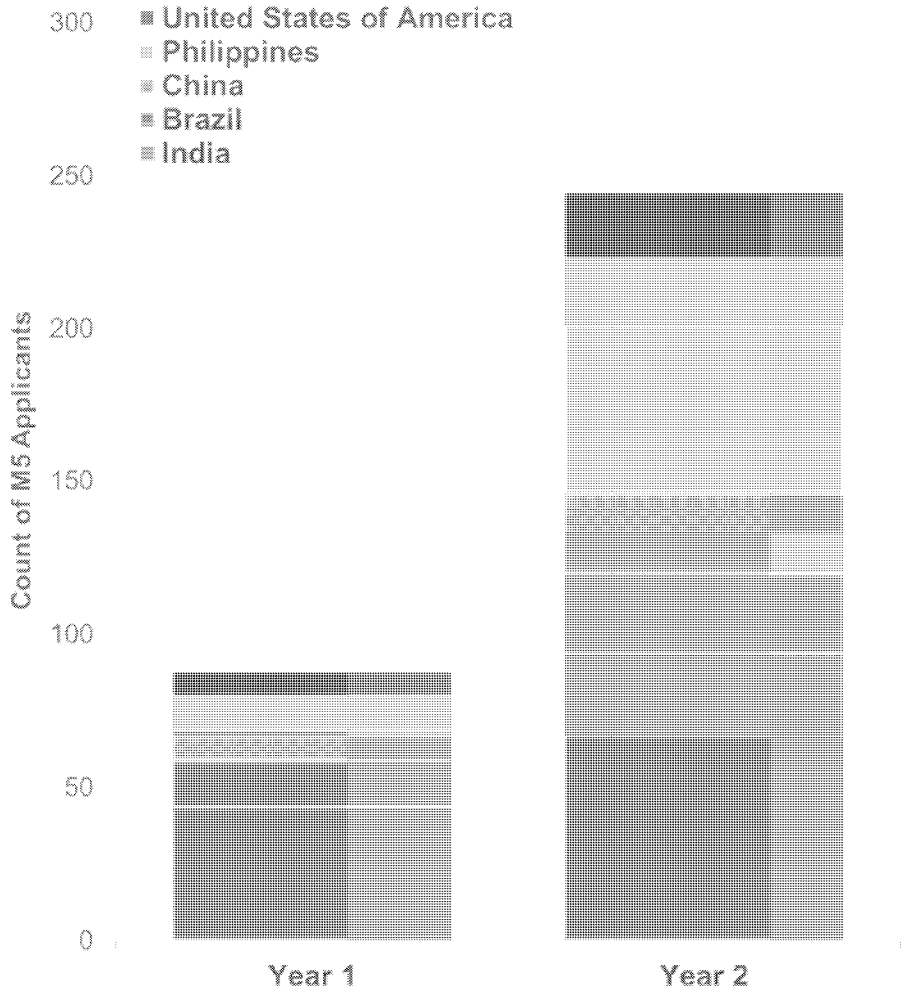


*Including permit extensions.

Temporary Residents (n = 313)



Top 5 Country of Citizenship



Client Country of Citizenship	Total Count of M5 Applicants
India	220
Philippines	154
Brazil	62
China	59
USA	58

Health Conditions

Primary Medical Diagnosis	Application Final Assessment			TOTAL
	Approved	Refused		
		Excessive Demand	Other Grounds	
Infantile Autism	189		13	202
HIV Positivity – Asymptomatic	171	2	29	202
Connective Tissue Disorder	106	2	4	112
Developmental Delay	98		8	106
Nervous System Disorders[1]	73	1	1	75
Renal Failure - Chronic	16	50	4	70
Senile Dementia	66	2		68
Congenital Anomaly	57		1	58
Other Conditions[2]	50	1	2	53
Cancer[3]	39	4	1	44
Intellectual Disability	34		1	35
Multiple Sclerosis	29		2	31
Cardiovascular Disease[4]	19	3		22
Hepatitis and Liver Disease[5]	17	2	2	21
Osteoarthritis	14	1		15
Cognitive and behavioral disorders[6]	14			15
Impaired Hearing or Deafness	7		1	7
		68	**69**	
TOTAL	999	137		1,136

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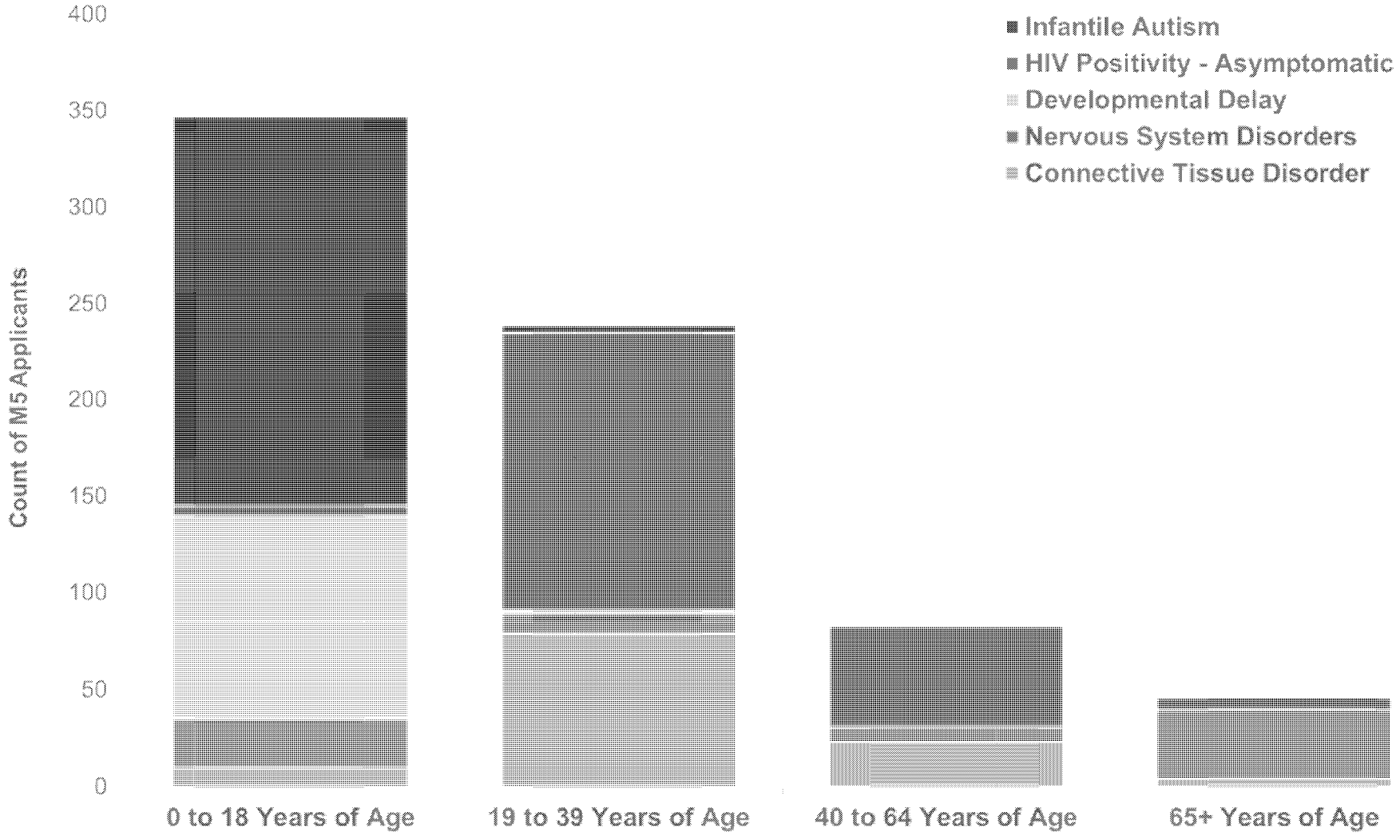
Top 5 Health Conditions distributed across Age Groups



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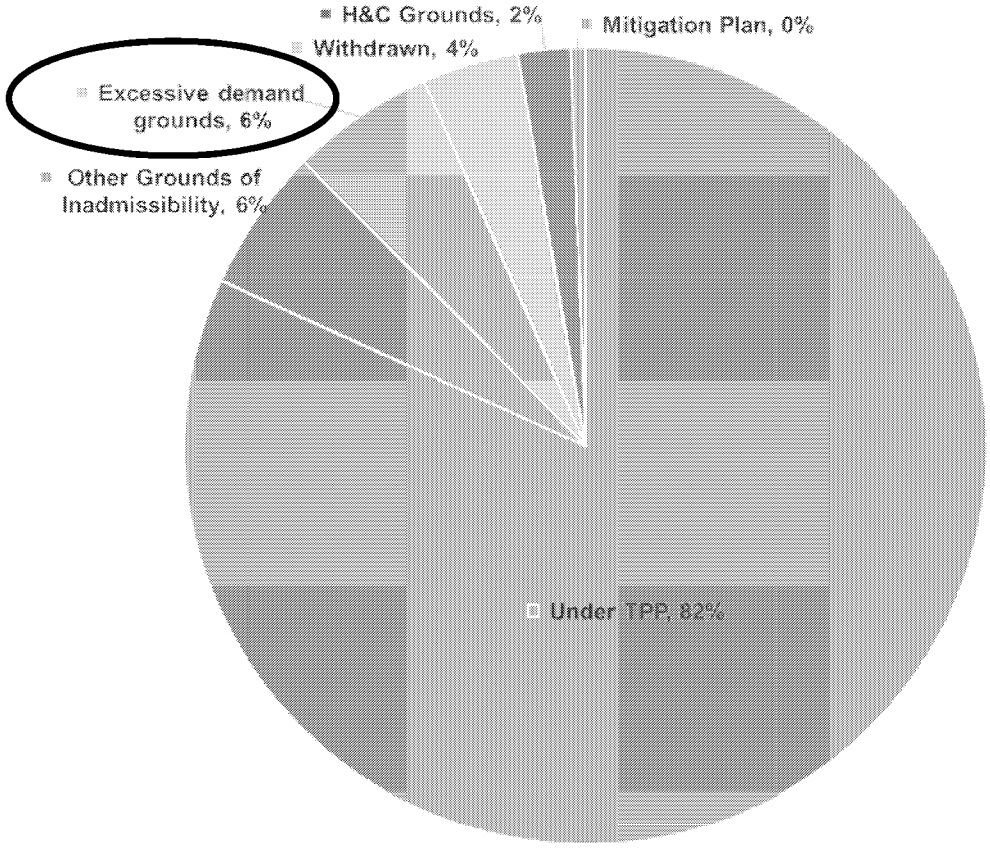
What do we know about the refused M5 applicants?



Refused on Excessive Demand Grounds: Who are affected?

A total of 68 M5 applicants (6%) in the cohort were refused on excessive demand grounds

- 44% **females** & 55% **males**.
- Most (62%) are within the **65+ age group**.
- Most applicants (71%) were applying for **Permanent Residence** (**Parent/Grandparent**).
- Most applicants applying for **Temporary Residence** (29%) were applying for a **TRV**.

- Most applicants were deemed inadmissible due to their **health condition** (*Health Services 38(1)(c)*).

Top 3 Client Country of Citizenship
Philippines
India
China

Main Reasons for Refusals (ED)

Count of M5 Clients	Analysis Year			
Reason for refusals under 38(1)(c) of the Act	Year 1 (2018-2019)	Year 2 (2019-2020)	Year 3 (2020-2021)	Grand Total
Cost of Treatment* & Displacement of a Canadian on Waiting List		8	42	**50**
Cost of Treatment*	2	2	5	**9**
Long-Term Care	1		3	**4**
Displacement of a Canadian on Waiting List		1	1	**2**
Migration Officer's Discretion	2	2		**4**
Grand Total	**5**	**13**	**51**	**69**

*Cost above the new cost threshold

Main Reasons for Refusals (ED)

Count of M5 Clients	Analysis Year			Grand Total
Reason for refusals under 38(1)(c) of the Act by health condition	Year 1 (2018-2019)	Year 2 (2019-2020)	Year 3 (2020-2021)	
Cost of Treatment* & Displacement of a Canadian on Waiting List		**8**	**42**	**50**
Renal Failure - Chronic		8	42	50
Cost of Treatment*	**2**	**2**	**5**	**9**
Cancer[1]		2	2	4
Cardiovascular Disease[2]			2	2
Connective Tissue Disorder	1		1	2
Hepatitis and Liver Disease[3]	1			1
Long-Term Care	**1**		**3**	**4**
Senile Dementia	1		1	2
Nervous System Disorder			1	1
Cerebrovascular Disease – Ill-Defined			1	1
Displacement of a Canadian on Waiting List		**1**	**1**	**2**
Osteoarthritis		1		1
Hepatitis and Liver Disease[3]			1	1
Migration Officer's Discretion	**2**	**2**		**4**
HIV Positivity - Asymptomatic	2	1		3
Cardiovascular Disease[2]		1		1
Grand Total	5	13	51	69

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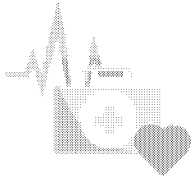
*Cost above the new cost threshold



Summary

- **Since the implementation of the TPP in 2018…**
  - Most applicants (82%) were approved under the TPP– Would have previously been refused under the old definition of excessive demand.
  - **Infantile Autism**, **HIV Positivity – Asymptomatic** & **Connective Tissue Disorder** are the top 3 health conditions.
  - Less applicants are refused on excessive demand grounds – A total of **137 applicants** over the last three (3) years.

- **Main reasons for refusals and health condition:**
  - Cost of Treatment & Displacement of a Canadian on Waiting List (**Renal Failure – Chronic**).
  - Cost of Treatment above the new cost threshold (**Cancer**).

Top health conditions among M5 applicants (2018-2021) & proportions from total (n=1,182)	
HIV Positivity – Asymptomatic	**83%** approved under TPP
	23% refused (of the refused, 42% on other grounds of inadmissibility)
Infantile Autism	**92%** approved under TPP
Connective Tissue Disorder	**91%** approved under TPP
Renal Failure - Chronic	**61%** refused (57% on excessive demand grounds)

Top Health Conditions by Age Groups

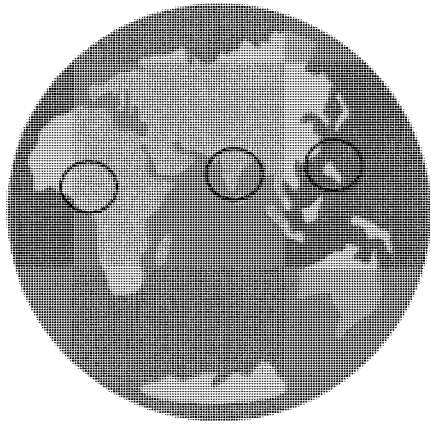
Count of Client UCI	Age Groups (Years of Age)				Grand Total
Row Labels	0 to 18	19 to 39	40 to 64	65+	
HIV Positivity – Asymptomatic	5	144	52	6	**207**
Infantile Autism	202	4			**206**
Connective Tissue Disorder	10	79	9	2	**116**
Developmental Delay	105	2			**107**
Renal Failure - Chronic	3	9	23	52	**88**
Nervous System Disorders	25	10	8	36	**79**
Senile Dementia			2	70	**72**
Congenital Anomaly	48	9	1		**58**
Other Conditions	9	11	9	26	**55**
Cancer	2	7	18	18	**45**
Intellectual Disability	18	10	5	2	**35**
Multiple Sclerosis		23	6	2	**31**
Cardiovascular Disease	1		8	14	**23**
Hepatitis and Liver Disease		12	7	4	**23**
Osteoarthritis				15	**15**
Cognitive and Behavioral Disorders	10	1	3	1	**15**
Impaired Hearing or Deafness	7				**7**
Grand Total	**445**	**321**	**165**	**251**	**1,182**

Refused on Other Grounds of Inadmissibility: Who are affected?

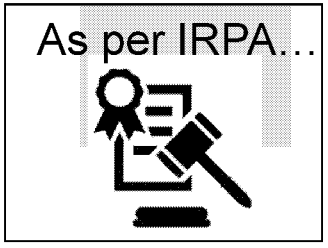
A total of 68 M5 applicants (6%) were refused on other grounds of inadmissibility

- Most applicants are **men** (70%) **under 40** years of age.
- Most applicants were applying for a **Study Permit**.
- All applicants were eligible for the TPP.

Top 3 Client Country of Citizenship
India
Nigeria
Philippines



Main Reasons for Refusals (Other Grounds)



- **Eligibility Failed (41%)**
  - Study Permits (SP)
  - Temporary Resident Visa (TRV)
  - Canadian Experience Class (CEC)
- **R216 (1) b (26%)**
  - *Foreign National will leave Canada by the end of the period authorized for their stay under Division 2 of Part 9* […]
- **A11.2 (10%)**
  - *Foreign National did not meet criteria set out in an instruction given.*
- **Non Compliance (4%)**
- **R216 (1) c (3%)**
  - *216 (1) Subject to subsections (2) and (3), an officer shall issue a study permit to a foreign national if, following an examination, it is established that the foreign national:*
    - *(c) […] meets the requirements of this Part.*

Year 1

	Approved			Refused		Total	Withdrawn
	Under the Temporary Public Policy	Acceptable Mitigation Plan	H&C Grounds	Excessive Demand Grounds	Other Grounds of Inadmissibility[5]		
Special Education & Related Services	70	0	0	0	5	**77**	2
Health Related	75	1	1	4	11	**98**	6
Total	145	**1**	**1**	**4**	**16**	**175**	**8**
	Total Approved: 147			**Total Refused: 20**			

Year 2

	Approved			Refused		Total	Withdrawn
	Under the Temporary Public Policy	Acceptable Mitigation Plan	H&C Grounds	Excessive Demand Grounds	Other Grounds of Inadmissibility[5]		
Special Education & Related Services	236	1	2	1	19	**259**	6
Health Related	168	1	7	12	28	**216**	17
Total	**404**	**2**	**9**	**13**	**47**	**475**	**23**
	Total Approved: 415			**Total Refused: 60**			

Year 3

	Approved			Refused		Total	Withdrawn
	Under the Temporary Public Policy	Acceptable Mitigation Plan	H&C Grounds	Excessive Demand Grounds	Other Grounds of Inadmissibility[5]		
Special Education & Related Services	265	1	2	1	1	**274**	3
Health Related	1153	1	7	50	6	**236**	12
Total	**418**	**2**	**9**	**51**	**7**	**510**	**15**
	Total Approved: 429			**Total Refused: 58**			

Table 1: Total number of IMEs performed in Canada and outside Canada, 2019-2021

	2019	2020	2021	Total
Canada	257,659	202,298	372,940	832,897
Outside Canada	632,385	394,880	821,342	1,848,607
Unspecified/Unknown	999	517	680	2,196
Grand Total	**891,043**	**597,695**	**1,194,962**	**2,683,700**

RMO London

	2019	2020	2021	Total
Canada	804	18	1,402	**2,224**
Outside Canada	144,197	84,998	166,107	**395,302**
Unspecified/Unknown	723	379	462	**1,564**
Grand Total	**145,724**	**85,395**	**167,971**	**399,090**

RMO Ottawa

	2019	2020	2021	Total
Canada	256,629	202,243	371,220	**830,092**
Outside Canada	58,532	37,623	73,070	**169,225**
Unspecified/Unknown	109	78	99	**286**
Grand Total	**315,270**	**239,944**	**444,389**	**999,603**

RMO New Delhi

	2019	2020	2021	Total
Canada	112	6	264	**382**
Outside Canada	284,077	188,406	388,078	**860,561**
Unspecified/Unknown	96	56	103	**255**
Grand Total	**284,285**	**188,468**	**388,445**	**861,198**

RMO Manila

	2019	2020	2021	Total
Canada	114	31	54	**199**
Outside Canada	145,579	83,853	194,087	**423,519**
Unspecified/Unknown	71	4	16	**91**
Grand Total	**145,764**	**83,888**	**194,157**	**423,809**

2,683,700

Data Source: GCMS Answers, June 16 2022
Excludes cancelled/not started IMEs
Date = IME Received Year
Canada = Medical organization country is equal to Canada
Overseas = Medical organization country is not equal to Canada
Unspecified/Unknown = Medical organization country is not specified

Application Stream	Number of IMEs
Asylum Claimants	10,930
Family Reunification	70,393
Family Reunification (Parents and Grandparents)	20,673
Federal Economic Immigration	134,835
Humanitarian Compassionate and Discretionary Immigration	15,043
International Students	190,453
Provincial Economic Immigration	68,707
Refugee Resettlement (Government Sponsored Refugees)	10,091
Refugee Resettlement (Privately Sponsored Refugees)	12,068
Temporary Workers	60,738
Unspecified	285,534
Visitors	36,990
Grand Total	**916,455**

Data Source: GCMS, October 5 2021
Data does not include "Cancelled and "Not Started" IMEs
Data filtered on IME Received Date between January 1st to September 30th, 2021

# of Medicals	IME - Received Date	Medical Organization Country
258,096	2019	Canada
633,582	2019	Overseas
1,010	2019	Unspecified/Unknown
202,735	2020	Canada
395,533	2020	Overseas
520	2020	Unspecified/Unknown
373,745	2021	Canada
822,566	2021	Overseas
687	2021	Unspecified/Unknown
80,177	2022*	Canada
325,273	2022*	Overseas
184	2022*	Unspecified/Unknown

Note:

*2022 data till April 30 2022 only

*Excludes cancelled/not started IMEs

*Data source: GCMS Answers, May 27 2022

Report on Volumes for IMPN – FOR INTERNAL USE ONLY

HAS NOT BEEN APPROVED BY DPU

- Total number of IMEs per RMO

Table 1: Number of IMEs received[a] in 2018 and 2019[b] by Regional Medical Office

Regional Medical Office	Number IMEs in 2018	Number IMEs in 2019[b]
London	120,985	145,534
Manila	152,625	145,714
Delhi	238,363	283,364
Ottawa	301,701	314,952
CMAU	1,486	1,280
TOTAL	**815,160**	**890,844**

a. IMEs with a status of "Not Started" were excluded
b. 2019 data covers period from January 1 – December 30, 2019

N/R

Table of Contents

COMPARISONS WITH PREVIOUS YEARS OF THE IMPLEMENTATION OF THE TPP

1- Final outcomes and costs avoided and incurred to P/Ts since 2018

Year 1 (pending and new applications)

Number of excessive demand applicants Year 1	Approved				Refused			Withdrawn	Grand Total
	Under TPP	Mitigation Plan	H&C Grounds	Approved Total	Excessive Demand Grounds	Other Grounds of Inadmissibility	Refused Total		
Health	360	71	38	469	84	40	124	96	689
Special Education & Related	603	1	2	606	3	13	16	33	655
Grand Total	963	72	40	1,075	87	53	140	129	1,344
Total projected costs avoided over 5 years		$12,883,327			$31,562,286	$4,484,910		$21,479,243	$70,409,766
Total projected costs incurred over 5 years	$21,689,323		$10,424,798						$32,114,121

Year 1 (new applications only)

Number of excessive demand applicants Year 1	Approved				Refused			Withdrawn	Grand Total
	Under TPP	Mitigation Plan	H&C Grounds	Approved Total	Excessive Demand Grounds	Other Grounds of Inadmissibility	Refused Total		
Health	73	1	1	75	4	11	15	5	95
Special Education & Related	72	--	1	72	--	5	5	3	80
Grand Total	145	1	2	147	4	16	20	8	175
Total projected costs avoided over 5 years		$407,500			$390,353	$623,835		$947,927	$2,369,615
Total projected costs incurred over 5 years	$4,582,174		$137,535						$4,719,709

Year 2

Number of excessive demand applicants Year 2	Approved				Refused			Withdrawn	Grand Total
	Under TPP	Mitigation Plan	H&C Grounds	Approved Total	Excessive Demand Grounds	Other Grounds of Inadmissibility	Refused Total		
Health	168	1	2	176	12	27	39	17	232
Special Education & Related	236	1	7	239	1	19	20	6	265
Grand Total	404	2	9	415	13	46	59	23	497
Total projected costs avoided over 5 years		$431,893			$4,744,150	$3,425,417		$3,832,609	$12,434,069
Total projected costs incurred over 5 years	$26,895,024		$2,501,847						$29,396,871

Year 3

Number of excessive demand applicants Year 3	Approved				Refused			Withdrawn	Grand Total
	Under TPP	Mitigation Plan	H&C Grounds	Approved Total	Excessive Demand Grounds	Other Grounds of Inadmissibility	Refused Total		
Health	153	3	12	168	50	6	56	23	224
Special Education & Related	265	1	3	269	1	1	2	3	271
Grand Total	418	4	15	437	51	7	58	26	495
Total projected costs avoided over 5 years		$1,083,720			$19,128,839	$569,458		$3,871,748	$24,653,765
Total projected costs incurred over 5 years	$27,457,895		$16,874,610						$44,422,505

Overall Three Years Combined (including "pending" applications in year 1)

Count of Client UCIs Application Final Assessment by Final Outcome	Year of Analysis			Average count of clients over the last 3 years (2018-2021)	Grand Total
	Year 1 (2018-2019)	Year 2 (2019-2020)	Year 3 (2020-2021)		
Approved	**1,075**	**415**	**437**	**642**	**1,927**
Under TPP	963	404	418	595	1,785
Mitigation Plan	72	2	4	26	78
H&C Grounds	40	9	15	21	64
Refused	**140**	**59**	**58**	**86**	**257**
Excessive demand grounds	87	13	51	50	151
Other Grounds of Inadmissibility	53	46	7	35	106
Withdrawn	**129**	**23**	**15**	**56**	**167**
Grand Total	**1,344**	**497**	**510**	**784**	**2,351**

***Note there are n=21 clients that appeared in two separate analyses, although under different applications (ex: year 1 under a TR application & year 3 under a PR application and vise-versa)**

***Grand Total in the last 3 years: 2,351 clients (minus 21 clients counted twice) =** 2,330 unique clients

*Two (2) clients less than in previous analyses – 2 clients who were refugee claim... Refugees are EDE, thus removed from analysis.

Three Years Combined (only "new" applications in year 1)

Count of Client UCIs Application Final Assessment by Final Outcome	Year of Analysis			Average count of clients over the last 3 years (2018-2021)	Grand Total
	Year 1 (2018-2019)	Year 2 (2019-2020)	Year 3 (2020-2021)		
Approved	**147**	**415**	**437**	**333**	**999**
Under TPP	145	404	418	322	967
Mitigation Plan	1	2	4	2	7
H&C Grounds	1	9	15	8	25
Refused	**20**	**59**	**58**	**46**	**137**
Excessive demand grounds	4	13	51	23	68
Other Grounds of Inadmissibility	16	46	7	23	70
Withdrawn	**8**	**23**	**15**	**15**	**46**
Grand Total	**175**	**497**	**510**	**394**	**1,182**

1- Excessive demand related finding by costs avoided and incurred to P/Ts

Note: Year 1 - New applications only.

	Count of Client UCIs			Sum of Costs INCURRED to PTs			Sum of Costs AVOIDED to PTs			Grand Total MS applicants
Application Final Assessment by Excessive Demand Related Finding	**Year 1**	**Year 2**	**Year 3**	**Year 1**	**Year 2**	**Year 3**	**Year 1**	**Year 2**	**Year 3**	(over 3 years)
Approved	**147**	**415**	**437**				**$407,500**	**$431,893**	**$1,083,720**	**999**
Health	75	176	168	$5,959,173	$14,721,060	$16,153,640	$407,500	$311,460	$931,485	419
Special Education & Related Services	72	239	269	--	--	$74,350*	--	--	--	580
Refused	**20**	**59**	**58**	--	--	--	**$1,014,188**	**$8,241,143**	**$19,698,297**	**137**
Health	15	39	56	--	--	--	$1,014,188	$7,882,103	$19,476,882	110
Special Education & Related Services	5	20	2	--	--	--	--	--	--	27
Grand Total	**167**	**474**	**495**	**$6,374,928**	**$29,443,956**	**$44,422,505**	**$1,421,688**	**$8,673,036**	**$21,782,017**	**1,136**

*Due to special education and other social services (i.e. personal support worker).

Incurred	Year 1	Year 2	Year 3	Average (over 3 years)
Health	$5,959,173	$14,721,060	$16,153,640	$12,277,958
Social	$415,755	$14,722,896	$28,194,515	$14,444,389
Special Ed	--	--	$74,350	$74,350

Avoided	Year 1	Year 2	Year 3	Average (over 3 years)
Health	$407,500	$311,460	$931,485	$5,003,936
(App & Ref)	$1,014,188	$7,882,103	$19,476,882	
Social	--	$120,433	$152,235	$213,281
(App & Ref)	--	$359,040	$221,415	
Special Ed	--	--	--	--

OVERALL OUTCOMES AND APPLICATION TIMEFRAMES

2- Approved and refused applications by final outcome

Application Final Assessment by Final Outcome	Count of Client UCI
Approved	**1,927**
Under TPP	1,785
H&C Grounds	64
Mitigation Plan	78
Refused	**257**
Excessive Demand Grounds	151
Other Grounds of Inadmissibility	106
Grand Total	**2,184**

3- Summarized application timeframes

Count of Client UCI	Approved				Refused				
Application Received Date by Application Final Assessment Year	Year 1	Year 2	Year 3	Approved Total	Year 1	Year 2	Year 3	Refused Total	Grand Total
Before June 1, 2018	958	147	94	**1,199**	121	9	36	**166**	1,365
June 1, 2018 to May 31, 2019	117	151	120	**388**	19	15	14	**48**	436
June 1, 2019 to May 31, 2020	--	117	129	**246**	--	35	5	**40**	286
June 1, 2020 to May 31, 2021	--	--	94	**94**	--	--	3	**3**	97
Grand Total	**1,075**	**415**	**437**	**1,927**	**140**	**59**	**58**	**257**	**2,184**

AGE GROUPS & GENDER

4- Age groups stratified by gender for approved and refused applications for excessive demand clients (i.e. M5 applicants)

Count of M5 Client UCI	Client Gender		Grand Total
Age Groups (Based on Application Final Assessment Date)	Male	Female	
0 to 18 Years of Age	644	260	**904**
19 to 39 Years of Age	339	168	**507**
40 to 64 Years of Age	172	154	**326**
65+ Years of Age	220	227	**447**
Grand Total	**1,375**	**809**	**2,184**

‡ Excluding Withdrawn applications
‡‡ Approved under the TPP, H&C and with a viable mitigation plan
‡‡‡ Refused on excessive demand grounds & other grounds of inadmissibility

5- Age groups stratified by gender for approved applications under the TPP only for excessive demand clients

Count of M5 Client UCI Age Groups (Based on Application Final Assessment Date)	Client Gender		Grand Total
	Male	Female	
0 to 18 Years of Age	612	247	**859**
16 to 24 Years of Age	286	138	**424**
25 to 64 Years of Age	119	113	**232**
65+ Years of Age	129	141	**270**
Grand Total	**1,146**	**639**	**1,785**

6- Age groups stratified by gender for approved and refused applications for excessive demand clients

Count of Client UCIs Age Groups (Based on Application Final Assessment Date)	Approved		Approved Total	Refused		Refused Total	Grand Total
	Male	Female		Male	Female		
0 to 18 Years of Age	614	251	865	30	9	39	**904**
16 to 24 Years of Age	298	148	446	41	20	61	**507**
25 to 64 Years of Age	141	131	272	31	23	54	**326**
65+ Years of Age	163	181	344	57	46	103	**447**
Grand Total	**1,216**	**711**	**1,927**	**159**	**98**	**257**	**2,184**

7- Approved and refused applications proportions by gender (M5 applicants only).

Count of Client UCI Application Final Assessment	Client Gender		Grand Total
	Male	Female	
Approved	1,217 (56%)	711 (33%)	**1,928**
Refused	159 (7%)	98 (4%)	**258**
Grand Total	**1,375 (63%)**	**809 (37%)**	**2,184**

‡ Excluding Withdrawn applications
‡‡ Approved under the TPP, H&C and with a viable mitigation plan
‡‡‡ Refused on excessive demand grounds & other grounds of inadmissibility

IMMIGRATION TYPE, CLASS AND CATEGORY

8- Immigration type and class for approved and refused applications for excessive demand clients and associated family members

Immigration Type and Class	Application Final Assessment				Total Count of M5 Clients	Total Count including family members
	Approved		Refused			
	Count of M5 Clients	Count of clients including family members	Count of M5 Clients	Count of clients including family members		
Permanent Resident	**1,676**	**4,739**	**166**	**412**	**1,842**	**5,150**
Economic	1,026	3,305	55	150	1,081	**3,454**
Family	349	874	100	240	449	**1,114**
Other	301	560	11	22	312	582
Temporary Resident	**251**	**251**	**91**	**91**	**342**	**342**
Grand Total	**1,927**	**4,990**	**257**	**503**	**2,184**	**5,492**

9- Immigration class and category for approved and refused applications (grouped) for excessive demand clients

Count of Client UCIs Immigration Class and Grouped Categories	Application Final Assessment		Grand Total
	Approved	Refused	
Economic	**1,026**	**55**	**1,081**
Provincial Nominee – Selected by a province other than Quebec	339	15	354
Skilled Worker*	268	15	283
Canadian Experience Class	177	9	186
In-Canada Live-in Caregiver	171	13	184
Investor*	18		18
Caring for Children Program	11	1	12
Atlantic High-Skilled Program	9		9
Dependent Residing Abroad Of A Member Of An In-Canada Live-In Caregiver	7	1	8
Skilled Trades – Federal	6	1	7
Caring For People With High Medical Needs	6		6
Atlantic Intermediate-Skilled Program	6		6
Self-employed – Federal	4		4
Entrepreneur – Quebec	2		2
Atlantic International Graduate Program	2		2
Family	**349**	**100**	**449**
Parent/Grandparent	337	97	434
Other Relative	6	2	8
Orphaned sibling/nephew/niece/grandchild	3	1	4
Spouse	2		2
Son/Daughter	1		1
Other	**301**	**11**	**312**
In-Canada Humanitarian and Compassionate Case	297	11	308
Permit Holder	3		3
Permit Holders Applying for Perm. Residence	1		1
Temporary Residents	**251**	**91**	**342**
Student Permit**	129	42	171
Work Permit**	63	17	80
Temporary Resident Visa	37	32	69
Visitor Record	22		22
Grand Total	**1,927**	**257**	**2,184**

*Includes Federal and Quebec.
**Includes extensions.

‡ Excluding Withdrawn applications

‡‡ Approved under the TPP, H&C and with a viable mitigation plan
‡‡‡ Refused on excessive demand grounds & other grounds of inadmissibility

HEALTH CONDITIONS

10- All primary diagnosis codes (all) for approved and refused applications for excessive demand clients

Count of Client UCIs by Primary Diagnosis Code Description	Application Final Assessment		Grand Total
	Approved	Refused	
Infantile Autism	344	16	360
HIV Positivity - Asymptomatic	282	39	321
Developmental Delay	218	11	229
Intellectual Disability	152	5	157
Connective Tissue Disorder	141	8	149
Renal Failure – Chronic	33	108	141
Congenital Anomaly	101	2	103
Nervous System Disorder	98	4	102
Senile Dementia	93	5	98
Multiple Sclerosis	45	3	48
Cerebrovascular Disease - Ill-Defined	42	5	47
Impaired Hearing or Deafness	37		37
Hepatitis - Chronic	32	4	36
Parkinson's Disease	27	4	31
Trachea, Bronchus and Lung - Malignant Neoplasm	18	7	25
Alzheimer's Disease	23	2	25
Osteoarthritis	21	2	23
Leukaemia - Unspecified Cell Type	18		18
Behaviour Disorder	17		17
Cardiomyopathy	13	2	15
Ischaemic Heart Disease - Chronic	13	1	14
Blood, and Blood-Forming Organ, Disease	11	2	13
Female Breast - Malignant Neoplasm	8	5	13
Genitourinary Organs- Malignant Neoplasm	12	1	13
Nonspecific Abnormal Findings	10	1	11
Schizophrenia	9	1	10
Hepatitis B	9	1	10
Heart Failure	8	1	9
Stomach - Malignant Neoplasm	7	1	8
Impaired Vision or Blindness	6	1	7
(See Narrative)	7		7
Neoplasm of Unspecified Nature	6	1	7
Endocrine Gland – Malignant Neoplasm	5	1	6
Pulmonary Fibrosis - Postinflammatory	4	2	6
Liver - Cirrhosis: Chronic Liver Disease	2	4	6
Liver and Intrahepatic Bile Ducts - Malignant Neoplasm	5		5
Aortic Valve Disease	5		5
Colon - Malignant Neoplasm	5		5
Lymphoid and Histiocytic Tissue – Malignant Neoplasm	4		4
Congestive Heart Failure	4		4
Renal Function Impairment Disorder	2	2	4
Organ or Tissue Transplant	3	1	4
Heart - Congenital Anomaly	3	1	4
AIDS: Acquired Immunodeficiency Syndrome – with or without Other Conditions	3		3
Multiple Myeloma	2	1	3
Schizoaffective Psychosis	1	1	2
COPD: Chronic Obstructive Pulmonary Disease	2		2
Haemophilia: Congenital Factor VIII Disorder	2		2
Rectum, Rectosigmoid Junction and Anus - Malignant Neoplasm	2		2
Nonspecific Abnormal Findings on Radiological and Other Examination of Body Structure	1	1	2
Nervous System - Malignant Neoplasm	2		2
Muscular Dystrophies and Other Myopathies	2		2
Nonspecific Abnormal Results of Function Studies	2		2
Bipolar Disorder – Manic-Depressive Psychosis	1		1
Mitral Valve Disease	1		1
Cardiomegaly	1		1
Aneurysm	1		1
Small Intestine – Malignant Neoplasm	1		1
Grand Total	**1,927**	**257**	**2,184**

‡ Excluding Withdrawn applications

‡‡ Approved under the TPP, H&C and with a viable mitigation plan
‡‡‡ Refused on excessive demand grounds & other grounds of inadmissibility

11- All diagnosis codes (grouped) for approved and refused applications for excessive demand clients

Count of Client UCI Grouped Health Conditions	Application Final Assessment		Grand Total
	Approved	Refused	
Infantile Autism	344	16	**360**
HIV Positivity - Asymptomatic	282	39	**321**
Developmental Delay	218	11	**229**
Intellectual Disability	152	5	**157**
Nervous System Disorders[1]	148	10	**157**
Connective Tissue Disorder	141	8	**149**
Renal Failure – Chronic	33	108	**141**
Other Conditions[2]	98	15	**113**
Cancer[3]	95	17	**112**
Congenital Anomaly	101	2	**103**
Senile Dementia	93	5	**98**
Cardiovascular Disease[4]	48	5	**53**
Hepatitis and Liver Disease[5]	43	9	**52**
Multiple Sclerosis	45	3	**48**
Impaired Hearing or Deafness	37	--	**37**
Cognitive and Behavioral Disorders[6]	28	2	**30**
Osteoarthritis	21	2	**23**
Grand Total	**1,927**	**257**	**2,184**

Data notes

[1]Includes Alzheimer's Disease; Nervous System Disorder; Parkinson's Disease.

[2]Includes Cerebrovascular Disease – Ill-Defined; Blood, and Blood-Forming Organ Disease; Nonspecific Abnormal Findings; (See Narrative); Impaired Vision or Blindness; Pulmonary Fibrosis – Postinflammatory; Renal Function Impairment Disorder; Organ or Tissue Transplant; AIDS: Acquired Immunodeficiency Syndrome – with or without Other Conditions; Haemophilia: Congenital Factor VIII Disorder; Nonspecific Abnormal Findings of Function Studies; Nonspecific Abnormal Findings and Other Examination of Body Structure; Muscular Dystrophies and Other Myopathies; COPD: Chronic Obstructive Pulmonary Disease ; Aneurysm.

[3]Includes Trachea, Bronchus and Lung – Malignant Neoplasm; Leukaemia – Unspecified Cell Type; Female Breast – Malignant Neoplasm; Genitourinary Organs – Malignant Neoplasm; Stomach – Malignant Neoplasm; Neoplasm of Unspecified Nature; Endocrine Gland – Malignant Neoplasm; Colon – Malignant Neoplasm; Liver and Intrahepatic Bile Ducts – Malignant Neoplasm; Lymphoid and Histiocytic Tissue – Malignant Neoplasm; Multiple Myeloma; Nervous System – Malignant Neoplasm; Rectum, Rectosigmoid Junction and Anus – Malignant Neoplasm; Small Intestine – Malignant Neoplasm.

[4]Includes Cardiomyopathy; Ischaemic Heart Disease – Chronic; Heart Failure; Aortic Valve Disease; Heart – Congenital Anomaly; Mitral Valve Disease; Cardiomegaly.

[5]Includes Hepatitis – Chronic; Hepatitis 'B' ; Liver - Cirrhosis: Chronic Liver Disease.

[6]Includes Behaviour Disorder; Schizophrenia; Schizoaffective Psychosis; Bipolar Disorder – Manic-Depressive Psychosis.

12- All diagnosis codes (grouped) for refused applications

Count of Client UCIs Grouped Primary Diagnosis Code Description	Excessive Demand Grounds	Other Grounds of Inadmissibility	Grand Total
Renal Failure – Chronic	101	7	**108**
HIV Positivity - Asymptomatic	3	36	**39**
Cancer[1]	12	5	**17**
Infantile Autism	1	15	**16**
Other Conditions[2]	9	6	**15**
Developmental Delay	1	10	**11**
Nervous System Disorders[3]	5	5	**10**
Hepatitis and Liver Disease[4]	4	5	**9**
Connective Tissue Disorder	2	6	**8**
Cardiovascular Disease[5]	4	1	**5**
Senile Dementia	5		**5**
Intellectual Disability	1	4	**5**
Multiple Sclerosis	1	2	**3**
Cognitive and Behavioral Disorders[6]	1	1	**2**
Osteoarthritis	1	1	**2**
Congenital Anomaly		2	**2**
Grand Total	**151**	**106**	**257**

Data notes

[1]Includes Trachea, Bronchus and Lung – Malignant Neoplasm; Female Breast – Malignant Neoplasm; Endocrine Gland – Malignant Neoplasm; Neoplasm of Unspecified Nature; Stomach – Malignant Neoplasm; Genitourinary Organs – Malignant Neoplasm; Multiple Myeloma.

[2]Includes Cerebrovascular Disease - Ill-Defined; Renal Function Impairment Disorder; Pulmonary Fibrosis – Postinflammatory; Blood, and Blood-Forming Organ, Disease; Nonspecific Abnormal Findings on Radiological and Other Examination of Body Structure; Impaired Vision or Blindness; Organ or Tissue Transplant; Nonspecific Abnormal Findings.

[3]Includes Parkinson's Disease; Nervous System Disorder; Alzheimer's Disease.

[4]Includes Hepatitis – Chronic; Liver – Cirrhosis: Chronic Liver Disease; Hepatitis 'B'.

[5]Includes Cardiomyopathy; Heart Failure; Ischaemic Heart Disease – Chronic; Heart – Congenital Anomaly.

[6]Includes Schizoaffective Psychosis; Schizophrenia.

‡ Excluding Withdrawn applications

‡‡ Approved under the TPP, H&C and with a viable mitigation plan

‡‡‡ Refused on excessive demand grounds & other grounds of inadmissibility

13- Summarized excessive demand related finding for excessive demand clients by application final assessment

Count of Client UCIs	Application Final Assessment		Grand Total
Excessive demand related findings (based on primary diagnosis code description)	Approved	Refused	
Health			
Special Education			
Social Services other than Special Education[a]			
Grand Total			

[a]Including Home care services provided by a personal support worker; displacement of a Canadian on waiting list; Long term care facility; Hospitalizations.

‡ Excluding Withdrawn applications

‡‡ Approved under the TPP, H&C and with a viable mitigation plan
‡‡‡ Refused on excessive demand grounds & other grounds of inadmissibility

COUNTRY OF CITIZENSHIP

14- All client country of citizenship by world region

Count of Client UCIs - Client Country of Citizenship by World Region	Application Final Assessment		Grand Total
	Approved	Refused	
South Asia	83	17	100
India	65	13	78
Pakistan	10	2	12
Bangladesh	6	2	8
Sri Lanka	1		1
Afghanistan	1		1
Southeast Asia	54	18	72
Philippines	48	16	64
Vietnam	4		4
Indonesia	1	2	3
Cambodia	1		1
East Asia	30	7	37
China	20	3	23
Korea, South	6	2	8
China (Hong Kong SAR)	2	1	3
Japan	2		2
Taiwan		1	1
South America	33		33
Brazil	21		21
Peru	4		4
Venezuela	3		3
Colombia	2		2
Chile	1		1
Guyana	1		1
Ecuador	1		1
Western Africa	32	1	33
Nigeria	22		22
Senegal	3		3
Guinea	2	1	3
Ivory Coast	2		2
Burkina Faso	1		1
Togo	1		1
Liberia	1		1
Western Europe	27	1	28
France	14		14
UK - British citizen	9		9
Belgium	2		2
Germany, Federal Republic Of	1	1	2
Netherlands, The	1		1
Caribbean	27	1	28
Haiti	8	1	9
Jamaica	6		6
Dominican Republic	5		5
Trinidad and Tobago	5		5
Grenada	2		2
Antigua And Barbuda	1		1
Bahamas	1		1
Saint Lucia	1		1
North America (USA)	27		27
Middle East	25	2	27
Iran	14	2	16
Lebanon	4		4
Israel	4		4
Iraq	1		1
Syria	1		1
Palestinian Authority	1		1
East Africa	21	3	24
Zimbabwe	5	1	6
Kenya	2	1	4
Rwanda	3		3
Burundi	3		3
Zambia	2		2
Ethiopia	2		2
Madagascar	2		2
Somalia	1		1
Mauritius	1		1
North Africa	21	3	24
Egypt	6	3	9
Algeria	5		5
Morocco	4		4
Tunisia	3		3
Sudan	2		2
Libya	1		1
Central Africa	12	1	13
Cameroon	8		8
Democratic Rep. of Congo	3	1	4
Angola	1		1
USSR (ex)	9	1	10
Ukraine	3	1	4
Russia	2		2
Lithuania	1		1
Kazakhstan	1		1
Azerbaijan	1		1
Latvia	1		1
Central America	7	1	8
Mexico	5	1	6
Costa Rica	1		1
Guatemala	1		1
Southern Africa	5	2	7
South Africa, Republic Of	5	1	6
Botswana		1	1
Eastern Europe	6		6
Albania	3		3
Romania	2		2
Serbia, Republic Of	1		1
Australasia	5		5
Australia	4		4
New Zealand	1		1
Southern Europe	5		5
Spain	2		2
Turkey	1		1
Italy	1		1
Portugal	1		1
Northern Europe	5		5
Ireland	4		4
Denmark	1		1
Bosnia and Herzegovina	1		1
Stateless	1		1
Unspecified	1		1
Grand Total	437	58	495

‡ Excluding Withdrawn applications
‡‡ Approved under the TPP, H&C and with a viable mitigation plan
‡‡‡ Refused on excessive demand grounds & other grounds of inadmissibility

15- Top 10 client country of citizenship for approved and refused applications for excessive demand clients and the associated family members

Top 10 Client Country of Citizenship	Application Final Assessment				Total Count of M5 Clients	Total Count including family members
	Approved		Refused			
	Count of M5 Clients	Count of clients including family members	Count of M5 Clients	Count of clients including family members		
India	65	149	13	27	78	176
Philippines	48	122	16	50	64	172
United States of America	27	65	--	--	27	65
China	20	58	3	9	23	67
Nigeria	22	81	--	--	22	81
Brazil	21	42	--	--	21	42
Iran	14	39	2	5	16	44
France	14	27	--	--	14	27
Pakistan	10	24	2	5	12	29
Haiti	8	13	1	3	9	16
Other Countries	188	399	21	54	209	453
Grand Total	437	1,019	58	153	495	1,172

16- Top 3 client country of citizenship for approved and refused applications for excessive demand clients

Count of Client UCI Client Top 3 Country of Citizenship by World Region	Application Final Assessment		Grand Total
	Approved	Refused	
South Asia	83	17	100
India	65	13	78
Pakistan	10	2	12
Bangladesh	6	2	8
Sri Lanka	1		1
Afghanistan	1		1
Southeast Asia	54	18	72
Philippines	48	16	64
Vietnam	4		4
Indonesia	1	2	3
Cambodia	1		1
East Asia	30	7	37
China	20	3	23
South Korea	6	2	8
China (Hong Kong SAR)	2		2
Japan	2		2
Taiwan		1	1
Grand Total	167 (38% of 437))	42 (72% of 58)	209 (42% of 495)

17- Client country of citizenship for approved and refused applications for excessive demand clients for clients with country of citizenship of India by health condition

Count of UCIs Top Health Conditions from Clients with India as their Country of Citizenship	Application Final Assessment		Grand Total
	Approved	Refused	
Infantile Autism	14		14
Renal Failure - Chronic	2	11	13
Senile Dementia	10		10
Connective Tissue Disorder	7		7
Other Conditions[1]	5		5
Developmental Delay	5		5
Nervous System Disorders[2]	3	1	4
Cancer[3]	3	1	4
HIV Positivity - Asymptomatic	4		4
Congenital Anomaly	3		3
Intellectual Disability	3		3
Cardiovascular Disease[4]	2		2
Cognitive and Behavioral Disorders[5]	2		2
Hepatitis and Liver Disease	1		1
Osteoarthritis	1		1
Grand Total	65	13	78

[1]Includes Cerebrovascular Disease – Ill-Defined; Nonspecific Abnormal Findings; Pulmonary Fibrosis – Postinflammatory; Muscular Dystrophies and Other Myopathies. | [2]Nervous System Disorder. | [3]Includes Neoplasm of Unspecified Nature; Leukaemia – Unspecified Cell Type; Colon – Malignant Neoplasm; Female Breast – Malignant Neoplasm. | [4]Includes Ischaemic Heart Disease – Chronic; Cardiomyopathy. | [5]Includes Schizophrenia; Behaviour Disorder.

18- Client country of citizenship for approved and refused applications for excessive demand clients for clients with country of citizenship of Philippines by health condition

Count of UCIs Top Health Conditions from Clients with Philippines as their Country of Citizenship	Application Final Assessment		Grand Total
	Approved	Refused	
Renal Failure - Chronic	2	14	16
Infantile Autism	15		15
Developmental Delay	12		12
Congenital Anomaly	4		4
Nervous System Disorders[1]	3		3
Intellectual Disability	3		3
Impaired Hearing or Deafness	3		3
Other Conditions[2]	2	1	3
Cancer[3]		1	1
Hepatitis and Liver Disease[4]			
Connective Tissue Disorder	1		1
Cognitive and Behavioral Disorders[5]	1		1
Senile Dementia	1		1
HIV Positivity - Asymptomatic	1		1
Grand Total	48	16	64

[1]Includes Parkinson's Disease; Nervous System Disorder. | [2]Cerebrovascular Disease – Ill-Defined. | [3]Female Breast – Malignant Neoplasm. | [4]Liver - Cirrhosis: Chronic Liver Disease. | [5]Behaviour Disorder.

‡ Excluding Withdrawn applications
‡‡ Approved under the TPP, H&C and with a viable mitigation plan
‡‡‡ Refused on excessive demand grounds & other grounds of inadmissibility

19- Client country of citizenship for approved and refused applications for excessive demand clients for clients with country of citizenship of United States of America by health condition

Count of UCIs Top Health Conditions from Clients with USA as their Country of Citizenship	Application Final Assessment	Grand Total
	Approved	
Infantile Autism	9	9
Connective Tissue Disorder	6	6
HIV Positivity - Asymptomatic	4	4
Congenital Anomaly	3	3
Nervous System Disorders	1	1
Cognitive and Behavioral Disorders	1	1
Other Conditions*	1	1
Developmental Delay	1	1
Multiple Sclerosis	1	1
Grand Total	27	27

*Impaired Vision or Blindness.

20- Top 5 health conditions for approved and refused applications by age groups for excessive demand clients

Top 5 Health Conditions by Age Groups (based on Application Final Assessment Date)	Application Final Assessment		Grand Total
	Approved	Refused	
0 to 18 Years of Age	174	2	176
Infantile Autism	82		82
Developmental Delay	36	1	37
Congenital Anomaly	20		20
Nervous System Disorder	10		10
Intellectual Disability	7		7
Other Conditions	19	1	20
19 to 39 Years of Age	116	9	125
HIV Positivity - Asymptomatic	47	1	48
Connective Tissue Disorder	30	1	31
Multiple Sclerosis	9		9
Renal Failure – Chronic	2	5	7
Nervous System Disorder	5	1	6
Other Conditions	23	1	24
40 to 64 Years of Age	62	12	74
HIV Positivity - Asymptomatic	27	1	28
Renal Failure - Chronic	3	9	12
Connective Tissue Disorder	10		10
Nervous System Disorder	3		3
Intellectual Disability	3		3
Other Conditions	16	2	18
65+ Years of Age	85	35	120
Senile Dementia	36	1	37
Renal Failure - Chronic	6	28	34
Cerebrovascular Disease - Ill-Defined	9	1	10
Osteoarthritis	6		6
Nervous System Disorder	5	1	6
Other Conditions	23	4	27
Grand Total	437	58	495

‡ Excluding Withdrawn applications

‡‡ Approved under the TPP, H&C and with a viable mitigation plan
‡‡‡ Refused on excessive demand grounds & other grounds of inadmissibility

IMPLEMENTATION OF THE TEMPORARY PUBLIC POLICY (TPP) & COSTS OVER FIVE YEARS

21- Application of the special program code "XSD" in GCMS for excessive demand clients

As per IRCC processing network instructions:

"Once the GCMS application has been updated to reflect the MHB assessment that the foreign national might reasonably be expected to cause excessive demand, the officer responsible for the application must apply the XSD special program code to the application".

Count of Client UCI Application Final Assessment and Outcome	Special Program Code		Grand Total
	XSD	Should have XSD	
Approved	356	81	437
Under TPP	337	81	418
H&C Grounds	15	--	15
Mitigation Plan	4	--	4
Refused	55	3	58
Excessive Demand Grounds	50	1	51
Other Grounds of Inadmissibility	5	2	7
Grand Total	411	84	495

22- Costs incurred and avoided to PTs over five years stratified by excessive demand finding (excluding costs for special education)

Application Final Assessment by Excessive Demand Finding	Count of Client UCIs	Sum of Costs INCURRED to PTs	Sum of Costs AVOIDED to PTs
Approved	437	$29,443,956	$431,893
Special Education	173	$74,350	--
Health	168	$16,153,640	$1,866,485
Social Services Other than Special Education	96	$28,194,515	$297,300
Refused	58	--	$19,698,297
Health	56	--	$19,476,882
Special Education	1	--	--
Social Services Other than Special Education	1	--	$221,415
Grand Total	495	$44,422,505	$21,862,082

‡ Excluding Withdrawn applications

‡‡ Approved under the TPP, H&C and with a viable mitigation plan

‡‡‡ Refused on excessive demand grounds & other grounds of inadmissibility