AN ETHICAL ANALYSIS OF THE MANDATORY EXCLUSION OF IMMIGRANTS WHO TEST HIV-POSITIVE

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I. Introduction

Should persons applying for immigrant status in Canada in order to improve their well-being or enhance their economic prospects be tested for HIV and refused permanent residence if they test positive? Should HIV-positive applicants automatically be excluded because they would be a threat to public health? Should they automatically be excluded on the presumption that they would cost Canadian society more than they could ever contribute?

Reactions to these questions can be sharp and uncompromising. Allowing HIV-positive immigrants into the country is perceived by some as a threat to public health: "To remove any screening procedures between Canada and the pool of infection south of the border or elsewhere (e.g., central Africa) is folly of the highest order and in nobody's best interests" (Parker 1990a: 525). It is claimed, furthermore, that providing care for HIV-infected immigrants would impose "severe strains on the taxpayer-funded health care system" (Parker 1990a: 525).

Endorsing these claims is politically tempting. Politicians who support HIV testing can be portrayed as actively defending the

interests of their constituents: "From the perspective of an uninformed and apprehensive public, for whom elected representatives want to be seen to be 'doing something,' screening seems an easy enough and necessary way by which to raise a barrier to the spread of disease and to protect the public purse" (Goodwin-Gill 1996: 64). Their support would court little political danger because those denied permanent residence would, of course, never vote.

Political expediency notwithstanding, how plausible are these claims? This is an important question, because HIV testing of immigrants could impose serious harms. Of greatest concern, perhaps, is that it would play upon and reinforce deep-seated fears and prejudices. It is easy to perceive immigrants as unlike "us" and to stereotype their beliefs, values, and behaviour. It is also easy to characterize HIV as a disease that is rampant among strange people with strange ways of life.[1] Discomfort with those who are perceived as different, and fear of a horrible disease, are a powerful combination and a powerful motivation for exclusion. Moreover, that stigmatization and rejection could spread to people with HIV who already live in Canada. The question is also timely because Citizenship and Immigration Minister Elinor Caplan recently announced that she accepts the public health rationale for HIV testing of immigrants. According to Minister Caplan, "The priority must always be what is in the public-health interests of Canadians" (Clark 2000: A4).

Given this setting and these dangers, proposals for HIV testing of immigrants require careful ethical scrutiny. Before proceeding to the arguments for and against testing, and mandatory exclusion of those who test positive, the legal situation in Canada will be quickly reviewed.

II. Canadian Law and Policy

Immigration law and policy in Canada are currently undergoing an extensive review, with the possibility of a major overhaul in the legislative framework. As one component of this review, Citizenship and Immigration Canada has sought advice from Health Canada about potential changes in the medical screening requirements of the immigration process. Currently, section 19 of the *Immigration Act* identifies as inadmissible on medical grounds:

> (a) persons who are suffering from any disease, disorder, disability or other health impairment as a result of the nature, severity or probable duration of which, in the opinion of a medical officer concurred in by at least one other medical officer,
>
> > (i) they are or are likely to be a danger to public health or to public safety, or
> >
> > (ii) their admission would cause or might reasonably be expected to cause excessive demands on health or social services....[2]

Thus, two distinct rationales exist for denying prospective immigrants admission on medical grounds, one related to public health and the other to public economy.

In 1994, then Minister of Immigration Sergio Marchi wrote to the Canadian AIDS Society that "persons living with HIV/AIDS do not generally represent a danger to the public under s. 19 of the *Immigration Act*" (cited in Jürgens 1998a: 199-200). According to Jürgens (1998a: 200), "This policy is still in place and is unlikely to change in the near future." But the current policy of the Canadian government, according to Jürgens (1998a: 200), is that people with HIV/AIDS would impose excessive demands on Canada's health and social service systems, and consequently "immigration applicants who are found to be HIV-positive are assessed as 'medically inadmissible' and will not normally be allowed to immigrate to Canada."

The medical and visa officers who determine medical admissibility exercise broad discretion in applying the "excessive demand" criterion, however, because "excessive demand" is not defined in the *Immigration Act.* A review of the medical inadmissibility provisions undertaken a decade ago by Employment and Immigration Canada (1991: 33, see generally 33-37) recognized the "ambiguity that surrounds the concept of excessive demand." Recent commentators have noted that "[t]his strange and otherwise undefinable phrase is ... left to haphazard and casual definition" (Rotenberg & Lam 1995: 4).

In sum, Canadian law does not explicitly bar immigrants because they are HIV-positive. But Canadian law does, *in theory*, authorize the exclusion of prospective immigrants who are HIV-positive, either because they pose a threat to public health or because their care and support would consume too many resources. Canadian

immigration policy, *in practice*, currently recognizes that HIV-positive immigrants do not represent a danger to public health, but it does allow that meeting their needs might impose an inordinate burden on Canada's health and social service systems and that their applications for permanent residence may be denied for that reason. Whether these positions are ethically defensible is examined in the sections that follow.

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III. Specific Arguments

1. For Mandatory Testing and Automatic Exclusion

i. Danger to Public Health or Safety

One of the reasons offered for screening prospective immigrants and barring those who test positive is a potential benefit to public health. A physician makes this point forcefully: "the threat of HIV infection to public health is at the core of the controversy [about testing immigrants], and it does not make much sense to me to deny that it exists" (Hall 1990: 172). If immigrants who test positive are not admitted to Canada, then obviously they cannot transmit HIV to people in the country. Would that not represent a substantial benefit to public health? The general answer to that question, which until recently has been accepted for purposes of Canadian immigration policy, is "no." In a report to British Columbia's Ministry of Health, the Special Advisory Committee on Ethical Issues in Health Care (1993: 1188) concluded: "The admission of immigrants who are HIV positive does not constitute a sufficient danger to public health to justify requiring applicants for immigration to undergo testing for HIV status and denying entry to those who test positive." How can this conclusion be defended?

Two lines of reasoning start from different premises but reach the same conclusion. The first begins with the concept of public health, which, as Somerville emphasizes, is not easy to define:

> [W]ho and what constitute a threat to public health[?] What is public health? How does this differ from the health of individuals? Do all infectious diseases constitute a risk to public health? If a risk is encountered in an occupational setting and that risk is an inherent part of that occupation, does it constitute a risk to public health or is it an occupational health risk?

> (1990: 172)

The notion of a "threat to public health" is commonly perceived to encompass a broad range of pathological conditions, including, for example, forms of environmental pollution (Somerville 1990: 173). A more precise sense of the term, the one used in public health protection legislation, limits it to controlling the spread of contagious diseases (Somerville 1990: 173).

When "public health" is understood in the narrower sense, the mere presence of HIV does not, Somerville argues, constitute a danger:

> I do not believe that this legislation should be interpreted as applying to people who are HIV antibody positive unless they engage in behaviour likely to transmit HIV. In such circumstances these people clearly are a threat to public health; in the absence of such behaviour they are not (1990: 173).

It is the possible behaviour of people living with HIV, and not the disease itself, that poses a threat to public health.

Somerville marshals evidence to demonstrate that, in both comparative terms and absolute terms, the threat to public health posed by the behaviour of immigrants is insignificant. She cites statistics (old but nonetheless illustrative) to show that, compared with visitors to Canada, the potential contribution of immigrants to the risk of spreading HIV is tiny:

> [I]f we were thinking about potential transmission hours (the total number of hours during which conduct that could result in HIV transmission is engaged in) and opportunities, such people [HIV antibody–positive immigrants] would constitute a minuscule proportion of the risk presented by the total number of people entering Canada each year. In 1987, 152 000 immigrants entered Canada, as compared with approximately 40 million visitors (1989: 890).

And she adds that one mode of transmitting HIV – casual sexual encounters – is much more likely with tourists and business travelers than it is with immigrants, "many of whom have families with young children and are seeking a new life, a home and work" (1989: 890).

The second line of argument begins by rejecting Somerville's focus

on behaviour that might constitute a threat to public health. The *Immigration Act*, in this view, does not require a medical officer to determine "*whether the exclusion of an individual applicant will in any way prevent the spread of a particular disease in Canada*" (Employment and Immigration Canada 1991: 45; emphasis in original). Consequently,

> the argument that screening immigrants ... for HIV/ AIDS will not prevent the spread of the disease in Canada, since an estimated 50 million short-term visitors enter the country each year untested, is irrelevant. Otherwise, by analogy, there would be no point in testing for any infectious disease, including active tuberculosis. *What the [Immigration] Act does demand is the medical officer's opinion on whether an individual applicant's medical condition is such that the applicant is likely to be a danger to public health. The distinction is important; the Immigration Act is not intended to stand for a Public Health Act* (Employment and Immigration Canada 1991: 45; emphasis in original).

The relevant comparison, therefore, is between HIV and other conditions that pose recognizable dangers to public health.

Tuberculosis is a disease for which mandatory testing is required and which, in its active state, renders an applicant temporarily inadmissible under the "danger to public health" provision of the *Immigration Act*. HIV is, like tuberculosis, a communicable disease, but HIV, unlike tuberculosis, is not an airborne disease, so it cannot be transmitted by so-called "casual contact." Given that difference, consistency does not require mandatory testing for HIV.

What about syphilis, however? Like HIV, syphilis is a communicable disease that is spread only through "high-risk" behavior. Testing for syphilis is mandatory, and in its infectious phase, syphilis also renders an applicant temporarily inadmissible. But HIV, unlike syphilis, cannot be cured; despite all the research and therapeutic advances, HIV remains a chronic condition. To bar applicants because they test HIV-positive would mean that they could never immigrate. The consequence of a positive test for syphilis is delay; the consequence of a positive test for HIV would be permanent exclusion. Given that difference, consistency does not require mandatory testing for HIV.

The real point about a communicable disease such as HIV,

however, is that it is not the mere presence of the disease that constitutes a danger to public health, but the possible behaviour of the person who has the disease:

> A person who is infected with the HIV virus is capable of infecting others and so such a person is *potentially* a threat to public health. *The real question is whether that person is "likely" to do so and, more importantly, whether the "risk" that the person will do so is sufficiently offset by public health education programs to consider such a person admissible under the Immigration Act* (Employment and Immigration Canada 1991: 46; emphasis in original).

That behaviour is, quite appropriately, located in its social context. HIV/AIDS already exists in Canada, and preventing the spread of the disease requires societal education about safe-sex precautions and individual adoption of those precautions.[3] The public health challenge is collective. The responsibility for prevention does not devolve to immigrants alone, so if immigrants were to transmit HIV to others, the responsibility for the spread of the disease would not be theirs alone. To refuse admission to immigrants solely because they test HIV-positive would be to deny society's collective responsibility for HIV/AIDS and to make immigrants scapegoats for society's failure to combat the disease more effectively.

ii. Excessive Demand for Health or Social Services

A seemingly more compelling reason for excluding immigrants who test positive is economic. Canada's health-care systems and social service networks appear to be financially strapped and incapable of meeting the needs of everyone who lives in the country now. How, then, can immigration policies that could impose an additional strain on these services be justified?

The *Immigration Act* recognizes this concern, but the criteria they provide are not very helpful. Medical and social services for people with HIV/AIDS are available and accessible in Canada (albeit with varying degrees of difficulty, depending upon where one lives), so that is not an issue. What about preventing or delaying the provision of services? Given the familiar phenomena of crowded waiting rooms and waiting lists, *any* use of health-care services could reasonably be expected to delay provision of those services to Canadian citizens or permanent residents. Every time someone makes an appointment with a family doctor and waits patiently to be seen, that person is delaying the provision of services to

everyone who has a subsequent booking. An immigrant also waiting to be seen by that family doctor would extend the delay. Does it thereby follow that admitting that immigrant causes an "excessive demand" on Canada's health-care system?

Part of the problem is that "excessive demand" has not been clearly defined in connection with medical inadmissibility, and perhaps cannot be defined with the requisite precision.[4] The *Medical Officer's Handbook* (Health and Welfare Canada 1992: 3-6) states that:

> The responsibility of the Medical Officer then is:
>
> First, to identify and appraise those medical conditions which will now, or in the foreseeable future, place a *substantial* demand on medical services; and
>
> Second, to arrive at a judgement as to whether or not that demand should be considered "*excessive*."
>
> Again, this cannot be done on a precise, statistical basis. The Medical Officer's recommendation must rest on his knowledge of the natural history of the disease or disorder with and without treatment and in relation to age, sex and other aspects of the individual's physical and mental make-up.

Data about the utilization of health services by immigrants as a class do not exist, but even if they did, that information would not be sufficient for making assessments about "excessive demand," for two reasons.

First, the criteria for acceptance as an immigrant – and to some extent for acceptance as a refugee – are designed to ensure that the individuals admitted will make financial contributions to Canadian society through taxes and premiums, in addition to making claims on tax-supported services. Determinations of "excessive demand" therefore require a comparison of potential benefits and costs. Moreover – and this is the second reason – that comparative judgment must be made on an individual, not a class, basis. The relevant issue is whether *this particular* immigrant would contribute more than he or she would cost. Somerville picks up on this point:

> [W]ould an immigrant whose net contribution to the gross national product has outweighed any health care

> cost that that person engendered constitute an excessive cost to the Canadian health care system? An immigrant, who may be more productive than the average person, could contribute more in 5 years of work within Canada than that person could cost, even if he or she were to become ill and die of HIV-related disease. Would this net benefit to the Canadian economy mean that such a person should not be considered an excessive cost to the health care system? Therefore, should people with at least a 5-year life expectancy not be regarded as inadmissible as immigrants on medical grounds? (1989: 891)

Because any judgment about "excessive demand" would have to be comparative and individualized, that criterion could not justify the automatic exclusion of a prospective immigrant who tested positive.

Moreover, making "excessive demand" judgments on a comparative, individualized basis raises worries about the fairness of those judgments. The criterion assumes that there is some projected cost for the use of health-care services that is acceptable, ie, not "excessive," and that applicants who are likely to exceed that acceptable level may be excluded. Would that criterion be applied neutrally?

> Presumably, this [test] applies whether the potential candidate is a Nobel laureate, a construction worker, or a billionaire; an open question is whether a rich person who could create tax revenues in excess of projected health costs should be more welcome than the Nobel laureate or the construction worker.... [5]

The problem is exacerbated by the sweeping discretion accorded medical officers and visa officers. Without standardized procedures to assess medical inadmissibility and determinate criteria to appraise "excessive demands," their decisions will inevitably be inconsistent and thus inequitable. And prospective immigrants will have no redress.

Although the financial pressures being exerted on Canada's health-care systems make every avenue for controlling costs appealing, it is not clear how or whether those pressures would be eased by barring prospective immigrants who are HIV-positive. Precise data are difficult to obtain, and estimates depend upon a host of assumptions. A cost–benefit analysis of immigrants to Canada in 1988 calculated the net benefits of testing in the decade after

immigration to be between $1.7 and $13.7 million (Zowall et al 1990). That estimate must be put in context, however. The overall demand for health-care services in Canada is driven by much bigger and more powerful forces, including: the aging of the population; the ever-expanding array of expensive pharmaceutical and technological interventions; the failure of health promotion efforts to have significant impacts on behaviour such as smoking; and the expectations of public and health-care professionals. Genuine attempts to address the perceived health-care crisis should be directed at those forces, and not deflected by worries about the "excessive demand" that immigrants might impose on health-care services.

iii. Conclusions

Being HIV-positive is not in itself a threat to public health: the spread of HIV is a result of the joint behaviour of the person from whom HIV is transmitted and the person to whom HIV is transmitted. For that reason, prospective immigrants who are HIV-positive should not be automatically excluded on the ground that they represent a danger to public health.

The notion of "excessive demand" is deceptively simple and deceptively plausible. Attempts to give it specific content and to apply it to decisions about the medical admissibility of prospective immigrants reveal, however, that it is rife with ethical problems. In the absence of compelling evidence about the contribution of HIV-positive immigrants collectively to the costs of health and social services and the likely cost of caring for individual immigrants who are HIV-positive, and in the absence of clearly defined procedures and criteria for assessing "excessive demand," prospective immigrants who are HIV-positive should not be automatically excluded on this ground.

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2. Against Testing

i. Stigmatization

Widely accepted principles of law and bioethics require that HIV testing in Canada be conducted entirely on a voluntary basis, that is, only with the specific voluntary and informed consent of the person being tested (see, eg, Jürgens, 1998a). To institute mandatory testing for immigrants would be to single them out and

treat them differently, and that special treatment would stigmatize them as people who are particularly dangerous, particularly irresponsible, or both. Treating them differently could play into and exacerbate existing prejudices and fears:

Sweden's ombudsman on ethnic discrimination found that citizens opposed to immigrants in general usually cloaked their prejudice by expressing it as a fear that immigrants might have some terrible, unknown disease that would be passed on to the citizens' children. AIDS has given an identifiable substance to these fears, but such prejudices should not be encouraged or given symbolic confirmation through implementation of mandatory HIV antibody testing (Somerville 1989: 893).

Moreover, that stigmatization could spread. As Galloway (1994: 161) points out in discussing the impacts of Canadian immigration law on Canadian residents: "The official exercise of prejudice against those who share the same personal characteristic will have indirect repercussions for those who, while not being subject to the specific law, are subject to the authority of the same law-maker." Given that people with HIV/AIDS continue to suffer stigmatization and discrimination that are debilitating to them and those around them, there is no reason to invite a backlash.

ii. Potential Harm to Applicants

HIV testing done in foreign countries to provide the medical documentation necessary to support an application for landing might not meet the standards required in Canada. The tests may not be as accurate, and counseling about the nature of the testing and the implications of the results could be absent or inadequate. Those being tested might not be told about the possibility of false positive results. Subsequent tests to confirm preliminary positive results might even be unavailable. In these circumstances, not only would some uninfected persons be unfairly denied entry without any means of rectifying such a serious error (Gostin et al 1990: 1745); they also could end up living with, and making decisions on the basis of, the false belief that they are HIV-positive.

In addition, people who lived in countries with harsh, coercive, or punitive policies on HIV/AIDS and who wanted to come to Canada would have to make a difficult decision. They "would be forced to choose between losing any opportunity to do this and taking a risk of what could happen to them in their country of origin if they were rejected as immigrants on the basis of HIV antibody positivity" (Somerville 1989: 893). They could pay a high price in

their countries of origin for their dream of a better life in Canada.

iii. Conclusions

In the absence of specific voluntary and informed consent to testing, high standards of accuracy and quality in testing, and adequate counseling before and after testing, HIV testing in Canada would not be ethically or legally acceptable. To subject potential immigrants to testing of a caliber lower than that required in Canada would deny their moral equality and expose them to risks and harms that are unacceptable and certainly not justified in terms of protecting this country's public purse.

3. Against Automatic Exclusion of Persons Who Test Positive

i. Parity With Other Diseases

With respect to the criterion of "excessive demand" on health or social services, how different is HIV-positive status from other medical conditions? This is an important question to ask, but apparently only one attempt has been made to answer it rigorously (Zowall et al 1992). The objective of this study was to compare the direct health-care costs of illnesses associated with HIV and coronary heart disease (CHD) in immigrants to Canada. As the authors of the study note, the potential economic burden of a disease on the health-care system cannot be determined by examining that disease in isolation. Rather, the economic burden of the disease "must be compared with that of other prevalent diseases (for which immigrants may or may not be currently screened) to develop a policy that is rational, practical and fair" (Zowall et al 1992: 1164). This comparison of HIV and CHD concluded that

> there are some economic savings to the health care system associated with mandatory HIV antibody screening of immigrants to Canada. However, HIV infection is not the only condition that imposes a financial burden. The impact of CHD, in terms of both the number of people affected and the associated health care costs, would be at least equal to the impact of HIV infection (Zowall et al 1992: 1170).

The list of potentially costly medical conditions and risk factors for future illness, such as tobacco consumption (Angus 1992: 1132) and over-use of alcohol, could easily be extended. Consistency and fairness demand that they be treated in the same way: "It is inequitable ... to use cost as a reason to exclude people infected with HIV, for there are no similar exclusionary policies for those with other costly chronic diseases, such as heart disease or cancer" (Gostin et al 1990: 1746). Jürgens (1998a: 207), going further still, asks:

> Should we hold persons of over 50 years of age medically inadmissible because they are unlikely to contribute significantly to Canadian society in monetary terms, but are likely to need costly health care relatively soon after immigrating to Canada? Should we screen for genetic disorders?

Such questions are not mere rhetorical devices; ethics, law, and public policy must take them seriously.

ii. A Slippery Slope to Genetic Testing

If mandatory HIV testing of immigrants were introduced, and if parity with other diseases were accepted, the slide down an ethically problematic slippery slope could be impossible to stop. The internationally funded and conducted Human Genome Project, which will map the entire human genome, is well ahead of schedule. One outcome of all the genetic information being produced will be the equally rapid development of an extensive set of genetic screening tools. The ability of medical science to identify individuals who are more likely than the population as a whole to develop serious or lethal diseases will be enormously enhanced. It is already possible to identify carriers of a limited number of hereditary conditions, to determine the probability of transmission to offspring, and (in a much smaller number of cases) to screen for individual susceptibility. Testing for Huntington's disease is an example of the latter category. The recent commercialization of a test for the BRCA1 mutation, which confers high hereditary susceptibility to breast cancer, is almost certainly a harbinger of a much broader range of genetic tests.

Would the "excessive demand" criterion justify expanding the medical screening of immigrants to include such tests? How might that criterion be interpreted as more and more tests become readily available? What apprehensions about the medical costs of treating the offspring of prospective immigrants who are carriers of a

particular condition might lead to blanket exclusions? Are we comfortable with a future in which, for example, prospective immigrants at high hereditary risk for breast cancer would be excluded based on the "excessive demand" criterion? After all, prospective immigrants are not our compatriots, and it is easy to imagine the subtle and covert introduction of "biological fitness" as a de facto test for admission to Canada.

iii. Objectification

Somerville and Wilson (1998: 831; see also Somerville 1989: 891) note that applying the "excessive demand" criterion for exclusion might

> indicate an unacceptable attitude toward migrants as persons – in that it views them only in terms of the economic benefit they offer. In addition, it places only a monetary value on their worth – in that it states that they do not merit the cost they would present to society.

The eighteenth-century philosopher Immanuel Kant (1949[1785]: 51) emphasized that the moral status of persons gives them dignity, not value: "Whatever has a value can be replaced by something else which is *equivalent*; whatever, on the other hand, is above all value, and therefore admits of no equivalent, has a dignity" [emphasis in original]. Kant (1949[1785]: 50) argues that persons are rational beings, and that means that they must always treat themselves and others "*never merely as means*, but in every case *at the same time as ends in themselves*" [emphasis in original]. And for Kant (1949[1785]: 51), possessing intrinsic worth, or dignity, is "the condition under which alone anything can be an end in itself...." In this view, regarding prospective immigrants solely in economic terms and therefore as potentially substitutable (eg, an applicant with a medical condition that could be expensive to manage can be replaced by a more cost-effective one who does not have such a condition) denies them their inherent moral dignity and status as persons.

iv. Conclusions

These concerns and dangers strengthen the ethical case against mandatory HIV screening of prospective immigrants, and the automatic exclusion of those who test positive. But they also point to a deeper, more insidious conflict. People can be readily regarded as means and as having value because ethics always has trouble

competing with economics. Money and what it can buy are real, tangible, and immediate. Ethical values, in contrast, can appear diffuse, intangible, and remote. The contest hardly seems fair.

For that reason, it is particularly important to identify the presumptions, both about the way the world works and the way it should work, that frame public policies and are embedded in them, often without being explicitly recognized (Schrecker & Somerville, 1998: 120-122). What conceptual commitments lie behind standards, rules, policies, and operational procedures? On what grounds are they justified? With reference to what basic values and priorities? And what rules are defined by the exceptions?

Such questions are crucial to the recognition and defence of emerging international norms incorporating human rights. With respect to immigrants, most nations begin with "a general presumption of exclusion, unless certain conditions are met" (Somerville & Wilson, 1998: 825). Somerville, though, makes a case for the ethical values that a policy of not testing immigrants would promote:

> Canada could provide an important, indeed critical, example to the rest of the world if it is prepared to state that the potential costs, in economic terms, to care for people admitted as immigrants who later develop HIV-related illness are more than compensated for by the values – humaneness, humanitarian concern and respect for human rights – that we wish to uphold in *choosing* not to test asymptomatic prospective immigrants for HIV antibodies (1989: 894).

Somerville's exhortation does exactly what morality is supposed to do: get people to go beyond self-interest. One may reject the call to think in more than dollars and cents, but that rejection should be seen for what it is – a dismissal of the very claims of morality.

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IV. Conclusions and Recommendations

Restrictions on immigration for reasons of medical inadmissibility must be carefully identified and solidly justified, and the evidence for them must be clear and compelling. It is too easy, in the absence of convincing arguments and firm data, to inflate fears and exaggerate dangers. The burden of proof, therefore, is on those

who want automatically to exclude immigrants who test HIV-positive in the interest of either public health or public economy.

With respect to public health, it has been accepted in Canada that that burden cannot be met. Because this position is ethically sound, we make the following recommendations.

1. The policy and practice of not deeming prospective immigrants who test HIV-positive medically inadmissible on the grounds that they represent a danger to public health should continue in Canada.

   With respect to public economy, the burden of proof might be seen to be met: providing health and social services to immigrants who are HIV-positive could be perceived as so costly as to warrant exclusion. Given the preceding analysis, this possibility must be circumscribed and developed along the lines set out in the following three recommendations.

2. The criteria for determining medical inadmissibility must not be formulated with respect to any single disease or condition:

   [W]hat is ultimately required is *not* a discrete approach to HIV/AIDS or any other disease. This would be a step backward. What is required is a set of criteria that can be applied consistently to all dangerous, communicable diseases (Employment and Immigration Canada 1991: 46; emphasis in original).

   Policies that appear to treat people with HIV/AIDS more favourably than people with similarly serious diseases inevitably encounter the charge of "AIDS exceptionalism" (Burris 1994; Slater 2000). A policy that treated people with HIV/AIDS less favourably than similarly serious diseases would be a reverse form of AIDS exceptionalism. The motivation for the kinds of policies that initially attracted this charge was to ensure that people with HIV/AIDS were treated humanely and were not discriminated against. That approach should also prevail with respect to immigration.

   The United Nations International Guidelines on HIV/AIDS and Human Rights note:

   Where states prohibit people living with HIV/AIDS from

longer-term residency due to concerns about economic costs, States should not single out HIV/AIDS, as opposed to comparable conditions, for such treatment and should establish that such costs would indeed be incurred in the case of the individual alien seeking residency. In considering entry applications, humanitarian concerns, such as family reunification and the need for asylum, should outweigh economic considerations (UNHCHR/UNAIDS, 1998: para 106).

Excluding prospective immigrants who are HIV-positive for economic reasons is not defensible unless analogous requirements are in place for other conditions such as cardiovascular disease, and unless anticipated future costs are assessed in a comparable way and on a comparably individualized basis.

3. Decisions about the medical inadmissibility of applicants for immigrant status should be made on an individualized, contextualized basis. Decision-making procedures that are equitable, flexible, and sensitive to changing medical and social conditions display the moral concern and respect that is owed to everyone.

4. Were the two preceding recommendations to be implemented, determinations of medical inadmissibility could in principle be made on economic grounds. The "excessive demands" criterion is, however, too conceptually thin and too ethically problematic to be the basis of such determinations. It would need to be replaced with an approach that rigorously measures the economic impact of the medical disease or condition in question, that provides substantive guidance to medical officers and visa officers, and that operates neutrally and consistently for all prospective immigrants.

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Bibliography

Angus, Douglas E. 1992. Can We Afford to Screen Immigrants for HIV Infection? *Canadian Medical Association Journal* 147: 1132.

Burris, Scott. 1994. Public Health, "AIDS Exceptionalism" and the Law. *John Marshall Law Review* 24: 251-272.

Citizenship and Immigration Canada. 1996. Assessment of Medical Excessive Demands, IP 96-08/OP 96-05 [memorandum]. Ottawa: author.

Citizenship and Immigration Canada. 1998. *Building on a Strong Foundation for the 21st Century: New Directions for Immigration and Refugee Policy and Legislation.* Ottawa: Public Works and Government Services Canada.

Clark, Campbell. 2000. Immigrants Facing Blood Tests. *Globe and Mail* (September 21): A4.

Employment and Immigration Canada. 1991. *Medical Inadmissibility Review: Discussion Paper*. Ottawa: author.

Galloway, Donald. 1994. Strangers and Members: Equality in an Immigration Setting. *Canadian Journal of Law and Jurisprudence* 7: 149-172.

Galloway, Donald. 1997. *Immigration Law*, Essentials of Canadian Law series. Concord, Ontario: Irwin Law.

Goodwin-Gill, Guy. 1996. AIDS and HIV, Migrants and Refugees: International Legal and Human Rights Dimensions. Pp. 50-69 in M. Haour-Knipe and R. Rector, eds., *Crossing Borders: Migration, Ethnicity and AIDS*. London: Taylor & Francis.

Gostin, Larry O.; Cleary, Paul D.; Mayer, Kenneth H.; Brandt, Allan M.; Chittenden, Eva H. 1990. Screening Immigrants and International Travelers for the Human Immunodeficiency Virus. *New England Journal of Medicine* 322: 1743-1746.

Green, Jeffrey H. 1993. Should Immigrants Be Screened? [letter] *Canadian Medical Association Journal* 148: 2107.

Hall, Philip F. 1990. The Case Against HIV Antibody Testing of Refugees and Immigrants [letter]. *Canadian Medical Association*

Journal 143: 172.

Health and Welfare Canada. 1992. *Medical Officer's Handbook: Immigration Medical Service*. Ottawa: Medical Services Branch, Health and Welfare Canada, December.

Jürgens, Ralf. 1998. *HIV Testing and Confidentiality: Final Report*. Montréal: Canadian HIV/AIDS Legal Network and Canadian AIDS Society.

Kant, Immanuel. 1949[1785]. *Fundamental Principles of the Metaphysic of Morals*. Thomas K. Abbott, trans. Indianapolis, IN: Bobbs-Merrill Company.

Rotenberg, Cecil L.; Lam, Mary. 1995. Annotation [of *Ismaili v. Canada*]. 29 *Immigration Law Reporter* (2d series): 2-7.

Sabatier, Renée. 1996. Migrants and AIDS: Themes of Vulnerability and Resistance. Pp. 86-101 in M. Haour-Knipe and R. Rector, eds., *Crossing Borders: Migration, Ethnicity and AIDS*. London: Taylor & Francis.

Schrecker, Ted; Somerville, Margaret A. 1998. Making Ethically Acceptable Policy Decisions: Challenges Facing the Federal Government. Pp. 69-133 in *Renewal of the Canadian Biotechnology Strategy, Resource Document 3.4.1, Background Research Papers, Ethics*. Ottawa: Industry Canada, March; http://strategis.ic.gc.ca/SSG/bh00195e.html.

Slater, Eric. 2000. AIDS Exceptionalism is No Longer Justifiable. Pp. 362-367 in R. Munson, ed., *Intervention and Reflection: Basic Issues in Medical Ethics*, 6th edition. Belmont, CA: Wadsworth.

Somerville, Margaret A. 1989. The Case Against HIV Antibody Testing of Refugees and Immigrants. *Canadian Medical Association Journal* 141 (November 1): 889-894.

Somerville, Margaret A. 1990. Dr. Somerville responds [to Hall, 1990]. *Canadian Medical Association Journal* 143: 172-173.

Somerville, Margaret A., Wilson, Sarah. 1998. Crossing Boundaries: Travel, Immigration, Human Rights and AIDS. *McGill Law Journal* 43: 781-834.

Special Advisory Committee on Ethical Issues in Health Care. 1993. It is Ethically Defensible to Test Potential Immigrants for HIV, BC Committee Says (Newsbriefs). *Canadian Medical Association Journal* 148 (April 1): 1188.

United Nations High Commissioner for Human Rights and Joint United Nations Programme on HIV/AIDS (UNHCHR/UNAIDS). 1998. *HIV/AIDS and Human Rights: International Guidelines*, HR/PUB/98/1. Geneva: United Nations.

Watney, Simon. 1990. Missionary Positions: AIDS, Africa, and Race. Pp. 89-106 in R. Ferguson, M. Gever, T.T. Minh-ha and C. West, eds. *Out There: Marginalization and Contemporary Cultures*. Cambridge, MA: MIT Press.

Wilson, Sarah. 1994. Recent Developments in Immigration Law. *Canadian HIV/AIDS Policy & Law Newsletter* 1,1 (October): 9-10.

Wilson, Sarah. 1995. HIV-Positive Refugee Admitted to Canada. *Canadian HIV/AIDS Policy & Law Newsletter* 1,3 (April): 5.

Zowall, Hanna; Fraser, Rod D.; Gilmore, Norbert; Deutsch, Antal; Grover, Steven. 1990. HIV Antibody Screening Among Immigrants: A Cost-Benefit Analysis. *Canadian Medical Association Journal* 143: 101-107.

Zowall, Hanna; Coupal, Louis; Fraser, Rod D.; Gilmore, Norbert; Deutsch, Antal; Grover, Steven A. 1992. Economic Impact of HIV Infection and Coronary Heart Disease in Immigrants to Canada. *Canadian Medical Association Journal* 147: 1163-1172.

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Endnotes

1. This is pointed out by Watney 1990 and Sabatier 1996, among many others.

2. Section 19.

3. For one physician, it also entails paternalistic state action: "We have an obligation to protect the weaker people in our society who are not sufficiently prudent or conscientious to follow guidelines to protect themselves" (Green 1993).

4. Draft regulations once tried to clarify the notion of "excessive demands" by directing Medical Officers to "bear in mind that excessive demands are caused when the total costs of health and any required prescribed social services, in the five years immediately following assessment, exceed by more than five times the average per capita expenditures for health and social services in Canada" (*Canada Gazette*, Part I, Vol 127, no 33 at 2561). For a critical assessment of this proposal, see Wilson 1994.

5. This quotation comes from the submission of the Canadian Liver Foundation and the Canadian Association for the Study of the Liver to the Medical Inadmissibility Review. Employment and Immigration Canada, "Summaries of Submissions Received from Non-Governmental Organizations," 1991: 20.

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