RIGHT TO HEALTH OF NEWCOMERS TO CANADA.
REFLECTIONS IN THE LIGHT OF A COMPARISON WITH ITALY

Viviana Molaschi

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1. SOME PRELIMINARY REMARKS.

Migration and population mobility are part of human history: people have been migrating or moving since the earliest of times. However, this phenomenon has increased in the last few decades, also thanks to globalization. Among the factors that have influenced this trend, wars, political instability, violation of human rights and economic crises play a fundamental role. The impact of climate changes must also be underlined.

The growth of migratory flows, together with the changes in immigration demographics and trends, puts stress upon the social welfare and health care systems of the various host countries.

In the past, the main focus of research and policy-making on migrant health was the threat of “importing” diseases, carried by migrants; today, although the risks of contagious diseases have not to be underestimated, the emphasis is on a different health perspective, that considers the well being of migrants themselves and, above all, their right to health. In 2008, the World Health Assembly adopted a Resolution on the “health of migrants”\(^1\), calling on Member States to explore options and approaches to improve the health of migrant populations.

The aim of this article consists in analysing and describing, from a critical point of view, the safeguard level of the right to health granted by the Canadian health care system to newcomers to Canada\(^2\).

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To this end, for Canadian health care system is meant the whole of the services supplied or sustained by any level of government (Federal, Provincial or Territorial). A health system is “the ensemble of all public and private organizations, institutions and resources mandated to improve, maintain or restore health”\(^3\). The term newcomers refers to permanent and temporary residents, refugee claimants and other protected persons. People without legal status will be also taken into consideration.

In particular, this paper will give an overview of the different categories of newcomers and of their corresponding legal entitlements to health services\(^4\).

To understand the extent of the study, it can be useful to recall the distinction between the concept of “access” and the one of “accessibility” or “usability”\(^5\). The former depends mostly on the structure and the completeness of the juridical system, while the latter is related to elements of fact. The analysis of the problems emerging from social, economic, cultural and linguistic barriers is beyond the scope of this work, which will be focused on the juridical regulation.

Finally, the research approach will be comparative: this article will compare briefly the Canadian system of migrant health protection with the safeguard of the right to health of foreigners granted by the Italian

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National Health Care System. It will investigate some of the reasons which, from an Italian perspective, could be at the basis of the distinctions between the two health systems in facing the issue of migrant health⁶.

2. Newcomers’ health between Provincial, Territorial and Federal Jurisdictions

Addressing the topic of newcomers’ health protection in Canada meets some difficulties due to the intersection of Provincial, Territorial and Federal legislative powers, which is not always perspicuous. Two are the fields involved in this theme: health care and migrant regulation and for both of them there is an intertwining of competences, particularly remarkable for health.

As to the architecture of the jurisdictions on migration phenomena in general, there are two important provisions of the Constitution Act (1867), which come into consideration.

First of all section 95, which establishes a concurrent power on “Immigration”⁷. Concurrent legislative powers are not common in the Canadian Constitution. Section 95 provides them only for “Immigration” and “Agriculture”. The link between the two subject matters, apparently unusual, can be understood thinking of Canadian history. When the Constitution Act was enacted, in 1867, the economy was mainly agricultural.

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⁶ Migrant health in Canada has been studied in the perspective of a comparison with France by Mbaye, E., “L’action publique intersectorielle entre politiques d’immigration et de lutte contre le sida en France et au Canada”, forthcoming, which focuses the attention on how the public policies of the two countries face the common problem of migrants living with Hiv/Aids.

and migrants who settled in Canada, spreading their farms, played an important role in it. Cooperation between the Federal and Provincial levels was necessary to legislate on their admission and settlement in this economic context.

The regulation of migration into Canada is represented by the *Immigration and Refugee Protection Act* (2001), known as IRPA, a Federal piece of legislation.

The concurrent power is structured so that any Law of the Legislature of a Province concerning migration “shall have effect in and for the Province as long and as far only as it is not repugnant to any Act of the Parliament of Canada”. Consequently, no Province regulates flows across the international border, an intervention that would be “repugnant” to the Act. A source of Federal legislative power over migrants is section 91(25), according to which the Federal legislator deals with “Naturalization and aliens”.

It is not easy to distinguish the latter subject matter, which is exclusively Federal, from “Immigration”, which, as we have seen, is concurrent.

Generally speaking, the procedures of admitting foreign nationals to Canada fall within the concurrent power over “Immigration”, with the limits underlined above for the Provincial Legislatures; while regulation of their rights and duties after admission pertains to the subject matter “Naturalization and aliens”.

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8 On this subject matter see Hogg, P.W., *supra* note 7, chapter 26.2.
9 On this distinction see Hogg P.W. *supra* note 7, chapter 26.2.
Health is not assigned by the Constitution Act (1867) either to the Federal or Provincial legislative authority. However, from sections 91 and 92 of the Act it is possible to hold that the Provincial competences are very wide. According to section 92(7) of the Constitution Act (1867), the Provincial Legislature may make laws in relation to “the Establishment, Maintenance, and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the Province, other than Marine Hospitals”. Marine hospitals are expressly excluded because they are in the list of the subject matters which belong to the authority of the Parliament of Canada, ex section 91(11).

Provincial jurisdiction finds grounds also in other provisions, which are more general, but are considered applicable also to the health field.

Among them we must recall section 92(16), which assigns to the Legislature of the Provinces “Generally all Matters of a merely local or private Nature in the Province”. On the basis of this provision the regulation of the compulsory apprehension, assessment and treatment of persons suffering from mental disorders or of drug addicts has been ascribed to Provincial power.

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12 R. v. Lenart [1998] 39 O.R. (3d) 55 (C.A.). Hogg, P.W., supra note 11, chapter 32-2, observes that even if the Court was not clear about which head of power authorized the legislation, section 92(16) is the evident one.

Section 92(13) gives Provinces the legislative competence on “Property and Civil Rights”, which comprises property, contracts, and tort. This provision is considered one of the pillars of Provincial power over health, because, if it is interpreted extensively, it can include the regulation of health insurance – both private and public –, employment-related health benefits, occupational health and safety requirements and health care professions.\(^{14}\)

For what concerns the Territories, pursuant to section 4 of the Constitution Act (1871), known as British North America Act, Parliament has legislative jurisdiction over them; however the Federal government has delegated the Territories wide powers in most of the matters assigned to Provincial jurisdiction according to section 92 of the Constitution Act (1867).\(^{15}\)

As to the Federal level, the power of Parliament, established by the opening words of section 91, of making laws “for the Peace, Order, and good Government of Canada, in relation to all Matters not coming within the Classes of Subjects by this Act assigned exclusively to the Legislatures of the Provinces” (POGG) allows Federal Legislature on public health issues\(^{16}\) having national dimensions\(^{17}\) and, in particular, dealing with emergencies: this is the case of epidemics.\(^{18}\)

This subject matter has a link with section 91(11), which assigns to the Canadian Parliament the legislative power on “Quarantine and the

\(^{14}\)This article covers also drug regulation and food standards, including the preparation and provision of food and drink in restaurants and bars.

\(^{15}\)See Jackman, M., supra note 11, at 116.

\(^{16}\)Safety of the public is also protected through the criminal law power: see infra.

\(^{17}\)The provision of the Federal power “for the Peace, Order, and good Government of Canada” is the “national equivalent” of the Provincial legislative authority on “Generally all Matters of a merely local or private Nature in the Province”, which, in any case, allows Provinces to legislate on some issues, having local dimensions, related to public health.

Establishment and Maintenance of Marine Hospitals”. Marine hospitals were created for the inspection and treatment of migrants arriving by sea. Their connection with immigration is at the basis of their allocation under the Federal authority.

Public health issues are implied by migrant flows. From this point of view, it must be underlined that among the goals of the Immigration and Refugee Protection Act (2001), enumerated by section 3(2), there is “to protect the health and safety of Canadians”\(^{19}\) (lett. g).

Moreover, it is noteworthy that the Federal Parliament has the power to legislate on some classes of individuals: veterans (s. 91(7))\(^{20}\), aboriginal people (s. 91(24)), and, as has been seen, immigrants (s. 91(25))\(^{21}\): as clarified by scholars\(^{22}\), this implies that, together with the Provinces, it extends its authority over their health.

A fundamental tool which allows the Federal intervention in the health care field is the so-called “spending power”\(^{23}\).

This Federal power is not explicitly established in the Constitution Act (1867), but it can be inferred by the Federal competence on the levy system, according to section 91(3), and on the Federal power to make laws on “Public property”, ex section 91(1A), and to appropriate Federal funds for the public service, in virtue of section 106.

Funds raised by Federal taxes can be used for activities which fall within the Provincial legislative authority. In this case Parliament is allowed to

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\(^{19}\) Other than “the security of Canadian society”.

\(^{20}\) Section 91(7) refers explicitly to “Militia, Military and Naval Service, and Defence”.

\(^{21}\) Section 91(25) confers the Parliament the power to make laws on “Naturalization and Aliens”.

\(^{22}\) See Hogg, P.W., supra note 11, 32-2.

\(^{23}\) Hogg, P.W., supra note 11, 6.8.
impose conditions on the Federal grants to Provinces, even if the subject matter is not ascribable to the Federal power.

The typical example of this mechanism is Medicare, Canada’s publicly funded universal health insurance, under which Provinces guarantee hospital and physicians’ services to their residents.

The terms of this programme are established in the Canada Health Act (1985), which sets the standards that Provincial health care plans must respect in order to obtain the Federal contributions. In particular, five criteria must be satisfied: public administration; comprehensiveness; universality; portability and accessibility.

For the sake of completeness, it must be remembered that there are two other Federal competences relevant in the health field, even if they are not specifically connected with jurisdiction over migrant health.

The first one is “Criminal law”, according to section 91(27): the Federal legislator can enact laws to regulate or punish behaviours which are dangerous to health. Take, for example, the use of narcotics, tobacco and the regulation of food safety and hazardous products. Moreover, criminal law is strictly related to the right to health, especially in ethically sensitive matters: in the past, for instance, abortion was prohibited by the Criminal code, until when this prohibition was declared unconstitutional by the Supreme Court of Canada. The Assisted Human Reproduction Act can be partly considered a valid exercise of the Federal criminal law power, even if the regulation of clinical uses of assisted reproductive technologies and

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related research activities exceed, in whole or in part, the legislative authority of the Parliament of Canada. The second competence is “Patents of Invention and Discovery”, which comprises the regulation of pharmaceutical patents.

In short, running through the health-related provisions of sections 91 and 92 of the Constitution Act (1867), it can be drawn that health protection of migrants sees an important role of the Provincial legislature, based fundamentally on section 92(7) – let us think of hospital-based health care services – and 92(13), significant because of the regulation of health insurance and professionals.

However, there are also grounds for the Federal intervention: the Federal role can be connected to the Federal subject matter “Naturalization and aliens”, ex section 91(25), to the concurrent power on “Immigration”, according to section 95, in the terms illustrated above, and to the POGG clause of section 91.

The main Federal act targeted at safeguarding the health of foreigners is the Interim Federal Health Program (IFHP), regarding mostly refugee claimants and other categories of protected persons in situations of severe economic hardship. It was instituted by the Order in Council 1957 – 11/848 of June 20, 1957, on the basis – it appears – of the Immigration Act (1952), in force in that period.

As it will be seen in the following pages, the Order has been recently repealed and substituted by the new Order Respecting the Interim Federal Health Program of April 5, 2012, which came into force on June 30, 2012.

3. Health Protection of Permanent and Temporary Residents

The first group of newcomers whose entitlement to health services is taken into consideration in this paragraph are permanent residents, individuals who have been admitted to Canada for permanent residence. They have the same access to health care as Canadian citizens. However, in some Provinces, such as Ontario, British Columbia, Quebec, new residents, with some exceptions, must generally wait up to three months before they become eligible for Provincial health insurance. Generally the month of arrival counts as the first month. Refugees selected abroad are eligible for permanent resident status after their entry in Canada. If there is a delay in getting this status, they can obtain temporary resident status and health benefits through the Interim Federal Health Program (IFHP).

The category of temporary residents comprises essentially foreign workers, international students and visitors. As to temporary foreign workers (TFWs), it is important to clarify that, like all workers in Canada, they are covered by workers’ compensation schemes in case of employment injuries or illnesses. This kind of health

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30 As to the exceptions, for instance, in Quebec women who are pregnant or victims of rape during the waiting period can access medical services free of charge.
31 For an overview of the Temporary Foreign Workers Program (TFWP) and on the ways through which foreign nationals can work in Canada on a temporary basis (Lower Skilled Occupations, Higher Skilled Occupations, Agricultural Workers, Live-in Caregivers) see the information given by Human Resources and Skills Development Canada (HRSDC)/Service Canada, on http://www.hrsdc.gc.ca/eng/jobs/foreign_workers/.
32 On this topic see, in general, Sikka, A., Lippel, K., and Hanley, J. “Access to Health Care and
care insurance, financed by employers, was one of the first social programs in Canadian Provinces\textsuperscript{33}. However, in these cases, the coverage concerns work-related health problems, a topic beyond the scope of this paper, which is focused on health care needs that do not depend on a job activity. Most Provincial or Territorial governments grant temporary foreign workers health insurance if they have long work permits (from six to twelve months)\textsuperscript{34}, while in case of shorter term permits workers have to provide themselves with health insurance, even if quite often the employers pay for it.

In any case, some foreign worker programs provide specific guarantees: for instance, in some jurisdictions, like Ontario and Quebec, TFWs included in the Seasonal Agricultural Worker Program are eligible to Provincial health insurance, notwithstanding the fact that they generally have shorter work permits\textsuperscript{35}.

As to temporary residents with a study permit\textsuperscript{36}, their health treatment across the country is not homogeneous. International students are entitled to publicly funded health insurance plans in only six Provinces (British Columbia\textsuperscript{37}, Alberta\textsuperscript{38}, Saskatchewan\textsuperscript{39}, Manitoba\textsuperscript{40}, Nova Scotia\textsuperscript{41}, Workers’ Compensation for Precarious Migrants in Québec, Ontario and New Brunswick”. MJLH 5.2 (2011): 203.


\textsuperscript{34} For a survey see Chen, Y.Y. B., supra note 4.

\textsuperscript{35} See the Ontario Health Insurance Act, R.R.O. 1990, Reg. 552, section 1.3(2); for Quebec see Health Insurance Act, R.S.Q., chapter A-29, r. 1, section 3(3).

\textsuperscript{36} The reference is to students undertaking post-secondary studies. On health coverage of international students see Reitmanova, S. “Health insurance for international students: taxation without representation”. Policy option 29.3 (2008): 71.

\textsuperscript{37} See on http://www.students.ubc.ca/international/international-students/health-care-and-health-insurance/.

\textsuperscript{38} See on http://www.health.alberta.ca/AHCIP/temporary-residents.html.
Newfoundland and Labrador\(^{42}\) and in the Northwest Territories\(^{43}\) and Nunavut\(^{44}\). In other Provinces mandatory health insurance is assured through the educational institutions.

As far as dependants of eligible newcomers are concerned, the various Provincial and Territorial health plans regulate the conditions for the medical coverage.

Visitors are not covered by Provincial health insurance plans and must pay out of pocket medical treatments and services they receive or purchase private health insurance.

Among the temporary residents are included victims of human trafficking, who hold a temporary resident permit; they are entitled to the *Interim Federal Health Program*, which will be discussed in the next section.

It may be interesting to highlight that, in the *Irshad* case (2001)\(^{45}\), the denial of public health care benefits to some foreign temporary workers and to international students was found by the Ontario Court of Appeal in conformity with the equality rights guarantee, enshrined in section 15 of the *Canadian Charter of rights and freedoms* (1982). According to the judge, the distinction in the coverage made in the Ontario Health Insurance Plan (OHIP) “between those persons who are ordinarily resident in Ontario and whose status under Federal immigration law is such that they are entitled or will shortly be entitled to be permanent residents of Ontario, and those persons who are ordinarily resident in Ontario but who, by

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\(^{41}\) See on http://www.gov.mb.ca/ie/study/medical.html.

\(^{42}\) See on http://www.health.gov.nl.ca/health/mcp/international.html.

\(^{43}\) For this information see Reitmanova, S., *supra* note 29, at 73.

\(^{44}\) See on http://gov.nu.ca/health/information/nunavut-health-care-plan.

virtue of their immigration status, are not entitled to become permanent residents in Ontario” – in short, between “permanent residents” and “non-permanent residents” – does not infringe section 15 of the Charter. In fact, a person’s status as a permanent or non permanent resident of a Province is not a ground enumerated in this section, which bans “discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability”. Nor is it an “analogous ground”, because it is not a “characteristic that we cannot change”, like the other personal features enumerated. It is not “immutable or changeable only at unacceptable cost to personal identity”\textsuperscript{46}.

It must be underlined that, in the same judgment, this reasoning has been followed by the Court to justify the waiting period before becoming eligible to the Provincial health coverage set out in the regulation. This period, which is the source of a distinction “between persons covered by provincial health care plans at the time they apply for OHIP and persons who are not covered by any provincial health care plan when they apply for OHIP”, in the judge’s view, “is not based on anything that could reasonably be described as a personal characteristic”.

4. Health protection of refugee claimants and of other individuals covered by the Interim Federal Health Program.

Health protection for refugee claimants without financial resources is established in the Interim Federal Health Program (IFHP), constituted, as

\textsuperscript{46} See Corbiere v. Canada (Minister of Indian and Northern Affairs), [1999] 2 S.C.R. 203, at paragraph 13.
we have seen, in 1957 and recently repealed and substituted by the new *Order Respecting the Interim Federal Health Program*, that came into force on June 30, 2012.

Beneficiaries of the program, with distinctions in the coverage according to the category of newcomer, are, other than refugee claimants, resettled refugees and certain other specific groups, like, for instance, most people who have received a positive pre-removal risk assessment, victims of human trafficking who have been issued a temporary resident permit, refugees whose claims have been accepted and also rejected refugee claimants. Benefits are provided only to those who have no public health insurance or full private insurance.

Before the new *Order Respecting the Interim Federal Health Program* health benefits were similar to those granted under most Provincial social assistance programs. The reform represents a real change of course: health care coverage has been deeply cut, limiting both who is eligible for it and the services and products granted. The idea at the basis of this radical shift is, as announced by Jason Kenney, Minister of Citizenship, Immigration and Multiculturalism, on April 25, 2012, to give refugee

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47 See, *infra*, footnote 54.


49 See the new released published on
claimants and the other protected persons included in the program health benefits that are “not more generous than what most Canadians receive”.

As to the refugee claimants, they are divided by the new Federal policy into two categories. Before the reform this distinction was not provided.

The first group is represented by refugee claimants from a “designated country of origin” (DCO). DCOs are countries from which it is unlikely to have refugees, because they are supposed to respect human rights; refugee claimants from these countries can have their claims processed faster. The reason for the DCO policy lies in the will to deter abuse of the refugee system by people who come from places which are normally considered safe.

The second group includes all other refugee claimants: refugee claimants who are not from a “designated country of origin” and those from a country of this kind, but who made their claim before December 15, 2012. Persons belonging to this latter group are eligible for the so called IFHP “Health Care Coverage”, which comprises similar services to those of Provincial or Territorial health insurance plans, with some significant limitations.

This coverage, in fact, consists of hospital services, services of doctors and registered nurses licensed in Canada, and laboratory, diagnostic and


50 For an explanation of what is meant by a DCO country see on http://www.cic.gc.ca/english/department/media/backgrounders/2012/2012-02-16i.asp.

51 The following countries have been designated as DCOs (until May 31, 2013): Australia, Austria, Belgium, Chile, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israel (with the exclusion of Gaza and the West Bank), Italy, Japan, Latvia, Lithuania, Luxembourg, Malta, Mexico, Netherlands, New Zealand, Norway, Poland, Portugal, Slovak Republic, Slovenia, South Korea, Spain, Sweden, Switzerland, United Kingdom, United States of America. For more information see on http://www.cic.gc.ca/english/refugees/reform-safe.asp.
ambulance services only if of an urgent or essential nature. Medications and immunizations are provided under the Program only if necessary to prevent or treat a disease that is a risk to public health or a condition of public safety concern (such as HIV and tuberculosis). All services and products must be rendered in Canada. An immigration medical examination is also provided.

Health care coverage, in any case, does not comprise other medications, vision and dental care, walkers, hearing aids, home care, elective surgery or rehabilitation. Ending coverage for most drugs and all vision, dental and other supplemental benefits represents one of the most significant changes introduced by the 2012 reform of the IFHP.

Since 30 June 2012 individuals coming from DCOs countries can benefit only from the so called “Public Health Or Public Safety Health Care Coverage”, which provides hospital services, services of doctors and nurses and laboratory and diagnostic services only if required to diagnose, prevent or treat a disease posing a risk to public health or to diagnose or treat a condition of public safety concerns (such as HIV and tuberculosis). Also medications and vaccines are given only to this aim. An immigration medical examination is granted too.

The condition of resettled refugees is distinguished according on whether they receive income support through the Resettlement Assistance Program (RAP) (or its equivalent in Quebec) or not.

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52 For immigration medical examination is meant a medical examination requested under paragraph 16(2)(b) of the Immigration and Refugee Protection Act. This examination is part of the process of applying to come to, or remain in Canada.

53 Resettlement assistance is offered by the Government of Canada to Convention Refugees Abroad and, in some cases, to individuals of the Country of Asylum Class who have been identified as refugees with particular needs and who have been admitted to Canada as
For resettled refugees under the RAP an “Expanded Health Care Coverage” is granted: this means firstly that services and products are provided independently from evaluations concerning their urgent and essential nature and from public health and public safety concerns. They are supplied until the refugees can qualify for Provincial or Territorial health insurance.

Supplemental health care benefits are also included, like, for instance, prescribed medications and other pharmacy products, limited dental and vision care, physiotherapy, prosthetics and devices to assist mobility, home care and long term care, psychological counseling given by a registered clinical psychologist and post arrival health assessments. Translation services for health purposes are provided too.

Similar “Expanded Health Care Coverage” is offered to people who are being resettled in Canada as a result of the Minister’s own initiative for humanitarian and compassionate considerations or for public policy considerations and who receive governmental resettlement assistance in the form of income support. They can have also an immigration medical examination carried out in Canada. This coverage lasts as long as these persons receive the income support, up to a maximum of twelve months.

If resettled refugees do not receive income support through the RAP (or its equivalent in Quebec) – most privately sponsored refugees –, they have

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Government-Assisted Refugees (GARs). Also Privately Sponsored Refugees (PSRs) can receive RAP income support (most Visa-Office Referred refugees and Joint Assistance Sponsorship Program refugees). Refugees who seek refugee protection from inside Canada are not eligible for this type of program. The money is used for paying: meeting the refugee at the airport or port of entry, temporary accommodation, help in finding permanent accommodation, basic household items, general orientation to life in Canada. Funds are also used to give the refugee income support for up to one year or until the person becomes self sufficient. For this information on the program see on http://www.cic.gc.ca/english/refugees/outside/resettle-assist.asp.
the IFHP “Health Care Coverage”, that is, as we have seen, the same coverage of refugee claimants not from DCOs. Family doctor services and hospital care are provided until they are eligible to obtain Provincial or Territorial health insurance; while covered medication and vaccines needed to prevent or treat a disease posing a risk to public health or to treat a condition of public safety concern last as long as they are under private sponsorship.

As to other categories of newcomers, victims of human trafficking who have been issued a Temporary Resident Permit are granted an “Expanded Health Care Coverage”, including an immigration medical examination; so, their situation can be assimilated to the condition of resettled refugees who benefit from the RAP.

Other protected persons, like refugees whose claims have had a positive outcome and most people who have received a positive pre-removal risk assessment (PRRA), have the IFHP “Health Care Coverage”, until they qualify for Provincial or Territorial health insurance. The coverage is analogous to that of refugee claimants not from DCOs and resettled refugees who do not receive help through the RAP.

If the refugee claim has been suspended, health benefits are fewer, and consist of the “Public Health or Public Safety Health Care Coverage”, for

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54 The pre-removal risk assessment (PRRA) is regulated by section 112 and by subsequent sections of the IRPA. This procedure gives the possibility to apply to the Minister for protection in case a person is given a removal order that is in force. The outcome of a successful application is either that the individual is recognized as a protected person or that the removal order is stayed, if the individual has been found inadmissible on serious grounds (see, in particular, section 112(3)). If the person claimed unfavourably refugee protection, he/she can introduce only new evidence in the application. The reason for this procedure is to ensure that people being removed from Canada are not sent to countries where they would be in danger or risk of persecution. For more information on the PRRA see on http://www.cic.gc.ca/english/refugees/inside/prra.asp.
the duration of the suspension. The same coverage is offered to persons whose refugee application has been rejected, until they leave Canada voluntarily or a removal order has been enforced. So the situation of these last two categories is equated to that of refugee claimants from DCOs. It must be pointed out that applicants for a PRRA who have not previously made a refugee claim have no health coverage, like refugee claimants who have withdrawn or abandoned their claim or who have been found not eligible.

Finally, the IFHP provides specific health benefits also for persons who are detained under the Immigration and Refugee Protection Act. “Coverage for Detainees” comprises urgent and essential services and products, including medication, considered necessary by a medical professional. They may be provided both on site in detention facilities through contracted medical staff and off site through IFHP registered health care facilities and professionals (e.g. hospitals, physicians’ offices).

5. Health protection of undocumented migrants

Undocumented migrants are individuals who have never had legal status in Canada or who have lost it, because their permit has expired or for some reason has been revoked. The Canadian health care system does not offer any coverage to them, with some very circumscribed exceptions: for instance, in Ontario funding is given to community health centres to provide limited health services to them.55

55 For this information see Elgersma, S., supra note 4, at 6.
In general, irregular migrants have to pay out of pocket for medical treatment they receive.

Not only can they not enjoy the Provincial health insurance, but they cannot benefit from the *Interim Federal Health Program* either. The exclusion from the coverage under the latter has been brought to the attention of the Ontario Federal Court of Appeal in a case known as *Toussaint II* (2011)\(^{56}\).

The appellant was a foreign national – a woman – who entered Canada as a visitor and had stayed in the country since that time, contrary to Canada’s immigration law. For seven years she worked and earned enough to support herself, but then health problems occurred. She applied to Citizenship and Immigration Canada for medical coverage under the IFHP, but her application was rejected.

The *Order in Council* of 1957 authorized the payment of medical expenses for two classes of individuals: “a) an immigrant, after being admitted at a port of entry and prior to his arrival at his destination, or while receiving care and maintenance pending placement in employment and b) a person who at any time is subject to Immigration jurisdiction or for whom the Immigration authorities feel responsible and who has been referred for examination and/or treatment by an authorized Immigration officer”. Toussaint did not fit within any category of alien taken into consideration by the *Order*.

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Her judiciary battle before the Federal Court of Ontario to have access to the IFHP did not succeed (Toussaint I)\textsuperscript{57}, so she sought for judicial review of the denial of medical benefits under the Program before the Ontario Federal Court of Appeal.

The appeal was dismissed and the case has not resulted in any achievement for undocumented migrants at the health safeguard level.

It must be pointed out that this case precedes the new \textit{Order Respecting the Interim Federal Health Program}, that came into force on 30 June 2012. However, the Court’s statement is still relevant, obviously until new judicial trends emerge.

The Court has not taken position against the exclusion of undocumented migrants from the IFHP\textsuperscript{58}, holding, in particular, that the \textit{Canadian Charter of Rights and Freedoms} (1982) “does not confer a freestanding constitutional right to health care”\textsuperscript{59}.

To understand the Court’s reasoning it is important to highlight that the absence of a specific section of the \textit{Charter} devoted to the right to health implies that the constitutional guarantee of health protection must be drawn from other constitutional provisions, in particular section 7, which

\textsuperscript{57} Toussaint v. Canada (Attorney General), 2010 FC 810.

\textsuperscript{58} It must be remembered that just before this decision the Court released its judgment in Toussaint v. Canada (Citizenship and Immigration), 2011 FCA 146, in which it held that the Minister should consider the appellant’s request for a waiver of fees because of her application for permanent residence in Canada. However, according to the ruling of Toussaint II, a decision of this kind by the Minister, in any case, has not led to the recognition of medical coverage under the \textit{Order in Council}. Moreover, as to the future vicissitudes of the appellant, the Court has underlined that “depending upon the terms of legislation in Ontario she may be entitled to health coverage or assistance from Ontario, now or at some point in the future”, but “that will be for others to decide”.

\textsuperscript{59} See Chaoulli v. Quebec (Attorney General), 2005 SCC 35, at paragraph 104 (per McLachlin C.J.C. and Major J.): “The \textit{Charter} does not confer a freestanding constitutional right to health care. However, where the government puts in place a scheme to provide health care, that scheme must comply with the \textit{Charter}.”
establishes the rights to life and security, rights which are clearly health-related, and section 15, regarding equality rights. However, the analysis of these constitutional references developed by the Court has not led to the recognition of any right to health care for undocumented migrants.

First of all, the judge has not found any violation of section 7 of the Charter. According to this, a person cannot be deprived of the rights to life and security “except in accordance with the principles of fundamental justice”. This means that a person who is convinced that his or her rights have been infringed has the burden of showing that the deprivation of them is contrary to the principles of fundamental justice.

As a matter of fact, it must be incidentally clarified that the appellant had not discharged the burden of showing that the Order in Council was the operative cause of the injury to her rights to life and security of the person. But even if she had done it, the Court has clearly held that providing access to health care to everyone inside the Canadian borders cannot be qualified as a “principle of fundamental justice” under section 7: the reason lies precisely in the consideration that, as has been already said, “the Charter does not confer a freestanding constitutional right to health care”.

Nor can it be said that in limiting access to health coverage the Order in Council on which the IFHP is based is arbitrary, something that would be

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contrary to the “principles of fundamental justice.” In fact, providing assistance to those who lawfully arrive and stay in Canada is “related to and consistent with the objective that lies behind” this act. The Court has stressed that the Order in Council “is not meant to provide ongoing medical coverage to all persons who have entered and who remain in Canada lawfully or unlawfully”.

According to the judge, nor does the exclusion of undocumented migrants from the benefits of the IFHP violate section 15 of the Charter, which establishes the equality rights: “equality before and under law and equal protection and benefit of law”.

First of all, immigration status does not fall within the scope of the section, which refers to “race, national or ethnic origin, colour, religion, sex, age or mental or physical disability”.

In the Court’s view this list is not absolute, must not be interpreted narrowly, literally; similar hypotheses can be ascribed to the provision. However, immigration status cannot be qualified “as an analogous ground under section 15 of the Charter”, because it is not a “characteristic that we cannot change”, like the other personal features enumerated. It is not “immutable or changeable only at unacceptable cost to personal identity”.

It can be observed that this reasoning is the same followed in the Irshad case (2001) to justify the denial of public health care benefits to some foreign temporary workers and to international students and the waiting

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period before becoming eligible to the Provincial health coverage established in the regulation. Secondly, the judge has stated that there is no infringement of the principle of equality “because the focus under subsection 15(1) is not differential treatment, but rather discrimination”. In fact, the Canadian Supreme Court has clarified in various judicial decisions that a piece of legislation which does not establish a particular benefit, without any demonstration of discriminatory intention, policy or effect, does not give rise to review under section 15(1): the legislature has the legitimate power to target the social programs – as a matter of public policy – provided that the benefits are not conferred in a discriminatory manner.

The Ontario Federal Court of Appeal has applied the same logic to the Government’s choices taken with the Order in Council, which cannot be evaluated as discriminatory: the Order “does not single out, stigmatize or expose the appellant and others like her to prejudice and stereotyping, nor does it perpetuate any pre-existing prejudice and stereotyping”. In particular, the exclusion of undocumented migrants from the IFHP coverage is consistent with the Order in Council’s purpose, which would be stretched well beyond its scope if the benefits were extended to all foreign nationals in Canada, including those present illegally.

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63 See supra paragraph 3.
It is interesting to underline that in order to demonstrate that the Order is not discriminatory, the Court has maintained that the application of its eligibility criteria leads to the denial of medical coverage under it not only to the appellant and individuals in the same situation as hers – that is undocumented migrants –, but to all Canadians, “rich or poor, healthy or sick”.

6. SOME CRITICAL ASPECTS REGARDING ACCESS OF NEWCOMERS TO THE CANADIAN HEALTH CARE SYSTEM

The analysis of the entitlement to health services of the different categories of newcomers, developed in the previous pages, shows that notwithstanding the fact that Canada is traditionally a welcoming country, where migration is valorized, the responsiveness of its health care system to it has some gaps.

As to individuals who qualify for the permanent residence permit, which gives them the same status as Canadians in accessing services, we must underline the issue of the waiting period before they become eligible for Provincial health insurance, established in Ontario, British Columbia and Quebec. The other Provinces and the Territories do not mandate the three month wait, but it is important to remember that annually most newcomers choose these three gateway Provinces as their first port of entry to Canada66.

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The waiting period is generally provided for Canadians who move from one Province to another; for them it does not represent a problem, because they can benefit from the coverage from their previous Province of residence. But newcomers to Canada do not have this kind of assistance and they have to purchase health insurance or to pay out of pocket in case of medical needs. This situation generally causes delays in seeking medical care.

Deficiency of protection can be seen particularly in the case of temporary residents, especially temporary workers who have short work permits. Provocatively the under-coverage of international students has been described as a situation of “taxation without representation” 67.

As to refugee claimants and other individuals who can benefit of the Interim Federal Health Program, after the reform that came into force on June 30, 2012 for many of them health coverage regards only services considered of an urgent or essential nature or cases in which it is necessary to diagnose, prevent or treat a disease posing a risk to public health or to diagnose or treat a condition of public safety concern; this is particularly true for medication and immunization. It seems that the attention of public policies is shifting from the aim of the well being of migrant themselves to a public health perspective, typical of the past, focused on the threat of “importing” diseases.

Most of the beneficiaries of the IFHP have lost pharmacy care, dental care, vision care, ambulance services, and mobility assistive devices. The importance of these benefits must not be underestimated: just think of what a prosthesis can mean for land mine amputees or for a Congolese

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67 See Reitmanova, S., supra note 36.
machete victim\textsuperscript{68}. This type of device can improve the possibility of employment.

The idea, claimed by the Government, that these cuts are aimed at avoiding asking Canadians to pay for benefits that are wider and more generous than what they receive themselves is not fair, because such extended care is typically offered by Provincial/Territorial plans for citizens of limited means and recipients of social assistance\textsuperscript{69}.

Some perplexities also arise towards the creation of the distinction between countries which are qualified as DCOs and countries which do not belong to this group, a distinction which has a deep impact on the health care coverage of the refugee claimants. It must be considered that sometimes it is not so easy to evaluate if a country is safe and if human rights are violated in it or not. An example can be seen in Hungary, which has been defined as a DCO: in this country the Roma endure frequent discrimination.

The fact that a remarkable number of international migrants residing in Canada are medically un- or under-insured has been criticized by scholars. In particular, some of them have argued that disentitlement of international migrants who lawfully reside in Canada on a non-transitory basis to Provincial and Territorial health insurance plans infringes the universality requirement stipulated in the \textit{Canada Health Act}\textsuperscript{70}.

But one of the most critical aspects is the almost total lack of publicly funded health care coverage for undocumented migrants.

\textsuperscript{68} For this observation see Arya, N., McMurray, J., and Rashid, M., \textit{supra} note 48, at 1876.

\textsuperscript{69} This aspect is underlined again by Arya, N., McMurray, J., and Rashid, M., \textit{supra} note 48, at 1876.

\textsuperscript{70} See Chen, Y.Y. B., \textit{supra} note 4.
However, it must be considered that the *Toussaint II* case (2011) is focused on a specific Federal program: the limited scope of the judicial decision could not say the last word on the issue whether the Canadian health care system should extend health coverage to irregular immigrants. Moreover, the limitation of the issue to Federal benefits does not prevent Provinces from granting some kind of services to them, given their competence in the health care field.

Finally, paradoxically, the Federal level, if there was the political will, could play an important role in this direction, if we think that one of the main principles of the *Canada Health Act*, as we have already seen, is universality, a concept that could be widened in order to give a certain, basic medical coverage also to people who are unlawfully present in the country.

### 7. Outline of the Right to Health of Foreigners in Italy

In Italy access to health services by migrants\(^\text{71}\) is regulated by the consolidation act governing immigration, legislative decree 286 of 25 July

1998, and by its implementing regulation, decree of the President of the Republic 394 of 31 August 1999. Health assistance to EU citizens is not taken into consideration in this paper.

Article 34 of the consolidation act governing immigration and article 42 of regulation 394/1999 provide for mandatory registration, that means by-right registration, to the National Health Care System (NHCS, known as SSN in Italian), with equal treatment to Italian citizens, for foreigners with a residence permit or waiting for the issue or the renewal of one for the following reasons: work, both self employment and employment (including seasonal work); family reasons – except for parents aged 65 and over reunified with regularly residing foreign citizens –; political and humanitarian asylum (including minors, leave to stay for social protection, extraordinary reception measures for exceptional events); application for asylum; awaiting adoption; foster care; acquisition of citizenship.

Moreover, those who have leave to stay and are enrolled at the employment office are entitled to register with the National Healthcare system.

Health care is also provided to regularly residing dependants.

Legally residing foreigners not belonging to the above-mentioned categories either have to purchase a private insurance or can register with the NHCS, which requires them to pay a yearly co-payment charge. Among the categories entitled to voluntary registration we can mention non EU nationals with leave to stay for more than three months, like students, au pairs, members of the clergy, holders of a permit to stay for elective residence, parents over 65 years of age reunited with their families,
employees of international organizations working in Italy, with the exception of the cases regulated by international agreements.

The absence of free health coverage for students, compared with other categories that can benefit from mandatory registration, catches the eye immediately. It must be considered that in Italy the phenomenon of international students is less widespread than in Canada, where there are lacks in health protection of this category too.

Registration is valid also for dependants.

There is no difference in coverage between mandatory and voluntary registration with the National Health Care System.

As to undocumented migrants, comparative studies of the various national policies in Europe\textsuperscript{72}, moving from the notion of “minimum rights” drawn up by the Council of Europe\textsuperscript{73}, show that Italy can be ascribed to the group of Member States granting “more than minimum rights”\textsuperscript{74}.

According to article 35 of the consolidation act governing immigration, foreign citizens present in Italy who do not comply with regulations regarding entry and stay, are guaranteed, in public and accredited health institutes, urgent or in any case essential outpatient and hospital treatment, also of a continuative nature, for illness and accidents. Article 43 of the regulation 394/1999 has extended the coverage, on the same conditions,

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\textsuperscript{73} See the Council of Europe Parliamentary Assembly Resolution 1509, adopted on 27 June 2006, according to which “In terms of economic and social rights, the Assembly considers that the following minimum rights, \textit{inter alia}, should apply: emergency health care should be available to irregular migrants and States should seek to provide more holistic health care, taking into account, in particular, the specific needs of vulnerable groups such as children, disabled persons, pregnant women and the elderly”.

\textsuperscript{74} The analysis of Björngren Cuadra, C., supra note 72, at 3, categorizes entitlement to health care in three levels – i) less than minimum rights; ii) minimum rights; iii) more than minimum rights – and divides Member States in three groups based on them.
to pharmaceutical treatment. Irregular foreigners can also benefit from preventive medicine schemes to safeguard individual and collective health. In particular, the following are guaranteed: the social protection of pregnancy and maternity, with the same treatment as Italian citizens, pursuant to laws 405 of 29 July 1975, and 194 of 22 May 1978, and of the Ministry of Health decree of 6 March 1995; the protection of the health of minors in compliance with the UN Convention on the Rights of the Child of 20 November 1989, ratified and rendered executive pursuant to law 176 of 27 May 1991; vaccinations according to regulations and within the collective prevention campaigns authorized by the regions; international preventive medicine actions; the prevention, diagnosis and treatment of infective diseases and the elimination of the relative foci of infection.

According to the circular of the Ministry of Health 24 March 2000, n. 5, by urgent treatment is meant a treatment that cannot be postponed without endangering life or health; by essential treatment is meant health services, including diagnostic and therapeutic treatment, regarding pathologies which are not dangerous in the immediate future and in the short term, but which over time could cause greater damage to health or risks for life (complications, chronic states, deteriorations). Moreover, legislation maintains the principle of the continuity of urgent and essential treatment, in order to provide the sick with the complete therapy and rehabilitation cycle that can solve the pathological problem.

The definition of urgent and essential treatment emerging from judicial decisions is stricter than the one given by the above circular. The Corte di Cassazione, which is the Italian Supreme Court, at the top of the judiciary, has correlated the essentiality to survival: in a case regarding the
deportation of an illegal migrant who had antiretroviral therapy while he was in prison, the judge has spoken of essential treatment *quoad vitam*. The Court\(^75\) has held that the guaranty of temporary suspension of the deportation regards only those medical interventions, following the administration of those life-saving drugs, which are indispensable to complete the latter or to achieve their efficacy; while are excluded those maintenance or control treatments, which, despite their indispensability to assure the patient’s *spes vitae*, do not have an instrumental, direct relationship with the immediate effectiveness of the not deferable and urgent health intervention.

It is clear that the reasoning is influenced by the specific kind of cases evaluated by the judge, in which health protection is seen as a condition not to enforce deportation.

According to article 43 of decree 394/1999, to enjoy the treatment granted, the undocumented migrant must request the local health authority to issue an STP Code, which is anonymous: STP stands for “Straniero temporaneamente presente”, that means temporarily present foreigner. The Code can be released also by public hospitals, for instance in the casualty department, by guidance centres, and so on. The Code is valid for six months and can be renewed.

The treatment received is paid by the migrant. However, if, when the STP card is assigned, the migrant fills in an indigence declaration form stating that he or she has not sufficient financial means, the treatment is provided free of charge, apart from a co-payment charge. The indigent migrant is

exempt from the co-payment charge in the same situations provided for Italian citizens.

8. BRIEF COMPARISON BETWEEN ACCESS TO HEALTH BENEFITS BY NEWCOMERS IN CANADA AND IN ITALY

A first difference in the health care coverage of migrants between Canada and Italy depends on the dissimilar structure of the health care systems of the two countries. In the previous pages\textsuperscript{76} it has been seen that health care in Canada is essentially a Provincial or Territorial matter, even if there is a common framework of guarantees, due to the \textit{Canada Health Act} (1985), and there are some examples of Federal intervention, like the IFHP, whose enactment preceded the creation of the various Federal and Provincial health care systems.

In Italy, according to article 117, paragraph 3, of the Constitution, health protection is the subject of a concurrent legislative power of State and regions, which has led to the creation of a National Health Care System on a regional basis, made up of various regional health care systems\textsuperscript{77}. However, the same article, in paragraph 2, lett m), reserves the State the possibility to determine the basic level of benefits relating to civil and social entitlements to be guaranteed throughout the national territory.

\textsuperscript{76} See paragraph 2.

Since the right to health is one of the social rights enshrined in the Constitution, this national competence regards also the health care system and is the source of a high level of uniformity in health care coverage – treatment and drugs – supplied by the various Italian regions, which can provide only superior levels of care.

Once a foreigner is registered with the NHCS, he or she can benefit from the essential levels of care, which have been embodied by the Decree of the President of the Council of Ministers 29 November 2001, and of the higher levels should they be supplied by the regional health care systems, in the same way as Italians.

It must be noted that also the health care coverage granted to undocumented migrants by article 35 of the consolidation act governing immigration is included in the essential levels of health care established at a national level by the Decree of the President of the Republic of 2001.

One of the outstanding elements of difference between health care coverage of newcomers in Canada and in Italy is the great variation in the comprehensiveness of the health care guarantees in the former, depending on the categories of newcomers: the coverage varies between the two extremes of the coverage of the permanent residents, which, after the waiting period that is sometimes established, is the same as that of Canadians, and the situation of the undocumented migrants, who have essentially no health benefits, with a few minor exceptions.

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Between these two extremes there is a significant graduation, which, for instance, emerges clearly from the analysis of the different levels of coverage of the beneficiaries of the IFHP, especially after the recently introduced cuts, expression of the incidence of financial reasons. The analysis developed79 shows that the new *Order Respecting the Interim Federal Health Program* provides four kinds of coverage – “Health Care Coverage”, “Public Health Or Public Safety Health Care Coverage”, “Expanded Health Care Coverage” and “Coverage for Detainees” – and it is complicated to identify the treatment included and which types of newcomers can enjoy it.

In Italy the coverage of which foreigners can benefit is not so fragmented, and most of them can take advantage of the mandatory registration with the NHCS, that means full health coverage, as offered to Italians. The categories excluded from it, that can ask for voluntary registration, are residuary.

Undocumented migrants, as we have already underlined, are not banned from the health care system and can enjoy, at least, urgent or in any case essential outpatient and hospital treatment; drugs, provided on the same conditions, are also included.

It is noteworthy that the two notions of urgency and essentiality, whose meaning is not always perspicuous, in Canada are used to limit the health coverage under the IFHP of some categories of newcomers who are in the country according to the law. Incidentally, it can be noted that the two concepts were non extraneous to the old IFHP, but in the past they were broadly interpreted.

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79 See paragraph 4.
As to drugs, it is interesting to underline that while in Italy their provision is part of the health care benefits granted by the NHCS, in Canada most Canadians do not receive publicly-funded drug coverage outside of hospitals. In other words, even for citizens, the Canadian Medicare may not offer the same guarantees as those offered by the Italian system.

The next few pages will analyze some factors that, from the Italian perspective, can give a partial explanation of the differences in migrant health protection of the two health care systems: the international and EU legal framework; the absence of a freestanding right to health in the *Canadian Charter of rights and freedoms* and a different concept of equality acknowledged by the Constitutions of the two countries.

9. **The Incidence of International and EU Law on Migrant Health**

Before trying to investigate the domestic reasons at the basis of the differentiations in health protection of newcomers in Canada and in Italy, it may be interesting to contextualize migrant health policies and regulations of the two countries in the framework of international law. Moreover, as to Italy, the European legal system must also be taken into account.

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For what regards the international perspective, Canada and Italy share many international rights norms.

The first document that comes into consideration is the *Universal Declaration of Human Rights* (UDHR) (1948), in particular articles 2 and 25. The former, more in general, grants all the rights and freedoms set in the *Declaration* itself, “without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status”. No distinction can be made “on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty”. The latter, more specifically, states: “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including ... medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control”.

Special care and assistance should be ensured for motherhood and childhood.

To enforce the UDHR, whose value wavers between a declaratory nature, not legally binding, as a soft law instrument, and customary international law, various Conventions were stipulated. Important in the health care law field is the *International Covenant on Economic, Social and Cultural Rights* (ICESCR) (1966). Article 2(2) requires all the rights protected therein, including the right to health under article 12, to be guaranteed “without discrimination” on the grounds enumerated in the *Declaration*. Article 12 establishes that State Parties “recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”. Article 9, devoted to “the right of everyone to social security, including social insurance”, is also significant.

The General Comment n. 14 (2000) of the UN Committee on Economic, Social and Cultural Rights\(^\text{81}\) has made an essential contribution to shaping the right to health, protected in article 12 of the *Covenant*. In particular, at paragraph 34, it stipulates that “States are under the obligation to respect the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including ... asylum seekers and illegal immigrants, to preventive, curative and palliative health services”.

The General Comment n. 19 (2007), concerning social security\(^\text{82}\) is also considerable. At paragraphs 37-38 it states that “All persons, irrespective of their nationality, residency or immigration status, are entitled to primary

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\(^{82}\) UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 19: The right to social security (Art. 9 of the Covenant)*, 4 February 2008, E/C.12/GC/19.
and emergency medical care”, and, specifically, that “Refugees, stateless persons and asylum-seekers, and other disadvantaged and marginalized individuals and groups, should enjoy equal treatment in access to non-contributory social security schemes, including reasonable access to health care and family support, consistent with international standards”. This last reference is to the Convention Relating to the Status of Refugees (1951), and to the Convention Relating to the Status of Stateless Persons (1954), articles 23 and 14 of both.

Furthermore, the right to health is recognized in article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination (CERD) (1965), which states that States Parties “undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law” in the enjoyment of “the right to public health, medical care, social security and social services”.

The Convention on The Elimination of All Forms of Discrimination against Women (CEDAW) (1979) is also relevant. It provides, at article 12(1), that “States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning”. The article establishes also a particular protection for pregnancy.

Recommendation n. 24 of the UN Committee on the Elimination of Discrimination against Women (1999)83 specifies that “special attention

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should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups, such as migrant women, refugee and internally displaced women, the girl child and older women, women in prostitution, indigenous women and women with physical or mental disabilities”.

The Convention on the Rights of the Child (CRC) (1989) must also be taken into account. It establishes, at article 24: “States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services”.

Another international instrument that may be significant in the field of migrant health is the Convention on the Rights of Persons with Disabilities (CRPD) (2006), whose article 25 gives a detailed definition of the right to health. In particular, the role of article 18, which recognizes persons with disabilities liberty of movement and nationality, could be valorized.

It must be highlighted that there is a series of Conventions related to migrant workers, which have met many obstacles in their ratification. The main example is given by the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICRMW) (1990), whose article 28 recognizes for all migrant workers and members of their families “the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned”; such emergency medical care cannot be refused “by reason of any irregularity with regard to stay or employment”. Moreover,
according to articles 43 and 45, State Parties must guarantee to migrant workers and to the members of their families to “enjoy equality of treatment with nationals of the State of employment in relation to ... [a]ccess to social and health services, provided that the requirements for participation in the respective schemes are met”.

However, neither Canada nor Italy are signatory to this last Convention, which has been ratified mostly by countries of origin of migrants; none of the EU Member States has signed, ratified or acceded to it. The reason for the indifference or, more realistically, the unwillingness of many countries to be part to it lies probably in the regulation on irregular migrants. One of the obstacles to the ratification of the ICRMW by the EU Member States is represented by article 25, which states that “migrant workers shall enjoy treatment not less favourable than that which applies to nationals of the State of employment in respect of remuneration”; moreover, according to it, “State Parties shall take all the appropriate measures to ensure that migrant workers are not deprived of any rights derived from this principle by reason of any irregularity in their stay or employment” and “employers shall not be relieved of any legal or contractual obligations, nor shall their obligations be limited in any manner by reason of such irregularity”.

Health issues related to work have also been addressed by the International Labour Organization (ILO), Conventions n. 155 on Occupational Safety and Health (1981), and n. 161 on Occupational Health Services (1985); neither

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Italy nor Canada has ratified them. Characterized by a limited number of ratifications is also ILO Convention n. 97 concerning *Migration for employment*, which provides expanded access to health care: Italy has ratified it with law 2 August 1952, n. 1305, Canada has not.

In any case, independently from the last mentioned series of Conventions that deal with migrant workers, as we have anticipated, all the other analyzed international human rights norms represent a common framework both for Canada and for Italy, even if there are distinctions between the two countries in the acknowledgement of them.

They should lead to the recognition of a human right to health care, regardless of legal status, and the values enshrined in them should direct both the legislator and governmental policies to guarantee a higher level of health safeguard for every kind of newcomer. Therefore, gaps in migrant health protection appear open to criticism. This is particularly true for undocumented migrants, excluded in Canada from essentially any kind of publicly funded health coverage.

Even if diversities between Italy and Canada in health protection of foreigners may find an explanation in the different Constitutional architecture of the two countries, as it will be made clear, a relevant role in explaining them can be also played by the respective reception systems of international law.

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87 See next paragraph.
In Italy, once a treaty or a convention is signed and ratified, it becomes part of its own legal system. We must remember that the ratification is authorized by an *ad hoc* previous law, to which the text of the international piece of law is attached.

Whereas in Canada an international source of law that has been signed and ratified by the Executive still requires specific implementation through domestic law to be enforceable at the national level\(^8\). Moreover, when a treaty or a convention regards a matter that belongs to Provincial jurisdictions, it is subject to implementation by Provinces. From this point of view, it is significant that health care falls mostly within Provincial legislative competence.

In the absence of implementation, international law can have (only) an hermeneutic meaning for Courts\(^9\). And, however, this last aspect is controversial: there is an animated debate in Canada on whether the values reflected in unimplemented international norms may be an interpretative tool in statutory exegesis and judicial review, especially when matters belonging to provincial jurisdictions are implied\(^0\).

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\(^9\) See *Baker v. Canada (Minister of Citizenship and Immigration)*, [1999] 2 S.C.R. 817, in particular at paragraph 70: “[T]he values reflected in international human rights law may help inform the contextual approach to statutory interpretation and judicial review. As stated in R. Sullivan, Driedger on the Construction of Statutes (3rd ed. 1994) at p. 330: [T]he legislature is presumed to respect values and principles enshrined in international law, both customary and conventional. These constitute a part of the legal context in which legislation is enacted and read. *In so far as possible, therefore, interpretations that reflect these values and principles are preferred*” (emphasis in original).

In this context, it can be interesting to draw attention to the *Toussaint II* case (2011), which has been analyzed in the previous pages\(^91\). Despite the appellant’s submission, the relevance of the *International Covenant on Economic, Social and Cultural Rights* in defining the “principles of fundamental justice” is practically not tackled in the judicial reasoning; one can note a sort of “hurry” on the part of the Court in excluding it. The reception system and the consequent force of this source of law in the Canadian legal system could probably clarify why the Court has been able to dismiss the international human rights claim so quickly.

At supranational level it is important to consider also the role in granting health protection played by the *European Convention for the Protection of Human Rights and Fundamental Freedoms* (ECHR) (1950), core instrument of the Council of Europe, enforced by the European Court of Human Rights, which applies to every person within the jurisdiction of a State Party, including non nationals. The *Convention* has become a fundamental pillar of the Italian legal system, but not of the Canadian one. In fact, while Italy is signatory to it, thanks to the law of ratification 4 August 1955, n. 848, Canada has neither signed, nor ratified it. Canada holds observer status with the Council of Europe\(^92\).

Notwithstanding the fact that the right to health does not find a specific article in the *Convention*, it can be drawn from other provisions, interpreted extensively.

\(^{91}\) See paragraph 5.
\(^{92}\) See on http://hub.coe.int/country/canada.
One of these health related articles is, for instance, article 2, dedicated to the right to life\textsuperscript{93}.

Article 3, according to which “No one shall be subjected to torture or to inhuman or degrading treatment or punishment”, is also relevant, because it can be invoked to prevent migrants who are ill from being deported to countries of origin or third countries, where they cannot get adequate treatment\textsuperscript{94}.

A State’s failure to provide access to health care could also potentially result in a violation of article 8, on the right to respect for private and family life\textsuperscript{95}.

Another important tool is article 14, which, together with \textit{Protocol 12 to the Convention (2000)}\textsuperscript{96}, in particular article 1, prohibits discrimination\textsuperscript{97}: this

\textsuperscript{93} Even if in both the cases the European Court of Human Rights did not ascertain a violation of article 2 of the ECHR, the relevance of this article with respect to the right to health can be seen in \textit{L.C.B. v. The United Kingdom}, 23413/94, 9 June 1998, in which the UK was sued by a person suffering from leukemia, because of the presence of the father at Christmas Island during four nuclear tests in 1957 and 1958, and in \textit{G.N. et al. v. Italy}, 43134/05, 1\textsuperscript{st} December 2009, concerning the case of persons who deceased because contracted Hiv or hepatitis C in the 1980s, following blood transfusions carried out by the Italian National Health Care Service.

\textsuperscript{94} See European Court of Human Rights, \textit{D. v. United Kingdom}, 146/1996/767/964, 2 May 1997, regarding the removal from the UK to St Kitts of a prisoner suffering from Hiv, in the advanced stages of a terminal and incurable illness; the Court concluded that his removal would expose him to a real risk of dying under most distressing circumstances and would thus amount to inhuman treatment. The relevance of article 3 can be seen, for instance, also in \textit{Mouisel v. France}, 67263/01, 14 November 2002, concerning the case of a French national, seriously ill, who was kept in continued detention, in controversial conditions.

\textsuperscript{95} For this interpretation see Pace, P., Shapiro, S., \textit{supra} note 80. Article 8 has found numerous applications in cases of damages to environment and health: see European Court of Human Rights, \textit{Tătar v. Romania}, 67021/01, 27 January 2009; \textit{Taşkin and others v. Turkey}, 46117/99, 10 November 2004; \textit{López Ostra v. Spain}, 16798/90, 9 December 1994.

\textsuperscript{96} Council of Europe, \textit{Protocol 12 to the European Convention on Human Rights and Fundamental Freedoms on the Prohibition of Discrimination}, 4 November 2000, ETS 177. The Protocol entered into force on 1\textsuperscript{st} April 2005. This Protocol has been signed by Italy, but not ratified.

provision can be valorized in order to promote migrants’ rights and, specifically, the rights of those who are in a situation of irregularity. It is noteworthy that in 2007 the Council of Europe has maintained that “States should provide free emergency health care regardless of legal status”.

Applying article 14, the European Court of Human Rights has maintained the discriminatory nature of travel restrictions on people living with HIV: in 2011 the Court stated that refusing a residence permit to a foreign national exclusively on the basis of HIV status constitutes an unlawful discrimination.

An interesting reference to the issue of access to health care can be read in the concurring opinion of Judge Pinto de Albuquerque in the judgment of 2012 of the European Court of Human Rights, which stigmatized the Italian Republic for having breached the non refoulement principle because of the interception and sending back to Libya of Somali and Eritrean nationals, who had left the North African state aboard vessels with

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100 See European Court of Human Rights, Kiyutin v. Russia, 2700/10, 10 March 2011. An interesting application of article 14 in the Italian health care field can be seen in the recent decision, M.C. et autres c. Italie, 5376/11, 3 September 2013 (French version), which has adjudicated unlawful decree law 31 May 2010, n. 78, converted into law by law 30 July 2010, n. 122, which had blocked the revaluation of the supplementary special compensation for the permanent damages suffered because of blood transfusions with contaminated blood.
the aim of reaching the Italian coasts\textsuperscript{101}. After having underlined that there is no distinction in international law protection between refugees and individuals benefiting from complementary protection, between refugees 	extit{de jure} and refugees 	extit{de facto}, the judge has observed that the same conclusion applies to situations of a mass influx of refugees. According to him, in particular, “to provide reduced, subsidiary protection (for example, with less extensive entitlements regarding access to residence permits, employment, social welfare and health care) for people who arrive as part of a mass influx would be unjustified discrimination.”

Finally, also article 1 of Protocol 1 of the \textit{Convention}, concerning protection of property, can come into consideration: there are examples of usage of this juridical tool, together with article 14, in the field of allowances for foreign disabled adults\textsuperscript{102}.

In this context the role of the Commissioner for Human Rights, an independent institution within the Council of Europe, mandated to promote the awareness of and respect for human rights in the Council of Europe Member States, must not be underestimated: for instance, in 2009, after a visit to Italy, he expressed concern about lifting the ban on doctors to report to the authorities irregular migrants who access the health

\textsuperscript{101} See European Court of Human Rights, \textit{Hirsi Jamaa and others v. Italy}, 27765/09, 23 February 2012.

\textsuperscript{102} See European Court of Human Rights, \textit{Koua Poirrez v. France}, 40892/98, 30 September 2003. The judgment assessed a breach of article 14 of the \textit{Convention}, taken in conjunction with article 1 of Protocol 1, in the refusal of an allowance for disabled adults to a French resident of Ivory Coast nationality, adopted son of a French national residing and working in France, who was severe disabled. The relevance of article 1 of Protocol 1 in the health field can be seen in the recent decision, \textit{Affaire M.C. et autres c. Italie}, regarding compensation for damages deriving from blood transfusions, already mentioned.
system\textsuperscript{103}. Fortunately the proposal was not adopted, also thanks to the strong protests of health professionals.

The ECHR has been supplemented by the \textit{European Social Charter} (1961) revised in 1996, a Council of Europe treaty, in the field of economic and social rights\textsuperscript{104}, applicable to Italy, in virtue of law 3 July 1965, n. 929 and 9 February 1999, n. 30, but not to Canada\textsuperscript{105}.

The \textit{Charter} completes the rights enshrined in the \textit{European Convention of Human Rights}, encompassing rights like housing, health, education, employment, social protection, and so on\textsuperscript{106}. Pursuant to article E, their enjoyments must be granted without discrimination. The migrant worker has rights prior to, upon entry into and once established, legally resident or working in the territory of another party, and in some cases even once having left.

In 2004 the European Committee of Social Rights, which supervises the application of the \textit{Charter}, in its decision on the complaint of the International Federation of Human Rights Leagues (FIDH) against

\begin{footnotesize}
\begin{itemize}
\item\textsuperscript{104} On the relevance of the \textit{European Social Charter} in the field of migrant health protection see the Information document prepared by the Secretariat of the ESC on \textit{Migrant’s Rights in the European Social Charter}, 22 June 2006, on http://www.coe.int/t/dghl/monitoring/Socialcharter/Theme%20factsheets/FactsheetMigrants2008_en.pdf.
\item\textsuperscript{105} For an overview of the members of the Council of Europe that have signed or ratified the \textit{Charter} and the \textit{Revised Charter} see the framework (updated on 26 March 2013) on http://www.coe.int/t/dghl/monitoring/socialcharter/Presentation/Overview_en.asp.
\item\textsuperscript{106} It must be noted that articles 18 and 19, regarding respectively the right to engage in a gainful occupation in the territory of other Parties and the right to protection and assistance regard specifically migrant workers. The other articles, from 1 to 17 and from 20 to 31, have relevance to migrant workers, even if they do not specifically refer to them: they apply to foreigners provided they are nationals of Parties lawfully resident or working regularly within the territory of the Party concerned.
\end{itemize}
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France\textsuperscript{107}, as to whether the health system reform of 2002 violated article 13 of the \textit{Charter}, regarding the right to medical assistance, or not, has held that “Human dignity is the fundamental value and indeed the core of positive European human rights law”, and that “legislation or practice which denies entitlement to medical assistance to foreign nationals, within the territory of a State Party, even if they are there illegally, is contrary to the Charter”\textsuperscript{108}.

As to the role played by this Committee with regard to Italy, it is interesting to remember that in 2010 it maintained that there was a violation of articles 16 (right of the family to social, legal and economic protection), 19 (right of migrant workers and their families to protection and assistance), 30 (right to protection against poverty and social exclusion) and 31 (right to housing) of the \textit{Revised European Social Charter} in a case alleging that the so-called “emergency security measures” and, in general, a racist and xenophobic discourse in Italy had resulted in unlawful campaigns and evictions leading to homelessness and expulsions excessively targeting Roma and Sinti migrants. The case also took into account social exclusion in access to health services and sanitary and healthy housing\textsuperscript{109}.

Finally, health protection in Italy must be also contextualized in European Union law.


\textsuperscript{108} The Committee, however, concluded that the French piece of legislation in question does not deprive illegal immigrants of all entitlement to medical assistance and therefore there was no violation of article 13, concerning the right to social and medical assistance, and 17, regarding the right of children and young persons to social, legal and economic protection.

First of all we must consider the *Charter of fundamental rights of the European Union* (2000), which, after the *Lisbon Treaty* (2009), has the same values of the Treaties, that means that it has become legal binding. The *Charter* has a specific article, article 35, entitled “Health care”: “Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities”. The last period is taken up by articles 9 and 168(1) of the *Treaty on the functioning of the European Union* (2008). The latter promotes cooperation and coordination among Member States with regard to health services, in particular in the sphere of public health, fostering complementary actions with third countries and the competent international organizations.

The reference of article 35 of the *Charter of fundamental rights* to the “conditions established by national laws and practices” leaves to national legislators the enactment of the rules for access to health care. In Europe the competence on health care is primarily a national matter, in virtue of the principle of subsidiarity; however the EU influence on the matter is increasing.

for returning illegally staying third country nationals”: article 5 provides that the State has to take account of “the state of health of the third-country national concerned” in relation to expulsion; article 14 establishes that “emergency healthcare and essential treatment of illnesses” must be provided to irregular migrants during the period given for the involuntary departure and when removal has been postponed. For what concerns irregular migrants, a fundamental breakthrough in implementing their health protection is constituted by the Resolution entitled “Reducing health inequalities in the EU”, adopted by the European Parliament in March 2011: it calls on Member States to ensure that “the most vulnerable groups, including undocumented migrants, are entitled to and are provided with equitable access to healthcare”.

The given examples demonstrate that the current legal framework of the EU can be considered advanced in giving migrants legal entitlement to health care. Moreover, an increasing attention to the health situation of irregular migrants can be observed. However, there are still many differentiations among the various Member States and gaps in migrant health safeguards, mostly ascribable to the inadequacy in addressing the determinants of health and in other kinds of barriers to access the services.

10. MIGRANT HEALTH AND THE RELEVANCE OF THE ABSENCE OF A FREESTANDING RIGHT TO HEALTH IN THE CANADIAN CHARTER OF RIGHTS AND FREEDOMS. REFLECTIONS ON THE MEANING OF ARTICLE 32 OF THE ITALIAN CONSTITUTION.

One of the reasons at the basis of the critical points of the responsiveness of the Canadian health care system towards newcomers may
be identified in the domestic legal framework, and, in particular, in the absence of a “freestanding right to health” in the *Canadian Charter of rights and freedoms*\textsuperscript{110}, which has a deep impact on the balancing of the values at stake.

The implications of this lack can be seen particularly in the *Toussaint II* case (2011), analyzed above, but this aspect seems to be also at the root of the limits in health coverage of other categories of newcomers, who, unlike undocumented migrants, are in Canada according to immigration law, like, for instance, refugee claimants, who are suffering severe consequences from the reform of the *Interim Federal Health Program*.

From a constitutional point of view, the *Canadian Charter of rights and freedoms* is considered by Canadian scholars a post WWII Constitution, characterized by a system of rights protection closer to the European approach than to the American one\textsuperscript{111}. However, it must be underlined that it mostly safeguards the classical freedoms, typical of the liberal regimes, and consequently, unlike the European post-war Constitutions, such as the Italian one (1948), does not mention social rights\textsuperscript{112}, among which the right to health has a prominent position.


\textsuperscript{112} From this point of view, it is significant that Weinrib’s article, *supra* note 111, is focused on freedom of expression, which is a negative right.
The explanations for this exclusion are various\(^{113}\): in any case, the inspiration of the paradigm of the U.S., whose Constitution does not comprise this kind of rights, is relevant, and, probably, the architecture of the Federal and of the Provincial competences, defined by the Constitution Act (1867), also plays an important role. In this framework the Charter defines a catalogue of rights equal for every citizen, with the exception of social rights – right to health, in particular –, which are mostly implemented by Provincial legislation\(^{114}\).

From this point of view, it is significant to remember that the IFHP (1957), which is a federal program, was issued in a period in which the Provincial health care systems had not been developed.

The absence of a specific article devoted to the right to health in the Canadian Charter does not mean, of course, that Canada has not a social vocation, as it emerges from the subsequent policies aimed at giving the population high health safeguard levels, through the establishment of national standards. The most important example is represented by the Canada Health Act (1985). Moreover, universal health care has become a core value of the Canadian national identity\(^{115}\).

However, this lack must not be underestimated. The importance of not undervaluing this aspect appears clearly from a comparison with other legal systems, where the right to health is constitutionally safeguarded: the


\(^{114}\) See paragraph 2.

comparative approach shows how the presence of a constitutional provision concretely operates in enlarging the level of health protection, from the point of view both of “universality”, and of “comprehensiveness”, using some Canadian conceptual categories\textsuperscript{116}. The Italian Constitution (1948), for instance, dedicates article 32 to the right to health. In this context the first subsection comes into consideration: “The Republic safeguards health as a fundamental right of the individual and as a collective interest, and guarantees free medical care to the indigent”.

The Italian legislation, in particular the legislative decree n. 286/1998, which can be considered progressive, especially for what concerns the health protection of undocumented migrants, is undoubtedly also the effect of the Constitutional datum.

Italian scholars have underlined that, according to article 32 of the Italian Constitution, the right to health is granted both to Italian citizens and foreigners\textsuperscript{117}.

Notwithstanding the fact that the right to health is financially conditioned\textsuperscript{118}, the Constitutional Court has singled out an “irreducible nucleus”, as an inviolable field of human dignity, which obliges the State to prevent situations of lack of health protection. This “irreducible nucleus” of the right to health, intended as a fundamental right, is also guaranteed to foreigners, whatever position they have with respect to legislation which

\textsuperscript{116} “Universality” and “comprehensiveness” are some of the criteria established by the Canada Health Act (1985): see paragraph 2.
\textsuperscript{118} On the financially conditioned nature of right to health see, \textit{ex mult\textipa{`s}}, Ferrara, R. (2007) \textit{supra} note 77. In partic. 37-64.
regulates their entry and their stay in the Italian State, even if the legislator can graduate the coverage granted. In the *Toussaint II* case (2011) it can be observed how the absence of a specific provision devoted to the right to health in the *Canadian Charter* has influenced the application of section 7, which establishes, as we have seen, the rights to life and security of the person: in fact, it makes it impossible for the appellant to demonstrate that the “principles of fundamental justice” require Canada to provide access to health care to everyone inside the borders and that, consequently, this access cannot be denied even to those who violate immigration laws.

In short, the lack of a section which safeguards explicitly the right to health leads to referring to other provisions, like, for instance, section 7, to enforce this right, but then, as in a sort of “short circuit”, this absence itself weakens the protection offered by these other provisions: with specific regard to section 7, because the infringement of the “principles of fundamental justice” cannot be proved.

Moreover, this gap also affects the balancing of the values at stake, giving prevalence to the consideration of the illegal status of undocumented migrants over their health.

It is significant to underline that in the *Toussaint II* case (2011) the Federal Court of Appeal of Ontario has mentioned another ruling of the Court itself, which criticized the attempt of the appellants to seek “to expand the law ... so as to create a new human right to a minimum level of health care”: in fact, “... (T)he law of Canada has not extended that far ... (A)

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119 See Constitutional Court, 17 July 2001, n. 252, on http://www.giurcost.org, which represents a leading case in the field of migrant health.

120 Covarrubias v. Canada (Minister of Citizenship and Immigration), 2006 FCA 365, at paragraph 36.
freestanding right to health care for all of the people of the world who happen to be... in Canada would not likely to be contemplated by the Supreme Court”.

The absence of a freestanding right to health in the *Canadian Charter* hinders the configuration of that inviolable level of protection, granted also to undocumented migrants, which the Italian judiciary refers to the concept of the “essential content” of the right to health, as it is enshrined in the Italian Constitution.

11. Migrant health and the prevalence of formal equality over substantive equality in the *Canadian Charter* of rights and freedoms.

The lack of a specific right to health in the *Canadian Charter* does not imply that the health subject is indifferent from a Constitutional perspective. As we have seen, in maintaining that “the *Charter* does not confer a freestanding constitutional right to health care”\(^{121}\), the Supreme Court has meant that this right can be derived from other Constitutional provisions, including section 15, devoted to equality rights.

But this interpretative reasoning raises other questions related to the formal or substantive dimension of the principle of equality.

According to section 15 of the *Charter*, “Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without

\(^{121}\) See again *Chaoulli v. Quebec (Attorney General)*, 2005 SCC 35, at paragraph 104 (per McLachlin C.J.C. and Major J.).
discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability”.

In the *Toussaint II* case (2011) the Court has underlined the prevalence, in this provision, of the logic of “discrimination” over that of “differential treatment”. Moreover, both in this statement and in the *Irshad* case (2001), the judge has evaluated the conformity of the latter to the *Charter* through a mechanical verification of its ascribability or not to the “labels” of section 15 or to the “analogous grounds”, identified by jurisprudence.

To understand this interpretative trend it is useful to remember that in section 15 it is possible to see two different concepts of equality: formal equality and substantive equality.

It would seem that the wording of the *Charter* itself requires a substantive approach to equality, as it guarantees not only equality before and under the law, but also equal benefit of the law. However, the substantive dimension of equality seems to be weaker than in other Constitutions, where it is more strongly maintained. An example can be seen, for instance, in the Italian Constitution, where the second subsection of article 3 states: “It is the duty of the Republic to remove those obstacles of an economic or social nature which constrain the freedom and equality of citizens, thereby impeding the full development of the human person and the effective participation of all workers in the political, economic and social organization of the country”.

In Canada there were some attempts to build up the substantive character of the principle of equality, but in the end they did not completely succeed.
A first step towards the development of substantive equality is represented by the decision *Law Society of British Columbia v. Andrews* (1989)<sup>122</sup>, in which the Supreme Court underlined the need to look at how concretely differential treatment impacts on the lives of members of stigmatized groups, and that the purpose of the *Charter* is “not to guarantee some abstract notion of similar treatment for the similarly situated”, but “rather to better the situation of members of groups which had traditionally been subordinated and disadvantaged”<sup>123</sup>.

One of the most significant decisions of the Supreme Court on substantive equality is *Eldridge v. British Columbia (Attorney General)* (1997)<sup>124</sup>, which showed the limits of the formal equality approach. The case regarded problems experienced by deaf people in accessing the Provincial health care services because of the lack of sign language interpretation services. According to the formal point of view, adopted by the Court of Appeal<sup>125</sup>, any inequality existed “independently of the legislation” and could not be said “in any way to be an effect of the legislation”, because the latter provided “its benefit of making payment for medical services equally to the hearing and the deaf”<sup>126</sup>.

The Supreme Court overturned this approach, stating, through the words of Justice La Forest, that what matters are the “adverse effects” of laws and government policies<sup>127</sup>. In particular, to receive the same quality of health

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<sup>126</sup> See at paragraph 35.
<sup>127</sup> See at paragraph 61.
care, the deaf had to pay language interpreters in order to communicate with their health care providers, and this denied them the “equal benefit of the law” and discriminated against them in comparison with persons without a hearing impairment.\footnote{128}

Unfortunately, the attempt of “giving real effect”\footnote{129} to substantive equality has found an obstacle in \textit{Auton} (2004),\footnote{130} a case brought by the parents of autistic children after they failed to obtain funding for Lovaas intensive behavioural autism treatment from the B.C. Ministries of Health, Education and Children and Families.

The Supreme Court held that this case was different from \textit{Eldridge} (1997). The latter concerned the provision of translators to the deaf, so they could have equal access to core benefits granted to everyone under the B.C. medicare scheme: therefore it had to do with a benefit that the law accorded. On the other hand, the \textit{Auton} case (2004) was concerned with access to a benefit that the law – the B.C.’s \textit{Medicare Protection Act} – did not confer.\footnote{131}

The main reason why the Court decided that there was not any violation of section 15(1) is that “the legislature is under no obligation to create a particular benefit. It is free to target the social programs it wishes to fund as a matter of public policy, provided that the benefit itself is not conferred in a discriminatory way”\footnote{132}.

\footnote{128} See at paragraph 80.
\footnote{131} See at paragraph 38.
\footnote{132} See at paragraph 41.
In short, everyone must be treated the same once the law and/or the Government decides to grant a particular service, but the initial choice of what to provide and fund is not subject to section 15 scrutiny. As underlined by scholars, from Auton (2004) it emerges that “the Charter speaks only to the formal equality of the medicare system, or to questions of equal access for those who are already in a publicly funded health care queue”\(^{133}\), and, from this point of view, it is significant that this decision is recalled by Toussaint II (2011).

The developing of a stronger concept of substantive equality in the Canadian legal system could lead, on the contrary, to enlarging health coverage for temporary workers and international students, whose lack of health protection has not been evaluated illegitimate in the Irshad case (2001), and could probably make it easier to challenge the cuts to the IFHP. Moreover, it could show the way for granting some health guarantees to undocumented migrants, overcoming the narrow reasoning of Toussaint II (2011).