Crossing Boundaries: Travel, Immigration, Human Rights and AIDS

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Humans create and use multiple boundaries for many varied and complex purposes. The concept and physical reality of the nation state to which non-nationals have no right but only a privilege of entry, has been an important boundary in defining many twentieth century societies. Other such boundaries — likewise, created through a "them" and "us" approach — are those between the stranger and the friend, the moral and the immoral person, and the diseased and the healthy. All of these boundaries are cumulatively operative in the context of the exclusion of visitors, immigrants or refugees on the basis of medical inadmissibility.

In this article, the authors explore, first, the role that disease plays in society, in particular, as a reason, means or excuse for the stigmatization of others, and how the refusal of entry to a country on the grounds of medical inadmissibility reflects a broad range of societal attitudes, values, beliefs, prejudices and aims often unrelated to health concerns. The authors then examine medical inadmissibility in travel and immigration law in the United States and Canada, using HIV infection and AIDS as the particular example. Finally, they reconsider the theories underlying present immigration law and argue that the notion of the absolute sovereignty of the state with respect to its right to exclude aliens should be modified in view of both historical and present realities.

It is proposed that there should be a presumption that all visitors to a country should have a right of entry, unless the state can show justification for excluding them; that while the state may exclude immigrants, including on medical grounds, such exclusion should comply with principles of human rights and justice; and that refugees should never be excluded on the grounds of medical inadmissibility.

Nous créons et utilisons de multiples frontières pour des usages variés et complexes. Le concept d'État-nation et son application selon laquelle les non-nationaux n'ont pas de droit mais plutôt un privilège d'entrée a servi d'importante frontière pour définir plusieurs sociétés au vingtième siècle. D'autres frontières, similairement crées selon une approche d'auto-identification, sont celles entre l'ami et l'étranger, le moral et l'immoral, et la personne en santé et le malade. Toutes ces frontières s'appliquent cumulativement dans le contexte d'exclusion des visiteurs, des immigrants et des réfugiés pour cause d'inadmissibilité médieale.

Dans cet article, les auteurs explorent d'abord le rôle joué par la maladie dans la société —en particulier comme raison, moyen ou excuse de stigmatisation d'autrui — et tentent ensuite de voir comment le refus d'entrée reflète, sur le plan social, un éventail d'attitudes, de valeurs, de croyances, de préjugés et d'objectifs bien souvent sans rapport aux objectifs médicaux. En prenant comme exemple l'infection du VIH et le SIDA, les auteurs examinent l'inadmissibilité médicale dans les lois d'immigration et de voyage aux États-Unis et au Canada. Enfin, les auteurs reconsidèrent les théories qui sous-tendent actuellement les lois d'immigration et, à la lumière des réalités historiques et présentes, proposent de revoir la notion de souveraineté de l'État et du droit d'exclusion des étrangers.

Les auteurs suggèrent qu'un droit d'entrée devrait être présumé pour tous les visiteurs à moins de preuve d'une justification pour l'exclusion, et que, bien que l'État ait le droit d'exclure les immigrants (notamment pour des questions médicales), une telle exclusion devrait se conformer aux droits de la personne et aux principes de justice. Les réfugiés, pour leur part, ne devraient jamais être exclus pour cause d'inadmissibilité médicale.

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Dedication

This article is dedicated to the memory of Kenneth Gobeille, who was tragically killed in a bicycle accident in Maine on 31 August 1991. Donations were given in honour of his memory by his family and friends, and these funded research for this article, a project which those closest to Ken felt he would have been interested to support.

WALLS

Man is
a great wall builder
The Berlin Wall
The Wailing Wall of Jerusalem
But the wall
most impregnable
Has a moat
flowing with fright
around his heart

A wall without windows
for the spirit to breeze through
A wall
without a door
for love to walk in.

OSWALD MITSHALI,
Soweto poet

Introduction and Overview

The law of entry restrictions[1] involves the creation of boundaries by people of one nation for the exclusion of people of a different nation. Such restrictions may be necessary for the economic protection and welfare of a state. However, they also reflect social and psychological boundaries which we as individuals and societies place between ourselves and the "outside". The poem, *Walls*, provides an insight in this respect; it suggests that one basis for exclusionary responses, such as entry restrictions, is that of fear. In the case of entry restrictions related to Human Immunodeficiency Virus (HIV), the fear may not only be of HIV-related disease itself and of being confronted with an image of our own mortality, but also of possible losses and harms in a wide range of activities, values and privileges which can be associated with HIV infection and Acquired Immune Deficiency Syndrome (AIDS).

This article will describe the process by which powerful conscious and unconscious fears, such as the fear of a perceived threat to a well-ordered society, can be triggered by being confronted with disease in the context of migration. It will also analyze how these fears can be translated into restrictive measures, often affecting or being directed

[1] This term is used to include restrictions relating to the entry of visitors as well as those who wish to reside permanently in a country of which they are not nationals (*e.g.* prospective immigrants). The term "immigration" is not appropriate with respect to all of these different groups, since visitors cannot be regarded as immigrants within the normal meaning of the word. Refugees should also be distinguished on the basis of special human rights considerations. In this article the word "migration" will thus be used as an inclusive term. Furthermore, it is suggested that there is a fundamental difference in nature between temporary presence and permanent residence in a foreign country. The formulation of entry restrictions should therefore reflect this distinction clearly.

against the least powerful members of society.[2] One function of entry restrictions may therefore be to provide protection against these deep fears, by providing an appearance of protection against the people on whom the fears are projected. In fact, these deep fears may be more important than the actual risk to public health as the real reason for implementing entry restrictions ostensibly aimed at the protection of public health.

The scope of the issues which need to be considered in relation to entry restrictions is extremely broad. We consider these in the context of medical inadmissibility. This examination will be divided into two main sections: first, we examine, in general, the complex interaction between society and its perception — whether theoretical, mythical, fabricated or real — of the threat or presence of disease. In particular, we examine the influence of social and economic factors on the adoption of public health measures. The social construction of disease plays a significant role in shaping medical and public health responses to it.[3] Second, we undertake an analysis of the use of medical inadmissibility criteria in migration law. For example, in the United States, the exclusion of HIV infected immigrants and visitors has been maintained on public health grounds, despite the recommendation of the Department of Health and Human Services that the legal provisions to this effect should be repealed.[4]

The second major section of this article focuses on the origins, theory and functions of the law governing migration because we believe that medical inadmissibility criteria should be examined within the wider context of migration laws. Within this context medical inadmissibility criteria are conceptualized by policy-makers around theories other than just those of protection of public health. Other factors such as the economic impact of allowing the entry for permanent residence of sick people may also be relevant, or even dominant, particularly where a comprehensive public system of health care exists, as for example in Canada.

The discussion focuses in particular on the concept which underlies much of modern migration law, namely the right of a state to exclude all non-resident aliens. This concept is, in turn, based on a certain absolutist notion of sovereignty of the state with respect to its territory. We argue that the right to exclude all aliens is not an inherent right of states, but a concept influenced, for example in its formulation, by the xenophobia of the early years of this century as well as by the theory of Legal Positivism.

At present an increasingly important subtext to migration legislation in many Western countries has been the rising social and political concern relating to the increasing numbers of people, often from developing nations, seeking refugee or immigrant status or moving illegally into these countries. This migration has been prompted by political repression, huge economic disparities between North and South, and changes in the

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[2] These groups are sometimes physically present in a society, but not perceived as full members of it (*e.g.* illegal immigrants). This perception has often facilitated the imposition of harsh, restrictive measures.

[3] See A.M. Brandt, "AIDS and Metaphor: Toward the Social Meaning of Epidemic Disease" (1988) 55 Social Research 413 at 415.

[4] See *infra* notes 75-82 and accompanying text.

world's political situation since the end of the Cold War. International travel is increasingly possible and "[h]undreds of millions of persons cross international borders each year, by boat, air, rail, motor vehicle and foot."[5] In 1983, 95,000 people sought asylum in OECD countries, which increased to 700,000 by 1991 — an increase of over 600 per cent.[6] Of the OECD countries, Germany has been by far the largest recipient where 438,000 refugee claimants were registered in 1992.[7] In 1991, the figure was only 256,000.[8] These movements, unprecedented in size, have been portrayed emotively as an invasion in many Western countries.[9] This has prompted political responses to reduce the numbers of refugee claimants and immigrants in general. These include the so-called "Fortress Europe" policy which appears to have been adopted by the European Community. There have also been legislative changes in several countries including France,[10] Canada[11] and Germany.[12] In the latter case, the constitution was altered to allow for the reduction of the number of asylum claims.

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[5] United States, National Commission on Acquired Immune Deficiency Syndrome, *Background Paper on AIDS and Immigration: An Overview of United States Policy* (Washington, D.C.: National Commission on AIDS, 1989) at n. 24 [hereinafter *Overview of U.S. Policy*].

[6] See Employment and Immigration Canada, *Managing Immigration: A Framework for the 1990s* (Ottawa: Employment and Immigration Canada, 1992) at 4.

[7] "Europe Tries to Shut the Floodgates" *The Financial Times* (3 June 1993) 3.

[8] Germany has taken over 1 million asylum seekers over the past four years, *ibid.*

[9] For example, in the words of former French President, Valéry Giscard d'Estaing, "[l]e type de problème auquel nous aurons à faire face se déplace de celui de l'immigration vers celui de l'invasion." *Le Figaro-Magazine* (21 September 1991) in *Le Nouvel Observateur* (24 June 1993) at 87.

[10] In France, immigration is regulated under an order made on 2 November 1945. Its provisions on refugees and family reunion were amended on 2 June 1993. They are now considerably more stringent. Charles Pasqua, the Minister who introduced the amendments declared that the government's objective was "une immigration zéro." See "Immigration: le gouvernement serre la vis: Les dispositions entendent réduire le flux migratoire et favoriser les expulsions" *Le Figaro* (3 June 1993) 11. The widely-used expression "flux migratoire" would seem to indicate an attitude that is disfavourable towards migration.

[11] See *An Act to amend the Immigration Act and other Acts in consequence thereof*, S.C. 1992, c. 49. Canada also decreased its refugee quota for 1993. See J. Bryden, "Refugee Quotas Cut: Boost for Business Immigration Shows Lack of Compassion: Critics" *The [Montreal] Gazette* (5 December 1992) A11.

[12] See "Germany Revokes Right to Asylum — Parliament Proposes New Law that Will Turn Away or Return Most Refugees" *The Globe and Mail* (27 May 1993) A7. This altered the constitution which, until 26 May 1993, provided for a guaranteed right of all foreigners to seek asylum in Germany. *Grundgesetz* (23 May 1949), see "Germany", ed. by G.H. Flanz in A.P. Blaustein & G.H. Flanz, eds., *Constitutions of the Countries of the World*, vol. 7 (New York: Oceana, 1994) Arts. 16a(1), 19(4). New regulations including a "safe country" rule were introduced. This is likely to be contested since adherence to a list of "safe" countries eliminates consideration of the individual circumstances of each applicant who may, for example, be a member of a persecuted minority. Such is the case of East European gypsies who may well be facing persecution, but whose countries — Romania, Bulgaria and the Czech Republic — have been deemed "safe". See "Germany's Refugee Dilemma" *The Globe and Mail* (31 May 1993) A16. Switzerland and Belgium have also introduced lists of "safe" countries. See G.S. Goodwin-Gill, "Safe Country? Says Who?" (1992) 89 Refugees 37.

In short, it would seem that the ancient right of asylum now codified to some extent in the 1951 UN *Convention Relating to the Status of Refugees*[13] is being diminished by Western governments. But unless a cooperative approach is taken to the resolution of the underlying problems that give rise to migration, migrants will continue to arrive in Western countries and will stay as illegal immigrants. As recognized by the United Nations, "[w]here legal channels are closed, migrants will enter by whatever means are available to them."[14] For example, it has been estimated that there are at least five million illegal aliens in Western Europe[15] and at least two million in the United States.[16]

It should also be kept in mind that the vast majority of migrants move between or are internally displaced within developing countries, with little hope of reaching the richer countries. The figure of 700,000 applicants in OECD countries seems relatively small when one considers that "[r]efugees in 1991 totalled approximately 17 million, 87 per cent of them in developing countries."[17] The United Nations Report *State of World Population 1993* also notes the greater generosity of developing countries, as compared with developed ones, in accepting large numbers of refugees.[18]

Keeping in mind this wider context of increasing intolerance towards migrants, we examine HIV-related entry restrictions in the United States and Canada. These countries have been chosen because they are countries "of immigration", and pride themselves on the human rights protections entrenched in their constitutions. It is our purpose to examine whether their policies in relation to HIV-related entry restrictions and immigration law in general match up to their stated human rights standards and, if not, how they should be re-formulated with these in mind. It is also suggested that the treatment of strangers provides an excellent indication of the fundamental values of a society and the extent to which it is willing to apply such values in general, and therefore can legitimately promote them globally. Concepts such as the "global community" are now

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[13] *Convention Relating to the Status of Refugees*, 28 July 1951, 189 U.N.T.S. 150, Can. T.S. 1969 No. 6 [hereinafter *Refugee Convention*].

[14] United Nations Population Fund, *The State of World Population 1993: The Individual and the World: Population, Migration and Development in the 1990s* (New York: UNFPA, 1993) at 22 [hereinafter *The State of World Population*].

[15] B. Newman, "Fortress Europe" *The [Montreal] Gazette* (10 July 1993) B1. In France it is recognised that illegal immigrants have created "une véritable culture souterraine" (F. Leclerq, "L'impossible expulsion" *L'Express* (13 December 1991) 24). The number of illegal immigrants is likely to increase, particularly in Western Europe given the proximity of the economically and politically troubled countries of Eastern Europe and Northern Africa.

[16] "Immigrants: The Target of U.S. Fears" *The Economist*, reprinted in *The Globe and Mail* (26 July 1993) A13.

[17] *The State of World Population*, *supra* note 14 at 7. The report also states that "[a] further 3.5 to 4 million were thought to be in 'refugee-like situations,' though estimates are probably extremely conservative, and an estimated 23 million people internally displaced" (*ibid.* at iii).

[18] Pakistan and Iran, for example, have sheltered over three million refugees each during the 1980s. Regional conventions in Africa and the Americas both have adopted broader definitions of the term "refugee" than that of the United Nations Convention (see *ibid.* at 32-33).

common place; this article suggests that if these concepts are not to ring hollow, greater attention must be paid to their substantive content.

I. Society and Disease

A. The Role Disease Plays in Society

Disease has cultural as well as biological and medical aspects. We need to take a wider and deeper perspective, because "[d]isease is simply too significant, too basic an aspect of human existence to presume that we could respond in fully rational or neutral ways."[19] Brandt says, "so complex a phenomenon as disease cannot be understood outside the culture in which it occurs."[20] There is an interaction between the biological reality of disease and culture:

> Throughout human history, epidemic disease has constituted a natural experiment in how societies respond to disability, dependence, fear and death. In this sense, the manner in which a society responds reveals its most fundamental cultural, social, and moral values. Disease is not merely a biological phenomenon; it is shaped by powerful behavioural, social and political forces. Social values affect both the way we come to see and understand a particular disease and the interventions we undertake. In this view, disease is "socially constructed."[21]

In consequence, responses to disease are often moulded by the preoccupations of a particular society, especially if those preoccupations relate to matters that the society regards as critically important.

Brandt identifies two such preoccupations which helped to determine the response of American society to sexually transmitted disease in the first two decades of the twentieth century: the search for technical and scientific answers to social problems and the search for a set of unified moral ideals.[22] The former is exemplified by the reporting, screening, testing and isolation requirements introduced in an attempt to control venereal disease. The latter may be seen in public health education campaigns which attempted to instil a fear of sex into the target audience as a means of reinforcing a moral code that emphasized the importance of reserving sexual activity until marriage.

The importance of social concerns in moulding public health responses is clear. Difficulties can arise, however, if attaining one social or public health aim is in conflict with attaining another and both are considered to be essential. For instance, if safe-sex education is seen as encouraging extra-marital sexual activity (which is regarded as undesirable), but as necessary to protect the health of persons, there is a conflict. The issue then becomes a matter of priorities: Should the protection of health or upholding moral

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[19] Brandt, *supra* note 3 at 416.
[20] *Ibid.* at 417.
[21] *Ibid.* at 414-15.
[22] See *ibid.*

rules seen as fundamental to the existence of a moral society take precedence? Brandt also observes that:

> [V]enereal disease became a metaphor for the anxieties of this time, reflecting deep social and cultural values about sexuality, contagion and social organization. But these metaphors are not simply innocuous linguistic constructions. They have powerful sociopolitical implications, many of which have been remarkably persistent during the twentieth century.[23]

A powerful illustration of the social and political implications of such meanings of disease is the way disease may be used to define and to re-emphasize social boundaries.[24] Disease and blame for its spread may be assigned to certain already stigmatized and vulnerable groups — for example, to the poor or prostitutes. HIV infection and AIDS, in particular, have been used by some persons to reinforce and act out their prior disapproval of homosexuality and to seek the agreement of others to this stance.

We may therefore consciously or unconsciously elicit and exploit the effects of attaching meanings and moral judgments to a particular disease for a variety of purposes. We may also do the same in failing to detach meaning or moral judgments from a certain disease. The nature of the purposes we seek to fulfil in these ways will be explored in greater detail later in this article. It is important to emphasize that society's response to disease is often guided by non-objective considerations. These considerations often override any concern for those affected. As a result, many legal and policy responses to disease are shaped primarily by factors other than medical or economic considerations. To illustrate further the social and cultural meanings of disease and their influence on legal, medical and political responses to disease, we examine these factors in the context of examples from some previous epidemics: leprosy, the Black Death, cholera and syphilis. Experiences reported in the context of those epidemics are compared to present day responses to HIV infection and AIDS.

B. Stigmatization as a Response to Epidemic Diseases

An examination of the history of "public health" responses to "dread" diseases shows that a common reaction is the stigmatization of those infected and the justification of such stigmatization on moral grounds.[25]

Leprosy, for example, was regarded as a punishment for sin. Since it was associated with sexual promiscuity, "leprosy became the metaphor for heresy, moral turpitude, and unnatural and excessive lust."[26] Syphilis also was associated with debauchery and moral punishment.

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[23] *Ibid.* at 422-23.

[24] See *ibid.* at 418.

[25] See N. Gilmore & M.A. Somerville, "Stigmatization, Scapegoating and Discrimination in Sexually Transmitted Diseases: Overcoming Them and Us" (1994) 39 Social Science and Medicine 1339.

[26] D.F. Musto, "Quarantine and the Problem of AIDS" (1986) 64 Milbank Q. 97 at 101.

The connection of HIV infection and AIDS with several taboo subjects such as sexuality, homosexuality and injection drug use has likewise facilitated the moral colouring of the HIV epidemic by some.[27] For many years, homosexuality was viewed as a "psychopathic disease." The immigration law in the 1960s and 1970s allowed the United States to exclude those immigrants whom it determined to be homosexual. In the 1980s, the Immigration and Naturalization Service (INS) continued to exclude individuals based on homosexuality, but the courts required a medical certificate for exclusion on this basis.[28]

A tug-of-war developed between the Judiciary and Congress concerning the jurisdiction for the exclusion of persons as immigrants on the basis of their homosexuality. The Judiciary stated that the power of Congress to regulate immigration was "plenary," "almost exclusive" and subject to "minimal judicial review."[29] Even with this severely limited power to review, there is, however, some evidence that the Judiciary will attempt to control exclusion provisions by strict interpretation of the statutory and procedural requirements.[30] This is evident in *Hill* v. *United States Immigration & Naturalization Service*, where the Court recognized Congress's right to exclude homosexuals, but held that, according to the statute, a medical certificate from a medical officer stating that the alien suffered from a mental disease was required.[31] The Surgeon General of the United States had issued a declaration that no medical officer could issue a certificate stating that a person had a mental disease just because the person was homosexual.[32] The Court specifically recognized that this would indirectly prevent the exclusion of aliens only for their homosexuality.[33] Not all circuit courts, however, held the same view. In *Longstaff*, which was heard around the same time as *Hill*, the Court held that Congress intended the term "psychopathic personality" to include homosexuals, and a medical certificate diagnosing a mental disease was not needed.[34] All that was needed to exclude aliens on the basis of homosexuality was an admission of homosexuality.[35] It seems that the exclusion of immigrants based on homosexuality has not been directly addressed by the courts since the 1980s. It is interesting to note the coincidental timing of the pressure

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[27] Brandt, supra note 3 at 429, relates the remarks of President Reagan's former speech writer Patrick Buchanan, who declared that: "The poor homosexuals — they have declared war upon Nature, and now Nature is exacting an awful retribution" (*New York Post* (24 May 1983)).

[28] See *Hill* v. *United States Immigration and Naturalization Service*, 714 F.2d 1470 (9th Cir. 1983), later proceeding 775 F.2d 1037 (9th Cir. 1985) [hereinafter *Hill*]; *Lesbian/Gay Freedom Day Committee, Inc.* v. *United States Immigration and Naturalization Service*, 541 F. Supp. 569 (Cal. 1982), aff'd 714 F.2d 1470 (9th Cir. 1983), later proceeding, 775 F.2d 1037 (9th Cir. 1985). Compare with *In re Longstaff*, 716 F.2d 1439 (5th Cir. 1983) [hereinafter *Longstaff*].

[29] F.G. Pendleton, "The United States Exclusion of HIV-Positive Aliens: Realities and Illusions" (1995) 18 Suffolk Transnat'l L. J. 269 at 288.

[30] See cases cited at *supra* note 28.

[31] See *Hill*, *supra* note 28 at 1480. See also Pendleton, *supra* note 29 at 293.

[32] See *Hill*, *ibid.* at 1472.

[33] See *ibid.* at 1481.

[34] See *Longstaff*, *supra* note 28. See also Pendleton, *supra* note 29 at 293.

[35] See *Longstaff*, *ibid.*

from the Judiciary to prevent exclusion on the grounds of homosexuality and the moves made by Congress to pass legislation excluding immigrants who were HIV positive, a condition strongly believed to be connected with homosexuality in itself, in the early years of the AIDS epidemic.[36] In reviewing the history of the "homosexual exclusion" and the development of the "HIV exclusion", it appears that the HIV exclusion may be a "surrogate test" for excluding homosexuals.

While many people infected with dread diseases have been ostracized, distinctions are drawn between some infected persons and other infected persons. These distinctions are sometimes made to exempt from disapproval those who were not infected through behaviour perceived by society to be immoral. This distinction is necessary to preserve the symbolic and moral messages associated with the transmission of the disease. The moral meaning of infection, in effect, would be lost if distinctions between "guilty" and "innocent" victims were not made.[37] For example, hemophiliacs could be described as "innocent bystanders"[38] in the path of a new disease. It can then be implied, however, that other persons with HIV are guilty in having acquired the infection. HIV infection thus can be seen as a punishment of homosexuals for immoral conduct.

C. Economic Influences on Policy Responses to Disease

Legal and medical responses to diseases, and the policies that reflect and implement these responses, have also been shaped by economic factors. The following examples illustrate how the decision whether to implement exclusionary measures may be more influenced by economic considerations than by public health analysis.

First, during the cholera epidemics of the late nineteenth century in several North American cities, scientific debate was greatly influenced by commercial needs. There were at least two schools of scientific opinion that attempted to explain the transmission of disease. Those who believed that disease was transmitted by animated particles, invisible to the naked eye (the theory of *contagion vitum*) were in opposition to those who believed that infection resulted from the inhalation of putrefied air or *miasma*. The latter theory was adopted by most of the business community since according to this explanation there was no need for quarantine and resulting inaccessibility to trading partners and delays. Therefore, this theory "served the practical purposes ... of businessmen interested in unimpeded free trade."[39]

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[36] The actions taken by the U.S. Congress and the Executive Branch are discussed below at Section II.A.1.

[37] It is interesting, however, that those deemed to be "innocent" victims are not exempt from harmful reactions to them based on fear and stigmatisation in everyday life. For example, infected hemophiliac children in schools, on several occasions, have been the object of protests by the parents of other children.

[38] See Brandt, *supra* note 3 at 430.

[39] J. Goudsblom, "Public Health and the Civilizing Process" (1986) 64 Milbank Q. 161 at 177.

Second, in times of plague, information regarding contagion was often suppressed because it had disastrous consequences for trade and employment. Even today, several countries deny that they have any HIV-infected nationals, or deliberately underestimate their numbers in order not to discourage investment, trade or tourism. Entry restrictions may also reflect such concerns. For instance, Cuba tests its own nationals and all permanent residents and long-term visitors for HIV infection,[40] but excludes short-term visitors staying less than three months (*e.g.* tourists) from this requirement in an effort to protect much needed tourist revenue.

D. Lessons from History: Exclusion from the Community of People Suspected of Being Infected

In order to understand the role of disease — in particular infectious disease — in a society and the treatment of those infected, the contemporaneous social, cultural and economic context must be considered. This is equally true of society's response to HIV infection and AIDS and its treatment of those infected.

Historical analysis shows that several dimensions often underlie decisions to exclude infected persons from a community. First, these decisions may be regarded on the basis of available medical knowledge, and either wholly or in part as simply essential and sensible measures to control disease. Few would argue with the isolation of people infected with active tuberculosis as a necessary precaution. Likewise, in times of plague, the implementation of quarantine and the requirement that all incoming travellers carry health certificates could be characterized as "organized attempts not just to ostracize the victims but indeed to combat the disease."[41] The latter was true because the plague could justifiably be seen as "something that came from the outside."[42] Moreover, at that time, the principal theory of transmission was that of *contagion vitum* or the transmission of disease by animated particles invisible to the naked eye. Consequently, even though the forty-day quarantine period adopted was arbitrary in terms of its length and there was no precise knowledge of the means of transmission of the infection, these measures were to some extent rationally related to the control of the disease.

Second, measures of exclusion and confinement have also been partly or principally fuelled by anxieties at a societal level. Demands of the public for protection from epidemics occasionally have "overwhelmed the medical experts' assurances that the disease was not contagious and that quarantine was an expensive and useless instrument with which to combat cholera."[43]

Third, measures of exclusion can serve psychological and symbolic functions for individuals and societies. Musto has described the "psychology of quarantine" as the

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[40] See M. Duckett & A.J. Orkin, "AIDS-related Migration and Travel Policies and Restrictions: A Global Survey" (1989) 3 (Supp. I) AIDS: A Year in Review S231 at S236-37.

[41] Goudsblom, *supra* note 39 at 169.

[42] *Ibid.* at 168.

[43] Musto, *supra* note 26 at 105.

marking of a *boundary* with a "deep[ly] emotional and broad[ly] aggressive character" between persons who are the "contaminating" and the "uncontaminated."[44] Another example of how policies of exclusion and confinement may be introduced as a result of anxieties and prejudice at the societal level is the quarantine of prostitutes during the First World War on the *presumption* that they had venereal disease. Based only on a presumption, this highly intrusive intervention represented an unjustified use of quarantine powers against a stigmatized group in society, but it was nonetheless upheld by the courts. The courts believed that if a woman were a prostitute it was reasonably probable that she was infected.[45] Public health officials were not required to prove whether an individual prostitute was in fact infected. Nor were they required to show reasonable grounds for belief of infection, other than the fact that she was a prostitute.

Fourth, the continued influence and use of concepts and approaches of exclusion and confinement (including quarantine), despite increasing medical knowledge over time that such measures were unnecessary with respect to certain diseases, deserves investigation — in particular because it has parallels in the present. As noted, the exclusion of people with HIV/AIDS within a community from that community, by means of quarantine or isolation, has not (barring exceptional circumstances) been officially endorsed in many countries. Neither the United States nor Canada has implemented such measures. However, in many countries, including the United States, the exclusion of infected foreigners has been officially condoned. This exclusion has taken the form of restrictions on immigration on the basis of medical inadmissibility. This difference in treatment of residents and foreigners may be explained by several factors, some of which are obvious. For instance, consideration of the effects of permanent immigration on the receiving state is a legitimate factor in the case of prospective immigrants, and from this perspective, some restrictions on the basis of medical inadmissibility are acceptable. Another difference arises because, in recent times, there has been great emphasis domestically on individual rights, including rights in relation to health care and in particular rights against discrimination. In the context of HIV infection and AIDS, claims to these rights have often been fuelled by the strong organization of lobbyists against coercive and restrictive measures. However, in practice and in law, human rights protections are often applied less stringently where foreigners not physically present are concerned. This reflects both general disidentification[46] from foreigners and their lack of influence over the political process.

E. Exclusion on the Basis of Genetics

According to Musto, there can be eugenic reasons underlying the exclusion of certain persons as immigrants. "Creating boundaries between groups to prevent entry of

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[44] *Ibid.* at 98.

[45] See W.E. Parmet, "Aids and Quarantine: The Revival of an Archaic Doctrine" (1985) 14 Hofstra L. Rev. 53 at 67 [hereinafter "AIDS and Quarantine"].

[46] See M.A. Somerville & A. Orkin, "Human Rights, Discrimination and AIDS: Concepts and Issues" (1989) 3 (Supp. 1) AIDS: A Year in Review S283 at S285.

undesirable biological characteristics, an essential element in the concept of quarantine, can be seen in the philosophy underlying some of the immigration laws of the United States."[47] Certainly, exclusion of potential immigrants on the basis of IQ tests, as has occurred in the United States,[48] is a clear example of such an approach.

The connection of immigration, genetics and eugenics raises some complex and highly sensitive issues. For instance, is the rejection of potential immigrants on health grounds just another manifestation of rejection on eugenic grounds? Did immigration restrictions on health grounds and the concepts and practice of eugenics arise at the same time? Could it be that immigration was seen as preventing "the undesirable" from coming in from outside, and eugenics as preventing persons characterized in this way from reproducing inside the society? Physicians in the United States were heavily involved in the international eugenics movement in the 1920s and 1930s, which culminated in the Nazi horrors.[49] It is noteworthy that both intelligence testing and medical examinations of potential immigrants were — and in the latter case still are — carried out by physicians who are not likely to identify personally with the vast majority of these people whom they assess. They are also less likely, therefore, to believe that these potential immigrants should be admitted to the society to which the physicians belong. In fact, McLaren states, in speaking of Canada, that there is evidence that, at least in the first half of the twentieth century, physicians considered immigrants a threat to the country.[50]

A discussion of genetics necessarily raises the issue of genetic testing of individuals, or screening of groups or populations, as part of a medical examination of prospective immigrants. The issues this raises, especially the ethical and legal issues, cannot be explored here. But in the context of excluding persons on the basis of their HIV status, it should be kept in mind that the acceptance of the use of tests which may be required to screen potential immigrants for certain conditions — such as HIV antibody tests — may pave the way for the use of other tests in the migration context, such as genetic testing. The analysis of past and present entry restrictions and practices indicates that such testing might be permitted to a far greater extent in this context than in the domestic one. It could be that fears raised by the advent of genetic testing would be realized to their fullest extent in the search for the "perfect migrant" or at least the perfectly healthy one. Paradoxically, however, the availability of such tests could mean that we might no longer be able to regard *ourselves* as healthy. These tests create a situation in which we may be forced to recognize, as Montreal's Dr. Ken Flegel noted, that "the well are only

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[47] Musto, *supra* note 26 at 109.

[48] See L.J. Kamin, *The Science and Politics of IQ* (New York: John Wiley, 1974) at 16 [hereinafter *Science and Politics*]. We are grateful to Jodi Lackman for bringing the *Science and Politics*, *ibid.*, and "Aids and Quarantine", *supra* note 45, references to our attention in her paper "Are We Wise Enough?: Eugenics, Genetics and Intelligence" (1995) [unpublished].

[49] See G.J. Annas & M.A. Grodin, eds., *The Nazi Doctors and the Nuremberg Code* (New York: Oxford University Press, 1992).

[50] See D. McLaren, *Our Own Master Race: Eugenics in Canada 1885-1945* (Toronto: McClelland Stewart, 1995) at 52.

the undiagnosed sick."[51] Would this mean that we might be less anxious to exclude those we perceive as being unhealthy?

Finally, in considering genetics within the context of immigration, we should also keep in mind that like other species (and indeed life on our planet as a whole), biodiversity is essential to our survival. Immigration is one important way in which a greater level of human genetic diversity than would otherwise be the case can be maintained; in a genetically diverse population, the prevalence of deleterious genes is lower than in an inbred one.[52]

F. The Relationship Between Societal Responses to Disease and the Development of Medical Inadmissibility Criteria

In this section we discuss the relationship of social factors, including the mistrust of foreigners, to the development of immigration restrictions on the basis of medical inadmissibility. We will also attempt to examine more closely the reasons for the importance attached to the presence of exclusionary measures, despite knowledge that such measures are often ineffective or highly discriminatory. Therefore, we are trying to identify the real functions served by these restrictions — functions which are, it would seem, valued more highly in some contexts than upholding the values of human rights in our Canadian and American societies.

It is suggested that one of the primary reasons for the kinds of stigmatizing, irrational reactions described above is a feeling of loss of control and uncertainty in the face of incurable disease.[53] It may be that this feeling of lack of control is more important than the fear of disease itself in promoting an exclusionary reaction. To regain certainty and control, we resort to various mechanisms:

> [T]he fear we have of our own collapse does not remain internalized. Rather we project this fear onto the world in order to localize it and, indeed, to domesticate it. For once we locate it, the fear of our own dissolution is removed. Then it is not we who totter on the brink of collapse, but rather the Other.[54]

This feeling of loss of control may be particularly acute in late twentieth century Western societies since their citizens are unaccustomed to allowing for uncertainty in their lives. To be in control is considered to be the "normal" state of affairs, and as such is regarded as a healthy state of affairs. The AIDS epidemic is therefore perceived as an

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[51] Interview by Dr. Somerville with Dr. K. Flegel, Royal Victorial Hospital, Montreal (1993).

[52] See J.J. Nora *et al.*, *Medical Genetics: Principles and Practice*, 4th ed. (Philadelphia: Lea & Febiger, 1994) and M.W. Thompson, R.R. McInnes & H.F. Willard, *Thompson & Thompson Genetics in Medicine*, 5th ed. (Philadelphia: W.B. Saunders Company, 1991).

[53] See Gilmore & Somerville, *supra* note 25 at 1340-46.

[54] S.L. Gilman, *Disease and Representation: Images of Illness from Madness to AIDS* (Ithaca, N.Y.: Cornell University Press, 1988) at 1 quoted in S. Watney, "AIDS, Language and the Third World" in E. Carter & S. Watney, eds., *Taking Liberties* (London: Serpent's Tail, 1989) 183 at 190.

"abnormal" or pathological situation which must be "solved" or "cured".[55] This has led to a situation where the inescapable role of politicians is as risk managers, which necessarily means managing the "dangerous future ... avoiding dangers *before* they arrive."[56]

Furthermore, the inability of researchers, thus far, to discover an effective treatments for the prevention of HIV infection or a cure for AIDS has fractured our confidence in the medical profession. This is of special importance in a society where faith in medicine has largely replaced religious faith. In short, medicine plays both a concrete and symbolic role in our society. Consequently, anything such as HIV infection and AIDS that "threatens" medicine in the sense that medicine cannot deal with it, or makes it seem impotent, is correspondingly perceived to threaten society.

A primary purpose of the construction of boundaries against infected people may therefore be both reassurance that something can be done to control the spread of an incurable disease and the protection of society against it. Consequently, the fact that boundaries, such as entry restrictions, are ineffective in practice can be less important than their symbolic functions — including such restrictions operating as a mechanism to overcome fear.

The exclusion of infected people may serve a further function on a societal level in pluralistic Western societies, namely, that of an "isolation ritual".[57] Such societies, in the absence of a strong sense of religion or cultural values common to all or the majority of its members, have little to bind themselves together. Therefore, "the primary purpose of such a ritual is not so much to exclude the isolated persons as to bind together the persons concurring in and carrying out the isolation."[58] The glue that cements this bonding may be the emotion of guilt. In other words, it is our shared guilt for doing to others that which we would not want done to ourselves which binds us together.

The factors described above provide an indication of some of the societal level anxieties which may, in some cases, lead to the imposition of exclusionary measures. As often is the case, the application of these measures has been advocated or used disproportionately against certain stigmatized groups — for instance, persons infected with HIV or AIDS. It is contended that such measures depend on and reflect our disidentification from those whom we perceive as the "other". This disidentification can allow us to impose exclusionary measures on HIV-infected people in breach of principles of human rights, instead of reacting rationally and compassionately towards them according to the human rights principles on which we claim our society is based.

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[55] See M.A. Somerville, "Law as an 'Art Form' Reflecting AIDS: A Challenge to the Province and Function of Law" in J. Miller, ed., *Fluid Exchanges: Artists and Critics in the AIDS Crisis* (Toronto: University of Toronto Press, 1992) 287 [hereinafter "Law as an 'Art Form'"].

[56] M. Woollacott, "Politicians Focus on Managing *the Risk* Society" *The [Montreal] Gazette* (17 February 1996) B6 [hereinafter "Risk Society"] (Republished from *The Guardian*, London, England.)

[57] "Law as an 'Art Form'", *supra* note 55 at 302 quoting D. Schulman, "Remembering Who We Are: AIDS and Law in a Time of Madness" (1988) 3 AIDS and Public Policy at 75-76.

[58] "Law as an 'Art Form'", *ibid.*

In relation to entry restrictions, a first level of disidentification is the "foreign" status of all entrants.[59] This disidentification is reinforced, first, when foreigners are infected with the agent of a feared disease such as HIV, and second, when they are from the "outside" of "respectable" society as in the case of homosexuals and drug users — two groups in which there is a higher rate of HIV infection than in the general population. In other words, HIV infection opens up multiple avenues for disidentification.

Any mistrust or fear of foreigners that exists is fortified by the fear of disease and the *a priori* association of foreigners with disease. Both this fear and association can be reinforced, without justification, by statements of "experts". During syphilis epidemics academics and physicians often called for tighter restrictions on immigration even though medical examinations at ports did not reveal a high incidence of the disease. These actions can have very long-lasting effects. It is noteworthy that immigrants are still required to be tested for syphilis for entry into both the United States and Canada.[60] A contemporary example of the fear of disease associated with the fear of foreigners is what Watney describes as the "relentless demonizing [by Western countries] of all the communities around the world that have been most devastated by AIDS."[61] Demonizing is yet another very powerful form of disidentification. We see the evils we fear as being personified in the others we demonize, and in doing so can feel that we are not tainted by the same evil.

Uncertainty about both disease and foreigners thus gives rise to anxiety, and anxiety to fear. When the two characteristics of disease and being a foreigner converge that person becomes a target for powerful disidentification by those who harbour such fears. On an emotional level, disidentification helps to assuage these fears, although there is no logical basis for this response.

As a result of this disidentification from foreigners by the public in general, the imposition of exclusionary measures is politically attractive. Migrants are the perfect target group for politicians who wish to be seen as strong and effective leaders, to be "doing something", and not afraid to take "tough" measures. In the context of exclusion on the basis of HIV infection or AIDS, they can also be seen to be managing a risk that has evoked profound fear in the public.[62] At the same time, politicians are politically safe in excluding non-nationals, including on the basis of their HIV status, because the persons most harmed by this (*i.e.*, those excluded) do not have a right to vote, and therefore cannot retaliate against these politicians. The dual effect of such political actions may partly explain what might seem to be a paradox in certain countries — namely the coexistence in law of anti-discrimination measures for the protection of nationals from discrimination on the basis of illness (or, likewise, on the basis of nationality), and exclusionary entry restrictions for non-nationals based on these same grounds. It is sug-

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[59] See Introduction, above, for more on this topic.

[60] See R. Mickleburgh, "Stop Syphilis Tests for Immigrants, Panel Urges" *The Globe and Mail* (3 November 1992) A6.

[61] Watney, *supra* note 54 at 191.

[62] See Woollacott, *supra* note 56.

gested that this apparent conflict can be understood by considering the desire of politicians to please both liberals and conservatives in their constituencies.[63] In such a scenario, it can be hoped that liberals will approve of and be appeased by the former type of measure, and conservatives by the latter.[64]

Foreigners can also be useful as political scapegoats. In *Managing Immigration: A Framework for the 1990s*[65] written by Employment and Immigration Canada to explain and to justify the proposed changes to the *Immigration Act*,[66] migrants are frequently referred to in association with criminal activity and abuse of the welfare system.[67] This characterization of migrants may both reflect and taint opinions of migrants, reducing sympathy for all of them, including those in very difficult and life-threatening circumstances.

The general characterization of migrants as abusers of social welfare systems or as criminals would indicate that migrants are perceived as morally different. We do not for example perceive the general population in similar terms although it also contains a certain proportion of abusers and criminals. This identification of a difference, here a moral difference, is an integral part of the process of disidentification. Similarly, we disidentify from an infectious disease by disidentifying from those infected with the disease, which means that we need to see them as different from us. We can do this by identifying the cause of the disease and our protection from it in terms of difference. Such a difference may relate to the behaviour of others, for instance, homosexual behaviour or injection drug use. Consequently, when we learn that such people are infected with HIV, we can reassure ourselves that we are unlike them (because we are not homosexual or injection drug users) and therefore are not at risk of HIV infection. Some people also classify homosexual behaviour or drug use as immoral. Such characterization can also function as a difference — allowing these people to disidentify further when they characterize themselves as moral persons.

It will be important to keep in mind factors such as those discussed in this section, particularly what they reflect in terms of the attitudes to foreigners — the "other" — in the second principal section of this article, namely the law relating to migration. Law both forms and reflects public opinion. It may seem an unusual question to some lawyers, but we need to ask whether our law, in particular our immigration law, is ethical?

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[63] See "Law as an 'Art Form'", *supra* note 55 at 299.

[64] See discussion regarding actions taken by the U.S. Congress in legislating the HIV exclusion below at Section II.A.1.

[65] *Supra* note 6.

[66] R.S.C. 1985, c. I-2.

[67] In all but five of the fourteen page introduction to this pamphlet, migrants are referred to in conjunction with one or more of the terms criminal, spy, terrorist and subversive.

II. The Legal Context of Exclusion on Grounds of Medical Inadmissibility

The following section describes American and Canadian medical inadmissibility provisions relating to HIV infection and AIDS. There is also a more detailed examination of the legal structure of immigration restrictions applicable to non-nationals.

A. Medical Inadmissibility in Travel and Immigration Law

1. United States of America

In 1891, a new law was passed restricting the admission of people "suffering from loathsome or contagious diseases."[68] The Public Health Service (PHS), influenced by the contemporary eugenics movement, interpreted this law to include venereal diseases. "The INA [*Immigration and Nationality Act*] identified diseases with a high degree of social stigmatization as grounds for exclusion, rather than using a public health methodology to determine those [diseases] capable of greatest harm to society."[69] In 1952, the *Immigration and Nationality Act* (*INA*) codified these provisions for the exclusion from the United States of aliens suspected of having certain diseases and disabilities.[70] It included both a general exclusion for aliens with "dangerous contagious diseases" and specifically excluded aliens with tuberculosis and leprosy.[71] The diseases listed in the Public Health Service Manual for the Medical Examination of Aliens were, and are, still socially stigmatized diseases. For example, in 1987, the seven "dangerous contagious diseases" listed were all associated with social stigmatization. Five of these were venereal diseases (chancroid, gonorrhea, granuloma inguinale, lympho-granuloma venereum and infectious-stage syphilis). The other two were tuberculosis and leprosy.[72]

On 8 June 1987, the PHS published a final rule adding AIDS to the list of "dangerous contagious diseases." Before the regulations implementing this rule had been issued by the PHS, Congress passed the *Supplemental Appropriations Act*.[73] Section 518 of this *Act*, known as the "Helms Amendment", directed the President to add HIV infection to the PHS list of diseases on or before 31 August 1987. On 1 December 1987, the legislative provision requiring serological testing of all immigrants for HIV infection and AIDS came into effect.[74]

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[68] *Overview of U.S. Policy, supra* note 5 at 1.

[69] G. Kirsch & R. Bayer, "Behind These Walls ...: HIV/AIDS and U.S. Travel and Immigration Policy" (Columbia University) [unpublished] at 7.

[70] 8 U.S.C. §1101ff. [hereinafter *INA*].

[71] See *Overview of U.S. Policy, supra* note 5 at 2.

[72] See *ibid.* at 3-4.

[73] Pub. L. No. 100-71, 101 Stat. 425.

[74] See *Overview of U.S. Policy, supra* note 5 at 5. The delay in implementing this provision was caused by administrative difficulties.

In the *Immigration Act of 1990*[75] Congress directed the Secretary of the Department of Health and Human Services to review the provisions for the exclusion of applicants for immigration on the basis of illness or medical condition according to "current epidemiological principles and medical standards."[76] Section 601(a) of this *Act* repealed the term "dangerous contagious diseases," replacing it with "communicable disease of public health significance."[77] This new terminology was adopted in order to reflect the intention that medical exclusion should be based only on public health grounds.[78]

The PHS's subsequent re-examination of the diseases listed led Secretary Sullivan to the conclusion that only active tuberculosis should be retained as a "communicable disease of public health significance."[79] He recommended that the other conditions listed, including HIV infection or that the person came from an area where HIV infection was endemic, therefore should be removed from the list, because:

> The risk of (or protection from) HIV infection comes not from the nationality of the infected person, but from the specific behaviors that are practiced. Again, a careful consideration of epidemiological principles and current medical knowledge leads us to believe that allowing HIV-infected aliens into this country will not impose a significant additional risk of HIV infection to the U.S. population, where prevalence of HIV is already widespread.[80]

This proposal, however, proved to be politically untenable. During the thirty-day comment period following its publication, approximately 40,000 written comments were received. Ninety per cent of these letters opposed the removal of HIV infection from the PHS list,[81] as did the Departments of Justice and State.[82] Their lobbying was successful. On 31 May 1991, an interim rule was issued according to which the list remained unchanged.[83] Paradoxically, it may have been because HIV was already widespread in the United States that those who were HIV infected were excluded. A high prevalence and incidence of HIV infection raises deep fears of being personally at the risk of a dread disease, and therefore, can elicit a perceived need for disidentification. In addition, the opportunity for disidentification with homosexuals and drug addicts — by making an objection to the proposed rule — could comfort those members of the American society seeking the affirmation of certain moral ideals.

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[75] *Immigration Act of 1990*, Pub. L. No. 101-649, 104 Stat. 4978 (1990) (codified as amended at 8 U.S.C. §1101ff.).

[76] See 136 Cong. Rec. H13203-01 at H13238 (1990) cited in E.J. Lynch, "Medical Exclusion and Admissions Policy: Statutes and Strictures" (1991) 23 J. Int. L. & Pol. 1001 at 1009-10.

[77] *Supra* note 75, §601(a).

[78] See Lynch, *supra* note 76 at 1009.

[79] See United States, National Commission on Acquired Immune Deficiency Syndrome, *Statement on Immigration* (Washington, DC.: National Commission on AIDS, 1991) [hereinafter *Statement on Immigration*].

[80] PHS, Medical Examination of Aliens, 56 Fed. Reg. 2,484 (1991) (codified at 42 C.F.R. §34).

[81] See "AFP Newsletter – May 1991" (1991) 43 American Family Physician 1495.

[82] See Kirsch & Bayer, *supra* note 69 at 8.

[83] See PHS, Medical Examination of Aliens, 36 Fed. Reg. 25,000 (1991) (codified at 42 C.F.R. §34).

A year later another attempt to remove HIV infection from the list of diseases was made, and this time Congress responded. In 1992, part of President Clinton's campaign plan was a promise to end AIDS immigration restrictions. In February 1993, the PHS Secretary appointed by the President was prepared to remove AIDS from the list of diseases. Prior to the PHS Secretary taking action, however, Congress passed legislation codifying the exclusion.[84] In the debate surrounding the passage of this bill, the focus was on the nation's healthcare system, and as part of this, the costs of allowing HIV-positive persons into the U.S.[85] There were questions whether the "public charge" ground for exclusion would be sufficient, since although the costs could be significant the applicant might not become a public charge.[86] A distinction between travelers and immigrants seeking permanent residence was discussed, but nothing appeared in the final legislation.[87] In short, all HIV-infected persons were *prima facie* excluded from entry into the United States. With the tug-of-war between the Executive Administration and Congress on the AIDS exclusion, and the pressure from the Judiciary for the avoidance of discrimination and for respect for human rights, it appears that the conservative Congress made a political power play in codifying the AIDS medical exclusion.[88]

All categories of migrants to the United States are affected by HIV-related entry restrictions, but in different ways. Certain groups, however, are exempt from testing. For example, minors under the age of fifteen need not be tested unless there is reason to believe that they have an excludable disease.[89]

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[84] See *ibid.* The addition to 8 U.S.C. §1182(a)(1)(A)(i) of the language "which shall include infection with the etiologic agent for acquired immune deficiency syndrome" was passed 10 June 1993, to be effective 30 days after enactment.

[85] See J. Fitzpatrick & W. M. Bennett, "A Lion in the Path? The Influence of International Law on the Immigration Policy of the United States" (1995) 70 Wash. L. Rev. 589 at 617.

[86] The "public charge" exclusion excludes an alien who, in the opinion of the Attorney General, is likely at any time to become a public charge. 8 U.S.C. §1182(a)(4) (1990). Compare this to the socialised healthcare system of Canada and "excessive demands" exclusion, in Section II.A.2, below.

[87] See Fitzpatrick & Bennett, *supra* note 85.

[88] For a discussion on the pressure from the Judiciary and an outline of some of the immigration cases dealing with homosexuality see Pendleton, *supra* note 29. This article proposes that the HIV-positive exclusion is unconstitutional on the grounds that it does not have a "fair and substantial relationship" to the exclusion's purpose, and it constitutes "invidious discrimination". The stated purpose for this exclusion is the containment of the disease. Although this may be a legitimate governmental interest, the exelusion is not rationally related to the achievement of this purpose since more than a million Americans are infected, and the disease can only be transferred in limited ways — not by merely entering the country.

[89] See D. Kuntz, "Contagious Diseases and Refugee Protection: AIDS Policy in the United States" (Seminar on Migration Medicine of the International Organization for Migration, Washington, D.C., 6-9 February 1990) at 4.

a. Visitors

Visitors to the United States are in principle excludable under *INA* section 212(a)(6) if known to be HIV positive, but are not routinely tested for HIV antibodies.[90] Visa applicants will be asked about their HIV status, and those visitors who do not require visas may be questioned about their seropositive status on entry. Thirty day waivers may be granted to HIV-infected visitors. At first, the same criteria for waivers that applied to all categories of excludable people were also applied to people with HIV infection or AIDS.[91] In March 1988, however, stringent conditions for waivers were applied specifically to people with HIV infection or AIDS.[92] The burden was placed on prospective visitors to show (i) that their presence in the United States would create minimal danger to public health; (ii) that the possibility of their spreading infection would be minimal; and (iii) that no cost would be incurred by any level of government agency in the United States as a result of their presence in the country, unless they had the prior consent of that agency. An objective application of these criteria should mean the exclusion of very few HIV-infected people, given the fact that HIV infection is not transmitted casually, and that the absence of a system of generally accessible health care in the United States eliminates concerns about potential burdens upon such a system. It may be, therefore, that the function of these three criteria is not to protect public health and the public purse, but rather to respond to "gut fears", as well as to satisfy the political need, referred to previously, of being seen to "do something" about HIV infection and AIDS.

Since May 1989, waivers allowing entry to the United States for ten days have been granted, on a discretionary basis, to HIV-positive visitors under *INA* section 212(d)(3), if it is determined that their proposed visit confers a public benefit that outweighs the assumed risk to public health.[93] Activities deemed to involve a public benefit include academic or health-related activities (including treatment), attendance at conferences, and business and family-related activities. However, tourism on the part of persons infected with HIV is not considered to be an activity that confers a public benefit.[94] This provision was enacted in an attempt to address criticism of the law stipulating that HIV infection was a "dangerous contagious disease,"[95] which meant that all HIV-infected aliens were excluded. In protest against this law, several governments and many international and national organizations boycotted the Sixth International Conference on AIDS held

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[90] *Supra* note 70.

[91] These criteria are (i) the risk of harm to society if the applicant is admitted; (ii) where relevant, the seriousness of the applicant's criminal law violation; and (iii) the nature of the applicant's reasons for wishing to enter the United States. See Lynch, *supra* note 76 at 1005-06.

[92] See Lynch, *ibid.* at 1006.

[93] *Supra* note 70.

[94] See *Overview of U.S. Policy*, *supra* note 5 at 9.

[95] See *supra* note 71.

in San Francisco in June 1990.[96] Similar protests against the restrictions that would apply to HIV-positive persons wishing to attend the Eighth International Conference on AIDS (scheduled to have been held in Boston in 1992) caused that conference to be moved to Amsterdam.

The application of these HIV-related restrictions to visitors does not comply with the recommendations of many influential organizations in the fields of health protection and law. These include the World Health Organization (WHO) which has declared that "HIV screening of international travellers would be ineffective, impractical and wasteful."[97] The American Bar Association (ABA), in 1989, likewise, made a declaration in relation to non-immigrants that there should be no restrictions on the entry of travellers on the basis of HIV infection.[98] This did not stop Congress in persisting with the exclusion of all aliens, including travellers and non-immigrants, testing HIV-positive.[99]

b. *Applicants for Permanent Residence*

There are several categories of permanent residents, and slightly different requirements apply to each of these. However, all applicants for permanent status in the United States must be tested for HIV infection, and may not be granted the status they seek if they test positive.

No waivers were provided for seropositive applicants for permanent residence in the United States until the *Immigration Act of 1990*.[100] By creating a new category of waiver, this *Act* made official the previous practice of the INS, which had granted "deferred status" on a discretionary basis to avoid the deportation of HIV-infected parents, children and spouses of United States citizens.[101]

Candidates for legalization of their status — namely undocumented aliens who have been in the United States since 1982 — may be granted waivers. Since the aim of the legalization process was to facilitate the integration of undocumented aliens into society, the original waiver policy was fairly liberal.[102] Waivers were granted where the ap-

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[96] See N. Gilmore, "Medical and Political Aspects of Travel for HIV-Positive Persons" in H.O. Lobel, R. Steffen & P.E. Kozarsky, eds., *Travel Medicine 2* (Proceedings of the Second Conference on International Travel Medicine, Atlanta, Georgia, 9-12 May 1991) 207 at 210.

[97] WHO, *Global Program on AIDS: Statement on Screening of International Travellers for Infection with Human Immunodeficiency Virus* (Geneva: WHO, 1987) at 1.

[98] See American Bar Association, "Report of the Aids Coordinating Committee" (1989) 21 Toledo L. Rev. 1 at 18 (Policy Recommendation N2) [hereinafter "Aids Coordinating Committee"].

[99] For a discussion of the International Health Regulations and the response by the U.S. *see* Fitzpatrick & Bennett, *supra* note 85.

[100] See *supra* note 75.

[101] See *Overview of U.S. Policy*, *supra* note 5, at 10.

[102] See C.L. Wolchok, "AIDS at the Frontier: United States Immigration Policy" (1989) 10 J. Legal Med. 127 at 131. This policy was introduced by the *Immigration Reform and Control Act of 1986*, Pub. L. No. 99-603, 100 Stat. 3359 §313 (as codified at 8 U.S.C. §1187).

plicant could show compelling family unity, humanitarian and/or public interest grounds for remaining in the United States.[103]

It is suggested that exclusion of legalization candidates may be particularly unjust since the legalization process is open only to people who have been in the United States since 1982, and therefore it is most probable that HIV-positive applicants among this group were infected within the United States. The American Bar Association has recommended, in relation to this category of migrants, that:

> Legalisation pursuant to the Immigration Reform and Control Act should not be denied to otherwise-qualified aliens solely because of HIV status.[104]

The current waiver provisions apply to all aliens, making no distinction between visitors and those seeking permanent residence. The waiver is issued at the discretion of the Attorney General where the alien has a compelling family unity interest, as specified by the provision.[105] The provisions do not provide other grounds for a waiver.[106]

c. *Refugees*

Refugees are subject to the same stringent conditions for waiver as legalization applicants. "In previous years waivers for refugees with contagious diseases were fairly routine; this policy was in accord with U.S. laws and practice that treat refugees as special cases. In the case of AIDS, however, waivers are the exception."[107] It is sobering to think that this could mean that the political need to be seen to act against HIV infection and AIDS may be given priority over the protection of perseeuted people — that is, the former could be valued more highly than the latter. The *a priori* exclusion of HIV-infected refugees does not comply with yet another recommendation of the ABA that, "[o]therwise-qualified political asylees and refugees should not be barred from the United States solely because of HIV status."[108] In the meantime the ABA has recommended that a more individual approach be taken to the granting of waivers.[109]

It merits keeping in mind the message conveyed by a country through the way it treats refugees. As a U.S. Department of State witness testified during congressional hearings on the *Refugee Act of 1980*, there can be,

> A foreign policy interest to project in countries around the world the image of U.S. humanitarian assistance for refugees. Such humanitarian assistance is a

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[103] See *Overview of U.S. Policy*, *supra* note 5 at 10.
[104] "Aids Coordinating Committee", *supra* note 98 at 18 (Policy Recommendation N1).
[105] See 8 U.S.C. §1182(g)(1) (1996).
[106] See *ibid.*
[107] Kuntz, *supra* note 89 at 6.
[108] *Supra* note 98 at 18 (Policy Recommendation N3).
[109] See *Overview of U.S. Policy*, *supra* note 5 at 17-18.

> glowing example of the purposes and processes of the free democracy which we are, and of the free society which makes such assistance possible.[110]

It can be added that reinforcing this message may also be important in the domestic community.[111]

2. Canada

There is no listing of named excludable diseases in the Canadian *Immigration Act* or the regulations made pursuant to it.[112] In this respect Canada, unlike the U.S., complies with the WHO recommendations. Instead, in theory at least, the *Act* "permit[s] much more discretion [than does the United States] for medical officers responsible for assessing ... [the] individual abilities [of a non-national seeking to enter Canada] to combat or adapt to medical conditions [from which they suffer]."[113]

Medical inadmissibility in travel and immigration law is governed in Canada under section 19(1)(a)(i) and (ii) of the *Immigration Act*.[114] Aliens may be excluded from Canada on the basis that they constitute a threat to public health, or that they would or could place "excessive demands on health and social services."[115] Only the latter ground is applied in relation to HIV infection or AIDS, since "HIV/AIDS is not considered a dangerous, infectious disease, but rather a chronic disease like cancer or heart disease for which the concern is potential excessive demand on health care and social services."[116] The concern, therefore, is cost to the taxpayer, in view of the fact that Canada has a universal, comprehensive, socialized health care system in which citizens (and permanent residents) have automatic access to advanced health care.[117]

With regard to the assessment of "excessive demands", Citizenship and Immigration Canada issued a proposal for assessing what would constitute these. In the case of

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[110] Cited in T.J. Jones, "The Haitian Refugee Crisis: A Quest for Human Rights" (1993) 15 Mich. J. Int'l L. 77 at 119-20.

[111] See M.A. Somerville, "The Case Against HIV Antibody Testing of Refugees and Immigrants" (1989) 141 Can. Med. Assoc. J. 889.

[112] *Supra* note 66 and *infra* note 124.

[113] Employment and Immigration Canada & Health and Welfare Canada, *Medical Inadmissibility Review* (Discussion Paper) (Ottawa: Employment and Immigration Canada, 1991) at 5 [hereinafter *Medical Inadmissibility Review*]. General criteria include the need for surveillance of the person, the potential employability of the applicant in Canada, and the applicant's probable response to treatment.

[114] *Supra note* 66.

[115] *Ibid.*, s. 19(1)(a)(ii).

[116] *Medical Inadmissibility Review, supra* note 113 at 44.

[117] AZT and many other drugs used by people with AIDS are covered by provincial health care plans. These plans, however, do not cover all drugs. For instance, some of those necessary to treat opportunistic infections are not covered. Most recently, debate arose concerning payment for persons other than those on welfare for expensive new drugs that promise reduction in morbidity and premature mortality (*e.g.*, so-called "triple therapy"). Regarding this debate in Quebec, see for example, J. Heinrich, "Only AIDS Patients on Welfare Will Get Second Drug for Free" *The [Montreal] Gazette* (20 February 1996) A7.

immigrants, "excessive demands are caused when the total costs of health and any required, prescribed social services, in the five years immediately following [medical] assessment, exceed by more than five times the average per capita expenditures for health and social services in Canada."[118] The stated aim in formulating this definition was to "make the Regulations more objective and more open so that people who apply to come to Canada will be able to understand the basis on which a determination of their medical status is made."[119] However, the implementation of these regulations did not take place, largely because of concern from the provinces about the health care costs they could incur.[120] A subsequent proposal was to adopt a "sliding window principle." This would have widened the period during which "costs" would be assessed, by estimating the highest cost, consecutive five year period in the ten years following the medical examination.[121] A case heard after this proposal was drafted, however, ruled that the Governor General does not have the authority to make such regulations.[122] Therefore, on the basis of this case, any defining factors must be in the form of an amendment to the *Immigration Act*.

In *Ismaili*,[123] the Court addressed the validity of section 22 of the *Immigration Regulations*,[124] which sets forth factors for the medical officer to consider in determining whether a particular applicant will cause excessive demand on health or social services. Effective 1 February 1993, Parliament had deleted from the *Immigration Act* the phrase that had enabled the Governor General to make regulations regarding the criteria for determining excessive demand. Based on the removal of this language, it was argued that the part of section 22 that defined factors for the medical officer to consider in determining "excessive demand" was *ultra vires*.

The Court held that the omission of this authority-granting language "must be presumed to be intentional."[125] The Court, however, did not find section 22 completely *ultra vires*. It held that section 22 is to be read as prescribing factors to be taken into account in assessing danger to public health or public safety, but that it is not applicable to determining whether there will be excessive demand on health or social services. Therefore, "excessive demands" within section 19(a)(ii) of the *Immigration Act* must be interpreted without reference to the regulations.

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[118] *Proposed Regulations*, C. Gaz. 1993.I.2558 at 2561. See also proposed amendments to *Immigration Regulations, 1978*, s. 2(1) in C. Gaz., *ibid.* at 2570, Sch. 1, s.1.

[119] C. Gaz., *ibid.* at 2561.

[120] Interview by Dr. M. Somerville with Dr. N. Heywood, Director, Immigration Health Policy Selection Branch, Citizenship and Immigration (28 February 1996).

[121] *Ibid.*

[122] *Ismaili* v. *Canada (Minister of Citizenship & Immigration)* (1995), 29 Imm. L.R. (2d) 1, 100 F.T.R. 139 (F.C.T.D.) [cited to Imm. L.R.]. This is based on the removal of language in the enabling legislation (s. 114 (1)(m) of the *Immigration Act*, *supra* note 66) which gave the Governor General the authority to make regulations regarding excessive demand.

[123] *Ibid.*

[124] *Immigration Regulations*, S.O.R./78-172, s. 22.

[125] *Supra* note 122 at para. 22.

With regard to review of the medical officer's opinion, the *Ismaili* Court found that it had the power to inquire into the reasonableness of this opinion as to "probable demands on government services," but did not provide any criteria for such determination.[126] Further, the Court stated that the visa officer must consider the reasonableness of the medical officer's decision and whether the medical officer ignored evidence. Past cases do not provide much guidance as to the criteria for assessing "excessive demand", apart from the requirement of reasonableness.[127] By not having a legislated definition of "excessive demand", the determination is in the sole discretion of the medical officer, who is governed only by the requirement of reasonableness.[128] Without the list of factors in section 22 or some other guidance on factors to consider, the problems that existed before section 22 in trying to determine "excessive demand" remain. The goals of objectivity and of helping the applicants to understand the basis on which a determination of their medical inadmissibility was made cannot be achieved when the decision is made pursuant to such broad discretion and with no defined criteria. This is especially true when, although the decision is taken by a medical officer, it is based more on economic factors than medical criteria.

With discretion and lack of definition comes the opportunity for decisions to be affected — sometimes unknowingly — by the stigmatization associated with certain diseases. As discussed in connection with the U.S. immigration laws, homosexuality is often associated with AIDS. Canada's immigration laws have a similar history to those in the U.S. with respect to homosexuality. For many years, homosexuals were excluded as

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[126] *Ismaili, ibid.* at 9ff. The court recognised that it is not competent to make findings of fact related to a medical diagnosis, but could review the reasonableness of the medical officers' decision. The Court further stated that grounds for unreasonableness "include incoherence or inconsistency, absence of supporting evidence, or failure to consider cogent evidence." (*ibid.* at 15). The Court found that the medical officer did not consider all the evidence and that the factors relied on did not amount to excessive use of the health and social services system. The court allowed the application, but referred it back to the Minister of Citizenship & Immigration for reconsideration as to whether there would be excessive demands.

[127] See K.H. Post, "Excessive Demands on Health and Social Services: s. 19(1)(a)(ii) *Immigration Act* — What is the Standard to Sponsor Infirm and Elderly Parents?" (1992) 8 J. L. & Soc. Pol'y 142 at 156. See also F. Marrocco & H. Goslett, eds., *The 1997 Annotated Immigration Act of Canada* (Scarborough, Ont.: Carswell, 1996) at 125-34. One case said "excessive" means more than normal. See *Jim* v. *Canada (S.G.)* (1993), 22 Imm. L.R. (2d) 261, 69 F.T.R. 252. This raises the question of what is "normal", and what pool of persons is looked at (*i.e.* old, young, no family history of disease) in determining the normal costs on the healthcare system.

[128] See *Immigration Act, supra* note 66, s. 19(1)(a). There has been some arguments made that the medical officers are not trained to determine what constitutes excessive demand, based on the complicated economic and legal analysis involved in making such determination. See Post, *ibid.* The *Ismaili* Court did not go so far, but does say that "the visa officer — wholly apart from the decision of the medical officers — is obliged to consider whether the applicant's medical condition would place excessive demands on health or social services. The visa officer, without second guessing the medical, diagnostic opinion, must consider all of the available evidence" (*Ismaili, supra* note 122 at para. 31).

a category of immigrants on the grounds that they had immoral purposes.[129] In the 1970s, Canada made substantial revisions to its immigration laws, and deleted many of the outdated moralistic and medical terms of exclusion.[130] Canada has progressed much further than the U.S. in this respect, and now only excludes homosexuals if they happen to be excluded by the grounds in section 19 which apply to all prospective immigrants.[131] Canada has responded to the change of attitudes toward homosexuals both medically and socially. "The Canadian legislative debates on revising immigration laws repeatedly addressed the humanizing aspects of the proposed Act and the elimination of tired, moralistic language."[132] Now that it has deleted the moralistic language and highlighted the humanizing aspects, Parliament needs to define the factors for determining exclusion under section 19 — perhaps even by stating factors that must not be taken into account. This step is necessary to avoid prior stigmatisation from influencing the exercise of diseretion by the medical and visa officers. Homosexuality is just one example of certain stigmatised characteristics that are associated with AIDS, injection drug use is also commonly associated with the disease.

A society's stigmatisation of certain diseases and its need to define morality contribute to the determination of the exclusionary factors for immigrants. The latter is one of the underlying drives determining the social and political factors which influence immigration law. Understanding these factors and their influence helps us to understand the need for a different concept of immigration law incorporating a broader application of human rights.[133]

a. Visitors

The entry of visitors into Canada is governed under the same provisions regarding exclusion on health grounds as immigrants. In practice, initially, visitors and immigrants with HIV infection or AIDS were both excluded from Canada if their status were known. In a speech to the 1991 Canadian AIDS Conference, the Minister of Health and Welfare announced that "we will ensure that visitors with AIDS or HIV will be treated in exactly the same manner as any other visitor to Canada."[134] This has been interpreted to mean that short-term visitors with HIV infection or AIDS would no longer be prevented from entering Canada. However, there has been concern that the language of this

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[129] See R. Green, "'Give Me Your Tired, Your Poor, Your Huddled Masses' (Of Heterosexuals): An Analysis of American and Canadian Immigration Policy" (1987) Anglo-Am. L.R. 139.

[130] See *ibid.*

[131] *Immigration Act*, *supra* note 66.

[132] Green, *supra* note 129 at 158.

[133] This raises an interesting question of what comes first to affect change in these sensitive areas, formal modification or modification of public attitudes? To what degree does one pull the other. Formal modification does not just mean legislation, but can also be recommendations or declarations by professional organisations, for example, the declaration by the American Psychiatric Association that homosexuality was no longer considered to be a mental disorder.

[134] Hons. P. Beatty (Minister of National Health and Welfare), "The National Strategy on AIDS Revisited" (National Conference on AIDS, Vancouver, British Columbia, 14 April 1991) at 9.

policy is too vague to guarantee the free entry of HIV-infected visitors into the country.[135] In fact there is some evidence that, in practice, short-term visitors suspected of being infected with HIV have still been excluded.[136]

b. Applicants for Permanent Residence

Prospective immigrants are not routinely tested for HIV infection, but they are required to submit to a medical examination — and testing may be required at the discretion of the examining medical officer.[137] Several issues are raised, however, by the form used by physicians performing medical examinations for migration purposes. In November 1990, a new routine question concerning the HIV status of applicants was included in this form. It is made clear to applicants that non-disclosure of conditions addressed by the questions may have serious consequences. If immigrant status were granted on the basis of an incomplete or false answer, revocation of this status and the person's removal from Canada may occur. Testing for the purposes of immigration constitutes mandatory testing, which raises the ethical question of the voluntariness of the testing. Mandatory testing is that which cannot be avoided if one wishes to achieve a certain benefit or status. It can be contrasted with compulsory testing, which cannot be avoided.[138] Certainly, if all applicants were obliged to find out their HIV status in order to be able to respond adequately to the questioning, this system might be characterised as "mandatory testing with no mandatory test."

It now appears that the screening for diseases is going to become more stringent.[139] Using a new computer model, Health Canada is assessing the risk posed by forty-seven infectious diseases. The computer model study will allow assessment of the need to screen immigrants for HIV, even though AIDS is not viewed as a public health issue. The issue is cost, and this is being debated in various government departments, includ-

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[135] See National Advisory Committee on AIDS, *HIV and Human Rights in Canada* (Ottawa: Department of Health and Welfare, 1992) at 16. The *Immigration Manual* states however that

> An applicant who is medically inadmissible as an immigrant is not necessarily inadmissible as a visitor. A prospective immigrant's medical condition may be likely to cause excessive demands on health or social services because the person may not be self-supporting and would need continuous family or social support. A visitor would not likely require such assistance during a short stay in Canada (Employment and Immigration Canada, *Immigration Manual: Selection and Control* (Ottawa: Employment and Immigration Canada, 1984) at 6).

[136] See K. Dunn, "HIV Carrier Suing Canada for Refusing to Allow Him to Enter Country" *The [Montreal] Gazette* (30 July 1992) A4.

[137] See *Immigration Act, supra* note 66, s. 11(2).

[138] See M.A. Somerville & N. Gilmore, *Human Immunodeficiency Virus Antibody Testing in Canada* (Ottawa: Health and Welfare Canada, 1989) at 22-25.

[139] See D. Jacobs, "Disease Screening for Immigrants Gets Tougher" *Ottawa Citizen* (25 July 1997) A1.

ing whether persons infected with HIV should be excluded because of the potential medical costs.[140]

Under the current approach, in analysing an individual's application, the medical officers use codes to identify different diseases. If an applicant is found to be HIV positive, then the appropriate code may be M-7 which stands for the finding that the applicant is excludable because of the possibility of becoming an excessive demand on the healthcare system. This classification is supposed to be a summary of the various factors looked at by the medical officer in determining the individual's ability to be a contributing member of society. But these codes could be used as rubber stamps to exclude people with certain diseases. Rather than looking at the individual's ability to contribute to Canada and whether his or her health status is likely to interfere with this contribution, if the applicant is found to be HIV positive, he or she may be automatically labelled an M-7 and excluded on this basis. In other words, the concern is that the codes are being used to state a particular medical condition and to exclude an applicant on that basis, rather than on a proper evaluation of the individual's condition and all relevant circumstances.[141] The medical officer looks up a particular condition in the Medical Officers' *Handbook*[142] and sets forth the applicable codes in the prospective immigrant's Medical Profile.[143] Leaving aside the issue of whether it is appropriate to have a medical officer assess what constitutes an excessive demand, this procedure appears to limit, almost prohibit, the proper exercise of discretion by the medical officer, and sets up a regime of rubber stamping certain conditions as being an excessive demand and therefore excluding the applicant automatically.

The use of codes in such a way that certain medical conditions or infirmities will always constitute an excessive demand contradicts the intention of the Canadian *Immigration Act* as a whole, and section 19 in particular. This section is meant to ensure that each applicant is individually assessed in terms of medical inadmissibility. This practice denies admissibility to individuals with certain ailments who are not likely to be an excessive demand on the health and social systems of Canada. The lack of definition as to what constitutes excessive demand, and of criteria for assessing this, contributes to the codes being used to identify ailments (and exclusion on this basis), rather than evaluation of the individual's potential for excessive demand. This results in a failure to take into account possible family support and the person's capacity to be a functioning member of society.

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[140] See *ibid.* at A2. According to the article, a research associate with Canadian Policy Research Networks in Ottawa states that a person with HIV costs anywhere from $110,000 to $178,000 in direct medical care, and other studies have added $600,000 as an indirect cost to society in lost productivity.

[141] See Post, *supra* note 127 at 161.

[142] Health and Welfare Canada, Medical Services Branch, *Medical Officers' Handbook: Immigration Medical Service* (Ottawa: Health and Welfare Canada, 1986).

[143] See *ibid.*

If the applicant is found to be seropositive, the person will be regarded as inadmissible on medical grounds under the *Immigration Act*[144] and, consequently, cannot be granted immigrant status because the *Act* requires that all such persons must be excluded. Persons with HIV infection may, however, be permitted to enter Canada if they are granted a Minister's Permit.[145] But the issuance of such permits is entirely discretionary. Furthermore, they cannot exceed twelve months duration. The applicant can, as an alternative, appeal the decision of inadmissibility on medical grounds. An appeal can be based on the humanitarian and compassionate provision in the *Immigration Act*, or on other legal grounds.[146] The difficulty with any appeal is that it is costly, and it is difficult to challenge the finding of inadmissibility of the medical officers and visa officers because of the lack of criteria and economic analysis used in their decision, and the undefined term "excessive demands." The courts have had problems developing a definition of excessive demands. The outcome of any appeal thus cannot be predicted. This unpredictability is a major deterrent when an applicant considers the costs and time that may be involved with an appeal.

c. Refugees

Refugees are also required to submit to a medical examination. However, the effect of this examination depends to a large extent on whether refugee status is claimed from inside or outside of Canada. If the person is outside of Canada, then entry may be refused on medical grounds, "although every effort is made to accommodate these people."[147] The medical examination may be waived if the refugee is in a third country where personal security is threatened. If the person is claiming refugee status from inside Canada, however, the medical examination will not serve to prevent entry into Canada, but only to provide an indication of the person's medical condition.[148] We strongly advocate that, although Canada is not obligated by international law to accept refugees, whether they present themselves at its borders or are within the country, refugees should never be excluded on the basis of medical inadmissibility — in particular, on the basis of HIV infection or AIDS. Such a policy would recognize the special human rights claims of refugees. In other words, although HIV status may be an issue at landing, in relation to what is required in terms of provision of health care and education about risk-avoiding behaviour, it should not be used as a basis for the non-conferral of refugee status.

B. The Legal Structure

Medical inadmissibility criteria should not be considered in isolation from the wider legal structure of which they are a part — namely migration laws. This context is im-

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[144] *Immigration Act, supra* note 66, s. 11(1).
[145] *Ibid.*, s. 37(1).
[146] *Ibid.*
[147] *Medical Inadmissibility Review, supra* note 113 at 47.
[148] See *ibid.* at 47-48.

portant because other factors, such as the legal conceptualization of the relationship between a migrant and the receiving state, must be considered to gain a more complete understanding of these criteria. A good example is the belief that there is a parallel between the development of inadmissible classes of potential immigrants (including medical inadmissibility grounds) and a more restrictive attitude towards migration in North America.[149] The theoretical concepts which underpin modern Western immigration law reveal, once again, the powerful influence of a wide variety of social and political factors on the development of these laws.

1. Theories Underlying Present Immigration Law

The basis of modern immigration restrictions is a state's absolute sovereignty over its territory. This concept logically leads to the idea that the state has an absolute right to exclude non-nationals, or to place conditions on their entry. As a result, entry into a foreign country has been considered a privilege, not a right. The theory that there is a right to exclude all non-nationals has been adamantly supported and promulgated with the advent of mass travel.

In this section the notion of absolute sovereignty is examined and questioned, in particular, as the basis of the right to exclude all non-nationals. First, it is suggested that sovereignty itself is not absolute or unlimited. Second, although sovereignty is often presented as "ancient",[150] the origins of its expression in such an extreme form are quite recent. This concept may be further understood as a response to the convergence of certain historical circumstances. Finally, the emphasis on the state's absolute right to exclude would seem inconsistent with many recent developments in international law which focus on greater cooperation between states.[151] It is suggested that migration law in general, and medical inadmissibility criteria in particular, should be re-evaluated to take such developments into account. For instance, the scope of the state's right to exclude non-nationals would be better defined in relation to different categories of non-nationals seeking entry, and human rights considerations should be applied more consistently in this area of law.

a. The Concepts of Sovereignty and the Right to Exclude All Aliens

The theory that a state has the right to exclude all aliens is by far the most prominent of those governing the relationship of migrants with a receiving state. Borchard wrote:

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[149] See J. Grey, *Immigration Law in Canada* (Toronto: Butterworths, 1984) at 12.

[150] See *Kleindienst* v. *Mandel*, 408 U.S. 753 at 765, 92 S. Ct. 2576 (1972) [hereinafter *Kleindienst*].

[151] It might also be suggested that such absolute rights are out-of-step with domestic legal structures in both Canada and the United States which provide for scrutiny of legislative acts. In this regard it should be kept in mind that the basis and concepts of immigration law are legislative, although its application in particular cases is through administrative action.

> [T]aking the sovereignty of the state and its right of self-preservation as the point of departure ... publicists, by far the more numerous, agree that there is an inherent right of the state to exclude aliens at its pleasure.[152]

The most vehement expressions of this concept of sovereignty are found in late nineteenth century Anglo-American case law. In *Nishimura Ekiu* v. *United States*, for example, it was stated that,

> It is an accepted maxim of international law, that every sovereign nation has the power, as inherent in sovereignty, and essential to self-preservation, to forbid the entry of foreigners within its dominions, or to admit them only in such cases and upon such conditions as it may see fit to prescribe.[153]

This and other cases (*e.g. Chae Chan Ping* v. *United States*)[154] claimed to base their pronouncements on the work of Vattel.[155] The use made of his writings will be examined later. This idea of absolute sovereignty, however, has retained a tenacious hold over the minds of judges who refer to it as "ancient".[156]

A logical result of the dominance of this theory is that there is no right of international freedom of movement or mobility. This means that freedom of movement protected under human rights provisions[157] is limited to internal travel and the right to leave and enter one's own state.[158] The only situation where there is a generalized right to enter a foreign country is with respect to non-nationals whose states have consented to the existence of :

> [S]pecial guarantees, written into a treaty and reinforced by provisions of municipal law. The high point at the present time is the special regime operating within the E.E.C.[159]

In the European Union the emphasis is on the interdependence of member states. Not only do EU citizens have the right to enter all participating states,[160] but the practical exercise of this right is facilitated by the extension of social security rights to residents from other member states. These rights, however, do not exist independently of a treaty signed by each member state. Furthermore, this *Treaty* was not signed to further the ideal of the cooperation of states, rather, it was signed on account of economic concerns.

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[152] E.M. Borchard, *The Diplomatic Protection of Citizens Abroad* (New York: Banks Law, 1916) at 45.

[153] 142 U.S. 651 at 659, 12 S. Ct. 336 (1892) [hereinafter *Nishimura* cited to U.S.].

[154] 130 U.S. 581, 9 S. Ct. 623 (1889) [hereinafter *Chinese Exclusion* cited to U.S.].

[155] E. de Vattel, *The Law of Nations* (London: Robinson, 1793)

[156] See *Kleindienst, supra* note 150.

[157] *See* art. 13, *Universal Declaration of Human Rights*, GA Res. 217(III), UN GAOR, 3d Sess., Supp. No. 13, UN Doc. A/810 (1948) 71.

[158] It is an interesting and important question whether it can be argued that persons whose life is in peril (refugees) have any right to enter states of which they are not nationals or seeking refuge.

[159] G.S. Goodwin-Gill, *International Law and the Movement of Persons Between States* (Oxford: Clarendon Press, 1978) at 196.

[160] *Treaty Establishing the European Economic Community*, 25 March 1957, 298 U.N.T.S. 3, U.K.T.S. 1979 No. 15, arts. 48(2), 3(c).

This is evident when one considers the present concern with immigration from outside the community.[161]

b. The Notion of Limited Sovereignty

The notion of sovereignty, outlined above, and the right to exclude all aliens were not intended to be as absolute as contended. According to Delbrueck, the notion of absolute sovereignty rests on a reading of Bodin[162] (the sixteenth-century authority cited for this concept), which pays little attention to the context and practical purpose of that author's work.[163] The latter's concern was not to elaborate an abstract notion of absolute power, but to provide a concept that would facilitate and justify the centralization of authority in the monarch as a means of ending religious strife. This was to the detriment of other powerful groups, such as the church and the nobility.[164] Moreover, Delbrueck argues that Bodin's notion of sovereignty with regard to external relations, should be understood in a functional way, as giving states "the necessary competence and power to act as stable partners in international relations."[165] Delbrueck also explains that other theorists, including Vattel, held that the power of the monarch was limited by divine or natural law.[166] Vattel's concept of sovereignty was that sovereign power was limited by sovereign duties. It is interesting to contemplate in modern societies that have stripped monarchs of their traditional powers and vested powers in the state and its constitutional instruments, whether the modern equivalent of sovereign duties is to be found within the state's obligations to protect human rights.

On closer examination, even the *Nishimura*[167] and *Chinese Exclusion*[168] cases do not espouse an absolute notion of sovereignty. Numerous examples used to illustrate the supposed absolute right to exclude refer only to situations in which the presence of aliens would present a danger to the state. "The control of the people within its limits, and the right to expel from its territory persons who are dangerous to the peace of the State, are too clearly within the essential attributes of sovereignty to be seriously contested."[169] Self-preservation in time of crisis is emphasized in these cases, rather than an absolute right to exclude all non-nationals.

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[161] See J. Eyal, "When the Millions Start to Flee" *The Globe and Mail* (3 August 1992) A-11.

[162] J. Bodin, *The Six Bookes of a Commonweale* (Cambridge: Harvard University Press, 1962).

[163] See J. Delbrueck, "International Protection of Human Rights and State Sovereignty" (1982) 57 Ind. L.J. 567.

[164] See *ibid.* at 569.

[165] *Ibid.* at 570.

[166] See *ibid.*

[167] *Supra* note 153.

[168] *Supra* note 154.

[169] *Chinese Exclusion, ibid.* at 607.

c. *The Contingency of Notions of Sovereignty and of the State's Right to Exclude Aliens on the Basis of Social and Economic Circumstances*

Although, by 1972, the state's absolute right to exclude had come to be considered an ancient principle of law, "[b]efore the late 19th century, there was little, in principle, to support the absolute exclusion of aliens."[170] Before this time there were no large-scale systematic immigration controls; but there was also no large-scale immigration. The development of such controls reflects, among other things, new social realities such as the much greater accessibility of long-distance travel, combined with large-scale upheavals during and in their wake.[171]

In Canada and the U.S., the development of a state's right to exclude all aliens, and its translation into immigration controls, represented a reversal of the laissez-faire attitude to immigration which had immediately preceded it:

> For nearly a century after the French Revolution ... freedom of movement was encouraged in the West by an expanding economy, an unusual compatibility of demographic interests between source and destination countries, Manifest Destiny in the Western Hemisphere, and the predominance of liberal thought conducive to the free circulation of human beings and capital.[172]

The social and economic conditions, as well as intellectual notions that led to the imposition of immigration restrictions, including the development of the right to privacy, the influence of the legal theory of positivism and the impact of "nativism"[173] will be examined in this section.

In the nineteenth century, the growth of increasingly unsanitary industrial cities coincided with the emergence of a bourgeois ideal of privacy.[174] Today the concept of privacy is more or less taken for granted. In a generalized form, however, this mental boundary between public and private space is a very recent concept.[175] In some respects, its introduction was revolutionary and led to the notion that well beyond the traditional doctrines of real and personal property law, we can own or control certain space (in-

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[170] J.A.R. Nafziger, "The General Admission of Aliens under International Law" (1983) 77 Am. J. Int'l L. 804 at 809.

[171] Many Immigration Acts were passed as war measures. See R. Plender, *International Migration Law*, rev. 2d ed. (London: Martinus Nijhoff, 1987) at 75-76.

[172] Nafziger, *supra* note 170 at 815.

[173] The influence of nativism or racism can be seen in the fact that the case law cited in favour of the right to exclude all aliens is almost exclusively concerned with excluding Asian immigrants. It should be noted, however, that the reasons for such racially biased exclusion go beyond racism, *per se*, and can be complex. See A. Macklin, "Canadian Immigration Policy towards Asians from Confederation to 1922: Lessons from the Past" (Halifax: Dalhousie University, 1987) [unpublished].

[174] See W. Rybczynski, *Home: A Short History of an Idea* (New York: Penguin, 1987).

[175] See Goudsblom, *supra* note 39 at 179.

cluding in recent times our own body) in order to keep others out.[176] This right of exclusion of others from our own private space is applicable at all times. It is this permanent element that distinguishes the concept of private space — and its public space corollary — from the imposition of exclusionary measures, such as quarantine, in times of crisis. The analogy between the emergence of this concept and the development of systematic immigration controls is interesting. This notion of micro or individual control over one's private space translates, on a macro or societal scale, to the idea of a state having permanent controls on the entry of aliens into its territory. Nafziger, moreover, argues:

> The proposition [that sovereign states had an absolute right to exclude aliens] arose just as the American and other frontiers of new settlement disappeared and at the peak of emigration from Europe and the Orient to the United States and the British Empire. Because these historical circumstances developed during the heyday of Austinian and Holmesian *positivism*, with its peculiar limitation of law to sovereign commands, the nativist pronouncements of courts became engraved in stone.[177]

Two important factors, which led to the adoption and maintenance of the notion of the state's right to exclude all aliens, are identified in this statement.

First, there was the influence of nativism. The impact of this movement on the introduction of medical inadmissibility criteria at the end of the nineteenth century has already been noted.[178] Nativist concerns, according to Nafziger, were also influential in the introduction of migration controls in general. It should be noted that the nineteenth century cases often cited to support the proposition that a state had a right to exclude all non-nationals, largely concerned the exclusion of Asian migrants — particularly those of Chinese origin. The *Chinese Exclusion* case,[179] for example, involved the exclusion of a returning Chinese migrant who had resided in California for many years, and who was in possession of a certificate entitling him to return to the U.S. The Court retroactively declared the certificate void on the grounds that a state always retained the right to exclude. The nativist influence on the decision is evident from the following excerpt:

> [A] limitation to the immigration of certain classes from China was essential to the peace of the community on the Pacific Coast, and possibly to the preservation of our civilization there.[180]

Nafziger believes that the influence of nativist case law was tenacious because it was elaborated when positivism dominated legal theory.[181] The positivist legal notions

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[176] See M.A. Somerville, "Ethics and Architects: Spaces, Voids, and Travelling-in-Hope" in L. Pelletier & A. Pérez-Gómez, eds., *Architecture, Ethics and Technology* (Montreal: McGill-Queen's University Press, 1994) 61.

[177] Nafziger, *supra* note 170 at 808 [emphasis added].

[178] See text accompanying note 58.

[179] *Supra* note 154.

[180] *Chinese Exclusion*, *ibid.* at 594. For a description of anti-Asian migration legislation in Canada see B. Ryder, "Racism and the Constitution: The Constitutional Fate of British Columbia Anti-Asian Immigration Legislation, 1884-1909" (1991) 29 Osgoode Hall L.J. 619.

[181] See Nafziger, *supra* note 170.

ruled out concern for the natural law obligations of the sovereign, which in effect were limiting devices on the exercise of sovereign power. Instead, positivists focused on a definitional, conceptualizing approach to the law, detaching it from an examination of the law's purpose.[182] However, as Sugarman points out, this exercise in conceptualization was motivated by several, somewhat paradoxical, purposes. These included the desire for stability in the face of greater democracy, and the fear of the socialist activity of parliament in the late nineteenth century:

> Dicey defined the political problem of the age as '...how to form conservative democracies ... to give constitutions resting on the will of the people the stability and permanence which has hitherto been found only in monarchical or aristocratic states'.[183]

Therefore, in promoting their concepts of sovereignty, Bodin in the sixteenth century and Dicey in the nineteenth century, shared the desire to reconceptualize the law in order to facilitate greater political and social stability. They differed in their conception of the sovereign, but these differences reflected the political contexts at the time each was writing. Bodin conceived of the monarch as sovereign, in contrast with others (such as Hobbes) who focused on parliament. Dicey's approach had to be more subtle. Although he could not deny the supremacy of parliament, he wished to avoid the concentration of power in the hands of that increasingly socialist body. Thus, a conceptualizing approach to the law — one example of which is legal positivism — and the boundary between public and private spheres became of major importance. The crucial importance of this approach and distinction particularly lies in the authority given to the legal profession to monitor it. This function "places judges, lawyers and jurists in the centre of government while protecting them from the charge of having usurped Parliament."[184]

Similar points relating to the motivation of jurists may be raised in relation to an opposing theory underlying immigration law — that of the interdependence of states. According to this viewpoint, there is a fundamental right of international movement "between states ... [and] no state can absolutely forbid entrance to aliens, although it may exclude those whose presence is a menace to the welfare of the state."[185]

This theory was supported by numerous continental European jurists, as well as members of the Latin American school.[186] Their perspectives were also subject, in part, to contemporary political and commercial needs. Spanish jurists, such as Vitoria, were concerned with the promotion of freedom of movement as a legal justification for the

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[182] See J. Boyle, "Thomas Hobbes and the Invented Tradition of Positivism: Reflections on Language, Power, and Essentialism" (1987) 135 U. Pa. L. Rev. 383 at 396.

[183] D. Sugarman, "The Legal Boundaries of Liberty: Dicey, Liberalism and Legal Science" (1983) 46 Mod. L. Rev. 102 at 109 quoting A.V. Dicey, *Introduction to the Study of the Law of the Constitution* (1885).

[184] *Ibid.* at 108.

[185] Borchard, *supra* note 152 at 45.

[186] See Plender, *supra* note 171 at 61.

Spanish colonization of the New World.[187] In the nineteenth century, Latin American writers such as Suárez, used this theory to promote immigration to Latin America.[188]

The concepts underlying migration law thus may be seen to be strongly influenced by political and social factors. The concept of absolute sovereignty, and by extension the notion of a right to exclude all aliens, has retained a powerful hold over the thinking and policy-making in relation to immigration law. In a recent American decision, reiterating the view that immigration into the U.S. is a privilege and not a right,[189] it was held that no alien has a right to enter the United States.[190] Such adamant statements in recent years are the result of the rising concern about migration from the South. The perception of an overriding absolute power to exclude aliens thus remains in place, even though an examination of present law and practice indicates that the concept of sovereignty is now understood to be limited in several important ways.

d. Limits on the Notion of Sovereignty Indicated by Actual Law and Practice

Sovereignty has traditionally been defined with reference to the internal structure of states. The scope of the notion, however, has never been fully defined with reference to the external relations of states.[191]

In recent years there has been less willingness to accept a notion of absolute sovereignty as part of either domestic or international law. In relation to international law, Kindred *et al.* have indicated that,

> [O]ther principles that deny the exclusiveness of state's rights have also been developing. These principles reflect the economic, military and political realities of this century, which is marked by interdependence of states, community of human interests, and unity of the global physical environment. Recognition of these realities has found expression in modern international law and their influence is a distinctive feature of the United Nations' era.[192]

For instance, "la souveraineté territoriale de l'État a été aménagée par voie conventionnelle et coutumière dans plusieurs domaines. Ainsi, l'immunité souveraine, les immunités diplomatiques et consulaires, le droit de passage inoffensif dans la mer territoriale des États côtiers ... sont autant d'exceptions à la souveraineté de l'État."[193] Chapter VII

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[187] See Nafziger, *supra* note 170 at 811.

[188] See Plender, *supra* note 171 at 73.

[189] See *United States ex. rel. Knauff* v. *Shaughnessy*, 338 U.S. 537 at 542, 70 S. Ct. 309 (1950).

[190] See *Haitian Centers Council, Inc.* v. *McNary*, 969 F.2d 1327 at 1369, 61 U.S.L.W. 2081 (2d Cir. 1992) [hereinafter *McNary* cited to F.2d].

[191] See J. Talpis, "La maîtrise du sol en droit international privé" (1991) (Numéro spécial Henri Capitant) R. du N. 55.

[192] H.M. Kindred *et al.*, *International Law Chiefly as Interpreted and Applied in Canada*, 4th ed. (Toronto: Emond Montgomery, 1987) at 820.

[193] C. Emanuelli, "La maitrise du sol en droit international public" (1991) (Numéro spécial Henri Capitant) R. du N. 71 at 95.

of the *Charter of the United Nations*[194] provides that the UN can interfere with member states' policies if they endanger international peace and security.[195] And the principle of non-discrimination, particularly on the basis of race, is now accepted in international law. Condemnations of the internal policies of different nations, moreover, are not judged to be unjustified intrusions into the national jurisdiction of a country.[196]

The principle of non-discrimination has affected migration law in Canada and the U.S.[197] Other human rights considerations and the practical impossibility of excluding all aliens also influence the law and practice in relation to aliens. The latter factor was recognized in the New Zealand case of *Chandra* v. *Minister of Immigration*.[198] Barker J. stated, "I consider from a common sense point of view there is much to be said for [the] submission that the old concept of the Royal prerogative to keep foreigners at bay has been superseded by the modern transportation and the mass population movements of the 20th century."[199]

A variety of humanitarian concerns have also mitigated, to a certain extent, the notion of an absolute right to exclude. Examples include the protection of refugees and the preferential treatment afforded to family class immigrants. At first glance the protection of refugees, however, would seem to be dependent on the good will of host states. The expression "right of asylum" (suggesting that refugees have a right to enter other countries) is in fact a misnomer. Rather, the basic obligation of signatory states to the *Refugee Convention* is that of non-refoulement.[200] State practice, moreover, affirms that,

> [T]he right of asylum is the right of the [s]tate to grant protection, which in turn is founded on the "undisputed rule of international law" that every [s]tate has exclusive control over the individuals within its territory.[201]

One can thus analyze and compare the crucial difference for refugee claimants between Germany and the U.S. Until May 1993, article 16a of the German Basic Law guaranteed the right of entry of those seeking asylum.[202] In the U.S., however, it was affirmed that, "[n]o alien, even one who satisfies the standard of 'refugee', has a right to asylum, or a right to enter the United States."[203]

In recent years, "[t]his exclusively jurisdictional approach has been mitigated somewhat by increased recognition of protection as a humanitarian duty."[204] While the

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[194] *Charter of the United Nations*, 26 June 1945, Can. T.S. 1945 No. 7, c. 7.

[195] See Delbrueck, *supra* note 163 at 571.

[196] See *ibid.* at 571-72. For example, the previous apartheid regime in South Africa.

[197] See Section **II.B.**2, below.

[198] [1978] 2 N.Z.L.R. 559.

[199] *Ibid.* at 568.

[200] *Supra* note 13.

[201] Goodwin-Gill, *supra* note 159 at 138.

[202] See *supra* note 12.

[203] *McNary*, *supra* note 190 at 1369 referring to *Immigration and Naturalization Service* v. *Cardoza-Fonseca*, 480 U.S. 421 at 428 n. 5, 107 S. Ct. 1207 (1987).

[204] Goodwin-Gill, *supra* note 159 at 138.

following developments do not provide asylum claimants with a right to enter another country, they may indicate the recognition of certain duties by states towards non-nationals to the point that state sovereignty may be considered less than absolute. With approval, Grey quotes Brownlie's view that the rules governing refugees may now form part of international law, independently of their being made applicable through treaty.[205] In other words, the obligations of a state towards refugees do not depend on their being explicitly consented to by that state. Goodwin-Gill is more guarded. He argues, however, that while "it is still to be doubted whether there is any rule which obliges [s]tates to admit those fleeing from persecution ... admission or continued residence may be secured in roundabout fashion."[206] This contention gains support from figures released by the European Consultation on Refugees and Exiles, claiming that "at least 80 per cent of all rejected asylum seekers remain [in their country of refuge] in one way or another."[207] Goodwin-Gill asserts that "[t]he Convention ... does oblige state parties not to impose penalties for illegal entry on refugees, provided that they report to the authorities without delay and show good cause for their actions."[208]

Another way refugees can be given a minimum level of human rights protection is through courts insisting that they have a right to procedural due process in the determination of their claim to refugee status. In the U.S.,[209] judicial deference to the executive branch of government to use its plenary power in relation to the admission of aliens in whatever manner it sees fit,[210] has been questioned on the basis of "the procedural methods used to effectuate the alien's exclusion."[211] Thus the "[Supreme] Court has scrutinized exclusionary procedures to ensure compliance with the Due Process Clause of the Fifth Amendment."[212]

The treatment of Haitian refugees illustrates how human rights issues may be ignored, including the concern for due process and the claims to fundamental justice that respect for this right upholds and implements. Regarding the internment of HIV-positive Haitian refugees at Guantanamo Bay Naval Base, nine members of the National Commission on AIDS alleged in a brief before a federal appeals court that:

> [United States'] immigration officials are not complying with federal regulations and procedures for HIV testing of aliens by physically abusing and forcibly coercing the Haitians to be tested, by failing to secure informed consent for the

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[205] See Grey, *supra* note 149 at 130.

[206] Goodwin-Gill, *supra* note 159 at 138.

[207] *Financial Times*, *supra* note 7.

[208] Goodwin-Gill, *supra* note 159 at 139.

[209] See K.A. Krzynowek, "*Haitian Centers Council, Inc.* v. *Sale*: Rejecting the Indefinite Detention of HIV-infected Aliens" (1995) 11 J. Contemp. Health L. & Pol'y 541.

[210] See *ibid.*, citing P.H. Schuck, "The Transformation of Immigration Law" (1984) 84 Col. L. Rev. 1 at 16.

[211] See Krzynowek, *ibid.* at 547, citing *Shaughnessy* v. *United States ex rel. Mezei*, 345 U.S. 206 at 219-21, 73 S. Ct. 625 (1953) (Jackson J. in dissent).

[212] Krzynowek, *ibid* at 548.

> tests, and by failure to conduct confirmatory tests before determining that Haitians are seropositive.[213]

There was hope, however, that case law might lead to some improvement in the general treatment of Haitian refugees. A U.S. Federal Appeal Court held that the administration's policy of intercepting Haitian refugees at sea and returning them to Haiti without a hearing was contrary to the U.S. *Immigration and Nationality Act*,[214] which endorses the principle of non-refoulement. The *INA*, in turn, was held to apply to the extraterritorial acts of U.S. officials.[215] The U.S. Supreme Court granted a writ of *certiorari*[216] and the case was heard as the restyled *Sale* v. *Haitian Centers Council, Inc.*[217] In what Jones has called the "Dred Scott Case" of immigration law, the Court held, "that Haitian refugees, intercepted on the high seas by the [United States] Coast Guard, have no cognizable legal rights under the domestic law of the United States or under conventional international law."[218]

Subsequent to this Supreme Court decision, the U.S. District Court in New York issued a judgment effectively ordering the U.S. to shut down the detention centre in Guantanamo Bay, describing this as "nothing more than an HIV prison camp,"[219] and ruling that the indefinite detention of HIV-positive persons was illegal. This decision was not appealed. The result was that these persons gained entry to the U.S. despite their HIV infection.[220] How such a decision would be dealt with by the U.S. Supreme Court thus remains an open question.

The humanitarian concerns mentioned above may be seen to influence domestic Canadian immigration law to some extent. The protection of refugees and the reunification of family members have been recognized as objectives of the Canadian *Immigration Act* in section 3.[221] These are not, however, the only aims expressed in that section:

> Section 3 expresses the ideology of Canadian society. It does not encourage immigration but with its emphasis on human rights, the reunion of families, and the enrichment of Canada's cultural heritage it sounds like a very liberal provision. However, s.3 contains no concrete provisions and one can see in subsection (a) the subordination of immigration to Canada's economic policies at any time.[222]

The Canadian recognition of a humanitarian duty to refugees and family member is, however, also tempered by other provisions. Refugees may be determined inadmissible

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[213] "AIDS: Commission Members Attack INS Policy Restricting Asylum for HIV-Infected Haitians" (1992) 7:10 AIDS Policy & Law 1 at 2.

[214] *Supra* note 70.

[215] See *McNary*, *supra* note 190.

[216] 509 U.S. 918, 113 S. Ct. 3028 (1993).

[217] 509 U.S. 155, 113 S. Ct. 2549 (1993).

[218] Jones, *supra* note 110 at 102.

[219] *Haitian Centers Council, Inc.* v. *Sale*, 823 F. Supp. 1028 at 1038 (N.Y. 1993).

[220] See Krzynowek, *supra* note 209 at 549.

[221] *Supra* note 66 s. 3.

[222] Grey, *supra* note 149 at 27.

to Canada under section 19(f), which bars those involved in terrorism or subversion.[223] Grey has criticized this provision as overly broad and has asserted that "a genuine refugee could be returned to his country merely because he seeks to overthrow its government. This could happen even if its government was morally repugnant."[224] With respect to family members, including of refugees, Grey also criticizes the fact that close relatives must show that they do not fall into an inadmissible class.[225]

While human rights considerations may have influenced domestic Canadian immigration law to some extent, other concerns play an important role in the elaboration of policy. The crucial topic of what these other concerns are will not be addressed here. However, relatively recent amendments to the *Immigration Act* in Canada,[226] and the Haitian interdiction programme in the U.S.,[227] indicate a strong negative political reaction to the arrival of increasing numbers of migrants — which can easily translate into human rights violations against the persons they are aimed at excluding. In the case of the Haitians, the seropositive status of some migrants, and the perception that there is a particularly high rate of HIV infection among Haitians, undoubtedly added to this political reaction and the likelihood of such human rights violations. It is hoped that governments will formulate their policies and consider the point of view that,

> [R]efugee protection is about neither immigration nor management[228] ... refugees in fact, in law, and by the terms of Canada's international obligations, are self-selected. ... Managing immigration in a refugee protection context means artificially denying protection to real refugees.[229]

e. *Conclusions with Regard to the Notion of Sovereignty and the Right to Exclude Aliens*

The law and practice in relation to aliens, particularly certain groups of aliens (such as refugees), would therefore seem to indicate a qualified right of states to exclude aliens. The fact remains, however, that,

> Although historically and analytically the concept [of the absolute right to exclude] may be doubtful in its application to alien admissions, it looms large in

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[223] *Supra* note 66 s. 19(f).

[224] *Supra* note 149 at 45. He further notes that "in immigration, we are spared embarrassment by the hard-line taken by other western governments and courts" (*ibid.* at 160, n. 328).

[225] See *ibid.* at 148. Furthermore, "[i]t is an inescapable conclusion that the definitions of 'family class' and the sponsorship process are far too complex and too technical and have too many restrictions capable of causing injustice" (*ibid.* at 141).

[226] *Supra* note 66.

[227] *Supra* note 213 and accompanying text.

[228] "Immigration management" is the term used by the Canadian government to describe its new policies, see *supra* note 6.

[229] D. Matas, *Brief of the Canadian Council for Refugees to the Legislative Committee on Bill C-86* (Montreal: Canadian Council for Refugees, 1992) at 1.

> judicial and legislative discussions concerning the general admission of aliens. It has a life of its own.[230]

This is the lasting effect of the conceptualizing, positivistic approach to law of Dicey and his followers — an approach which still influences legal training today. The logic thus generated by an unlimited right to exclude aliens continues to influence policy-making with regard to immigration and refugee law. A more nuanced approach with regard to the admission of certain groups of aliens, and the grounds on which they may be excluded, has not yet been accepted in mainstream theory. At present, it is also unlikely to be accepted by policy-makers.

The re-evaluation of migration law, a different basic concept in recognition of qualifications on the state's right to exclude, and more flexibility in relation to the different categories of migrants might provide a more honest reflection of migration in practice. A new concept could take greater account of the interests of migrants, and not only those of the receiving state. The current position in Canada is that only at the "moment [that foreigners] step on to Canadian soil [are they] subject to [the] various legal obligations and ... rights" of Canadian law.[231]

If the underlying concepts of migration law were to be re-considered in the light of a broad approach to human rights, it would be more likely that domestic human rights protections would be applied more generally to include those seeking entry to the country in question. For example, the *Canadian Charter*[232] and the American *Bill of Rights* might be applied, respectively, to the actions of Canadian and American embassies abroad. It could be contended that the *Singh* case[233] does not expressly rule out the application of the *Charter* to this situation. The matter, however, has not yet been litigated in Canada. In the *McNary* case,[234] the Federal Court of Appeal's decision that the Fifth Amendment of the U.S. Constitution applied to Haitians detained by the American government at Guantanamo Bay was overruled by the Supreme Court.[235] Even in the Court of Appeal's judgment, care had been taken to limit the general application of the case by the Judge's insistence on its "unique facts."[236] For example, these unique facts were "the

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[230] Nafziger, *supra* note 170 at 822.

[231] J. Hucker, "Immigration, Natural Justice and the Bill of Rights" (1975) 13 Osgoode Hall L.J. 649 at 682. *Singh* v. *Canada (Minister of Employment and Immigration)*, [1985] 1 S.C.R. 177, 17 D.L.R. (4th) 422 [hereinafter *Singh*], The Federal Court of Appeal in *Re Singh and M.E.I.* ((1983), 144 D.L.R. (3d) 766, 47 N.R. 189 (Fed. C.A.))had held that judicial review of Singh's claim to refugee status should be refused "because the potential danger to the petitioner's life, liberty or security of the person could only exist in his native land and the Canadian Charter did not guarantee basic rights outside Canada." (Grey, *supra* note 149 at 154). The Supreme Court therefore held that the *Canadian Charter* applies to aliens physically present in Canada.

[232] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 [hereinafter *Canadian Charter*].

[233] *Supra* note 231.

[234] *Supra* note 190.

[235] See *supra* note 217 and accompanying text.

[236] See *McNary*, *supra* note 190 at 1340.

interdiction of plaintiffs by United States officials, the status of the territory upon which they are detained [the Guantanamo base is under the exclusive jurisdiction of the United States, and American law applies there], and the 'credible' asylum claim they [the screened Haitian complainants] have already been found to possess."[237] In view of these facts, the Supreme Court's holding can be considered especially hardline.

Nafziger articulates another approach in reconsidering the concepts underlying migration law:

> [The] "highest duty" of the sovereign implies a right of self-preservation. The question remains, however: what measures are reasonable and necessary to preserve the state? That question is usually ignored. Instead, the mere right of self-preservation, together with the sovereign's plenary authority and jurisdiction within its territory, is said to be sufficient to justify the sovereign's "inherent right" or "power" to exclude aliens. In the absence, however, of something like "vast hordes of [aliens] crowding in upon" a state, self-preservation would not seem to be at issue, for an act of self-preservation must be limited to what is strictly imposed by an emergency.[238]

In other words, the point of departure in matters of migration law should be what is reasonably necessary for the self-preservation of the state, rather than the concept of the state's absolute right to exclude. Nafziger would seem to advocate exclusion only in cases of clear necessity. The concept of self-preservation, however, is flexible. For example, it could involve consideration of serious economic effects on the receiving state. The concept of self-preservation is also sufficiently flexible to allow for the differential treatment of separate categories of migrants.

On this basis, the status of one group of aliens (namely visitors), should most obviously be re-examined. The entry of visitors is currently regulated by means of the same legislative framework as governs the entry of permanent residents. On reflection, aside from matters of administrative ease, it would seem illogical to deal with visitors under the same rubric as permanent residents. While providing immigrants with a right to enter might be economically and socially harmful to the state, a *prima facie* right to enter for visitors would not threaten the state's security. Such a right of entry for visitors might be seen as analogous to the right of innocent passage through the territorial sea. According to international law, "innocent passage" is defined as that which does not threaten the peace, good order or security of the coastal state.[239] The same conditions could apply to the entry of visitors. The existence of this right of innocent passage illustrates, in theory and in practice, that it is possible to strike a balance between sovereignty and competing interests, such as navigation.[240]

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[237] *Ibid.*

[238] *Supra* note 170 at 817 [footnotes omitted].

[239] See *United Nations Convention on the Law of the Sea*, 10 December 1982, 516 U.N.T.S. 205 (entered into force 16 November 1994) art. 19.

[240] See Kindred, *supra* note 192 at 722.

The facilitation of travel also might be in the state's interest. Grey points out that, "[m]odern society requires a great deal of international travel and it is essential to provide for the admission of large numbers of foreign residents for many purposes."[241] Such an open-door approach has recently been taken by Australia (for which tourism is now a major industry) and international business travel (an economic necessity).[242] "Visitors to Australia will be granted entry when they buy airline tickets. ... The Minister for Immigration [announced that] ... there would be no visa labels or stamps and no detailed application forms to fill out."[243] The valid interests of the state would be protected by provisions which are presently in force, allowing deportation in cases where a visitor to whom entry has been granted might threaten the public interests of the host state. It would also be appropriate to allot visitors a certain time in the host country.[244] This limitation can be justified on the grounds that it reflects an inherent attribute of the status of visitor, as compared with that of permanent resident. It would also maintain the distinction, emphasized by Grey,[245] between visitors and those with a greater connection to the state.

In legal terms, the distinction between different categories of entrants could be expressed by legal presumptions. The choice of a basic presumption is not neutral in terms of the outcome of the decision that it governs. First, it determines those with the burden of proof, *i.e.* either non-nationals to show they should be admitted, or the state to justify exclusion of the persons concerned. Second, in cases of equal doubt about whether the burden of proof has been fulfilled, the persons with the burden of proof lose their claim.[246]

An analysis of the complex considerations which would need to be taken into account in determining which basic presumptions should be used to govern the entry of non-nationals to a country, and the nature and extent of the exceptions to these that should be allowed is beyond the scope of this article. However, a general presumption of exclusion, unless certain conditions are met, may be justifiable for prospective immi-

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[241] Grey, *supra* note 149 at 17.

[242] It is interesting that this change was precipitated by the unavailability of United States' visas for Australians wishing to visit the United States during the impasse between Congress and President Clinton over the *Budget Appropriation Bill*, that shut down United States' consulates in Australia which issue the visas. Australians require a visa to visit the United States because Australia requires United States' citizens to have a visa to visit Australia, and a principle of reciprocity is applied. Consequently, by easing the rules on Australian visas, the Australians eased them with respect to their obtaining United States' visas.

[243] "Visa System Eased" *The [Adelaide] Advertiser* (18 January 1996) 6. See also Editorial Opinion, *The [Adelaide] Advertiser* (12 January 1996) 12.

[244] It is a further question what proof, if any, that they did not constitute a threat to the host state, it would be reasonable to require of visitors before they would be admitted to a foreign country. For example, identity checks and verifications of purpose would still be maintained to ensure the security of citizens.

[245] See Grey, *supra* note 149 at 17.

[246] See M.A. Somerville, "The Song of Death: The Lyrics of Euthanasia" (1993) 9 J. of Contemp. Health L. & Pol'y 1 at 63-67.

grants because — by definition — they are asking to permanently reside in a new country.[247] There may be particular characteristics, however, with respect to which there should be a presumption of admissibility until the contrary is shown. We propose that medical admissibility is one such characteristic. This will be especially important in light of new medical diagnostic technologies, particularly genetic technologies.[248] Although it is also true that refugees seek permanent residence in a new country, recognition that refugees have special human rights claims that others do not have means there should be a presumption that they should be admitted, unless conditions clearly justifying their exclusion are shown to exist. In contrast to immigrants, since the presence of visitors in a country is temporary, a rebuttable presumption of admission may be more appropriate. Accordingly, visitors would be permitted to enter a country unless their presence in that country would threaten peace, good order or the security of citizens. A justification of exclusion of visitors based on self-preservation defined more precisely would also encourage a reconsideration of the medical grounds upon which prospective immigrants may be excluded. One example is when they are suffering from certain infectious or contagious diseases.

2. Grounds for Exclusion

The pervading influence of the concept of absolute sovereignty has also resulted in a lack of scrutiny of grounds for exclusion. For example, there has been minimal consideration of what might reasonably be necessary for the self-preservation of the state in relation to various groups of non-nationals. Recent human rights considerations, particularly the principle of non-discrimination, have also been recognized as limitations on the scope of state action with regard to grounds of exclusion. "In racial matters, non-discrimination has a normative character and may be adjudged a part of *jus cogens*."[249] Racial discrimination, for example, is prohibited by article 2 of the *Universal Declaration of Human Rights*.[250] Recourse is provided in article 7 of the *Declaration* concerning the right to equal protection of the law. Both Canada and the U.S. have recognized their obligation to the international community, in this respect, by removing the overt racial bias that had previously formed part of their immigration laws.[251] It is suggested that human rights analysis should be extended to other grounds of exclusion, such as medi-

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[247] Thus, as matters going to rebut the presumptions of exclusion, the country in question would take into account factors such as that certain immigrants, who have close family members in the receiving country, may have greater claims on the receiving state.

[248] See Section I.*E*, above.

[249] Goodwin-Gill, *supra* note 159 at 85.

[250] *Supra* note 157. Racial discrimination is also prohibited by specific declarations. See *United Nations Declaration on the Elimination of All Forms of Racial Discrimination*, GA Res. 1904 (XVIII), UN GAOR, 3d Sess., Supp. No. 15, UN Doc. A/5603 (1963) 35 and the *International Convention on the Elimination of All Forms of Racial Discrimination*, 7 March 1966, 660 U.N.T.S. 212, Can. T.S. 1970 No. 28.

[251] For example, discrimination in the issue of visas based on race, sex, nationality, place of birth or place of residence was outlawed in the United States by 8 U.S.C. s.1152(a) enacted in 1965.

cal inadmissibility criteria. This would mean that persons could still be determined to be medically inadmissible, but the basis for such decisions would need to conform with principles of human rights.

The grounds of medical exclusion provided for in Canadian and American legislation will be examined in the following analysis from two perspectives. The first considers the self-preservation of the state (which includes preservation of the life and health of the population) and the second deals with ethical and human rights considerations. In terms of self-preservation, a central factor should be the degree of risk posed to the state with respect to the potential transmission of a disease, and the cost to the social infrastructure by the entry of migrants affected by certain medical conditions. Although the *Universal Declaration of Human Rights* does not protect against discrimination on the grounds of disability, it is contended that medical exclusion should be examined according to international principles governing discrimination. These principles are described by Goodwin-Gill:

> [D]ifferential treatment is not unlawful (1) if the distinction is made in pursuit of a legitimate aim; (2) if the distinction does not lack an "objective justification"; (3) provided that a reasonable proportionality exists between the means employed and the aims sought to be realized.[252]

Moreover, Canadian law (which we will take as an example of such domestic law) prohibits discrimination on the basis of disability.[253] It is suggested that both perspectives are necessary to come to a balanced appreciation of the way in which the relationship between migrants and a receiving state should be governed from a human rights perspective with respect to exclusion on the basis of disability.

a. *Exclusion of HIV-Infected People on Public Health Grounds: The American Approach*

Using the approach outlined above to justify the exclusion of HIV-infected people on public health grounds, it would need to be shown that this action was reasonably necessary to achieve a legitimate protection aim. The criterion of public health would be relevant to a determination of whether there is a sufficient degree of risk to justify the exclusion of HIV-infected individuals on the basis of state self-preservation, and to whether discrimination on the basis of HIV infection was justified. It would seem that the exclusion of people with HIV infection in any category of non-nationals would fail at this first hurdle. HIV infection cannot be transmitted through casual contact, thus the entry of an infected person poses no direct and unavoidable risk to the health of the general public. Commenting on United States policy, the National Commission on AIDS states:

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[252] Goodwin-Gill, *supra* note 159 at 78.

[253] Section 15 of the *Canadian Charter*, *supra* note 232, prohibits discrimination on the basis of "mental or physical disability."

> The issuance on May 31, 1991, of an interim rule that extends [to HIV] the same travel and immigration restrictions as "communicable diseases of public health significance" that previously were classified as "dangerous contagious diseases" *defies public health knowledge.* This action perpetuates the misleading and discriminatory effects of prior HIV inclusion on an outdated list of diseases.[254]

As mentioned earlier, however, both immigrants and visitors to the U.S. continue to be excluded on this basis. Furthermore, the American provision for discretionary waiver, even if it were liberally employed (which it is not), does not justify excluding HIV-infected persons on the grounds that they constitute a public health risk.

b. *Exclusion of HIV-Infected People on the Grounds of an Excessive Burden on Health and Social Services: The Canadian Approach*

The excessive demand criterion under which prospective immigrants may be excluded from Canada,[255] at first glance, seems to be a reasonable restriction — particularly with reference to the huge costs of health care.[256] Several questions, however, may be raised about the fairness and scope of this provision.

First, this provision does not specify particular health conditions which, if present, will automatically disqualify an applicant. It may be argued, however, that the great amount of attention paid to HIV infection has resulted in a discriminatory implementation of this provision in relation to persons with HIV infection. Using a modelling approach, Zowall *et al.* compared the direct costs to the Canadian health care system which are posed by illnesses associated with the HIV virus and by coronary heart disease among immigrants to Canada.[257] They projected costs over the ten years following entry and found that the costs attributed to immigrants with coronary heart disease would be slightly higher than for those infected with HIV. It was therefore concluded that in the absence of a consistent logic of exclusion (or measurement of excessive demand), to single out persons with HIV infection, and not to exclude persons with diseases likely to generate comparable costs, would be arbitrary and discriminatory.[258]

The potential arbitrariness of applying the excessive demands criterion is further indicated by the fact that the precise meaning of the provision has not been defined and it is difficult to do so. Until very recently, there also had been little research to ascertain the precise demands that HIV-infected immigrants would, in fact, place on the Canadian

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[254] *Statement on Immigration, supra* note 79 at 1 [emphasis added].

[255] *Immigration Act, supra* note 66, s. 19(1)(a)(ii).

[256] In theory, visitors are no longer excluded on this ground.

[257] See Zowall *et al.*, "Economic Impact of HIV Infection and Coronary Heart Disease in Immigrants to Canada" (1992) 147 Can. Med. Assoc. J. 1163. It was assumed that immigrants with HIV would have been recently infected, since their seropositive status would otherwise have resulted in signs or symptoms that would have been clinically detectable. A similar assumption was made for those with coronary heart disease.

[258] See *ibid.*

health and social services systems.[259] This lack of precise data has been recognized in the reviews of medical inadmissibility criteria conducted by Employment and Immigration Canada.[260] It would therefore seem that the probability of immigrants with HIV infection placing an excessive demand on health and social services has simply been assumed. It is true, however, that if one postulates a pool of "healthy" immigrants, the rejection of a potential immigrant who has a diagnosable disease or pre-cursor of disease, in favour of a person who does not have such a condition, is likely to mean that there will be less demand on the health care system than if the former person became an immigrant.

The potential economic and social contribution to society of migrants with HIV infection, or other diseases, must also be factored into the equation. With respect to HIV infection, any assessment of the demand placed on services must take into account that,

> Because persons with HIV infection can remain asymptomatic for ten or more years, and during that time remain active and productive members of society, it is not clear that all persons with HIV infection will necessarily place demands on the health care system that are out of proportion to the benefits they may bring to Canada.[261]

Thus, there are serious questions related to the practical implementation of the excessive demand provision. Even if the application of this provision were better articulated and defined, serious legal and ethical questions would still remain for deliberation. According to Zowall *et al.*,

> Once such analyses are completed, important social, legal and ethical considerations must then be addressed if the final policy is to reflect both the goals of our government and the values of our society.[262]

Such questions relate to the extent to which governments should seek to eliminate potential future economic costs through its method of selecting new immigrants. The concern of a government is, of course, to prevent heavy medical costs from migration. The Canadian government has argued that in the absence of strict medical exclusion provisions, Canada's publicly-funded health care system would become "a clinic for the world."[263] In an era of rising health care costs and the political concern for such costs, this argument merits some attention. Moreover, this argument, of course, could be characterized in terms of economic self-preservation.

There are, however, additional concerns to those of economic self-preservation which also should be kept in mind. First, policy-makers should be aware of a possible symbolic function of the exclusion of migrants on the ground of excessive demands on health and social services. It implies, at one extreme, that only perfectly healthy persons are acceptable and welcome as immigrants. This constitutes a deprecating message for

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[259] See Jacobs, *supra* note 139.

[260] See *Medical Inadmissibility Review*, *supra* note 113 at 35.

[261] *HIV and Human Rights in Canada*, *supra* note 135 at 16.

[262] Zowall *et al.*, *supra* note 257 at 1170.

[263] *Medical Inadmissibility Review*, *supra* note 113 at 31.

ill and disabled members of our communities. Such persons, moreover, will be increasingly difficult to find, as developments in molecular biology and genetic research allow us to identify the healthy ill.[264]

Second, the perception that Canada would become a "clinic for the world" appears to be exaggerated. The medical examination is just one of a series of demanding hurdles which applicants for resident status must pass before being accepted into Canada. The most important of these hurdles is the points system in which applicants are assessed in relation to work experience, skills, age and language abilities. Medical inadmissibility, therefore, only works to exclude those applicants who would otherwise have satisfied immigration officers of their suitability to immigrate to Canada according to other stringent criteria.

It should also be noted that medical inadmissibility criteria presently apply to the admission to Canada of persons with refugee status and to those applicants for residence who have family within Canada. It is suggested that particularly in the former case, humanitarian considerations should outweigh economic concerns, if indeed the latter should be given any weight at all.[265] Moreover, from time to time one hears heart-wrenching stories of families which include a sick or disabled child that they are seeking to hide or abandon because of fear that the entire family will be rejected as immigrants on the basis of the medical inadmissibility of that child.

In the case of individual immigrants, it has also been argued that medical inadmissibility criteria, in general, should not apply. For example, the Canadian Bar Association (CBA), has contended that:

> [S]ection 19(1)(a) of the *Act* "may be in contravention of the *Canadian Charter of Rights and Freedoms*" on the grounds that "it is an issue whether exclusion because of a potential danger to the public or demands on the health care system would be considered to be 'reasonable and demonstrably justified'."[266]

These remarks suggest that both grounds of medical exclusion fail to meet the human rights standards set by the *Canadian Charter*, and are therefore invalid. The CBA's perspective is shared by the WHO which believes that medical examinations of prospective immigrants should serve only to screen people with diseases into the receiving country's health care system. In other words, people should not be refused immigrant status on medical grounds, but referred to medical services once settled in a new country. "Any

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[264] See above at Section I.E.

[265] It should be noted that this would not imply an end to medical screening, in general, of refugees. The consequences of that screening would however be different: for instance, an immigrant with a contagious disease could be directed to treatment facilities and not excluded from Canada.

[266] *Medical Inadmissibility Review*, *supra* note 113 at 39 quoting the Canadian Bar Association. The quotation refers to section 1 of the *Canadian Charter*, *supra* note 232, according to which discriminatory measures which infringe a constitutionally protected right and do not accord with "the principles of fundamental justice", may be upheld if they constitute "reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society."

health related restrictions on international migration ... would be both discriminatory and inhumane."[267]

Therefore, it is proposed that governments should be required to justify the maintenance of such restrictions — in particular their compliance with ethical considerations. Using potential health and social services costs alone as a sufficient basis for exclusion of people with certain diseases has unacceptable dimensions which need to be given serious consideration. For instance, such an approach would indicate an unacceptable attitude towards migrants as persons — in that it views them only in terms of the economic benefit they offer. In addition, it places only a monetary value on their worth — in that it states that they do not merit the cost they would present to society. This runs the risk of treating persons as objects through a process called reification. This is harmful, not only to the persons directly affected, but also to the excluding state as a result of the impact of such attitudes on the values, beliefs and symbolism that make up the "ethical and legal tone" of the society. Arguably, that tone is best judged by how a society treats persons who are weakest and most in need (which is often true of prospective immigrants and always true of refugees), not those who are powerful and strong. We need to ensure that approaches such as the points system (which function to assess prospective immigrants in terms of their potential to contribute to the Canadian economy) do not cause this wider kind of damage to Canadian society. Even from an economic perspective, excluding people simply on the basis of potential health and social services costs fails to recognize the contribution to the receiving state made by migration. It also takes no account of the ability of the state to pay for care that these migrants might need.

The scope of medical inadmissibility restrictions, therefore, should be carefully evaluated. Evaluation should take account of different considerations relevant to the situation of various groups of non-nationals. Such evaluation should be based on credible research and decisions taking into acount principles of human rights and human responsibility, and after weighing respect for humanitarian and ethical norms against burdens on the state. Otherwise, the decisions are likely to be influenced by unstated, and perhaps unjustified, assumptions concerning the desirability of certain persons as immigrants, the diseases from which they suffer, and the risks and costs which they would present to society.

Conclusion

The discussion of HIV-related entry restrictions has indicated that they serve no useful public health purpose. It can be added that they may be indirectly harmful to the protection of public health, since they divert scarce resources from more useful initia-

[267] *Medical Inadmissibility Review, ibid* at 30.

tives.[268] In this sense, they are not cost-effective. Such laws and their enforcement may also offend human rights standards and principles of ethics.

The stigmatisation of people living with certain feared diseases, evident in the history of responses to disease, has also been described.[269] These exclusionary responses to disease, including HIV-related entry restrictions on the grounds of public health protection, result from our fear of certain diseases and of other threatening realities — in particular our own mortality. The exclusions may be considered mechanisms for coping with these fears and the loss that they threaten in a much wider context.

Based on a re-assessment of the concept of sovereignty and the extent of the state's right to exclude aliens, we have made several suggestions for reforming Canadian and American entry restrictions. It has been contended that the scope of exclusionary measures should be limited with reference to humanitarian and human rights concerns, and a consideration of what is actually necessary for the preservation of the state. For example, it has been argued that there is a difference in the effect on the host state of the admission of visitors as compared with permanent residents, and that a presumption of exclusion relating to visitors is unnecessary for the self-preservation of the state. It has been suggested that the point of departure for the law, in relation to the entry of visitors, should be a rebuttable presumption of a right to enter other communities. The existence of this right would recognize the interdependence of modern states and the necessity of travel. It would not, however, imply a right to stay in the host country.

With respect to restrictions relating to permanent residence, it has been argued that the state may have a right to exclude, but that there might be certain limits on this right — notably in relation to the grounds on which aliens may be excluded. The importance of conforming with humanitarian considerations has been particularly emphasized, and the compatibility of medical exclusion on public health or economic grounds with human rights standards has been questioned.

The re-examination of the law of entry restrictions must take into account the social and psychological forces which have played a primordial role in the development of such law — both in the past and at present. These broader considerations of the sentiments underlying immigration laws must inform our analysis if the function these laws serve in Western societies is to be understood. Underlying forces include the need of many people to respond to uncertainty and fear by distancing and disidentifying themselves, practically and symbolically, from the perceived source of this fear — which in the case of HIV means those who are infected. These factors have resulted in entry restrictions which primarily serve a symbolic function, although they are adopted on the basis that they are needed for practical protection. This is evident in entry restrictions placed on HIV-infected people that are based on a public health exclusion. It is also true that the excessive burden exclusion criterion — depending on how this is interpreted

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[268] See N. Gilmore *et al.*, "International Travel and AIDS" (1989) 3 (Supp. 1) AIDS: A Year in Review S225.

[269] See also Gilmore & Somerville, *supra* note 25.

and applied — may reflect a powerful emotional rejection of those afflicted by a certain disease (such as AIDS) rather than being necessary to achieve the purported purpose for which it is used (namely avoiding health care costs).

We must ensure that the symbolism we create and hand on to future generations is acceptable — particularly in those countries like Canada and the U.S. which claim to uphold human rights and are regarded as models to be emulated. This will require us to recognize our fear and consequent disidentification from ill people, and to find ways to re-identify with them. We can do this by keeping in mind that:

> Illness is the night-side of life, a more onerous citizenship. Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place.[270]

In enacting entry restriction law as a symbolic response to the need to "do something" to protect ourselves and our society from the dangers we perceive HIV infection presents, it is important to be aware that such law is not neutral and may inflict great suffering on those affected. "It is essential to ensure that any enactment or use of law fights AIDS and its harmful effects on those affected, and not the *persons* affected by HIV infection or AIDS."[271] Any such laws which harm people living with HIV or AIDS can also be counter-productive in reducing the spread of HIV infection. They can alienate those infected and could make them less open to taking care to protect others, while falsely reassuring those who are not infected. This could also place these persons at greater risk of becoming infected.[272]

While this type of exclusionary law and the symbolism it entails is a reflection of our society, it should be recognized that the acceptance of such measures will also form the "ethical and legal tone" of our society. The acceptance of wrongfully discriminatory provisions in immigration laws shows an intolerance of certain people in times of "crisis". This intolerance indicates the degree to which the rights of certain, often stigmatised, groups of people may be suspended at times of a perceived challenge to the well-being of society. The general unwillingness to treat the human rights of aliens with the same respect as those of citizens indicates that, despite increased emphasis on the global community, the physical boundaries constituted by national frontiers remain significant mental boundaries in relation to how we consider our fellow human beings should be treated — and how we do treat them.

In affluent countries, HIV infection and AIDS has presented a real challenge in a form we do not often face: whether we would accept some additional perceived risk in order to respect the human rights of infected members of society, and of those who seek to become members. A refusal to do so would lead to the devaluation of the importance

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[270] S. Sontag, *Illness as Metaphor and AIDS and Its Metaphors* (New York: Doubleday, 1988) at 3.

[271] "Law as an 'Art Form'", *supra* note 55 at 291.

[272] See *ibid.* at 296.

of human rights in these societies.[273] This has important implications. Nafziger, for example, points out that, "mindless acceptance of the concept of a state's exclusive jurisdiction inhibits the growth of international cooperation and law-making in response to intrinsically international, and important, issues of migration."[274] At a time when migration is increasing, and has become a very important political issue, it is hoped that the concerns we have raised will be addressed, because:

> *Before I built a wall I'd ask to know*
> *What I was walling in or walling out,*
> *And to whom I was like to give offence.*
> *Something there is that doesn't love a wall,*
> *That wants it down.*
>
> *The Poems of Robert Frost*
> *The Modern Library, New York, 1946*

Afterword

This article deals entirely with the exclusion from entry into a country of non-nationals on the basis of their illness or disability. Just as it was completed, a report appeared in the New England Journal of Medicine, entitled, "Self-mutilation and Malingering Among Cuban Migrants Detained at Guantanamo Bay."[275] The report described cases in which persons injected foreign substances into themselves, inflicted major burns with molten plastic, and ingested various foreign bodies. As the authors state, "[t]hese cases illustrate graphically how Cuban migrants attempted to use self-mutilation and malingering to gain entry to the United States."[276] Serious accident cases at Guantanamo Bay had been medically evacuated to the U.S. for medical treatment which was unavailable locally. The accident victims were not subsequently deported from the U.S. In stark contrast to the cases dealt with in this article, this was a situation in which illness and medical need provided the basis for entry as an immigrant to the U.S. which others sought to use regardless of the terrible costs in pain, suffering and permanent injury, to themselves. If nothing else, this horrifying example should bring home to us the extraordinary depths of despair and desperation of some would-be immigrants.

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[273] This may be particularly evident in Western Europe, at present, since large numbers of refugees have been arriving there after fleeing the war in Yugoslavia and the economic problems of Eastern Europe and North Africa. The effect of this migration on societal values is exemplified by the behaviour, amongst others, of "politicians who, instead of confronting a rising tide of xenophobia, capitalise on it, by warning of a 'foreign invasion.'" (Eyal, *supra* note 161).

[274] Nafziger, *supra* note 170 at 822.

[275] T.C. Andrews *et al.*, "Self-mutilation and Malingering Among Cuban Migrants Detained at Guantanamo Bay" (1997) 336 New Engl. J. Med. 1251.

[276] *Ibid.* at 1252.