



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



Canadian  
Strategy on  
HIV/AIDS

La Stratégie  
canadienne  
sur le VIH/sida



CANADIAN AIDS MEMORIAL QUILT  
LA COURTE-POINTE COMMEMORATIVE  
CANADIENNE DU SIDA





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Canadian La Stratégie  
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## Section

# 1

## Introduction

Should persons claiming refugee status in Canada to escape danger or persecution be tested for HIV and refused asylum if they test positive? If refugees are admitted to Canada on humanitarian and compassionate grounds, should that compassion not extend to individuals who have the additional misfortune of being HIV-positive?

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

Those are the immediate ethical questions raised by proposals to screen prospective refugees and immigrants for HIV and deny admission to everyone who tests positive. Answering them requires that deeper background issues be addressed: What is the moral status of national borders? Is the sovereignty of the nation-state absolute, so that a grant of permanent residence is no more than a privilege that a nation-state may bestow or withhold for any reason? Do affluent countries have an obligation to help those who are worst-off in the world, or is whatever aid they choose to dispense merely a matter of charity? If prosperous countries have an ethical duty to provide foreign aid, may they admit refugees and immigrants as an alternative way of fulfilling that duty? And perhaps most difficult of all, how much national sacrifice may morality reasonably demand on behalf of people outside a nation's borders?

What is the moral status of national borders?

Reactions to these matters can be sharp and uncompromising. Allowing HIV-positive refugees or immigrants into the country is perceived by some as a threat to public health: "To remove any screening procedures between Canada and the pool of infection south of the border or elsewhere (e.g., central Africa) is folly of the highest order and in nobody's best interests" (Parker, 1990a: 525). It is claimed, furthermore, that providing care for HIV-infected refugees or immigrants would impose "severe strains on the taxpayer-funded health care system" (Parker, 1990a: 525). Proposals for testing refugees and immigrants and excluding those who are HIV-positive ultimately rest, however, on a claim about partiality: "AIDS is a tragedy, but charity still begins at home. Let's clean up our own corner of the global village before we open the doors to the problems of another" (Girdauskas, 1990: 1037). This could be merely a strategic point — that we would be more successful if we were to tackle familiar problems close to home. But the claim also has moral force because it affirms the priority of those who are near (if not necessarily dear) to us. It insists that our concern and our collective resources are owed, first and foremost, to our fellow citizens — our compatriots.

Such reactions could be politically inviting. Politicians who endorsed HIV testing could be perceived as actively defending the interests of their constituents: "From the perspective of an uninformed and apprehensive public, for whom elected representatives want to be seen to be 'doing

something', screening seems an easy enough and necessary way by which to raise a barrier to the spread of disease and to protect the public purse" (Goodwin-Gill, 1996: 64). This stance would court little political danger because those denied permanent residence would, of course, never vote. Political attractiveness is, nevertheless, not the same as moral defensibility.

Even more worrisome is the possibility that HIV testing of refugees and immigrants could both reflect and reinforce deep-seated fears and prejudices. It is easy to perceive refugees and immigrants as unlike "us" and to stereotype their beliefs, values, and behavior. It is also easy to characterize HIV as a disease that is rampant among strange peoples with strange ways of life.<sup>1</sup> Discomfort with those who are perceived as different and fear of a horrible disease are a powerful combination and powerful motivation for exclusion.

Given this setting and these dangers, proposals for HIV screening of refugees and immigrants require ethical scrutiny. Because HIV testing is never an end-in-itself but always a means, the goals of that testing need to be carefully identified and justified. Here the aim of the testing is to deny admission to applicants who test positive. An ethical analysis therefore must compare the anticipated benefits of automatic exclusion with the potential harms that such a policy would impose. This evaluation has to take place in the context of Canada's obligations to those who live outside the country, but before surveying general views about the moral duties of a nation-state and then proceeding to specific arguments for and against screening refugees and immigrants and excluding those who test positive, the legal situations in Canada and the United States will be quickly reviewed.

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



## Section

# 2

## Law and Policy

### Canada

The ostensible purposes of Canadian immigration policy are stated in the lengthy preamble to Canada's *Immigration Act*. They reflect the tension between altruism and national interest that pervades immigration policies throughout the world. Thus, section 3 of the *Act* refers not only to "such demographic goals as may be established by the Government of Canada in respect of the size, rate of growth, structure and geographic distribution of the Canadian population" and to "the development of a strong and viable economy and the prosperity of all regions in Canada," but also to the need "to ensure that any person who seeks admission to Canada on either a permanent or temporary basis is subject to standards of admission that do not discriminate in a manner inconsistent with the Canadian Charter of Rights and Freedoms," and "to fulfil Canada's international legal obligations with respect to refugees and to uphold its humanitarian tradition with respect to the displaced and the persecuted."<sup>2</sup>

Economic and demographic criteria predominate in the routine determination of prospective immigrants' admissibility. Broadly speaking, applicants for landing (permanent residence) under the independent immigrant category are assessed either with reference to education, experience, occupational qualifications, and age or, if they are applying as business immigrants, with reference to their financial resources and business experience and the feasibility of the business they propose to establish in Canada (Galloway, 1997: 153-174). Applicants for admission under the family class need not satisfy these selection criteria, but they must as a rule be sponsored by someone willing to assume financial responsibility for up to ten years. This requirement is less stringently interpreted in the case of a spouse or dependent child (Galloway, 1997: 142-152).

Admission of immigrants on humanitarian or compassionate grounds is the exception to the rule. Such admission is provided for in several ways. When admission has been denied to someone as a member of the family class, the sponsor involved may appeal the decision "on the ground that there exist compassionate or humanitarian considerations that warrant the granting of *special* relief."<sup>3</sup> Otherwise inadmissible individuals may also be granted entry to Canada under a minister's permit, which does not confer a right to permanent residence.<sup>4</sup>

To some extent, Canadian immigration policy distinguishes applicants for refugee status from other applicants for permanent residence. Refugee status is defined in the *Immigration Act*<sup>5</sup> with reference to the terms of the United Nations *Convention Relating to the Status of Refugees*, to which Canada acceded in 1969; hence, the term "Convention refugee" is used throughout the *Act*. The *Act* further authorizes the designation of classes of immigrants "the admission of members of which would be in accordance with Canada's humanitarian tradition with respect to the displaced and the persecuted."<sup>6</sup>

The process of determining who is and is not a Convention refugee or a member of another so-called “humanitarian class,” which is undertaken on an individual basis, is complex and sometimes contentious (Galloway, 1997: 175-180, 251-310). For our purposes, the significant point is that “members of the humanitarian class are not required to meet the selection criteria imposed on independent immigrants” (Galloway, 1997: 175) but *are* as a rule required to have sponsorship, financial assistance, or sufficient financial resources to support their resettlement in Canada. Partial, and discretionary, exceptions to this rule exist under the Disabled Refugee Program and the Women at Risk Program (Galloway, 1997: 177-178).

The *Immigration Act* does not, however, substantially distinguish between refugee claimants and other categories of prospective immigrants with respect to medical issues. Section 19 of the *Act* identifies as inadmissible on medical grounds:

- (a) persons who are suffering from any disease, disorder, disability or other health impairment as a result of the nature, severity or probable duration of which, in the opinion of a medical officer concurred in by at least one other medical officer,
  - (i) they are or are likely to be a danger to public health or to public safety, or
  - (ii) their admission would cause or might reasonably be expected to cause excessive demands on health or social services....<sup>7</sup>

Thus two distinct rationales exist for denying admission on medical grounds, one related to public health and the other to public economy. For purposes of determining medical inadmissibility, the *Act* does not distinguish between refugees and other immigrants beyond a directive about the timing of medical examinations:

- 11. (1) Every immigrant and every visitor of a prescribed class shall undergo a medical examination by a medical officer.
- (1.1) Every person, other than a permanent resident, who claims to be a Convention refugee shall undergo a medical examination by a medical officer within such reasonable period of time as is specified by a senior immigration officer.<sup>8</sup>

Consequently, from now on we will use the term “immigrant” to refer generically to those applying for either refugee or immigrant status, except when the distinction has legal or policy significance.

HIV testing is not automatically included in medical examinations carried out as part of the process of determining admissibility, and there are no clear criteria for determining when HIV testing should be conducted.

Two distinct sets of decision-makers are involved in determining the medical admissibility of prospective immigrants: medical officers and visa officers. Medical officers assess admissibility based on their own examinations or with reference to assessments of medical records “and other medical or laboratory reports, as necessary” (Health and Welfare Canada, 1992: I-3). Visa officers are the front-line employees of Citizenship and Immigration Canada who determine whether prospective immigrants are admissible. Recent case law indicates that in doing so visa officers should not rely simply on the assessments provided by medical officers; rather, “without second-guessing the medical, diagnostic opinion, [they] must consider all of the available evidence.”<sup>9</sup> HIV testing is not automatically included in medical examinations carried out as part of the process of determining admissibility, and there are no clear criteria for determining when HIV testing should be conducted.

Section 22 of the *Immigration Regulations* sets out a number of factors pertinent to the determination of medical inadmissibility:

- 22. For the purpose of determining whether any person is or is likely to be a danger to public health or to public safety or whether the admission of any person would cause or might reasonably be expected to cause excessive demands on health or social services, the following factors shall be considered by a medical officer in relation to the nature, severity or probable duration of any disease, disorder, disability or other health impairment from which the person is suffering, namely,

- a) any reports made by a medical practitioner with respect to the person;
- b) the degree to which the disease, disorder, disability or other impairment may be communicated to other persons;
- c) whether medical surveillance is required for reasons of public health;
- d) whether sudden incapacity or unpredictable or unusual behaviour may create a danger to public safety;
- e) whether the supply of health or social services that the person may require in Canada is limited to such an extent that
  - (i) the use of such services by the person might reasonably be expected to prevent or delay provision of those services to Canadian citizens or permanent residents, or
  - (ii) the use of such services may not be available or accessible to the person;
- f) whether medical care or hospitalization is required;
- g) whether potential employability or productivity is affected; and
- h) whether prompt and effective medical treatment can be provided.<sup>10</sup>

However, in 1995 the Federal Court of Canada (in *Ismaili v. Canada*) ruled that the *Immigration Act* does not provide statutory authority for regulations dealing with the assessment of “excessive demands,” although regulations could be made with respect to assessing prospective immigrants based on considerations of public health and safety.<sup>11</sup> The upshot of the decision is that medical and visa officers must continue to assess prospective immigrants with respect to the “excessive demands” criterion but must do so without the guidance and direction provided by regulations.

An operations memorandum issued by Citizenship and Immigration Canada (1996) in response to the *Ismaili* decision noted that “we have presently no authority to regulate the assessment of excessive demands,” a situation that persists to this day, but continues:

The ruling does not prevent medical officers from deciding if an applicant’s admission would or might reasonably be expected to cause excessive demands. It simply means they must exercise ‘discretion’ rather than apply the factors set out in R22 (emphasis in original).

“Excessive demand” is not defined in the *Immigration Act*.

That discretion is broad because “excessive demand” is not defined in the *Immigration Act*. Commentators on the *Ismaili* decision have noted that “[t]his strange and otherwise undefinable phrase is now left to haphazard and casual definition” (Rotenberg and Lam, 1995: 4). The resulting problems were noted in a 1998 review of immigration law and policy:

The current excessive demands provision as applied to spouses and dependent children is often perceived as inhumane, and the decision-making process slow. A significant number of refusals of spouses and dependent children on excessive demands grounds are overturned either on appeal to the Immigration Appeal Division of the Immigration and Refugee Board or on humanitarian or on compassionate grounds when a Minister’s permit is issued (Citizenship and Immigration Canada, 1998: 24).

Indeed, even before the *Ismaili* decision, a review of the medical inadmissibility provisions undertaken by Employment and Immigration Canada (1991: 33, see generally 33-37) recognized the “ambiguity that surrounds the concept of excessive demand.”

In 1994, then-Minister of Immigration Sergio Marchi wrote to the Canadian AIDS Society that “persons living with HIV/AIDS do not generally represent a danger to the public under s. 19 of the *Immigration Act*” (cited in Jürgens, 1998a: 199-200). According to Jürgens (1998a: 200), “[t]his policy is still in place and is unlikely to change in the near future.” But the current policy of the Canadian government, according to Jürgens (1998a: 200), is that people with HIV/AIDS would impose excessive demands on Canada’s health and social service systems, and consequently “immigration applicants who are found to be HIV-positive are assessed as ‘medically inadmissible’ and will not normally be allowed to immigrate to Canada.” No case law appears to exist on the use of

seropositive status as a determinant of inadmissibility based on the “excessive demand” criterion, although determinations of inadmissibility under this criterion for other medical reasons are often appealed. (We have not reviewed the relevant case law for purposes of this paper, just as we have not addressed the vexed question of the applicability of the *Charter of Rights and Freedoms* to prospective refugees and immigrants.) At the same time, and again according to Jürgens (1998a: 202), “persons who are found to be refugees do not have to meet any medical criteria” — which may be accurate as a description of current policy, but which appears to be inaccurate as a matter of law — and “[t]here has been at least one case where a self-declared person with HIV/AIDS has been allowed into Canada as a refugee.”<sup>12</sup>

## United States<sup>13</sup>

Like Canadian law, U.S. legislation (the *Immigration and Nationality Act*) contains two distinct grounds for medical exclusion. The first involves the prospect of contagion. In 1987 Congress directed the U.S. Public Health Service (PHS) to add HIV infection to the list of “dangerous contagious diseases” that warrant exclusion and passed legislation requiring HIV screening for all immigrants. A subsequent legislative review replaced the reference to “dangerous contagious diseases” with “communicable disease of public health significance,” and efforts were made by the executive branch to remove AIDS from the list of diseases. In response, Congress added HIV infection to the legislation itself, with the result that the *Immigration and Nationality Act* now excludes:

... any alien who is determined (in accordance with regulations prescribed by the Secretary of Health and Human Services) to have a communicable disease of public health significance, which shall include infection with the etiologic agent for acquired immune deficiency syndrome.<sup>14</sup>

Because “aliens” refers to all non-citizens, this exclusion would, in theory, apply to business travelers and casual visitors as well. Although visitors are not routinely tested or required to show evidence of HIV serostatus, the U.S. policy prompted several governments and non-governmental organizations to boycott the Sixth International Conference on AIDS in San Francisco in 1990, and it led organizers to relocate the Eighth International Conference in 1992 from Boston to Amsterdam.

Although testing is not required of applicants for visas that do not involve permanent residency, such as students, these applicants are asked whether they have a “communicable disease of public health significance.” If visa applicants fail to disclose their serostatus knowing that AIDS constitutes such a disease for purposes of U.S. law, they have committed immigration fraud. Thus, the U.S. policy has the effect of encouraging potential visa applicants not to become aware of their own serostatus — a consequence whose perversity, from the standpoint of public health, was pointed out a decade ago (Gostin et al., 1990).

The second potentially relevant provision of the *Immigration and Nationality Act* specifies that:

- (A) Any alien who, in the opinion of the consular officer at the time of application for a visa, or in the opinion of the Attorney General at the time of application for admission or adjustment of status, is likely at any time to become a public charge is inadmissible.
- (B) Factors to be taken into account.
  - (i) In determining whether an alien is excludable under this paragraph, the consular officer or the Attorney General shall at a minimum consider the alien’s—
    - (I) age;
    - (II) health;
    - (III) family status;
    - (IV) assets, resources, and financial status; and
    - (V) education and skills.<sup>15</sup>

At the moment, these provisions are not directly relevant to HIV-positive aliens, who are excluded by specific legislation. Were that legislation to be repealed, however, HIV infection could, pursuant to this provision, be treated as grounds for exclusion in at least some cases.

## Summary

Canadian law, unlike U.S. law, does not explicitly bar immigrants because they are HIV-positive. But Canadian law does, *in theory*, authorize the exclusion of prospective immigrants who are HIV-positive, either because they pose a threat to public health or because their care and support would consume too many resources. Canadian immigration policy, *in practice*, recognizes that HIV-positive immigrants do not represent a danger to public health, but it does allow that meeting their needs might impose an inordinate burden on Canada's health and social service systems and that their applications for permanent residence may be denied for that reason. Whether these positions are ethically defensible is examined in the sections that follow.

Canadian law, unlike U.S. law, does not explicitly bar immigrants because they are HIV-positive.

<sup>2</sup> *Immigration Act*, R.S.C. 1985, s. 3. Given Canada's history of highly restrictive and frequently racist immigration policies (Galloway, 1997: 10-18), many would see the *Immigration Act*'s reference to a humanitarian tradition as bitterly ironic.

<sup>3</sup> R.S.C. 1985, s. 77(3)(b); emphasis added.

<sup>4</sup> *Ibid.*, s. 37.

<sup>5</sup> *Ibid.*, s. 2(1), 2(2), and 2(3).

<sup>6</sup> *Ibid.*, s. 6(3).

<sup>7</sup> *Ibid.*, s. 19.

<sup>8</sup> *Ibid.*, s. 11.

<sup>9</sup> *Ismaili v. Canada (Minister of Citizenship and Immigration)* [1995], 29 *Immigration Law Reporter* (2d) 1, at 17.

<sup>10</sup> SOR/78-172, s. 22, as amended.

<sup>11</sup> *Ismaili v. Canada*, *supra* note 9.

<sup>12</sup> For a summary of this case, see Wilson, 1995: 5.

<sup>13</sup> Endnote Text

<sup>14</sup> 8 U.S.C. 1182, s. 212(a)(1)(A)(i).

<sup>15</sup> *Ibid.*, s. 212(a)(4).

## Nationalism versus Cosmopolitanism

At the turn of the twentieth century, philosopher Henry Sidgwick analyzed the ethical issues posed by the possibility of open borders in a way that remains influential today. Sidgwick recognized that international law adopts “the principle of mutual non-interference,” which allows each country “complete freedom in determining the positive relations into which it will enter with States and individuals outside it...” (1919: 308). But, Sidgwick continued, trying to decide “how far the exercise of this right of exclusion is conducive to the real interest of the State exercising it, or of humanity at large” raises a conflict between what he calls “the cosmopolitan and the national ideals of political organization...” (1919: 308-309). Those ideals embody fundamentally different notions of how much priority we may assign to our compatriots:

According to the national ideal, the right and duty of each government is to promote the interests of a determinate group of human beings, bound together by the tie of a common nationality...and to consider the expediency of admitting foreigners...solely from this point of view. According to the cosmopolitan ideal, its business is to maintain order over the particular territory that historical causes have appropriated to it, but not in any way to determine who is to inhabit this territory, or to restrict the enjoyment of its natural advantages to any particular portion of the human race (Sidgwick, 1919: 309).

Sidgwick’s assessment of these competing ideals is pragmatic and realistic. He appreciates that sympathy to and empathy for strangers, which he calls “the wider sentiment connected with the conception of our common humanity,” is too weak and tenuous to displace “national and patriotic sentiments which have in any case to be reckoned with as an actually powerful political force, and which appear to be at present indispensable to social wellbeing” (1919: 309).

In support of this conclusion, Sidgwick offers three more specific reasons for restricting immigration. First, the motley collections of people that would result “from perfectly unrestrained immigration would lack internal cohesion.” Second, governmental efforts to promote “moral and intellectual culture might be rendered hopelessly difficult by the continual inflowing streams of alien immigrants, with diverse moral habits and religious traditions.” Third, the efficient and well ordered operation of political institutions would be impeded by “a large intermixture of immigrants brought up under different institutions” (1919: 309).<sup>16</sup>

Effective governance, with respect not only to matters of security and administration but also to the establishment of unifying social and cultural values, requires a minimal level of solidarity and commonality. Sidgwick fears that those preconditions could be jeopardized by unrestricted immigration. At the same time he acknowledges the benefits of immigration. Immigration makes it possible for a country “to share the advantage of the special faculties and empirical arts in which other countries excel” and diffuses “mutual knowledge and sympathy among nations” (1919: 310).



Nevertheless, he concludes that the dangers of absolutely free immigration make it proper for a country to restrict immigration “...if ever it should threaten...to interfere materially with the internal cohesion of a nation, or with the efforts of its government to maintain an adequately high quality of civilised life among the members of the community generally” (1919: 310).

Sidgwick’s analysis and conclusion continue to set the terms of debates about immigration. Contemporary Canadian immigration policy still struggles to reconcile the duty to help strangers with obligations to compatriots and the necessities of effective governance:

Canadian immigration policy struggles to reconcile the duty to help strangers with obligations to compatriots and the necessities of effective governance:

The immigration program is built on two fundamental ideas. One is the idea of facilitation, of assisting people who want to come to Canada and who have something to contribute to Canadian society, of helping families reunite in Canada, and of aiding refugees who flee oppression. The other is the idea of sovereignty or Canada’s right to exercise what it sees as reasonable control over who crosses its borders. It is perhaps inevitable that these two ideas should, from time to time, come into conflict with one another, the one being so firmly rooted in the needs of the individual, the other in the protection of the state (Employment and Immigration Canada, 1991: 3-4).

That conflict emerges pointedly in the medical screening of immigrants. Three general perspectives on the conflict are identified in the next section, and specific arguments for and against screening immigrants for HIV infection and excluding those who test positive are then assessed in Section V.

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<sup>16</sup> For a critical assessment of these reasons, see Walzer, 1983: 37-39.

## Ethical Perspectives

### Realism

Sidgwick's concession to the political power of nationalism and patriotism has subsequently been developed into a general orientation to matters political and moral. In discussions of the relation between ethics and public policy, realism invokes the divide between what is ideally desirable and what can be achieved in the face of a variety of human limitations and imperfections. In the study of international relations and foreign policy, realism has a narrower and more specialized meaning: it refers to an approach that regards nation-states as self-interested and self-contained entities that are concerned primarily, if not exclusively, with their own power and security. Hendrickson (1992: 214) has observed: "Political realism is less a doctrine than a disposition....It is sceptical, pessimistic and anti-utopian," particularly with respect to the prospect of transcending "the essentially self-interested character of human beings." Realism is omnipresent in public policy and widespread in everyday moral reasoning, as Schmitter (1997: 301), a political scientist, points out:

[M]ost self-proclaimed economic or political liberals are also nationalists. As politicians, they may not consciously practice 'realism' by incessantly seeking to maximize the power and wealth of their own country without regard for others, but they are held exclusively accountable by their fellow nationals for the benefits they produce at home, not for those they provide abroad.

The same is true, of course, for benefits provided to those "abroad" seeking residence in one's own country, who may even be viewed as direct competitors for a scarce pool of resources.

Realism has a natural affinity with immigration policy because in almost all the world's nation-states, choices about who gets in, who gets to stay, and who does not are determined largely by considerations of national interest, defined with reference to the relative costs and benefits to the nation-state of admitting the individual (or members of the group) in question. Following the legislative lead provided by s. 19 of the *Immigration Act*, a review of the criteria for medical inadmissibility conducted a decade ago unabashedly adopted a realist stance: "...[A] system of selection which makes distinctions based on personal characteristics, like health, is justified if Canada is to avoid becoming a clinic for the world" (Employment and Immigration Canada, 1991: 31; emphasis deleted). A Toronto physician put it more bluntly:

AIDS is a killer. With the frustrations of an aging population, shrinking number of hospital beds and difficulty in obtaining home care for our locals, can we really afford to shrug our shoulders and import an incurable infection?...We can certainly not afford to open the doors to just anybody suffering from any disease and offer to look after him or her (Girdauskas, 1990: 1037).



Although realism represents a distinct and highly influential perspective on the obligations (or lack thereof) of nations to non-nationals, it should not be accepted uncritically or regarded as immune to ethical scrutiny.

Why, then, might Canada be justified in adopting patently self-interested immigration policies? For some, the answer is remarkably simple. Countries, like individuals, are egoistic: those inside the castle walls will always seek to protect what they have against those outside. As it stands, that response is unsatisfactory. It concerns only what *is* the case, not what *ought* to be the case. It is not enough simply to assert that countries or individuals are always self-interested. What must be defended is the position that it is ethically permissible for them always to be self-interested. How might that argument be made? One attempt invokes the familiar doctrine of moral philosophy that “ought” implies “can.” If it is impossible for countries (and the governments that speak for their citizens) or individuals to act on motivations other than self-interest, then countries or individuals cannot be ethically required to act on motivations other than self-interest. But the contention with which this argument begins — that countries and individuals are in fact incapable of acting contrary to their perceived self-interest — is certainly dubious. And the conclusion the argument reaches — that countries and individuals ought to act so as to promote their perceived self-interest — is equally contentious. Were this argument sound, the possibility of altruism would disappear, along with the demands of morality, since “[t]he most elementary form of moral reasoning — the ethical equivalent of learning to crawl — is to weigh others’ interests against one’s own” (Anon., 1995: 11).

If realism offers nothing more than observations about how countries and individuals as a matter of fact behave, then it is not clear what, if any, ethical implications follow from realism or that realism can sustain a distinct, coherent *ethical* perspective. Perhaps realism evinces no more than a resigned, even fatalistic, view of the role of self-interest in human interactions, both within and across national borders.

In the international context Midgley (1999: 171) questions the ethical pronouncements of realism when she observes that it

calls on us to recognise the nation-state as a specially real entity, a peculiarly hard fact in the world, a unit so uniquely solid and objective that it can fix the limits of our moral obligations. In view of the changes that have continually taken place during history in the way the world is organised, this strikes me as a remarkably arbitrary proposition. I know of no good reason why the burden of proof should be put on anyone who proposes that people can have duties to other people outside their own nation-state rather than on someone who does not.

For Midgley national borders do not necessarily have any ethical significance, let alone the moral strength that realism attributes to them. Moreover, realism does not countenance the ethical stance of Angel, a Mexican who entered the United States illegally, worked there for several years, and was subsequently caught and deported, when he explained why he intended to return illegally again: “There are no frontiers for hunger. You have the right to look for opportunity wherever you can.”<sup>17</sup> Realism ignores or suppresses Angel’s claim. The next two approaches we discuss give it credence.

## Liberal Egalitarianism

Within Western democracies a standard argument for freer movement of people across national boundaries invokes a moral and political theory known as liberal egalitarianism (Goodin 1992a: 7). The liberal component of the theory propounds a moral point of view that is universal rather than limited, selective, or parochial. Morality applies to people because they are people, not because they reside in a particular place or belong to a particular country. The egalitarian component of the theory holds that “distributions of life prospects ought to be roughly equal, or at least substantially more equal than they now are” (Goodin 1992a: 7). Comparisons of people’s life prospects therefore should be global — they should focus “upon people in general rather than merely upon people living within some particular political jurisdiction” (Goodin 1992a: 7).

If rich countries are not willing to move money to where the poor people are, they could move the poor people to where the money is.

Recognizing the enormous disparity in life prospects across the globe, and the unimaginable squalor and poverty in which countless people exist, liberal egalitarianism posits a strong ethical obligation on the part of the richer countries of the world to redistribute wealth. This transfer of wealth is a matter of moral duty — of compensation — not a mere act of charity. But rich countries are notoriously reluctant to provide foreign aid on the scale and magnitude that liberal egalitarianism demands. An alternative, and probably second-best, way of fulfilling that obligation would be to grant permanent residence to large numbers of immigrants from poor countries. If rich countries are not willing to move money to where the poor people are, they could move the poor people to where the money is. But that option is, if anything, even more politically unpalatable: “Citizens of rich nations are likely to be even more reluctant to welcome lots of destitute foreigners into their country than they historically have been to shipping substantial sums of money abroad to relieve their suffering” (Goodin, 1992a: 8).

Given that either alternative would encounter fierce, implacable, and extensive opposition, liberal egalitarianism seems naïve, idealistic, and utopian. So what’s the point? The point is that if morality is to have any force whatsoever, it must sometimes require actions that are contrary to self-interest, whether that self-interest is individual or national. Engaging in moral reflection assumes that people can recognize the demands of morality and can be motivated to act on those demands. The same assumptions have to apply when ethical questions are raised about the policies adopted by national governments:

The goal of such exercises is precisely to put rich countries on the spot. The aim is to argue that, if arguments for international distributive justice are valid and if rich countries do not want to give generously of their money to meet the demands that those arguments impose, then they are morally obliged to pay instead in a currency that they hold even dearer (Goodin 1992a: 8).

The alternative for rich countries is to open their borders. Carens, a leading proponent of a liberal egalitarian justification for the largely unconstrained movement of peoples, acknowledges that this idea is “not politically feasible” and thus serves mainly “to provide a critical standard by which to assess existing restrictive practices and policies” (1992: 45). Carens recognizes that “in every polity, domestic political considerations will confine feasible policy options to a relatively narrow range, excluding alternatives that would entail major costs to current citizens” (1992: 45). Nevertheless, Carens holds that liberal egalitarians “should almost always press for more openness towards immigrants and refugees” (1992: 45).

At the same time, Carens is willing to accept limitations on a country’s obligation to admit immigrants. The presumption in favor of free movement that follows from liberal egalitarianism can sometimes be overridden, for example, when a legitimate, serious threat to national security exists. Could restrictions also be justified to protect and preserve existing liberal egalitarian institutions and cultures? That is harder to determine. One possibility is provided by “the backlash argument”:

On this view, the commitment to liberal egalitarian principles is not very secure even in liberal societies. Current citizens might object to the ethnic and cultural characteristics of new immigrants, fear them as competitors in the workplace, and perceive them as economic burdens placing excessive demands upon the social welfare system. At the least, this reaction might erode the sense of mutuality and community identification that makes egalitarian and redistributive programmes politically possible. At the worst, it might threaten the basic liberal democratic framework (Carens 1992: 31).

Carens thinks that although this possibility could not in principle justify restrictions on immigration from a liberal egalitarian perspective, it might do so in practice. One must be skeptical of that claim: it could, for instance, justify restrictions on the number of African-Americans or Asians who were allowed to rent or buy housing in predominantly white neighborhoods based on worries ranging

from “white flight” to vigilantism. It could, in other words, vindicate policies rooted in self-interest or even outright prejudice rather than challenge the legitimacy of those concerns.

More compelling are arguments for restricting immigration grounded in considerations of fairness. Carens points out that fairness can operate at both individual and collective levels, and he begins with an example of the former:

Suppose a person, age sixty, has lived for many years in the United States, earning a substantial income and paying lower taxes than Canadians because of the absence of a universal, publicly financed health care system. He now finds that he needs very costly medical care. It would clearly not be fair for him to come to Canada and expect the Canadians to pay for his care. He could have afforded to purchase health insurance in the United States and did not; Canadians should not be asked to pay the costs of his imprudence. He has not done his fair share in contributing to the Canadian health care system. This argument appeals to the sense of reciprocity that is implicit in social insurance schemes in the welfare state. It would not be fair for a citizen to opt out of social insurance arrangements for years and then opt in just at the moment when he knows that he needs a disproportionate share of the benefits provided. Of course, citizens are not permitted to do this. At the very least, the same principle of fairness would seem to justify excluding noncitizens who seek to join a community for the sake of obtaining welfare-state benefits just at the moment when they need those benefits (Carens, 1988: 219).

But what about a poor person who could not afford health insurance in the United States? Would individual Americans who are not responsible for their predicaments be morally entitled to enter Canada to obtain health care? Carens thinks not, given a sense of fairness that operates at a collective level:

Crudely put, the central intuition here is that communities should look after their own. Recall that we are considering...only affluent liberal democratic welfare states such as the United States and Canada. We have put aside...the questions raised by vast inequalities among states. Given broadly comparable economic resources, it would be unfair for the members of one community to expect the members of another to bear the burden of providing for a social need such as health care that will emerge in every community. The principle of fairness based on collective responsibility also applies to other goods supplied by the welfare state, such as employment opportunities, education, and income support (1988: 220).

In deciding how these goods are to be provided, Carens holds, a welfare state has “considerable room for legitimate collective self-determination...” (1988: 220). Moreover, a policy of free movement across borders would create perverse incentives, “for it penalizes the most generous communities and rewards the most stingy” (Carens, 1988: 221). The upshot, for Carens, is that “[p]eople do not have a right to move in order to take advantage of benefits provided by another democratic political community, when their own community could have provided the same benefits but chose not to do so” (1988: 222).

The issues and the outcome are different, according to Carens, when prospective immigrants come from poor countries that cannot afford anything close to the medical or social benefits offered by an affluent country. On the one hand, admitting destitute immigrants who would need extensive medical and social services would pose a more serious threat to the welfare state. On the other hand, the argument from fairness collapses because the inequalities in benefits now reflect the different capacities of the countries not different collective choices. Excluding immigrants is, Carens points out, no longer a matter of protecting the collective self-determination and identity of the more affluent country; rather, it is a matter of preserving resources and collective privilege (1988: 227). Consequently, “[p]reservation of the welfare state does not justify restriction of immigration from poor countries to rich ones” (Carens, 1988: 227).

Carens' argument from fairness at a collective level raises important questions because he appears to presume that all residents of affluent countries are members of a "democratic political community" in some meaningful sense. This may or may not be the case. For example, Guinier (1995) has shown that it is quite possible for members of a minority group to be excluded from any real influence on policy outcomes, even in communities where political institutions are superficially democratic. The quarrel here is not with the values at the core of liberal egalitarianism, but rather with Carens' willingness to defer to policy choices that reflect the rules of the political game within a particular jurisdiction, without inquiring too deeply into the biases built into those rules and how those rules actually operate. In other words, Carens is too willing to presume that the sole appropriate level of analysis is a prospective immigrant's country of origin, rather than his or her situation *within* that country. Such deference to political choices made by national governments has obvious implications for immigration policy, but it is not logically required by a liberal egalitarian perspective. As we show in the next section, a human rights perspective builds on liberal egalitarianism in a way that is important for purposes of law and public policy, at least in part because it is less deferential toward such choices and thus more faithful to the values of impartiality and equality.

## Human Rights and International Justice

The ethical and legal notion of human rights is perhaps most familiar to Canadians from the provisions of the *Charter of Rights and Freedoms* and various federal and provincial anti-discrimination statutes (human rights codes). The concept has a longer history in the international context, stretching back to revulsion at the horrors of World War II, the establishment of the United Nations, and the adoption by its General Assembly in 1948 of the ambitious and comprehensive Universal Declaration of Human Rights (UDHR).

Despite such national and international affirmations, considerable debate persists about the epistemological status of human rights: where do human rights come from, how are they justified, and how are their content and scope determined?<sup>18</sup> Critics never fail to point out that many human rights cannot be taken as absolute. Nevertheless, a strong presumption against infringement is essential if the concept is to make any sense. (The importance of understanding the initial presumptions that guide arguments about ethics and public policy is emphasized at the end of section V.) Perhaps most fundamentally, the transformative effect of human rights on international law and the norms of international conduct depends upon their presumed applicability across national borders and their adoption of the individual rather than any group (including, of course, a political community defined by national borders) as the primary unit of analysis (see Table 1).

**Table 1: Six Essential Presumptions About Human Rights**

1	"People have rights simply because they are human"; individuals need not earn or vindicate them.
2	"Human rights are universal, applying equally to all people around the world," although they may be "elaborated upon at a regional or national level, taking into account the specific circumstances and cultural backgrounds of various geographic areas."
3	The concept of human rights "does not require that all people should be treated the same or regarded as the same but requires that people should be treated equally and given equal opportunity," with particular attention to "the specific needs of persons who are in a vulnerable position in society" such as women, children, and disabled persons.
4	Human rights "are primarily the rights of individuals," and constitute claims on "society or government, arising as a matter of right, not as a result of privilege or special favour...."
5	"Human rights encompass the fundamental principles of humanity." In some cases no infringement may be accepted; in other cases, infringement "is justified only if and when a number of stringent criteria are met. In other words, a strong (sometimes absolute) presumption always exists against infringement.
6	"The promotion and protection of human rights is not bounded by the frontiers of national states."

Source: *International Federation of Red Cross et al.*, 1999: 21-22.

The potential for infringing human rights exists whenever public health measures are designed to control or circumscribe individual conduct. That potential is particularly worrisome with respect to policies designed to limit the spread of HIV because “the HIV/AIDS pandemic has intensified preexisting prejudices against communities associated with the disease” (Gostin and Lazzarini, 1997: 75). In response, and with reference not only to HIV but also to sexually transmitted diseases and tuberculosis, Gostin and Mann (1999) have proposed a methodology for a human rights impact assessment of public health policies, which is summarized in Table 2.

**Table 2: A Methodology for Evaluating The Human Rights Consequences of Public Health Interventions**

Step 1	Clarify the public health purpose, with an emphasis on avoiding vague, general goals like the prevention of HIV infection.
Step 2	Assess the probable effectiveness of the proposed measures, alone and in comparison with other available options, with reference to such questions as the accuracy of screening programs.
Step 3	Determine whether the measure is appropriately targeted: in other words, is neither over- nor under-inclusive.
Step 4	Examine each of the feasible policy measures for human rights burdens. “The human rights assessment involves a meticulous balancing of the potential benefits to the health of the community with the human rights repercussions of the policy,” with reference to such statements as the UDHR and with the recognition that “human rights burdens may outweigh even a well-designed policy.” The assessment may take into account: “(1) the nature of the human right, (2) the invasiveness of the intervention, (3) the frequency and scope of the infringement [of human rights], and (4) its duration.”
Step 5	Determine whether the policy is the <i>least restrictive alternative</i> , in terms of human rights, that will achieve the public health objective or whether there are “alternative public health policies that burden human rights to a lesser extent, while still protecting the health of the community.”
Step 6	If the least restrictive alternative still carries a significant human rights burden, ensure that its application is based on “an <i>individual determination</i> that the person poses a <i>significant risk</i> to the public....Significant risk must be determined on a case-by-case basis by means of fact-specific, individual inquiries. Blanket rules or generalizations about a class of persons do not suffice.”
Step 7	In the process of making such determinations, fair procedures must be guaranteed for the persons affected.

Source: Gostin and Mann, 1999: 55-68. (This framework was originally proposed in 1994.)

What is the probable result of using this framework to evaluate HIV screening of immigrants? First of all, it is worth noting the view of the United Nations Commission for Human Rights (UNCHR) that “discrimination on the basis of HIV status, actual or presumed, is prohibited by existing international human rights standards, and that the term ‘or other status’ in non-discrimination provisions in international human rights texts should be interpreted to cover health status, including HIV/AIDS.”<sup>19</sup> A policy of mandatory testing and mandatory exclusion of all those who test positive would probably fail several of the tests that comprise the framework. The goal of reducing the threat to public health is general and vague, as well as over-inclusive because HIV infection is not transmitted by casual contact and there is no reason to infer recklessness in this respect on the part of those living with HIV infection. The effectiveness of the policy could be questionable because of concerns about the quality of HIV testing in some countries. The compulsory nature of the testing would not give prospective refugees and immigrants the same right to make voluntary, informed decisions about testing that is morally and legally required for everyone in Canada. There is no demonstration that mandatory testing represents the least restrictive way of pursuing whatever the specific goals of such testing might be. And because exclusion of those who test positive would be mandatory, decisions would not be made on an individualized, case-by-case basis. Since a policy of blanket exclusion could not be justified for health-related reasons, mandatory screening could not be justified on that basis. Nor would it be possible to justify mandatory screening of immigrants from



If safeguards for individual human rights are to be meaningful, they should be at least as strong when the collective objective against which they are counterposed is the protection of the public treasury as when it is the protection of public health.

only certain regions, or with only certain characteristics, because such a selective policy would reflect and reinforce invidious stereotypes.

Any putative justification of HIV testing therefore would have to be based on the “excessive demand” criterion. It is not clear whether Gostin and Mann intend their framework to be applicable to such an economic rationale. However, if safeguards for individual human rights are to be meaningful, they should be at least as strong when the collective objective against which they are counterposed is the protection of the public treasury as when it is the protection of public health.

Can the moral force of human rights be pressed further in the international arena? Perhaps. Discussing the desperation that drives people in poor countries to risk their lives to enter rich ones illegally, Martinez-Alier (1991: 133) characterizes “the right to choose one’s place of habitation on earth” as “the most elusive of human rights.” It is certainly elusive. None of the standard texts on human rights proposes an unrestricted right of immigration. Nevertheless, assertions, such as those in the UDHR, of rights to rest and leisure; to an adequate standard of living including food, clothing, housing, and medical care and necessary services; and to education must force this question in a world of massive and growing economic disparities that deny to some people, by geographic accident of birth, what is routinely available to others. In the face of these realities, how do we draw a moral line between “us” and “them,” and how compelling are the arguments for a moral boundary between “us” and “them”? Those are the questions to which a human rights perspective inexorably directs our attention, even as it struggles to answer them.

## Summary

The walls of the nation-state are highest and thickest in a realist perspective, but their strength derives from the self-interest they guard so zealously. Whether realism can produce an ethical justification for the formidable protection it gives to self-interest is doubtful, though, given that a primary task of morality always has been to legitimize the interests of others. Consequently, while realism attends carefully to how nations do regulate immigration, it is not helpful in determining how they ought to regulate immigration.

In contrast, liberal egalitarian and human rights perspectives address the ethical dimensions of immigration directly. They impose obligations on affluent countries to help impoverished people outside their borders, and they regard immigration as one way of fulfilling those obligations. Neither a human rights approach nor its supporting philosophy of liberal egalitarianism precludes restrictions on immigration, however. Both accept that nation-states are entitled to control and limit immigration. At the same time, though, both constrain the nature of those restrictions. As Walzer (1983: 40) crisply puts it, “To say that states have a right to act in certain areas is not to say that anything they do in those areas is right.” Liberal egalitarianism offers arguments about the fairness of immigration policies, and a human rights perspective yields more specific criteria for the ethical assessment of immigration policies. That takes us to the immediate questions. Even though Canada has the right to regulate immigration, is it ethically permissible for Canada to mandate HIV testing of prospective immigrants? If so, may Canada automatically exclude everyone who tests positive?

<sup>17</sup> Newsweek, August 12, 1985, p. 48. Quoted in Carens, 1988: 207.

<sup>18</sup> See generally Dunne and Wheeler, eds., 1999.

<sup>19</sup> The Protection of Human Rights in the Context of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), UNCHR Resolution 1996/43, 1; reiterated in the preamble to UNCHR Resolution 1999/49 of the same title, and in the United Nations’ *international guidelines on HIV/AIDS and Human Rights* (UNHCHR/UNAIDS, 1998: 86).

## Section

# 5

## Specific Arguments

### For Mandatory Testing and Automatic Exclusion

#### Danger to Public Health or Safety

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

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

...[W]ho and what constitute a threat to public health[?] What is public health? How does this differ from the health of individuals? Do all infectious diseases constitute a risk to public health? If a risk is encountered in an occupational setting and that risk is an inherent part of that occupation, does it constitute a risk to public health or is it an occupational health risk? (1990: 172)

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

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

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

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

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

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

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

The second line of argument begins by rejecting Somerville’s focus on behavior that might constitute a threat to public health. The *Immigration Act*, in this view, does not require a medical officer to determine “*whether the exclusion of an individual applicant will in any way prevent the spread of a particular disease in Canada*” (Employment and Immigration Canada, 1991: 45; emphasis in original). Consequently,

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

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

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

The public health challenge is collective. The responsibility for prevention does not devolve to immigrants alone, so if immigrants were to transmit HIV to others, the responsibility for the spread of the disease would not be theirs alone.

What about syphilis, however? Like HIV, syphilis is a communicable disease that is spread only through “high risk” behavior. Testing for syphilis is mandatory, and in its infectious phase, syphilis would render an applicant inadmissible until the condition is cured. So why mandatory testing for syphilis and not for HIV?

The answer brings us back to the behavior of people living with HIV:

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



That behavior is, quite appropriately, located in its social context. HIV/AIDS already exists in Canada, and preventing the spread of the disease requires societal education about safe sex precautions and individual adoption of those precautions.<sup>20</sup> The public health challenge is collective. The responsibility for prevention does not devolve to immigrants alone, so if immigrants were to transmit HIV to others, the responsibility for the spread of the disease would not be theirs alone. To refuse admission to immigrants solely because they test HIV positive would be to deny society's collective responsibility for HIV/AIDS and to make immigrants scapegoats for society's failure to combat the disease more effectively.

## Excessive Demand for Health or Social Services

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

The *Immigration Act* and the *Immigration Regulations* recognize this concern, but the criteria they provide are not very helpful. Medical and social services for people with HIV/AIDS are available and accessible in Canada (albeit with varying degrees of difficulty depending upon where one lives), so that is not an issue. What about preventing or delaying the provision of services? Given the familiar phenomena of crowded waiting rooms and waiting lists, *any* use of health care services could reasonably be expected to delay provision of those services to Canadian citizens or permanent residents. Every time someone makes an appointment with a family doctor and waits patiently to be seen, that person is delaying the provision of services to everyone booked afterwards. An immigrant who was also waiting to be seen by that family doctor would extend the delay. Does it thereby follow that admitting that immigrant caused an "excessive demand" on Canada's health care system?

Part of the problem is that "excessive demand" has not been clearly defined in connection with medical inadmissibility and perhaps cannot be defined with the requisite precision.<sup>21</sup> The *Medical Officer's Handbook* (Health and Welfare Canada, 1992: 3-6) states that:

The responsibility of the Medical Officer then is:

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

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

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

...[W]ould an immigrant whose net contribution to the gross national product has outweighed any health care cost that that person engendered constitute an excessive cost to the Canadian

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

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

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

Presumably, this [test] applies whether the potential candidate is a Nobel laureate, a construction worker, or a billionaire; an open question is whether a rich person who could create tax revenues in excess of projected health costs should be more welcome than the Nobel laureate or the construction worker...<sup>22</sup>

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

Although the financial pressures being exerted on Canada’s health care systems make every avenue for controlling costs appealing, it is not clear how or whether those pressures would be eased by barring prospective immigrants who are HIV-positive. Precise data are difficult to obtain, and estimates depend upon a host of assumptions. A cost-benefit analysis of immigrants to Canada in 1988 calculated the net benefits of testing in the decade after immigration to be between \$1.7 and \$13.7 million (Zowall et al., 1990). That estimate must be put in context, however. The overall demand for health care services in Canada is driven by much bigger and more powerful forces, including the aging of the population; the ever-expanding array of expensive pharmaceutical and technological interventions; the failure of health promotion efforts to have significant impacts on behavior such as smoking; and the expectations of the public and health care professionals. Genuine attempts to address the perceived health care crisis should be directed at those forces, and not deflected by worries about the “excessive demands” that immigrants might impose on health care services.

Being HIV-positive is not in itself a threat to public health.

The notion of “excessive demand” is deceptively simple and deceptively plausible.

## Conclusions

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

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

# Against Testing

## Stigmatization

Widely accepted principles of law and bioethics require that HIV testing in Canada be conducted entirely on a voluntary basis, that is, only with the specific voluntary and informed consent of the person being tested (see, e.g., Jürgens, 1998a). To institute mandatory testing for immigrants would be to single them out and treat them differently, and that special treatment would stigmatize them — as people who are particularly dangerous, particularly irresponsible, or both. Treating them differently could play into and exacerbate existing prejudices and fears:

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

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

## Potential Harm to Applicants

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

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

To subject potential immigrants to testing of a caliber lower than that required in Canada would deny their moral equality and expose them to risks and harms that are unacceptable and certainly not justified in terms of protecting this country's public purse.

## Conclusions

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

# Against Automatic Exclusion of Persons Who Test Positive

## Parity With Other Diseases

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

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

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

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

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

## A Slippery Slope to Genetic Testing

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

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

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

## Objectification

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

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

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

## Conclusions

These concerns and dangers strengthen the ethical case against mandatory HIV screening of prospective immigrants and automatic exclusion of those who test positive. But they also point to a deeper, more insidious conflict. People can be readily regarded as means and as having value because ethics always has trouble competing with economics. Money and what it can buy are real, tangible, and immediate. Ethical values, in contrast, can appear diffuse, intangible, and remote. The contest hardly seems fair. It is therefore particularly important to identify the presumptions, both about the way the world works and the way it should work, that frame public policies and are embedded in them, often without being explicitly recognized (Schrecker and Somerville, 1998: 120-122). What conceptual commitments lie behind standards, rules, policies, and operational procedures? On what grounds are they justified? With reference to what basic values and priorities? And what rules are defined by the exceptions?

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

Canada could provide an important, indeed critical, example to the rest of the world if it is prepared to state that the potential costs, in economic terms, to care for people admitted as immigrants who later develop HIV-related illness are more than compensated for by the values — humaneness, humanitarian concern and respect for human rights — that we wish to uphold in *choosing* not to test asymptomatic prospective immigrants for HIV antibodies....[T]he benefits accruing to Canada from this approach and the example that Canada would set to the rest of the world in adopting this position...far outweigh any cost to

Ethics always has trouble competing with economics.

Ethics gets people to think in terms that go beyond self-interest.



Canada in terms of the economic burden that asymptomatic HIV-antibody-positive immigrants would impose on our health care system (1989: 894).

Making that case to committed realists is, of course, difficult because moral values are not hard enough for their tough-minded, self-interested approach. Somerville's exhortation does, however, exactly what morality is supposed to do. It gets people to think in terms that go beyond self-interest. Realists may reject Somerville's call, but then their rejection should be seen for what it is — a dismissal of the very claims of morality.

.....  
<sup>20</sup> For one physician, it also entails paternalistic state action: "We have an obligation to protect the weaker people in our society who are not sufficiently prudent or conscientious to follow guidelines to protect themselves" (Green, 1993).

<sup>21</sup> Draft regulations once tried to clarify the notion of "excessive demands" by directing Medical Officers to "...bear in mind that excessive demands are caused when the total costs of health and any required prescribed social services, in the five years immediately following assessment, exceed by more than five times the average per capita expenditures for health and social services in Canada" (*Canada Gazette*, Part I, Vol. 127, no. 33, p. 2561). For a critical assessment of this proposal, see Wilson, 1994.

<sup>22</sup> This quotation comes from the submission of the Canadian Liver Foundation and the Canadian Association for the Study of the Liver to the Medical Inadmissibility Review. Employment and Immigration Canada, "Summaries of Submissions Received from Non-Governmental Organizations," 1991: 20.

## Section

# 6

## Conclusions and Recommendations

This paper has reviewed the medical inadmissibility provisions of Canadian immigration law and policy and has assessed proposals for mandatory HIV screening of prospective immigrants and automatic exclusion of those who test positive in terms of general ethical perspectives on immigration and specific arguments for and against the policy proposals. A strong moral argument can be made, in principle, that citizens of rich countries and their governments have an obligation to help people in poor countries. That duty can be fulfilled either by providing substantial amounts of foreign aid to poor countries or by admitting significant numbers of immigrants from poor countries. Given the evident reluctance of rich countries to pursue the former course, the onus is on them to adopt generous immigration policies. Restrictions on immigration — thought necessary to protect a highly valued social program, for example — must be carefully identified and solidly justified, and the evidence for them — that immigration not restricted in a particular manner would in fact jeopardize an important social program — must be clear and compelling. It is too easy, in the absence of convincing arguments and firm data, to inflate fears and exaggerate dangers. The burden of proof, therefore, is on those who want automatically to exclude immigrants who test HIV-positive in the interest of either public health or public economy.

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

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

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

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

Policies that appear to treat people with HIV/AIDS more favorably than people with similarly serious diseases inevitably encounter the charge of “AIDS exceptionalism” (Burris, 1994; Slater, 2000). A policy that treated people with HIV/AIDS less favorably than similarly serious diseases would be a reverse form of AIDS exceptionalism. The motivation for the kinds of policies that

initially attracted this charge was to insure that people with HIV/AIDS were treated humanely and were not discriminated against. That approach should also prevail with respect to immigration.

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

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

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

3. Decisions about the medical inadmissibility of applicants for immigrant status should be made on an individualized, contextualized basis. Decision-making procedures that are equitable, flexible, and sensitive to changing medical and social conditions display the moral concern and respect that is owed to everyone.
4. Were the two preceding recommendations to be implemented, determinations of medical inadmissibility could in principle be made on economic grounds. The “excessive demands” criterion is, however, too conceptually thin and too ethically problematic to be the basis of such determinations. It would need to be replaced with an approach that rigorously measures the economic impact of the medical disease or condition in question, that provides substantive guidance to medical officers and visa officers, and that operates neutrally and consistently for all prospective immigrants.

Finally, with respect to determinations of medical inadmissibility, prospective refugees should be treated differently from prospective immigrants. The humanitarian and compassionate ideals with which Canadian immigration policy is supposedly imbued apply acutely and urgently to refugees. Consequently, we make the following recommendation.

5. The *Immigration Act* should be amended to make it clear that refugee claimants may not be rejected on grounds of medical inadmissibility.



## Section



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