Re: Seeking feedback on the Disability Tax Credit

TO: DAC subgroup committee
July 3rd, 2018

Thank you for reaching out to us.

The National ME/FM Action Network is a Canadian charity working on behalf of Canadians with Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS), Fibromyalgia (FM), or both.

People with ME/CFS and FM have impairments of energy production and/or pain signalling which reduce the quantity of physical and mental activities they can undertake. People with relatively mild cases have to cut back on some of their activities, people with more severe cases are largely or completely homebound, while people with the most severe cases are bedridden. In other words, the ability of people with ME/CFS and/or FM to participate in society is reduced to some degree due to impairment. This is the essence of disability as described by the United Nations Convention on the Rights of Persons with Disabilities (CRPD).

One of our organization's key concerns has been the eligibility criteria of the Disability Tax Credit (DTC). Eligibility for the DTC is the entry point for income support programs like the Registered Disability Savings Plan (RDSP). The purpose of these programs is to recognize the additional expenses and loss of earning capability that come with disabilities. The DTC also signals to the public what the federal government means by disability.

The DTC eligibility criteria focus on specific activities. Many of our people, even some who are homebound and unable to work or study, can technically do each of the activities on the list if they have to. However, doing an activity means setting other activities aside. Further, people may experience repercussions from the effort of doing the activity. The DTC criteria, including the cumulative criteria, were written without considering this scenario. As a result, people may be very disabled and still not apply or qualify for the DTC.

The Canadian Community Health Survey (2014) showed that over 800,000 Canadians had a diagnosis of CFS, FM or both. Most people who are affected are women and of working age. People diagnosed with CFS and/or FM showed high rates of unemployment, poverty, food insecurity, and social isolation. This shows that social programs are not adequately reaching the ME/FM community You can see the statistics here:

English: http://mefmaction.com/docs/CCHS_Stats_2014.pdf

French: http://mefmaction.com/docs/CCHS_Stats_2014_Fr.pdf

We first raised our concerns with the Minister of National Revenue two years ago. Our key issues were described in an email to CRA in August 2016 and are repeated below.

We subsequently wrote to the Minister of Finance suggesting the addition of a new “activity” to deal with reduced functional capacity. We have shared this letter with the DAC previously. We received from the Minister's office explaining how the cumulative provisions could be interpreted. Incorporating this information on form T2201 would improve the situation, but would address only part of our concerns. Our organization believes that a much more fundamental review of the criteria is needed. We should be involved in those discussion.

The CRPD describes disability as an evolving concept. We hope that the DTC criteria will evolve to recognize impairments in energy production and pain signalling so that people with reduced functional capacity will receive the social and financial support they badly need.

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Problems with the DTC:

(From an email to Lynn Gotcher, Manager of the DTC program, CRA, August 2016)

Highly-selective qualification criteria.

Conclusion: The theoretical foundation of DTC is weak. The legislation needs to be reviewed and rewritten.

The DTC is, according to the ITA, based on the restrictions in the ability to carry out basic activities of daily living, Traditionally, basic ADLs are self-care activities like feeding, dressing, eliminating and mobility. The concept of basic activities of daily living is appropriate for hospitals and care homes where other needs such as shopping and housekeeping are provided. It is a limited and incomplete model of disability for someone living in the community.

The DTC does not stick to the basic ADL concept. The ITA selectively adds four impairments to the basic ADL list – impairments in seeing, hearing, speaking and mental functions. Then Form 2201 expands feeding to include food preparation and describes mental functions as going well beyond self-care to include health and safety and social interactions.

We are not objecting to expanding the DTC criteria. We think that basic ADLs is a poor starting point for DTC eligibility. We do object to the fact that the additions are selective and piecemeal. Other impairments could be included such as energy impairments or pain impairments.

Qualifying for the DTC is a requirement for opening a registered disability savings plan. The legislation setting up those plans states: The purpose of this Act is to encourage long term savings through registered disability savings plans to provide for the financial security of persons with severe and prolonged impairments in physical or mental functions.

There are two points to note. Firstly, there is nothing in that Act which limits the severe and prolonged impairments to those on the DTC list, yet this is what is effectively done by requiring DTC qualification. Was this intended? Secondly, the purpose of that legislation is financial security which could be affect by both high disability expenses and limited ability to earn income. This seems to be what DTC should be about.

The DTC model of disability is not aligned with the recent UN Convention on the Rights of Persons with Disabilities which describes disability as an evolving concept and states that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others. The DTC focuses on impairments and activities rather than participation. The DTC should be reconsidered in light of the CRPD.

Confusing qualifiers

Conclusion: Form 2201 is difficult to interpret and should be clarified.

Form 2201 generally uses the qualifier of being unable or taking an inordinate amount of time to do particular activities.

Being unable to do tasks sounds straightforward, but higher up on the form, there are instructions to health professionals to assess patients in comparison to someone of similar age with no impairment. Is the test absolutely unable or alternately unable at an age-appropriate level? The supporting literature seems to support the former interpretation.

Taking an inordinate amount of time to do tasks is one sign of difficulty doing tasks, but there are many other signs. For example, tasks may get simplified (sweatsuits and slip on shoes to avoid complicated dressing, canned or prepackaged meals to avoid complicated meal preparation), tasks may be avoided (staying in pajamas all day, skipping meals), or someone may step in to help. Further, individuals may be able to do activities but at a price, such as triggering pain episodes or having to forgo other activities. Form 2201 does not allude to these possibilities.

The 90% of time phrase is completely confusing, as is the distinction between significantly restricted and markedly restricted.

Need for medical practitioner certification

Conclusion: Requiring medical certification makes it very difficult for many people with ME/CFS or FM to apply.

It is, or should be, well known that Canadians with ME/CFS and FM receive a poor level of service from the medical system. There is no medical specialty that has ever adopted ME/CFS. The medical specialty that adopted FM is letting go of it. People all across the country have great difficulty finding medical support. It will be years and possibly decades before the situation is resolved. And yet the DTC requires certification by a medical practitioner.

Compounding the problem is the complexity of ME/CFS and FM cases. Documenting these cases is not nearly as easy as filling in vision test results. Many family doctors are not willing to take on the challenge. Then the question of reimbursement arises.

In this scenario, asking for medical certification is putting up a barrier to qualifying.

Strategies are needed to alleviate the problem. Here are a few varied ideas for discussion purposes:

- automatically approve any application that has been approved by CPP-D or a provincial disability plan. These cases have already been medically supported as having severe and prolonged disabilities so why should someone go another review process?
- base approval on the functional capacity scale used in our community. Cases at level 7 or below get automatically approved since the applicant's ability to participate fully and effectively in society is severely limited, while cases at higher levels can be put forward for consideration.
- follow the lead of the passport office which previously require the signature of a recognized professional but changed the criteria to allow regular citizens as references.
- Reimburse medical practitioners for completing the forms.
- Support our efforts to get better medical care for patients.