Health insurance, a false dichotomy and a negative right to abortion in Canada's Maritime provinces

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Abstract

This thesis examines the jurisdictional movement of abortion regulation resulting from *R v Morgentaler* and the barriers to abortion which emerged as a result of the transition in the Maritime provinces. Following decriminalization, the Maritime provinces responded by implementing health insurance barriers to clinic abortions, restricting access. While contemporary scholarship has predominantly examined the issue through a health law and positive rights lens, this thesis asserts that these barriers can most successfully be challenged as a negative rights violation of the *Charter*'s section 7 guarantee of security of the person. This is because, although the dichotomy between positive and negative rights is at times superficial, Canadian courts have taken more favourably to negative rights challenges, particularly in regard to section 7.

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INTRODUCTION

The Supreme Court of Canada's 1988 judgment in *R v Morgentaler*[1] is celebrated as a landmark victory for pro-choice advocates and believed by some to have secured a positive right to abortion in Canada. While the decision to strike down the criminal prohibition enabled more widespread access, it far from ensured a guaranteed positive right to abortion across the country. The *Morgentaler* judgment ensured a negative right: the freedom from state interference by threat of criminal sanction. Following *Morgentaler*, Canadian women have been free to access abortion without fear of criminal prosecution, if they are able to find a service provider, meet the varying institutional administrative requirements, and afford, when not insured, to pay for it out-of-pocket. While criminal prohibition no longer exists, a number of barriers to access still remain across the country.

The jurisdictional movement post-*Morgentaler* from the federal government's criminal law power to the provincial governments' jurisdiction over healthcare has led to varying responses in regulation and widespread inconsistencies across the country. Provincial responses to decriminalization varied, with certain provinces, such as Ontario and Québec, allowing for increased access to services. All three Maritime provinces responded with dramatic attempts to restrict service, at times enacting regulations with sanctions and fines comparable to recriminalization. All three Maritime provinces have also been host to a variety of abortion access-based litigation, particularly regarding their attempts to prohibit abortions performed outside of hospitals, as well as their sustained failure to insure abortions performed in clinics, effectively creating a two-tiered system.

[1] *R v Morgentaler*, [1988] 1 SCR 30, 82 NR 1 [*Morgentaler 1988*].

As this thesis will discuss, prohibitions on clinic funding exacerbate a number of the other existing barriers to abortion services, including by limiting service providers. In addition, historically the two-tiered system has proven virtually unsustainable within Canada's Maritime provinces. All abortion clinics which have operated in the Maritime provinces without provincial funding have closed, citing lack of funding as the reason. The Supreme Court of Canada has stated on two occasions that legislation mandating an in-hospital requirement for abortion is unnecessary and can be considered unconstitutional as such legislation further exacerbates wait times, contributing to section 7 violations. Provincial governments' refusal to fund clinic abortions effectively produces the same result. As clinics are unable to operate without provincial funding, women are then forced to either access abortion through the hospital system or to travel outside of their home province for service.

In order to address these barriers, Canadian legal scholarship has predominantly examined the issue through either a positive rights lens or the remedies available in Canadian health law, at times arguing for a multi-faceted approach. While pursuing a positive right to abortion would ensure comprehensive access to the service, Canadian courts have been reluctant to recognize positive rights violations. In addition, remedies in Canadian health law have historically proven to be seldom utilized and have been ineffectual in influencing provincial governments. Although negative rights claims do not provide for the same extent of redress as positive rights, as this thesis will discuss, the dichotomy between the two is not always as black and white as some argue. Rights arguably fall along a spectrum of state intervention at one end, and indifference at the other. Canadian courts respond more favourably to claims which lie at the non-interventionist or negative rights end of the spectrum. Therefore, although numerous barriers still exist to abortion today, one of the most legally tenable approaches to redress would be to challenge the insurance barriers, as

they are a negative rights infringement resulting from interfering legislation. As this thesis will also discuss, there are positive rights implications which result from a negative rights challenge.

Insurance barriers effectively produce the same outcomes as prohibiting abortions outside of hospitals, previously found to be unconstitutional by the Supreme Court. By refusing to fund clinic abortions provinces are restricting the access framework and forcing women to endure longer wait times for the procedure as well as, at times, travel great distances to access service. Both of these factors were previously addressed in the 1988 *Morgentaler* judgment and found to violate a woman's right to security of the person. In addition, the prohibition cannot be considered to be in accordance with the principles of fundamental justice as it is arbitrary and ultimately hinders the government objectives it purports to promote. While the negative rights challenge will remove the insurance barrier to abortion, it is still reliant on health care providers opening clinics to offer service. In addition, insurance restrictions are only one of the numerous barriers to accessing abortion in Canada's Maritime provinces. However, evidence from other provinces demonstrates that when the provincial health plan fully insures clinic abortions, access points for service providers increase. In addition, as this thesis will discuss, health insurance barriers aggravate other barriers to access which means addressing insurance barriers helps to minimize the deleterious effect of other obstacles.

The provincial governments of the Maritime provinces have attempted to restrict abortion access since the procedure was decriminalized. While political and legal activism has increased access in the Maritime provinces, insurance prohibitions still remain. Canadian jurisprudence on abortion access in Canada provides a promising precedent for challenging the problematic restrictions on health insurance funding through a negative rights challenge. Further, insurance barriers to abortion create unique obstacles for low-income populations. Canadian human rights

jurisprudence shows a willingness on the part of Canadian courts to engage section 7 for socio-economic issues when framed from a negative rights perspective and where the public system is failing to comprehensively offer a necessary government service.

In outlining the above arguments this thesis begins, in the first chapter, by examining the historical context of the decriminalization of abortion, the jurisdictional movement from criminal law to healthcare, as well as the varying provincial responses to decriminalization. In Chapter 2 this thesis will discuss the contemporary barriers to accessing abortion in the Maritime provinces and the privatized market for clinic abortions which has emerged following decriminalization. In Chapter 3, this thesis will examine the contemporary scholarship on the issue and the various approaches to addressing the issue through positive and negative rights, as well as through Canadian health law. Finally, this thesis will examine the issue through a negative rights lens in Chapter 4, applying both the *Morgentaler* judgment and precedent from the Manitoba provincial court, ultimately asserting that a negative rights challenge to insurance prohibitions in the Maritime provinces is the most legally tenable approach and will have widespread effects on a number of other existing barriers. In doing so, this thesis will apply the framework established for assessing claims under section 7, highlighting how the contemporary health insurance barriers remain in violation of the *Charter*.

CHAPTER 1- HISTORICAL CONTEXT

I. 1969 Abortion Law

In 1969 then Prime Minister Pierre Trudeau's government amended the *Criminal Code*[2] in an attempt to enable an accessible regulatory framework for abortion.[3] Karina Ackerman discusses the amendments saying they were meant to create greater access to abortion but "merely created the illusion of access."[4] The amendments (now former section 251 of the *Criminal Code*), criminalized the "intent to procure a miscarriage"[5] outside of the designated scheme provided for under the *Code*. The 1969 amendments created a framework which allowed for physicians to perform abortions at specific institutions with authorization from an approved Therapeutic Abortion Committee (TAC) deeming that the continuation of the pregnancy would endanger the life or health of the pregnant woman. The new framework permitted abortion only if performed by a qualified medical practitioner other than a member of the TAC at an accredited hospital after garnering the prior approval from a TAC.[6] Abortion performed outside of the designated framework was still in violation of the *Criminal Code,* punishable up to life imprisonment for anyone who performed the procedure.[7]

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[2] *Criminal Code*, RSC 1985, c C-46.
[3] Katrina Ackerman, "The Dark Well-Kept Secret: Abortion Experiences in the Maritime Provinces" in Shannon Stettner, Travis Hay & Kristin Burnett, eds, *Abortion: History, Politics and Reproductive Justice* (Vancouver: UBC Press, 2017) at 134.
[4] *Ibid*.
[5] *Morgentaler 1988, supra* note 1 at 6.
[6] *Ibid.*
[7] Linda Long, "Abortion in Canada" (26 November 2020) online: *The Canadian Encyclopedia* <www.thecanadianencyclopedia.ca/en/article/abortion#:~:text=%C2%A9%20Americanspirit%2FDreamstime)-,Crime%20of%20Abortion%20and%201969%20Amendment,the%20penalty%20was%20two%20years>.

In the 1988 *Morgentaler* judgment rendered by the Supreme Court of Canada, then Chief Justice Dickson outlined the process for obtaining an abortion under the scheme. According to Dickson CJC, in order to access an abortion, the pregnant woman was required to first apply to the TAC at the accredited hospital for approval. The TAC would then examine the application and was empowered to issue a certificate allowing the abortion if it was of the opinion that the "continuation of the pregnancy would be likely to endanger the pregnant woman's life or health."[8] Once the certificate was issued, a separate qualified medical practitioner was then allowed to perform the abortion, and the woman to receive it, without criminal liability.[9]

In the mid-70s, in response to growing concern over whether this scheme was operating equitably across Canada, the Trudeau government established the Committee on the Operation of the Abortion Law to examine the operation of the 1969 law, led by sociologist Robin F Badgley.[10] The committee's findings were published almost a decade later in 1977 and would go on to be the principal evidence cited at the Supreme Court supporting abortion's decriminalization in 1988.

II. Badgley Report

In 1977 the Committee on the Operation of Abortion Law published a report on its findings, more commonly known as the Badgley Report. According to the Report, the terms of reference for the committee were to, "conduct a study to determine whether the procedure provided in the *Criminal Code* for obtaining therapeutic abortion is operating equitably across Canada."[11] Further, the Committee was "asked to make findings on the operation of this law rather than

[8] *Morgentaler 1988, supra* note 1 at 41.
[9] *Ibid.*
[10] Katrina Ackerman & Shannon Stettner, "The Public is Not Ready for This: 1969 and the Long Road to Abortion Access" (2019) 100: 2 The Canadian Historical Review 239 at 245.
[11] *Report of the Committee on the Operation of the Abortion Law*, (Ottawa: Ministry of Supplies and Services, 1977) (Chair: Robin Badgley) at 3 [Badgley Report].

recommendations on the underlying policy."[12] After completing the study, the Report's findings were clear and extensive: the current legislative scheme operated in a manner that perpetuated inequitable access to abortion. The Report stated, "the procedures set out for the operation of the Abortion Law are not working equitably across Canada,"[13] as "there was considerable confusion, unclear standards or social inequity involved with this procedure."[14] The 480-page Report documented numerous barriers and obstacles to obtaining abortion within the designated framework in Canada, leading to extensive delays and approximately 9600 Canadian women travelling to the United States each year to access abortion.[15]

According to the Report, barriers to accessing abortion in 1977 included: limited establishments of TACs, long wait times of on average eight weeks, financial costs, and widespread misinformation. The Report noted many women across the country did not have reasonable access to hospitals with established TACs, in turn limiting access to approval for abortions. In order to qualify for a TAC, the designated scheme required the hospital not only be accredited, but one with "diagnostic services and medical, surgical and obstetrical treatment."[16] According to the Report, the limitations not only restricted the hospitals which could qualify for TACs but further, of the ones that did qualify, many did not establish TACs. According to the Badgley Report in 1976, 58.5 per cent of non-military hospitals were deemed ineligible for TACs, and of the 559 hospitals meeting the procedural requirements only 271 established TACs, accounting for 20.1 per cent of Canadian hospitals.[17] The Report also documented misinformation to be a substantive barrier to accessing abortion in the 1970s. The Committee observed that a

[12] *Ibid.*
[13] *Ibid* at 17.
[14] *Ibid*.
[15] *Ibid* at 384.
[16] *Ibid* at 88.
[17] *Ibid* at 90 and see *Morgentaler 1988, supra* note 1 at 45.

number of commercial agencies, based in the United States, intentionally providing misinformation to Canadian women in order to encourage cross border traffic for the procedure.[18] The agencies were known to advertise in Canadian newspapers under the guise of being a resource for Canadian women looking for information on abortion services. When called, the agencies provided women with misinformation on gestational limits, costs, and even the legality of the procedure in Canada.[19]

One of the most notable barriers to accessing abortion the Report discussed was cost of the procedure. Financial barriers included widespread extra-billing in certain areas of the country occurring both before the procedure on referral and then again when the patient attended the abortion.[20] Although at times extra-billing charges occurred without legislative authority, some provinces—including Nova Scotia and New Brunswick—allowed for extra-billing in their provincial health insurance frameworks.[21] The Report found in 1975-76, 44.8 per cent of the patients who received an abortion in Nova Scotia were extra-billed, as compared to the national average of 20.1 per cent.[22] In addition, the Report found the charges were not "evenly distributed," but "affected most those women who were young, were less well educated, or were newcomers to Canada."[23] Joanna Erdman speaks to the effect of the 1969 abortion law writing, "criminalization did not outlaw abortion practice so much as it revealed it, regulated it, and distributed its risks."[24] According to Erdman, criminalizing abortion shaped the abortion market, resulting in a two-tiered system. Erdman says, "poor and working-class women were largely confined to the vagaries of

[18] Badgley Report, *supra* note 11 at 383.
[19] *Ibid.*
[20] *Ibid* at 391.
[21] *Ibid* at 394.
[22] *Ibid* at 397.
[23] *Ibid* at 22.
[24] Joanna N Erdman, "Constitutionalizing Abortion Rights in Canada" (2017-2018) 49 Ottawa L Rev 221 at 231 [Erdman, "Constitutionalizing Abortion"].

the back alley," and in contrast, "women with means turned to private spaces, the seclusion of a physician's office, or a maternity home.[25]

III. R v Morgentaler (1988)

In 1988 the inequitable access scheme created by the 1969 amendments faced a constitutional reckoning when an appeal on an indictment for Dr. Morgentaler and two other practitioners reached the Supreme Court of Canada. In the 1980s Dr. Morgentaler, and the two others charged, opened an abortion clinic in Toronto and began to offer services to women who had not obtained a certificate from a therapeutic abortion committee allowing the procedure.[26] The three doctors were charged with conspiring with intent to procure a miscarriage of a female person, contrary to former section 251 of the *Criminal Code.*[27] Morgentaler was no novice to challenging the criminal prohibition on abortion, by 1988 he had spent the better part of the previous two decades on trial for committing the offence in various provincial courts across the country.[28] At trial, the three doctors were acquitted by a jury, but on appeal the acquittal was set aside and a new trial ordered.[29] This decision was appealed to the Supreme Court of Canada where Dr. Morgentaler argued the *Code* sections were unconstitutional for violating sections 7 and 12 of the *Canadian Charter of Rights and Freedoms*.[30]

Writing for the majority, then Chief Justice Dickson found the scheme for accessing abortion as allowed under the *Criminal Code* in violation of section 7 of the *Charter* and struck down the provisions. Citing the barriers documented in the Badgley Report throughout his

[25] *Ibid.*
[26] *Morgentaler 1988, supra* note 1 at 9.
[27] *Ibid* at 10.
[28] Long, *supra* note 7.
[29] *Morgentaler 1988, supra* note 1 at 11.
[30] *Ibid.*

judgment, Dickson CJC found the impugned scheme interfered with the right to life, liberty, and security of the person on two grounds. First, Dickson CJC found the delays caused by the scheme interfered with a woman's bodily integrity, the consequences of which were "potentially devastating,"[31] due to the time sensitive nature of pregnancy and increased health risks associated with delaying the procedure.[32] Dickson CJC noted, even though the mortality rate for pregnant women who undergo abortions was low, "the increasing risks caused by delay are so clearly established," that he had, "no difficulty in concluding that the delay in obtaining therapeutic abortions caused by the mandatory procedures of (section) 251 is an infringement of the purely physical aspect of the individual's right to security of the person."[33] Second, Dickson CJC also found former section 251 of the *Code* interfered with a woman's psychological integrity in violation of section 7. Discussing evidence from a medical expert at trial Dickson CJC wrote, "there is increased psychological stress imposed upon women who are forced to wait for abortions, and that this stress is compounded by the uncertainty whether or not a therapeutic abortion committee will actually grant approval."[34]

Having found two violations of section 7, Dickson CJC inquired into whether the deprivations were in accordance with the principles of fundamental justice. In his judgment, Dickson CJC noted numerous problems with the administration of the scheme, including the unnecessary requirements hospitals were required to meet in order to establish TACs,[35] and a "failure to provide an adequate standard for therapeutic abortion committees."[36] Specifically, Dickson CJC spoke to inconsistent and unclear applications of the word "health," in determining

[31] *Ibid* at 30.
[32] *Ibid.*
[33] *Ibid* at 32.
[34] *Ibid* at 33.
[35] *Ibid* at 45.
[36] *Ibid* at 48.

whether women were eligible for abortions.[37] In totality, Dickson CJC found the administrative practices could not be considered to work in accordance with the principles of fundamental justice.[38] Dickson CJC wrote, "[o]ne of the basic tenets of our system of criminal justice is that, when Parliament creates a defence to a criminal charge, the defence should not be illusory or so difficult to attain as to be practically illusory."[39]

Having determined the framework was in violation of section 7 as the deprivation was not in accordance with the principles of fundamental justice, Dickson CJC inquired into whether the provision could be saved as a reasonable limit under section 1 of the *Charter* applying the test outlined in *R v Oakes*.[40] Although at the first stage of the test, Dickson CJC acknowledged the government objective of promoting health and safety of pregnant women was sufficient to warrant state interference, he ultimately found the former *Code* provisions failed the *Oakes* inquiry. Continuing on with the *Oakes* test, Dickson CJC concluded that the government means could not satisfy the minimal impairment inquiry at the second stage, or the proportionality inquiry at the third.[41] He wrote, "[t]he procedures established to implement the policy of s. 251 impair s. 7 rights far more than is necessary because they hold out an illusory defence to many women who would prima facie qualify under the exculpatory provisions of s. 251(4)."[42] Striking down the provision as arbitrary Dickson CJC said, "to the extent that s. 251(4) is designed to protect the life and health of women, the procedures it establishes may actually defeat that objective."[43]

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[37] *Ibid*.
[38] *Ibid* at 51.
[39] *Ibid.*
[40] *R v Oakes,* [1986] 1 SCR 103, [1986] SCJ No 7 [*Oakes*].
[41] *Morgentaler 1988, supra* note 1 at 60.
[42] *Ibid*.
[43] *Ibid.*

IV. Provinces Gain Jurisdiction Over Abortion

With the federal government's criminal prohibition struck down, questions of jurisdictional control over abortion arose in the late 1980s. Emmett Macfarlane discusses a jurisdictional void resulting from the *Morgentaler* judgment stating, "Parliament was famously unable to pass replacement legislation, leaving a vacuum in federal criminal law."[44] Macfarlane says, as a result provinces were then left with de facto control to regulate abortion through, "their jurisdiction over health care matters."[45] Colleen Flood, Brian Lahey, and Bryan Thomas discuss provincial authority over the delivery of healthcare services as resulting from two provisions of the 1867 *Constitution Act*.[46] This is first, through granting provinces authority to establish, maintain, and manage hospitals. Then second, under the provincial jurisdiction over property and civil rights, which provides authority for regulating health care professionals.[47]

Financing of health jurisdiction and over health more broadly is divided, according to Flood, Lahey, and Thomas. Provinces have jurisdiction over health insurance by virtue of their control over property and civil rights.[48] However, according to Flood, Lahey, and Thomas, the federal government maintains some control by means of the federal spending power.[49] Under the

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[44] Emmett Macfarlane, "Positive Rights and Section 15 of the Charter: Addressing a Dilemma" (2018) 38 Nat'l J Const L 147 at 154 [Macfarlane, "Addressing a Dilemma"].
[45] *Ibid.*
[46] Colleen Flood, Brian Lahey & Bryan Thomas, "Federalism and Health Care in Canada: A Troubled Romance?" in Peter Oliver, Patrick Macklem & Nathalie Des Rosiers, eds, *The Oxford Handbook of the Canadian Constitution*, (New York: Oxford University Press, Oct 2017) at 449.
[47] *Ibid* at 450. It should be noted that the federal government also has constitutional jurisdiction in health care over "Quarantine and the Establishment and Maintenance of Marine Hospitals" under section 91(11) of the *Constitution Act*. In addition, the federal government has influence over other areas of health care by means of a number of other constitutional jurisdictions including the criminal law power, the federal government's power to enact laws affecting Peace Order and Good Governance, their authority over Indigenous populations, federal penitentiaries, immigration, and the military. See Martha Butler & Marlisa Tiedemann, "The Federal Role in Health and Health Care" (20 September 2013) online: Library of Parliament <https://lop.parl.ca/sites/PublicWebsite/default/en_CA/ResearchPublications/201191E>.
[48] Flood, Lahey & Thomas, *supra* note 46 at 450.
[49] *Ibid.*

Canada Health Act, (CHA)[50] the federal government maintains quasi-control over the provision of health care across the country. Through their spending power, the federal government provides cash contributions to the provinces through the Canada Health Transfer.[51] The majority of health care expenditures in Canada, approximately 70 per cent, are funded by public funding.[52] The remaining amounts are covered by private sources such as private insurance and out-of-pocket expenses.[53] In 2019 the Canada Health Transfer accounted for 23.5 per cent of all public health expenditures across the country.[54]

The Canada Health Transfer is provided to the provinces contingent on the provinces establishing and maintaining a health care insurance plan satisfying the requirements of the *Act,* with respect to the five program criteria outlined in section 7 of the *CHA*.[55] The five program criteria include: public administration, comprehensiveness, universality, portability, and accessibility.[56] In order for provinces to qualify for their full cash contribution from the federal government, the province's health insurance plans must satisfy the five program criteria.[57] In addition, there are also two conditions for receiving the transfer. The provinces are required to provide the Minister of Health with information regarding provincial health services and further, must provide recognition to the Canada Health Transfer in "any public documents, or in any

[50] *Canada Health Act*, RSC 1985, c C-6 [*Canada Health Act*].
[51] "Canada Health Act" (24 February 2020) online: Health Canada <www.canada.ca/en/health-canada/services/health-care-system/canada-health-care-system-medicare/canada-health-act.html>.
[52] Sonya Norris, "Federal Funding for Health Care" (29 December 2020) online: *Library of Parliament* <https://lop.parl.ca/sites/PublicWebsite/default/en_CA/ResearchPublications/201845E#:~:text=The%20federal%20contribution%20is%20made,home%20care%20beginning%20in%202017>.
[53] *Ibid.*
[54] *Ibid.*
[55] *Canada Health Act*, *supra* note 50 at s 7.
[56] *Ibid*.
[57] *Ibid*.

advertising or promotional material, relating to insured health services and extended health care services in the province."[58]

With newfound jurisdictional control post-*Morgentaler*, each province began testing out various approaches to regulation, more often than not attempting to implement regulatory barriers restricting access to abortion. As Rachel Johnstone points out, "the decriminalization of abortion was not the final battle for women's reproductive rights, as provincial actions to restrict women's right to choose make clear."[59] According to Erin Nelson, following the *Morgentaler* judgment the provinces found a new approach to restricting abortion access. Nelson says, "[i]nstead, regulation of, and access to, abortion services is accomplished by a combination of health care professional guidelines, hospital policies, and provincial policies relating to access to, and public funding for, abortion services."[60] However, provincial regulatory responses varied across the country, leaving widespread inconsistencies in access. Macfarlane observes that in the immediate aftermath, "most provinces, with the exception of Ontario and Québec, implemented laws or regulations designed to limit access"[61] and although some were struck down as ultra vires, "wide disparities in access persisted across the country."[62] Rachel Johnstone similarly attributes the response to a "federal-policy vacuum that emerged around the regulation of abortion services."[63] According to Johnstone, this led to the reclassification of abortion as a healthcare issue and "failed to provide clear

[58] *Ibid at* s 13.
[59] Rachael Johnstone, "The Politics of Abortion in New Brunswick" (2014) 26:2 Atlantis 73 at 83 [Johnstone, "Abortion in New Brunswick"].
[60] Erin Nelson, "Special Issue: Health Law Autonomy, Equality, and Access to Sexual and Reproductive Health Care" (2017) 54:3 Alta L Rev 707 at 22.
[61] Macfarlane, "Addressing a Dilemma", *supra* note 44 at 154.
[62] *Ibid.*
[63] Rachael Johnstone, *After Morgentaler: The Politics of Abortion in Canada* (Vancouver: UBC Press, 2017) at 79 [Johnstone, "After Morgentaler"].

protections for women."[64] Johnstone writes the "resulting patchwork of services"[65] created inequalities in access similar to those that lead to the decriminalization.[66]

Following decriminalization, certain provinces – such as Ontario – saw increased access to services, while others saw reattempts at criminalization. The Maritime provinces were home to some of the most severely restrictive responses to the *Morgentaler* judgment. Nova Scotia, Prince Edward Island, and New Brunswick all made attempts to limit access to abortion following the decriminalization and each province saw numerous legal challenges as a result. To this day, New Brunswick is still facing ongoing litigation due to restrictions on abortion. While numerous barriers to accessing abortion exist across the country, the Maritime provinces have uniquely responded to decriminalization by attempting to restrict access through the use of insurance funding regulations. This barrier, which is discussed in greater detail in Chapter Two, allows for health insurance coverage for abortion only if performed in a hospital setting. As we will see, there are unique limitations for accessing abortions in hospitals in Canada, including limited service providers and additional wait times. In addition, historically clinics in the Maritime provinces have been unable to maintain service without provincial funding. The restrictions disincentivize medical professionals from performing abortions in clinics and in effect, limit access. The contemporary resulting access scheme in the Maritime provinces is thus splintered, enabling access for those who can afford to travel out-of-province to access services and restricting access to hospitals for those who cannot.

Unsurprisingly, the Maritime provinces have a lower percentage of their population identifying as pro-choice. According to a Dart & Maru / Blue Voice Canada Pole published by the

[64] *Ibid.*
[65] *Ibid* at 80.
[66] *Ibid.*

National Post in January of 2020, 22 per cent of people polled in Canada's Atlantic provinces,[67] believe abortion should be illegal during the first three months of pregnancy.[68] This was the highest percentage of all the responding provinces, with Alberta following behind at 18 per cent.[69] When polled regarding the second trimester, 55 per cent of respondents in Atlantic Canada believed abortion should be illegal during the second three months of pregnancy.[70] The Atlantic provinces maintained the highest percentage of those in favour of illegality, as compared to 43 percent of respondents in Alberta and Ontario, as well as 39 per cent in BC and Québec.[71] With these statistics in mind, it is not surprising the Maritime provinces attempted to implement further restrictions on abortion following decriminalization. They also provide insight into the deeper values and beliefs that may be behind attempts to restrict abortion access by means of insurance funding.

A. 1991 – 2021 Prince Edward Island's response

According to Joanna Erdman, following the Supreme Court judgment in the 1988 case of *R v Morgentaler,* Prince Edward Island's (PEI) provincial government immediately passed a resolution stating opposition to any provision of abortion services on the Island.[72] The resolution formally announced the then PEI legislature's opposition to abortion and called for a new abortion law.[73] In 1991, the government issued notice of a policy restricting funding of abortions for

[67] The categorization of Atlantic provinces includes Newfoundland in addition to the Maritime provinces which are New Brunswick, Prince Edward Island, and Nova Scotia.
[68] Sharon Kirkey, "As abortion debate becomes increasingly polarized, poll shows the views of many Canadians are more complicated" *National Post* (31 January 2020) <https://nationalpost.com/news/as-abortion-debate-becomes-increasingly-polarized-poll-shows-the-views-of-many-canadians-are-more-complicated>.
[69] *Ibid.*
[70] *Ibid.*
[71] *Ibid.*
[72] Joanna N Erdman "A Constitutional Future for Abortion Rights in Canada" (2017) 54:3 Alta L Rev 727 at 728 [Erdman, "Future of Abortion"].
[73] "Resolution No 17," Journal of the Legislative Assembly of Prince Edward Island, 57th Parl, 3rd Sess, Daily Journal (22 February 1988, 29 March 1988, 7 April 1988) at 11, 90–91, 117–18, online: <www.peildo.ca/fedora/repository/leg:3295>.

residents.[74] The policy of the provincial government's Hospital and Health Services Commission provided that the province "will only pay for an abortion deemed to be a medical necessity provided that the abortion is performed at a hospital."[75] In effect, the policy meant the provincial government did not fund abortions as no hospitals in PEI performed them,[76] and women had to travel off the Island to access services.[77]

In 1994 the province's Health & Community Services Agency crafted regulation 2(a.2)(iv) under the provinces *Health Services Payment Act.*[78] The section defined "basic health services" as, "(iv) services provided in respect of termination of pregnancy performed in a hospital when the condition of the patient is such that the service is determined by the Agency to be medically required."[79] Dr. Morgentaler once more returned to court, challenging the regulation by asserting that it was, "made for an unauthorized purpose and not in pursuit of the Agency's mandate of operating a health services payment plan for the residents of this province."[80] Further, Morgentaler asserted the regulation was beyond the scope of the authority of the enabling Act and further, was inconsistent with the *Canada Health Act.*[81]

In 1995, the PEI Supreme Court sided with Morgentaler, finding the regulation was not authorized under the Act and was beyond the mandate of the Health and Community Services Agency. Further the Court noted the regulation was, "contradictory to and inconsistent with the objects and purposes of the parent legislation."[82] Explaining its judgment the court said, "[t]here

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[74] *Morgentaler v Prince Edward Island (Minister of Health & Social Services),* [1994] 1 PEIR D-138, [1994] PEIJ No 16 at 1.
[75] *Ibid*.
[76] *Ibid.*
[77] *Ibid at 22.*
[78] *Morgentaler v Prince Edward Island (Minister of Health & Social Services),* [1995] 122 DLR (4th) 728, 126 Nfld & PEIR 240 at 1.
[79] *Ibid.*
[80] *Ibid* at 5.
[81] *Ibid.*
[82] *Ibid* at 92.

is no apparent reason rationally related to the administration of the provincial health payment plan for limiting payment to abortions where the Agency in its discretion determines that the condition of the patient is such that the service is medically required."[83] However, the following year the judgment was overturned by the PEI Court of Appeal as the appeal court found the Act specifically contemplated the government's ability to determine what is medically required, making it intra vires.[84] The Court of Appeal found the Act authorized the agency to determine what services would be paid for under the provincial health insurance plan noting the definition of "basic health services" in section 1 to be, "all services rendered by physicians that *in the opinion of the agency* are medically required."[85] "Thus, by virtue of definition," the Court wrote, "a physician's services, whether in respect of abortion or anything else, do not constitute 'basic health services' so as to qualify for payment of benefits under s. 3 unless the Agency considers them medically necessary and unless they meet the conditions and limitations prescribed in the Regulations."[86]

Following Morgentaler's challenge, the restriction on funding and the failure to create abortion access on the Island lasted for years. Joanna Erdman notes that it was not until 2016 that there was substantial movement for increased access to abortion on the Island. The premier at the time, Wade MacLauchlan, announced a revision to the former policy that would allow for abortions to be performed on the Island, and plans to "open a hospital-based reproductive health clinic on the Island."[87] PEI began performing abortions in province in 2017. According to the Canadian Institute for Health Information (CIHI), in 2016 PEI performed zero abortions but 162

[83] *Ibid*.
[84] *Morgentaler v. Prince Edward Island (Minister of Health & Social Services),* [1996] 139 DLR (4th) 603, 144 Nfld & PEIR 263 at 9.
[85] *Ibid* at 8 [emphasis in original].
[86] *Ibid* at 9.
[87] Erdman, "Future of Abortion", *supra* note 72 at 728.

of the women who accessed abortion in other provinces and territories were residents of PEI.[88] In contrast, in 2017 the Island reported performing 147 abortions and 170 women who accessed a reported abortion elsewhere in Canada were residents of PEI.[89] According to the CIHI's most recent published data, in 2019 PEI performed 234 abortions in hospital, zero in clinic and 225 of the reported abortions elsewhere in Canada were for residents of the Island.[90] Clearly access has increased dramatically on the Island, however as this thesis will discuss later, the province still ranks as one of the lowest for abortions performed per capita. In 2021, PEI's *Health Services Payment Act Regulations* still contain a funding barrier in that they deem insured basic health services to include "services provided in respect of termination of pregnancy," if performed in hospital.[91]

B. 1993 – 2021 Nova Scotia and *R v Morgentaler* (1993)

A year after the 1988 *Morgentaler* judgment the provincial government in Nova Scotia enacted three regulations which, similar to the previous criminal prohibition, faced a constitutional reckoning in *R v Morgentaler* (1993).[92] The regulations were commonly referred to as the March regulations, one was enacted under the province's *Health Services and Insurance Act,*[93] and two identical regulations were enacted under the province's *Hospitals Act*[94] and the *Health Act*.[95] The regulations under the *Hospitals Act* and the *Health Act* prohibited performing abortions in any

[88] Canada, Canadian Institute for Health Information, *Induced Abortions Reported in Canada in 2016* (Ottawa, ON: CIHI; 2016).
[89] Canada, Canadian Institute for Health Information, *Induced Abortions Reported in Canada in 2017* (Ottawa, ON: CIHI; 2017).
[90] Canada, Canadian Institute for Health Information, *Induced Abortions Reported in Canada in 2019* (Ottawa, ON: CIHI; 2021) [CIHI Induced Abortions 2019].
[91] PEI Reg EC499/13 s 1(c)(iv).
[92] *R v Morgentaler,* [1993] 3 SCR 463, [1993] SCJ No 95 [*Morgentaler 1993*].
[93] *Health Services and Insurance Act*, RSNS 1989, c 197.
[94] *Hospitals Act*, RSNS. 1989, c 208.
[95] *Health Act*, RSNS 1989, c 195, *Morgentaler, supra* note 92 at 4.

location other than an approved hospital under the *Act*.[96] Anyone in contravention of prohibition was guilty of an offence and liable upon summary conviction for a fine of not less than 10,000 dollars.[97] The regulation under the *Health Services and Insurance Act* denied funding for abortions performed outside of hospitals.[98] In 1989 Dr. Morgentaler, ignoring the Nova Scotia legislation, performed 14 abortions in the province. At the same time, Nova Scotia's provincial government introduced new legislation, the *Medical Services Act*, which (together with the *Medical Services Designation Regulation*[99] made thereunder) in effect amalgamated the previous prohibitions under one Act and simultaneously repealed the March regulations.[100] Dr. Morgentaler was then charged with 14 counts of "unlawfully performing a designated medical service, to wit, an abortion, other than in a hospital approved as such under the *Hospitals Act*, contrary to s. 6 of the *Medical Services Act*."[101]

At trial, Morgentaler did not dispute that he performed the abortions and violated the regulations but once more challenged the prohibitions, arguing they were ultra vires the jurisdiction of the provincial government. He argued the prohibitions were in pith and substance criminal law and therefore under federal jurisdiction.[102] The final judgment, delivered by the Supreme Court of Canada in 1993, agreed with Morgentaler. The court found the provincial legislation in essence was a prohibition of abortion with penal consequences, calling them a reproduction of the now defunct section 251 of the *Criminal Code*.[103] The court recognized the objective of the legislation to be, "suppressing the perceived public harm or evil of abortion

[96] *Morgentaler 1993, supra* note 92 at 4.
[97] *Ibid at 6.*
[98] *Ibid at 4.*
[99] NS Reg 152/89.
[100] *Morgentaler 1993, supra* note 92 at 6.
[101] *Ibid at 7.*
[102] *Morgentaler 1993, supra* note 92.
[103] *Ibid at 82.*

clinics,"[104] and that "any concern with the safety and security of pregnant women or with health care policy, hospitals or the regulation of the medical profession was merely ancillary."[105]

Justice Sopinka, writing for the majority and drawing from the Court's previous *Morgentaler* judgment, once more reiterated the problematic nature of in-hospital requirements for performing abortions. He wrote, "women may not wish to have an abortion in a hospital for any number of legitimate reasons. Clearly restrictions as to place can have the effect of restricting abortions in practice, and indeed it was the operation of s. 251 of the *Criminal Code* in restricting abortions to certain hospitals that contributed largely to its demise." [106] Sopinka J found the in-hospital requirements to be one of the leading barriers which contributed to the previous *Criminal Code* scheme's demise. Sopinka J wrote, "the in-hospital requirement in that section led to unacceptable delays, undue stress and trauma, and a severe practical restriction of access to abortion services."[107]

The Court, however, did not speak to the prohibition on funding under section 5 of the province's *Medical Services Act*, as the court stated, "no argument was directed toward the 'de-insurance' section in this Court,"[108] leaving the funding barrier unaddressed.[109]Although the de-insurance regulations were not argued in Morgentaler's challenge, they were enabled by the prohibition on performing abortions outside of hospitals as section 5 denied funding for services performed in contravention of the other two regulations. As those two regulations were found by

[104] *Ibid.*
[105] *Ibid.*
[106] *Ibid* at 84.
[107] *Ibid.*
[108] *Ibid* at 48.
[109] See later discussion on health insurance funding under the MSI program in Nova Scotia. As this thesis will discuss in the next section, the current status of insurance funding for clinic abortions in Nova Scotia is unclear. While the former prohibition sections of the *Medical Services Act* were struck down in 1993, the province continued to deny insurance funding for abortions performed in clinics for years after. Today there is no abortion clinic in Nova Scotia.

the Supreme Court to be ultra vires the provincial government's jurisdiction and therefore unconstitutional, although section 5 was left unaddressed, it was effectively moot.

Following the 1993 *Morgentaler* decision, Nova Scotia's provincial government continued to refuse to fully fund abortions performed in clinics. Up until 2003, Dr. Morgentaler continued to operate an abortion clinic in Nova Scotia. According to Hansards from the Nova Scotia Legislature, the provincial government covered the cost of physician fees for performing the service, that is the fee billed by the doctor for their service. All other costs associated with the procedure, referred to as clinic fees, were uninsured.[110] However, there is no apparent or reported legal authority for this denial. Further, as discussed later, charging clinic fees is considered to be extra-billing and in contravention of the *Canada Health Act*. As a result, they were later subject to deductions from the Canada Health Transfer of approximately $370,000.[111] When the clinic closed in 2003, management cited the availability of free-of-charge abortions in hospital as one of reasons for the closure. Clinic users were required to pay out-of-pocket as the provincial government was still failing to fully fund abortions performed in clinic.[112] Since this time, no private abortion clinic has operated in Nova Scotia.

C. 1988 – 2021 New Brunswick's Regulation 84-20

Since the 1988 *Morgentaler* judgment, New Brunswick has seen more abortion related litigation than any other Canadian province and remains a pivotal legal battle ground for access to abortion. Following the judgment in *Morgentaler,* New Brunswick enacted Regulation 84-20 of the *Medical Services Payment Act*, defunding abortion services in the province unless performed

[110] Nova Scotia, Nova Scotia Legislature, *Orders of the Day*, 56-2 (10 January 1995) (George Moody).
[111] Canada, Health Canada, *Canada Health Act Annual Report 2014 – 2015* (Ottawa: ON, Health Canada, 2021) at 14 [CHA Annual Report 2014-2015].
[112] "Morgentaler closes Halifax abortion clinic" *CBC News* (29 November 2003) online: <www.cbc.ca/news/canada/morgentaler-closes-halifax-abortion-clinic-1.376738>.

by a specialist in obstetrics or gynecology, in an approved hospital, and with certification from two medical professionals that it was "medically required."[113] In 1994 Dr. Morgentaler opened an abortion clinic in Fredericton and was shortly after restrained by "Order of the Council of the College of Physicians and Surgeons from performing abortions outside a hospital"[114] contrary to then sections 56 (b.1) and 56.2 of the province's *Medical Act.* The *Act* enabled physicians to be found guilty of misconduct if they performed abortions outside of hospitals.[115]

In June of 1994 Dr. Morgentaler performed five abortions at his clinic in Fredericton.[116] In response to a complaint from the provincial Minister of Health, on July 5th,1994 the Council of the College of Physicians and Surgeons imposed restrictions on Morgentaler's license and appointed a board of inquiry.[117] Morgentaler then launched a legal challenge asserting the provisions of the Act were ultra vires the authority of the provincial government as they were in pith and substance, criminal law.[118] Later that year, a provincial court sided with Morgentaler. The court found the legislation was enacted, "not with a view to controlling or ensuring the quality and nature of health care or the maintenance of professional standards, but to prohibit abortions outside hospitals with a view to suppressing or punishing what the members of the government and of the Legislative Assembly perceived to be the socially undesirable conduct of abortion."[119]The court found the specific provisions to be in pith and substance criminal law, making them outside the provincial government's jurisdiction and Morgentaler reopened his Fredericton clinic.[120] The province appealed the lower court's judgment but at the Court of Appeal the judgment was upheld.[121]

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[113] *Morgentaler v New Brunswick*, 2009 NBCA 26, [2009] ANB No 139 at 13 [*Morgentaler v NB 2009*].
[114] *Ibid* at 13.
[115] *Morgentaler v New Brunswick (Attorney General),* [1994] ANB No 342, [1994] NBJ No 342.
[116] *Ibid* at 25.
[117] *Ibid.*
[118] *Ibid* at 2.
[119] *Ibid* at 44.
[120] *Morgentaler v NB* 2009, *supra* note 113 at 13.
[121] *Morgentaler v New Brunswick (Attorney General),* [1995] ANB No 40, [1995] NBJ No 40.

In 2004 Dr. Morgentaler subsequently brought another legal challenge to the *Medical Services Payment Act's* prohibition on abortion funding. The case was ongoing for years, in part due to the province's unsuccessful attempt at challenging Dr. Morgentaler's standing. Rachael Johnstone and Emmett Macfarlane speak of New Brunswick's lengthy record of legal challenges over regulation 84-20 following the 1988 Supreme Court judgment. According to Johnstone and Macfarlane, "the amendment was the subject of legal proceedings in the province until Morgentaler's death in 2013 brought the case to a close."[122] In 2014, a year after Dr. Morgentaler's death, the newly elected Liberal government slightly amended regulation 84-20. According to Johnstone, "[a]lthough the regulation is still in place, the requirement that a specialist must perform abortions is gone, and women no longer require written permission from two doctors to access services."[123] Regulation 84-20 still deemed, and does to this day, abortion not to be an entitled service unless "performed in a hospital facility approved by the jurisdiction in which the hospital facility is located."[124] However, later that same year, Morgentaler's Fredericton Clinic shut its doors due to lack of provincial funding.[125]

In 2015, Clinic 554 opened in the old Fredericton Morgentaler Clinic. The clinic operated unfunded by the provincial government for years, requiring patients to pay for abortions out-of-pocket, ranging between $700 and $850 depending on gestational term.[126] In March of 2020, the federal government withheld $140,000 from the federal health transfer to New Brunswick, citing the funding restrictions being in violation of the *Canada Health Act*. However, the money was

[122] Rachael Johnstone and Emmett Macfarlane, "Public policy, rights and abortion access in Canada" (2015) 51 Journal of Canadian Studies 97 at 105.
[123] Johnstone, "After Morgentaler", *supra* note 63 at 91.
[124] *NB Reg 1984-20, Schedule 2, (a.1)*.
[125] "Morgentaler Clinic in Fredericton performs last abortions before closure", *CBC News* (18 July 2014), online: <www.cbc.ca/news/canada/new-brunswick/morgentaler-clinic-in-fredericton-performs-last-abortions-before-closure-1.2710909>.
[126] "Reproductive Health" (6 March 2021) online: *Clinic 554* <www.clinic554.ca/reproductivehealth.html>

subsequently returned, due to the Covid-19 pandemic.[127] Similarly to its predecessor, Clinic 554 was placed up for sale in 2020 due to lack of provincial funding.[128] On January 8, 2021 the Canadian Civil Liberties Association (CCLA) filed a notice of action with statement of claim commencing legal proceedings against the New Brunswick government, challenging regulation 84-20.[129] The CCLA's statement of claim challenges the regulation on a number of grounds, including an assertion that the legislation is ultra vires the provincial government's authority as it is in pith and substance, criminal law.[130] The claim also requests a declaration that regulation 84-20 is inconsistent with and in violation of the *Canada Health Act,* as well that the regulation is of no force or effect as it is in violation of sections 7 and 15 of the *Charter*.[131] As of August 2021, the CCLA's legal challenge is currently ongoing.

[127] Jacques Poitras "New Brunswick being sued over abortion access", *CBC News* (7 January 2021) online: <www.cbc.ca/news/canada/new-brunswick/abortion-new-brunswick-lawsuit-civil-liberties-association-medicare-1.5864555>.
[128] *Ibid.*
[129] *Canadian Civil Liberties Association v New Brunswick (Attorney General),* FC 9 21 (Notice of Action with Statement of Claim Attached, Plaintiff) [*CCLA v New Brunswick*].
[130] *Ibid* at 1(b).
[131] *Ibid* at 1 (a), (c).

CHAPTER 2 - BARRIERS TO ACCESSING ABORTION IN 2021

More than 30 years after the landmark 1988 Supreme Court judgment numerous barriers remain in accessing abortion in Canada, similar to those documented in the 1977 Badgley Report. Although abortion is no longer criminalized, it is far from accessible in many areas of the country. Similar to the abortion scheme documented in the Badgley report, barriers in access still include lack of physical access to hospitals offering the service, financial barriers, misinformation, and time constraints. Canada's Maritime provinces still continue to have unique barriers to access and some of the most problematic access frameworks in the country. While this thesis will specifically examine the constitutionality of insurance restrictions on abortion, it is important to discuss the numerous other barriers to access, as all of the barriers are intersecting, at times exacerbating each other. Further understanding what populations are accessing abortion and how, helps us to understand the true impact of current provincial regulation. Additional restrictions discussed include: gestational limits; lack of physical access; limited access to information resources; as well as the additional barriers unique to abortions performed in hospital, as opposed to clinic.

Before continuing, it is important to note that there is little reported and published statistical information on abortion in Canada. Statistics Canada stopped gathering and reporting information on abortion in 2006.[132] At that time, the task was passed to the authority of the CIHI. The CIHI gathers information on abortions from the provincial and territorial ministries of health as well as hospitals and independent clinics.[133] However, data from private clinics is submitted voluntarily and therefore does not accurately reflect how many abortions are performed in clinics or who is accessing those clinics.[134] For example, in both Manitoba and Ontario the province only reports

[132] CIHI Induced Abortions 2019, *supra* note 90.
[133] *Ibid.*
[134] *Ibid.*

clinic abortions that are funded by the provincial government, which are estimated based on Fee For Service charges. In both of those provinces all unfunded abortions are unreported.[135]

The CIHI collects broad demographic data of the reported abortions such as age bracket of patients, province of residence, gestational age, complications, previous abortions, method of procedure, and previous deliveries. Ontario clinics do not report abortions if the patient is under the age of 25.[136] However, we can see from the data collected by the CIHI, the majority of abortions performed in all other provinces and territories across the country are for patients in the 18 to 24 age bracket.[137] Younger adult populations are more likely to access abortion than older, making it more likely patients are lower income.[138] The CIHI also breaks down the statistics for each province, allowing for a geographical analysis. For example, we can see that per capita, the Maritime provinces perform the lowest number of abortions of any of the Canadian provinces, not including the territories. Taking the territories into account, New Brunswick and Nova Scotia still perform the lowest number of abortions per capita, with the Yukon coming in third and PEI moving to fourth place. In addition, New Brunswick's previous clinic abortions, prior to the closure of Clinic 554, were reported to the CIHI. In 2019 the province reported 98 clinic abortions.[139] Based on the statistics of reported abortions, Ontario performs almost three times as many abortions per capita as New Brunswick, not including the numerous unreported clinic abortions in Ontario.[140]

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[135] *Ibid.*
[136] *Ibid.*
[137] *Ibid.*
[138] According to Statistics Canada, the average income in 2019 for women aged 16 to 24 years was $15,600 as compared to $49,800 for women aged 25 to 54. See "Income of individuals by age group, sex and income source, Canada, provinces and selected census metropolitan areas" (9 May 2021) online: *Statistics Canada* <www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1110023901&pickMembers%5B0%5D=1.1&pickMembers%5B1%5D=2.3&pickMembers%5B2%5D=3.3&pickMembers%5B3%5D=4.1&cubeTimeFrame.startYear=2019&cubeTimeFrame.endYear=2019&referencePeriods=20190101%2C20190101>.
[139] CIHI Induce Abortions 2019, *supra* note 90.
[140] *Ibid.* As discussed, Ontario does not report abortions which are not paid for under the provincial plan nor clinic abortions for women under the age of 25. Based on information provided by other provinces, clinic abortions for the 18-24 age bracket typically account for one of the highest percentage of abortions performed within the province, if the province has abortion clinics. As with many areas surrounding abortion, there remains a data gap as to how

I. Lack of Physical Access to Abortion Clinics due to Limited Service Providers

Physical access to abortion providers across the country is limited and the lack of access disproportionately impacts northern and rural populations. According to a publication from the Abortion Rights Coalition of Canada (ARCC), less than 17 per cent of all Canadian hospitals perform abortions,[141] and some provinces and territories have no abortion clinics.[142] Abortion service providers are often located in southern areas of the country and around urban centres, making it difficult for rural and northern populations to access services.[143] According to Action Canada, the majority of providers are located less than 150 kilometres from the Canada / US border. [144] Both ARCC and American scholar Howard Palley attribute lack of access, in part, to Catholic ownership of Canadian hospitals, which ARCC says "refuse to provide abortion services despite the hospital being a public institution."[145] Howard Palley notes an increase in Catholic-run hospitals in Canada in the late 1990s stating, "[b]etween 1997 and 1998, the number of Catholic-operated hospitals increased by 11 per cent, whereas the number of secular public-run hospitals

many abortions are paid for under the provinces provincial plan. The information is not reported by the CIHI. While the exact number is unknown, one can see in Canada's most populous province, a substantial number of abortions are going unreported.

[141] "*Position Paper #7* Access to Abortion in Rural/Remote Areas" (July 2020) at 1, online (pdf): *Abortion Rights Coalition of Canada* <www.arcc-cdac.ca/wp-content/uploads/2020/06/07-Access-Rural-Remote-Areas.pdf>.

[142] As discussed, there are no longer any abortion clinics in the Maritime provinces with the announced closure of Clinic 554. In addition, there are no abortion clinics in Yukon, Northwest Territories, or Nunavut. See "List of Abortion Clinics in Canada" (12 March 2020) online (pdf): *Abortion Rights Coalition of Canada* <www.arcc-cdac.ca/wp-content/uploads/2020/08/list-abortion-clinics-canada.pdf> [ARCC List of Clinics].

[143] In Alberta and Saskatchewan abortions are only available in the urban centres Calgary, Edmonton, Regina, and Saskatoon. Women who live outside of these areas must travel into the cities to access service. The territories each only have one single hospital access point in their capital cities of Whitehorse, Yellowknife, and Iqualuit. See ARCC List of Clinics, *supra* note 142.

[144] See "Unequal Access to Abortion Across Canada" (25 July 2019), online: *Action Canada* <www.actioncanadashr.org/news/2019-07-25-unequal-access-abortion-across-canada>.

[145] "Position Paper 8 – Problems with Hospital Access to Abortion" (April 2017) at 1, online (pdf): *Abortion Rights Coalition of Canada* <www.arcc-cdac.ca/wp-content/uploads/2020/06/08-Hospital-Access-Problems.pdf>.

decreased by 2 per cent. Of the 127 hospital mergers between 1990 and 1998, 50 percent resulted in the elimination of some reproductive services."[146] Rachael Johnstone says limitations in service providers are also, in part, due to reluctance on the part of medical professionals to perform abortions. According to Johnstone, many doctors are hesitant to perform abortions due to fear of harassment or violence.[147] Jocelyn Downie and Carla Nassar say of those willing to perform abortions, many do not live in rural areas and that most who do live in urban centres.[148]

With the announced closure of Clinic 554, there are now no abortion clinics across the Maritime provinces. Residents of PEI can access abortion within their home province only at one location, the Prince County Hospital in Summerside.[149] In Nova Scotia, there are access points in Halifax, Bridgewater, Truro, and Kentville.[150] However, there is no access point for the 132,000 people living on Cape Breton Island,[151] meaning the residents' closest access point would be in Truro, a seven-hour round-trip drive from Sydney, Nova Scotia. In New Brunswick, two hospitals in Moncton perform abortions and one hospital in Bathurst. There is now no access point in the province's capital city Fredericton, following the closure of Clinic 554. Further, according to the statement of claim filed by the CCLA, the hospital in Bathurst will only accept patients from the Bathurst area, meaning all other provincial residents must travel to Moncton.[152] According to the CCLA, this means residents living in Edmundston would be required to make an eight-hour return trip by car in order to access the service. The CCLA notes numerous issues with these limitations

[146] Howard A Palley, "Canadian Abortion Policy: National Policy and the Impact of Federalism and Political Implementation on Access to Services" (2006) 36:4 Publius: Oxford University Press 565 at 582.
[147] Johnstone, "After Morgentaler", *supra* note 63 at 132.
[148] Jocelyn Downie & Carla Nassar, "Barriers to Access to Abortion Through a Legal Lens" (2007) 15 Health LJ 143 at 17.
[149] ARCC List of Clinics, *supra* note 142 at 14.
[150] *Ibid* at 11.
[151] "Nova Scotia Q&A: How secure are abortion rights in Nova Scotia?" *CBC News* (17 May 2019) <www.cbc.ca/news/canada/nova-scotia/canada-abortion-laws-1.5140036>.
[152] *CCLA v New Brunswick, supra* note 129 at 30.

in access, stating that it would often require an overnight stay, two days off work, along with a support individual to accompany the woman on the trip, as hospitals require patients be accompanied by a support individual.[153] In addition, financial resources are required to cover expenses for the entire trip.[154]

II. Gestational Limits

Gestational limits vary widely across the country depending on the institution. There are often no provincial guidelines or parameters on setting limits, they are determined by the specific institution. The one access point in PEI will only perform abortions up until 12 weeks of pregnancy. [155] In Nova Scotia, the Halifax provider offers abortion up until 15 weeks of pregnancy, but all other provincial providers have a 12 week gestational limit.[156] In New Brunswick, women can access abortion up until 13 weeks and 6 days of pregnancy.[157] In contrast, women in Alberta can access abortion up until 20 weeks, in British Columbia until 23 weeks, and Ontario until 24 weeks.[158] Joanna Erdman concludes that gestational age is an "arbitrary means of regulating access to abortion and thereby runs afoul of human rights protection."[159] The lack of consistency in gestational limit between institutions and provinces appears to support Erdman's claim.

According to the "Induced Abortion Guidelines" published in the Society of Obstetricians and Gynecologists of Canada's Clinical Practice Guidelines, although there is increased risk of hemorrhage during pregnancy later in the second gestational term, "both medical termination and

[153] *Ibid* at 30.
[154] *Ibid*.
[155] ARCC List of Clinics, *supra* note 142.
[156] *Ibid* at 11.
[157] *Ibid at 10.*
[158] *Ibid*.
[159] Joanna N Erdman, "Theorizing Time in Abortion Law and Human Rights" (2017) 19:1 Health & Hum Rts 29 at 32 [Erdman, "Theorizing Time"].

dilatation and evacuation (D&E) are safe and effective methods of uterine evacuation in the second trimester."[160] It is evident that abortions can be safely performed in the second trimester as many institutions will do so. Therefore begging the question, why do certain institutions choose to restrict the gestational limit to the first trimester or earlier? Erdman argues, "[t]he ethical dilemmas of abortion are most pronounced, philosophically and publicly, later in pregnancy."[161] Erdman refers to the limits as "boundary crossing" in abortion law, where the moral, as opposed to medical, implications are the governing force. According to Erdman, this "presents significant problems for women's access to care and for the legitimacy of the law in regulating access, insofar as it masks moral judgment in medical discretion."[162]

III. Lack of Data

As mentioned earlier, there is limited information regarding access to abortion in Canada, consequently the full extent of the Maritime provinces' access problem is unknown. What statistical data does exist from the CIHI does not fully represent the numbers, as clinic abortions are reported on a voluntary basis. However, only one clinic in the Maritime provinces has been in operation in the last decade, Clinic 554, which reported the number of abortions it performed to the CIHI. Therefore, the statistical information in the Maritime provinces is likely more accurate, as compared to other provinces with unreported clinic abortions, such as Ontario, Manitoba, and Québec. In the Maritime provinces, the limited access to abortion clinics means there are no unreported clinics and therefore no unreported clinic abortions, enabling more comprehensive understanding of the numbers of abortions performed in the province.

[160] Victoria Jane Davis, "Induced Abortion Guidelines" (2006) No 184 Journal of Obstetrics and Gynecology Canada 1014 at 1014.
[161] Erdman, "Theorizing Time", *supra* note 159 at 31
[162] *Ibid* at 33.

In contrast, accessing reliable information on abortion services, including the procedure, administrative issues, and regulation within each of the Maritime provinces is exceedingly difficult. There is limited information on the access framework, where the nearest providers are located, how much the procedure costs if not insured, lengths of wait times, and what is insured under the provincial health insurance frameworks. Erin Nelson says this is the case for reproductive health data in general, noting that "there is almost no Canadian data available that would provide a clear picture of how accessible reproductive health services actually are."[163] Rachel Johnstone and Emmett Macfarlane call the lack of information available another bureaucratic hoop to jump through in accessing abortion. Further, according to Johnstone and Macfarlane, "[w]hat data is available on these arrangements is not readily accessible, and neither is it comprehensive."[164] Nelson, as well as Johnstone and Macfarlane, also observe that what little there is, has been documented by activist groups or not-for-profit organizations.[165] According to Johnstone, no nation-wide study on access to abortion has been commissioned since the 1977 Badgley Report.[166]

These issues are exemplified in what supporting information has informed this thesis, as the majority is informed by publications from not-for-profit organizations. Issues of transparency are also clear when attempting to access information on health insurance funding for abortion in Nova Scotia. Currently there is no abortion clinic in Nova Scotia, but it remains somewhat unclear as to whether one would be funded if it were to open. There is currently no published policy regarding abortion funding in Nova Scotia. However, as discussed earlier, following the 1993 *Morgentaler* judgment the provincial government continued to refuse to fully fund clinic abortions

[163] Nelson, *supra* note 60 at 44.
[164] Johnstone & Macfarlane, *supra* note 122 at 108.
[165] Johnstone & Macfarlane, *supra* note 122 at 107, Nelson, *supra* note 60 at 44.
[166] Johnstone, "After Morgentaler", *supra* note 63 at 104.

up until the early 2000s when the Morgentaler Clinic shut its doors. The legal authority for this denial is also not known.

In 2021, according to a report published by the Halifax branch of the Women's Legal Education Action Fund (LEAF), there are currently no legislative prohibitions on the funding of abortion clinics. However, according to the report, there remain disincentives for opening a clinic in the province. These include, according to the LEAF report, that while "the provincial health plan covers the cost of abortions performed at hospitals in Nova Scotia for all individuals registered with MSI (Medical Services Insurance) in the province," it does not cover the cost of clinic abortions.[167] Similar findings are reported from the National Abortion Federation and the Halifax Sexual Health Centre which both report that Nova Scotia funds abortions performed in hospitals.[168] MSI's website and their insured services brochure provide no information on the funding of abortion in the province.[169] There also appears to be no information on any government website or in any of the province's health legislation or accompanying regulations. Due to lack of government reporting and transparency, there is no definitive answer to the funding question in Nova Scotia, including whether abortions are fully unfunded or whether the cost of only the physician fee is insured, as it was under the former Morgentaler Clinic. However, it is likely that similar to the former Morgentaler Clinic, if an abortion clinic were to operate in Nova Scotia it would be either partially or fully unfunded by the MSI plan.

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[167] Julianne Stevenson and Jennifer Taylor "Access to Choice: The legal framework for abortion access in Nova Scotia" (May 2020) at 13, online (pdf) *LEAF* <www.leaf.ca/wp-content/uploads/2020/05/Abortion-Access-Framework-May-2020.pdf>.

[168] "Abortion Coverage by Region" (23 March 2021) online: *National Abortion Federation Canada* https://nafcanada.org/abortion-coverage-region/ and see also "Pregnancy Options" (23 March 2021) online: *Halifax Sexual Health Centre* <http://hshc.ca/pregnancy-options/>.

[169] See "Insured Health Services in Nova Scotia" (November 2017) online (pdf): *Medical Services Insurance* <https://novascotia.ca/dhw/msi/docs/MSI_Brochure.pdf>.

IV. Hospital Specific Barriers

According to the CIHI, clinics perform the majority of abortions in Canada. This is notwithstanding many provinces and territories do not have abortion clinics and reporting of clinic abortions to the CIHI is voluntary. The limited statistics available demonstrate a preference for abortions performed in clinics despite their lack of availability in certain areas. According to the CIHI, in 2019 clinics performed 58,724 of the 83,576 reported abortions in Canada.[170] According to Downie and Nassar, women cite a preference for a clinic abortion, "because they perceive the environment to be more supportive, the staff or techniques to be more expert, or privacy to be better maintained."[171] According to the statement of claim filed by the CCLA, in New Brunswick the former Morgentaler clinic performed 60 per cent of the province's abortions before it closed.[172]

In addition, another reason that clinics are at times preferable is that hospitals have unique barriers which can make services even more inaccessible. According to a report from ARCC, hospitals often have shorter gestational limits and can be more costly when service is uninsured. ARCC notes hospital charges can range up to, "$1,425 or more (depending on the province)".[173] Hospitals often have longer waitlists, at times up to six to eight weeks long, according to ARCC.[174] Further, there are differences in the procedure, many hospitals use general anaesthesia – as opposed to local – making the procedure more lengthy and increasing potential risks.[175] Lastly, hospitals often require a doctor's referral, an additional step in the process which is not accessible to all.

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[170] CIHI Induced Abortions 2019, *supra* note 90.
[171] Downie & Nassar, *supra* note 148 at 21.
[172] *CCLA v New Brunswick, supra* note 129 at 37.
[173] As compared to the $700 to $850 cost range for the procedure at Clinic 554. "Position Paper 8 – Problems with Hospital Access to Abortion" (April 2017) at 2, online (pdf): *Abortion Rights Coalition of Canada* <www.arcc-cdac.ca/wp-content/uploads/2020/06/08-Hospital-Access-Problems.pdf>.
[174] "Position Paper # 9 Hospitals versus Clinics: Comparisons of Abortion Care" (April 2017) at 1, online (pdf): *Abortion Rights Coalition of Canada* <www.arcc-cdac.ca/wp-content/uploads/2020/06/09-Hospitals-vs-Clinics.pdf>.
[175] *Ibid.*

Downie and Nassar say obtaining a referral can be difficult for women who do not have a primary care physician or have one who is opposed to abortion. [176] In Canada, the conscientious objection policy allows doctors to refuse to treat patients based on religious beliefs. According to ARCC, Ontario is the only province that requires "effective referral" to a provider or agency that is able to perform the service.[177] ARCC also notes that in the Maritime provinces, New Brunswick and PEI require referral for information but it is not an effective referral as required in Ontario, as the referral is for information only and not the performance of the service.[178]

V. Health Insurance Restrictions

Each of the Maritime provinces has unique restrictions on health insurance funding for abortion, either legislative or policy based. New Brunswick's regulation 84-20 under the province's *Medical Services Payment Act*,[179] discussed earlier, still contains the problematic provision that Dr. Morgentaler challenged almost 20 years ago. Schedule 2 of the regulation deems specific procedures "not to be entitled services" including "abortion, unless the abortion is performed in a hospital facility approved by the jurisdiction in which the hospital facility is located."[180] PEI's regulations under the province's *Health Services Payment Act* define insured "basic health services" as "services provided in respect of termination of pregnancy performed in a hospital."[181] As noted earlier, Nova Scotia's policy for funding of abortion services outside of hospitals is unclear. The province currently has no clinic and no regulatory prohibition on funding,

[176] Downie & Nassar, *supra* note 148 at 4.
[177] "Position Paper #95 The Refusal to Provide Health Care in Canada" (October 2020) at 1, online (pdf): *Abortion Rights Coalition of Canada* <www.arcc-cdac.ca/wp-content/uploads/2020/06/95-refusal-to-provide-healthcare.pdf>.
[178] *Ibid.*
[179] *Medical Services Payment Act*, RSNB 1973, c M-7.
[180] *NB Reg 1984-20, Schedule 2, (a.1)*.
[181] PEI Reg EC499/13 s 1(c)(iv).

but numerous sources report that the province's provincial health plan does not provide comprehensive funding for clinic abortions. This was the case when the previous provincial clinic was in operation. Therefore, as noted earlier, it is likely that if a clinic did open it would go either fully or partially unfunded, similar to the former Morgentaler Clinic.

Interprovincial billing is another issue for the funding of clinic abortions across the country. Interprovincial billing is part of the *CHA*'s portability requirement. Under the *CHA*, provincial health insurance plans must provide payments for insured services while a resident is temporarily absent from the province, either in another province or outside of the country, subject to certain limitations.[182] Bilateral agreements for interprovincial billing between the provinces facilitate payment and regulate the administration of interprovincial billing.[183] Representatives from each provincial health body make up the Interprovincial Health Insurance Agreements Coordinating Committee which determines, among other things, what rates can be charged and what services are covered when a resident is out of province.[184]

Until 2015 abortions were listed in the Excluded Services Regulations for interprovincial billing, meaning for women who had to travel to access abortion prior to 2015, such as those in PEI, the service was unfunded unless prior arrangements had been made between the home and visiting province. Documents obtained from Health Canada through an Access to Information and Protection of Privacy request show policy discussions involved in the 2015 change acknowledged the previous restriction was in violation of the portability requirements under *Canada Health*

[182] Prior consent from the provincial authority is required for elective procedures, meaning services provided in any situation that is not an emergency or requires medical care without delay, according to the *CHA*. See *Canada Health Act*, *supra* note 50 at s 11.
[183] See "Have Health Card, Will Travel: Out-of-Province/-Territory Patients" (March 2010) online (pdf): *Canadian Institute for Health Information* <https://secure.cihi.ca/free_products/out_of_province_aib_201003_e.pdf>.
[184] Canada, Health Canada, *Canada Health Act Annual Report 2019 – 2020* (Ottawa: ON, Health Canada, 2021) at 31 [CHA Annual Report 2019 – 2020].

Act.[185] In 2015 the Interprovincial Health Insurance Agreements Coordinating Committee quietly removed abortion from the excluded services regulations.[186]

Although the excluded service regulation was amended, without clear and transparent government acknowledgement or discussion on the issue, many remain confused as to the implications of the change. ARCC reports the change means, "women and transgender people can now obtain fully funded abortions at the point of service when they are living or travelling out of province."[187] Rachel Johnstone says, "fortunately for women in need of care, abortion was quietly removed from the list of prohibited services in 2015."[188] But Erin Nelson says this is only a partial victory and "only abortion services provided in a hospital are covered and, as noted earlier, the vast majority of Canadian hospitals do not offer abortion services.[189] An info bulletin from the Health Services Branch of the Ontario Government dated September 8, 2015 states, "claims for medically/therapeutically necessary abortions rendered to out-of-province residents at a publicly funded hospital that can bill reciprocally should be submitted through the reciprocal hospital billing system using service code 02 (Day Care Surgery) unless the patient is an admitted in-patient in which case the hospital's per diem rate applies."[190] According to this bulletin, abortion will be insured interprovincially if performed in a publicly funded hospital and be "medically/therapeutically necessary."

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[185] Email from Ursula Scott to Gigi Mandy & Serge Lafond R (18 August 2015) *Subject: anticipatory media lines on abortion and recip billing for your comments*, document released under the Access to Information Act by Health Canada.
[186] *Ibid.*
[187] "Position paper #4 Abortion and Reciprocal Billing" (February 2017) at 1, online (pdf): *Abortion Rights Coalition of Canada* <www.arcc-cdac.ca/wp-content/uploads/2020/06/04-Reciprocal-Billing.pdf>.
[188] Johnstone, "After Morgentaler", *supra* note 63 at 117.
[189] Nelson, *supra* note 60 at 26.
[190] Government of Ontario, Info Bulletin, NA6, "Re: Reciprocal Billing of Abortion Services (8 September 2015) online (pdf): *Health Services Branch* <www.health.gov.on.ca/en/pro/programs/ohip/bulletins/na_65/na_65.pdf>.

Considering the above-mentioned barriers, restrictions on clinic funding are clearly problematic. Refusal to fund clinic abortions not only requires women to pay for services out-of-pocket but it also disincentivizes the operation of clinics in the province, further limiting access. In addition, as previously discussed, all previous clinics which have operated in the Maritime provinces have been forced to close their doors due to lack of funding. Therefore, even the two-tiered system existing within the Maritime provinces which emerges from the funding denial ultimately collapses into itself. Clinics are integral to ensuring effective and meaningful access to abortions. Not only because women tend to prefer clinics but because clinics are often more accessible, have later gestational limits, shorter wait times, and no referral requirements. Further, by refusing to fund clinic abortions, governments are effectively refusing to fund abortions performed after the first trimester.

The Supreme Court of Canada has acknowledged on two occasions that in-hospital requirements are arbitrary restrictions which can be found in violation of the *Charter*.[191] Refusing to fund clinic abortions in effect, has the same outcome. It forces women to access abortions in hospital either because they are unable to afford private clinic abortions or because there are no local clinic access points as they were unable to maintain operation without government funding. Clinics are a meaningful component of the framework for access to abortion in Canada, enabling a more accessible market for women across the country. It is clear from the per capita data on abortion access in Canada, as discussed at the beginning of this Chapter, that provinces with larger access frameworks which fund clinic abortions, perform more abortions. Creating barriers to clinic funding limits access to abortion as fewer providers will open and offer services and fewer abortions will be performed.

[191] See *Morgentaler 1993, supra* note 92 at 84 and see also *Morgentaler 1988, supra* note 1 at 153.

VI. A Privatized Market

As discussed, following the decriminalization of abortion, each of the Maritime provinces made attempts to restrict the provision of abortion in their provinces. This was achieved, either by restricting insurance funding or attempting to prohibit the delivery of the service. However as demonstrated by the jurisprudence, any attempts to restrict the actual delivery of the service were met with pith and substance legal challenges – such as the 1993 challenge in Nova Scotia. Sarah Birmingham discusses this trend and notes that in response, provinces attempted to restrict access using frameworks under their own jurisdiction. "Provincial governments are not entirely precluded from enacting laws with a moral cast or gleam, but they must be rooted in a section 92 head of power,"[192] Birmingham writes. For abortion, this means "the most obvious candidates are the provincial health care powers, namely protection of women's health, regulation of hospitals or the medical profession, or provision of safe, cost-effective medical services."[193] Therefore, Birmingham asserts that provincial regulation of abortion must in pith and substance deal with one of these jurisdictional heads: "[a]n inquiry into the validity of abortion regulation will usually turn on whether the provincial law is truly aimed at one of these objectives."[194]

Thus, provinces have often chosen to limit abortion by allowing the provision of services but then placing restrictions on funding the service in order to make it less accessible.[195] The provincial governments are then able to claim jurisdictional control, arguing the restrictions are not fundamentally about morality but instead fall within provincial jurisdiction. This is done by

[192] Sarah Burningham, "Provincial Jurisdiction over Abortion" (2019) 45 Queens LJ 37 at 64.
[193] *Ibid.*
[194] *Ibid.*
[195] This is evident in responses to restrict insurance funding for abortions in Nova Scotia, PEI, and New Brunswick. As discussed earlier, when the legislation was challenged by Dr. Morgentaler, Maritime courts found the provincial governments motives for restricting insurance funding within these provinces following decriminalization to be restricting access to abortion in general. As we will discuss later, similar findings were made in Manitoba during a challenge involving provincial regulations on abortion funding in *Jane Doe v Manitoba.*

asserting the regulations are concerned with allocating limited resources for health care, concerned with promoting health and safety through regulation, or maintaining and regulating a public health care system. Speaking to the bureaucratic restrictions on health insurance funding, Johnstone says, "[i]t is evident that these roadblocks are not motivated by a desire to create improved health care for women, but to block access to what is portrayed as an immoral and undesirable procedure."[196] As a result of insurance barriers, a privatized market of abortion has emerged following *R v Morgentaler*. This means for some women seeking to access abortion, it is available but at a high cost. This includes women who need abortion services after 12 weeks, women who do not live near one of the few hospital access points, and women who do not realize they are pregnant in time to join a waiting list before reaching the hospital's gestational limit.

Sanda Rogers argues that privatization results, in part, from failings in the public sector. Rogers writes, "access to abortion services is so compromised in the public sector that private clinics have increased access for some women in some provinces – mainly women with financial resources – who are disproportionately white, middle class, educated women living in urban areas."[197] However, Erdman says the two-tiered scheme is nothing new, speaking to the previous access framework enabled under former section 251 of the *Criminal Code*. She writes, "the 'therapeutic reserve' in abortion funding regulation clearly reflected the logic of the 1969 criminal law, which created two categories of abortion: publicly supported therapeutic care and illegal private market transactions."[198] Under the previous scheme, Erdman says approval from TACs was more accessible to privileged populations. She writes, "(m)arried, white, middle class women, who could afford a family physician of good standing, fared better in approvals – especially if

[196] Johnstone, "Abortion in New Brunswick", *supra* note 59 at 83.
[197] Sanda Rogers, "Abortion Denied: Bearing the Limits of Law" in Colleen M Flood, ed, *Just Medicare: What's In, What's Out, How We Decide* (Toronto, ON: University of Toronto Press, 2006) 107 at 117.
[198] Erdman, "Constitutionalizing Abortion" *supra* note 24 at 247.

willing or able to bear the label of "mentally unstable" in their medical records."[199] Erdman says the previous 1969 reform, "was formal sanction of a class-based system of abortion access."[200]

According to Erdman, the 1988 *Morgentaler* judgment did little to address this imbalance. She maintains that the "*Morgentaler* 1988 judgment did not disturb these categories, but rather re-inscribed them onto the logic of *Charter* rights."[201] She voices similar sentiments to Johnstone and Rogers saying that post-*Morgentaler*, access to abortion is available to those who can afford it. She writes, "in this liberal tradition, the constitutionalizing of abortion not only decriminalized the market in abortion services, it affirmed a competitive private market as the means of rights fulfillment, and thereby acceded to its rationalities and inequalities."[202] Erdman says reforms post-*Morgentaler* not only failed to ensure social equality in access, they provided women with "the freedom to seek abortion as a private commodity in a newly decriminalized market."[203] Erdman's commentary is relevant across the country, especially in regards to rural and remote populations as limited access throughout the provinces in non-urban centres requires certain populations to travel for service making it more accessible for those who can afford it. However, her commentary is particularly relevant for the Maritime provinces where increased insurance restrictions further exacerbate the disparities in access for low-income populations who are unable to afford clinic abortions in a private market or to travel long distances. Restrictions on clinic funding limit access to clinics by disincentivizing their operation, creating fewer service providers for abortion service and narrowing the access framework. As discussed, when in operation, the Maritime clinics charged a fee for service (in New Brunswick the full fee, in Nova Scotia a portion of the fee)

[199] *Ibid* at 233.
[200] *Ibid* at 232.
[201] *Ibid* at 247.
[202] *Ibid* at 249.
[203] *Ibid* at 247.

requiring women to pay for the service out-of-pocket, meaning only those who can afford abortion can access it at the clinic.

Although in 2021 abortion is no longer criminalized, it is far from accessible in the Maritime provinces. As discussed, insurance prohibitions on clinic funding enable a two-tiered system for access, disproportionately impacting low-income populations who cannot to pay for abortion out-of-pocket or take days off work to travel across, or out of, the province for access. Further, although problematic in and of itself, the two-tiered system is unsustainable. As demonstrated historically in the Maritime provinces, private clinics are unable to maintain operation without government funding. Although barriers in access exist across the country, as a result of the ban on clinic funding in the Maritime provinces, clinic abortions can only operate in a privatized market which has, historically, led to clinic closures and narrowing access schemes. All of the clinics which have existed at one point in the Maritime provinces have closed, with the majority of them citing lack of funding as the cause[204]

Therefore, even the problematic two-tiered abortion access framework within the Maritime provinces, in some ways effectively collapses into itself. Historically, without provincial funding clinics have been unable to operate collapsing the two-tiered framework within the province. This effectively forces women to either access abortion through a hospital within their individual province or travel for service, which only those with financial means can afford. As women with financial means are able to access clinic abortion service by travelling and paying for the interprovincial clinic abortion out-of-pocket, hallmarks of the two-tiered framework remain. In addition, the Maritime provinces have some of the most inflexible access frameworks with fewer

[204] As previously discussed, both the former New Brunswick Morgentaler Clinic and Clinic 554 cited the lack of funding as the reason for their closure. In addition, the previous Morgentaler Clinic in Nova Scotia was unfunded and cited the option for free services in hospital as the reason for their closure.

access points, tighter gestational limits, and additional bureaucratic hoops to jump through when seeking an in-hospital abortion. The additional barriers further exacerbate the impact felt by Maritime women on clinic insurance funding. Because of this, it is even more important to guarantee clinic funding in the Maritime provinces in order to ensure effective and meaningful access to abortion.

CHAPTER 3 – ADDRESSING THE BARRIERS

While seeking to address the contemporary limitations in access to abortion in Canada, more recent legal scholarship has predominantly focused on two approaches to addressing the issue legally. The first approach is in human rights law and looks to the constitutionality of the current access scheme. This approach examines the issue through the lens of sections 7 and 15 of the *Charter,* arguing that the government's failure to ensure access to abortion across the country is in violation of its positive rights obligations. While Canadian jurisprudence demonstrates a willingness on the part of Canadian courts to find access to abortion claims engage the *Charter*'s section 7 guarantee to life, liberty, and security of person, it has done so through negative rights claims.[205] However, more recently, discussions on the topic also examine the issue through the equality guarantees of section 15, as abortion is a gendered issue.[206] The second approach to challenging access involves examining the issue through the lens of Canadian health law and principles of Canadian Medicare. This approach argues that the failure to ensure access to abortion services is in violation of the *Canada Health Act* and is therefore subject to the remedies under the *Act.* Advocates for this approach claim the provision of abortion in Canada is inconsistent with the five mandatory criteria outlined in the *CHA*. In addition, they argue provinces allowing or mandating private billing of abortion procedures by means of uninsured clinic fees, violates the *CHA*'s ban on extra-billing.[207]

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[205] See *Morgentaler 1988, supra* note 1 and see *Jane Doe v Manitoba*, 2004 MBQB 285, 260 DLR (4th) 149 [*Jane Doe v Manitoba*].
[206] See Macfarlane, "Addressing a Dilemma", *supra* note 44 at 162 and see Margot Young, "Social Justice and the Charter: Comparison and Choice" (2013) 50 Osgoode Hall LJ 669 at 672 [Young, "Social Justice and the Charter"] and see also Downie & Nassar, *supra* note 148 at 152.
[207] All three arguments will be discussed in greater detail in Chapter 3.

I. Health Law

Martha Jackman advocates for a multi-faceted argument encompassing both approaches. Jackman advocates for a human rights approach to healthcare, as she says it creates two enforcement mechanisms.[208] Jackman maintains that the failure on the part of the federal, provincial, and territorial governments to "to address individual and systemic barriers to abortion within their respective jurisdictions," is not only in violation of the *Charter*.[209] Jackman argues it is in contravention of the *Canada Health Act,* and it "would also directly infringe the right to 'health care that is comprehensive, universal, portable, accessible, and publicly administered' under section 1(b) of the *Alternative Social Charter*."[210] Jackman's arguments are compelling, however, as we will discuss in this section, the enforcement mechanisms in health law have historically proven ineffective at remedying provincial barriers to abortions.

While arguments advanced through Canadian health law have their own inherent obstacles, so too does the positive human rights claim. While the majority of recent human rights discourse has centred on a positive rights approach to abortion access, historically, the Supreme Court has demonstrated a reluctance to find positive rights violations under the *Charter*, particularly in regard to section 7. In health law, the potential remedies for violations under the *CHA* are seldom used and often ineffective in ensuring compliance with *the Act.* As a result, access to abortion issues remain stagnant with major barriers to access remaining, particularly in Canada's

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[208] Martha Jackman, "The Future of Health Care Accountability: A Human Rights Approach" (2015-2016) 47 Ottawa L Rev 437 at 466.
[209] *Ibid.*
[210] *Ibid.* The Alternative Social Charter was developed during negotiations for the Charlottetown Accord of 1992 by a number of equality-seeking groups and coalitions. It was released in response to the Ontario Government's call for "for recognition of social objectives in an expanded version of the non-justiciable principles contained in Section 36 of the Constitution Act, 1982." See "Social Charter" (14 June 2021) online: *Centre for Constitutional Studies* <www.constitutionalstudies.ca/2019/07/social-charter/>.

Maritime provinces. Below this thesis will examine the contemporary legal scholarship on the issue and how access to abortion can be challenged through each framework. This thesis will also discuss the inherent challenges in the proposed approaches leaving limited recourse for addressing access issues, by way of a legal challenge, under these frameworks and will propose an alternative approach.

A. Remedies under the *Canada Health Act*

One approach to challenging access to abortion comes through the remedies available in Canadian health law. Erdman discusses the focus on health care claims as intertwined with those of equality rights. According to Erdman, in response to the inequalities that emerged post-*Morgentaler*, "feminist activists shifted discursive strategy and sought to rework the abortion right to secure access and equality."[211] In doing so, Erdman says activists claimed, "all abortions are therapeutic care, or in Canadian health care discourse, a 'medically necessary' service."[212] Erdman notes the appeal of this claim is obvious, "[o]n reclassification as therapeutic care, abortion is fully absorbed into the public health care system, to be treated and funded like every other health care service."[213] Macfarlane also ties claims for abortion as a healthcare issue to equality rights claims. "Along the lines of Eldridge," Macfarlane writes, "the failure of some provinces to ensure ready access to abortion services is a form of sex-based discrimination in the context of a state-funded health care system operating on the principle of ensuring the provision of core medically-necessary services regardless of the ability to pay."[214]

[211] Erdman, "Constitutionalizing Abortion", *supra* note 24 at 250.
[212] *Ibid.*
[213] *Ibid.*
[214] Macfarlane, "Addressing a Dilemma", *supra* note 44 at 163.

As discussed earlier, health jurisdiction in Canada is divided between the provincial and federal governments. Although delivery and regulation of health care predominantly falls under provincial jurisdiction, the federal government has jurisdiction over marine hospitals and healthcare associated with a number of other jurisdictional heads, including Indigenous populations and the military. In addition, the federal government maintains influence over provincial health insurance via its spending power. This results from the structure of the Canadian health care system, where provincial governments receive funding from the federal government for health care through the Canada Health Transfer. The *CHA* establishes criteria and conditions that the provincial governments must meet in order to receive their federal funding contribution.[215] If the provinces fail to comply with the five program criteria, then the federal government can deduct funding from the next year's transfer. The authority for withholding contributions is under section 15 of the *CHA.* Section 15 states if of the opinion that one of the provincial governments has failed to comply with the criteria, the Governor in Council may "direct that any cash contribution to that province for a fiscal year be reduced, in respect of each default, by an amount that the Governor in Council considers to be appropriate, having regard to the gravity of the default;"[216] or, "where the Governor in Council considers it appropriate, direct that the whole of any cash contribution to that province for a fiscal year be withheld."[217]

As noted, the five program criteria under the *CHA* are universality, portability, comprehensiveness, accessibility, and public administration. In order for the provincial health insurance plans to meet the public administration criteria, the plans must be publicly run on a non-profit basis.[218] According to the *CHA*, the comprehensiveness criteria is satisfied if a province's

[215] *Canada Health Act*, *supra* note 50 at s 4.
[216] *Ibid* at s 15 (1)(a).
[217] *Ibid* at s 15 (1)(b).
[218] *Ibid* at s 8.

plan covers, "all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners."[219] For universality, the health insurance plan of the province must, "entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions."[220] The portability criteria requires that provinces not impose a minimum residency requirement to be eligible for funding in excess of three months and must cover residents' non-elective services while temporarily absent from the province or while moving to another province before they meet the three month criteria.[221] Lastly, the accessibility criterion mandates the provinces to create a health insurance system which has uniform terms and conditions for all residents allowing for reasonable access, as well as insuring physician and hospital services in accordance with a tariff system authorized by provincial law.[222]

Arguably, the current access scheme for abortion in the Maritime provinces violates all five criteria under the *CHA*. Howard Palley speaks to how abortion access in Canada violates the requirements of the *CHA* quoting a 2003 report from the Canadian Abortion Rights Action League (CARAL). Quoting the CARAL report, he asserts that portability is violated when abortion is excluded from interprovincial billing.[223] As previously mentioned, although hospital abortions can now be interprovincially billed, clinic abortions are still excluded. Next, Palley writes, accessibility "is breached when provinces such as Prince Edward Island, refuse to provide any abortion services, forcing women to travel to the mainland to receive care."[224] Although PEI now performs abortions, it only does so up until the end of the first trimester and only at one location in the province.

[219] *Ibid* at s 9.
[220] *Ibid* at s 10.
[221] *Ibid* at s 11.
[222] *Ibid* at s 12.
[223] Palley, *supra* note 146 at 575.
[224] *Ibid.*

Comprehensiveness is breached, according to Palley, when provinces refuse to pay for a medically necessary procedure performed at a free-standing clinic,[225] such as pursuant to the insurance restrictions in PEI, New Brunswick, and most likely in Nova Scotia.

Palley argues that the criteria for public administration is disregarded when, "as a result of hospital mergers between Catholic and secular hospitals, the publicly funded Catholic-run institutions eliminate all reproductive health care services for women, including contraception and abortion."[226] Arguably, public administration is also breached when a province's health insurance plan fails to insure services outside hospitals. This limits the availability of abortions to the first trimester and limits access. In effect this arrangement results in the creation of a two-tiered system and the privatization of services in order to fill a sizeable gap in the system. Lastly, Palley asserts, "the principle of universality is clearly meaningless when it comes to abortion because the availability of hospital services can vary from 0% to 35% depending on where a woman lives."[227] The access framework in the Maritime provinces exemplifies this position. While abortions may be reasonably accessible in the public system for women in the first trimester in Moncton, they are virtually inaccessible for those in the second trimester in Edmundston.

Flood, Lahey, and Thomas assert, "the broad provisions of the *CHA* mean the federal government has wide and virtually unreviewable discretion as to whether a province has complied with any of its criteria and then, further, whether to penalize a province."[228] While all of these violations of the *CHA* are occurring in the Maritime provinces in the context of abortion provision, it is unlikely that the remedy under section 15 of the *CHA* will address the issue. This is due to the federal government's historical approach to remedying violations under the *CHA*. Despite

[225] *Ibid.*
[226] *Ibid.*
[227] *Ibid.*
[228] Flood, Lahey & Thomas, *supra* note 46 at 457

numerous barriers to abortion existing for years across the Maritime provinces in violation of the *CHA*, the enforcement mechanism under section 15 of the *CHA* has never been used.[229]

Section 15 of the *CHA* is not the only enforcement mechanism under the *Act*. Outside of the program criteria, the *CHA* also contains a prohibition on extra-billing and enforcement mechanisms to accompany the ban. Extra-billing is defined in the *CHA* as, "the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province."[230] If provinces allow for extra-billing of patients, the *CHA* mandates the federal government to deduct a dollar-for-dollar amount from the next year's transfer.[231] Sanda Rogers notes the extra-billing prohibitions apply to clinic abortions not covered by provincial plans. Discussing the remedy under the *CHA* she writes, "because abortion is a medically necessary health care service, extra billing and user charges associated with it are the subject of mandatory (dollar for dollar) penalties under the *CHA*."[232]

B. Unpersuasive remedies and limited enforcement

One of the ways in which provinces escape enforcement or refuse funding of a service is through claiming the service is not medically necessary and therefore is not covered under the *CHA* and provincial health plans. The *CHA* mandates the funding of insured health services, the definition of which includes medically necessary hospital services. Medically necessary hospital services are defined as "medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability."[233] As Rachel Johnstone notes,

[229] CHA Annual Report 2019 – 2020, *supra* note 184.
[230] *Canada Health Act*, *supra* note 50 at s 2.
[231] *Ibid* at s 20 (1).
[232] Rogers, *supra* note 197 at 115.
[233] *Canada Health Act*, *supra* note 50 at s 2.

"the *Canada Health Act* does not, however, provide a definition of medical necessity or, for that matter, of health."[234] Johnstone says those who argue against the funding of abortion claim the service is elective and not medically necessary. Johnstone writes, "they contend that abortion often happens for social reasons rather than purely medical ones and should therefore not be considered a required medical service."[235] However, to Johnstone, this argument fails to consider the wider implications. She writes, "this critique depends on a narrow definition of health that seems to exclude both mental health and social determinants of health."[236] Sanda Rogers and Howard Palley both contend abortion is a medically necessary procedure. Palley writes, "[a]bortion is a procedure that, in Canada, must be performed by a medical doctor, and it is a procedure that has been declared a medically necessary one by all provincial/territorial colleges of physicians and surgeons."[237] Rogers says even though abortion is recognized as a medically necessary service, "many [provinces] nonetheless limit their funding to specified parameters which often render access illusory."[238]

Flood, Lahey, and Thomas describe the federal enforcement mechanisms under *the Act,* as a "carrot and stick approach to incentivize provinces to comply with national standards in their respective public insurance plans."[239] They write, "[i]n theory, if provinces do not comply with *CHA* criteria (e.g., related to preventing out-of-pocket billing of patients at point-of-service), the federal government can in future years withhold funding from the offending province."[240] However, according to Flood, Lahey, and Thomas, the reality is that the enforcement provision for

[234] Johnstone, "After Morgentaler", *supra* note 63 at 108.
[235] *Ibid* at 111.
[236] *Ibid.*
[237] Palley, *supra* note 146 at 567.
[238] Rogers, *supra* note 197 at 115.
[239] Flood, Lahey & Thomas, *supra* note 46 at 453.
[240] *Ibid.*

criteria violations is not used. According to them, "federal governments over the decades have taken a lenient if not a permissive approach to enforcement."[241]

Sanda Rogers agrees, and notes "the federal government has never demonstrated a willingness to impose harsher penal ties on provinces which fail to comply with the principles of Canadian health care."[242] However, in contrast, Rogers discusses the dollar-for-dollar enforcement mechanism mandated for extra-billing by the *CHA*. Which, according to Flood, Lahey, and Thomas, is the stronger of the two enforcement mechanisms, as the *CHA* mandates deductions for violations resulting from extra-billing.[243] The dollar-for-dollar deduction has been used on multiple occasions to enforce extra-billing charges, including for clinic abortion fees.[244] However, Rogers does not think the mechanism is effective, especially when it comes to ensuring access to abortion. She writes, "the provinces have been willing to forgo the minimal funds that the federal government has withheld, rather than to address the issue of privatized health care services generally or abortion in particular."[245] Palley discusses the use of the federal claw back power regarding private clinic charges for abortions in Nova Scotia in the early 2000s. According to Palley, in 2001-2002 the federal government withheld transfer payments to Nova Scotia in response to facility fees not insured at the former Morgentaler Clinic.[246] However, Palley says the mechanism was ineffective. He writes, "the government of Nova Scotia, subject to bottom-up

[241] *Ibid* at 457
[242] Rogers, *supra* note 197 at 115.
[243] Flood, Lahey & Thomas, *supra* note 46 at 457.
[244] As this thesis discusses, the federal governments have used funding claw backs for clinic abortion fees in Nova Scotia in the early 2000s and in 2020 in New Brunswick, although ultimately returned. The claw back was also used for clinic abortion fees in Alberta in 1996 and in Newfoundland in 1998. See CHA Annual Report 2019 – 2020, *supra* note 184.
[245] Rogers, *supra* note 197 at 115.
[246] Palley, *supra* note 146 at 579.

political pressure, indicated that it willingly would forgo the federal revenue rather than comply with the federal interpretation of the requirement of the *Canada Health Act."*[247]

One of the mechanisms for addressing conflicts in Canadian health law is the Dispute Avoidance and Resolution (DAR) action. The DAR process was introduced in 2004 to encourage cooperation between the provinces and the federal government during instances of non-compliance with the *CHA*.[248] According to Rachel Johnstone, the process is "launched in the event of disagreements over the application of the *Canada Health Act* by different levels of government."[249] Johnstone says the process begins with a government-to-government fact finding negotiation but the final authority to interpret the *CHA* lies with the federal health minister.[250] According to Johnstone, should the parties be unable to come to an agreement the non-compliance provisions come into effect which allows for deductions from the Canada Health Transfer.[251]

In 2005 the federal health minister initiated a DAR process against New Brunswick for failing to cover the cost of abortions in private clinics.[252] Johnstone says New Brunswick's progressive conservative government's health minister at the time, Elvy Robichaud, publicly announced that the government would not bow to the pressure of the federal liberal government.[253] According to Johnstone, before the process was completed an election was called and the federal liberal government lost to Stephen Harper's conservatives. Johnstone says the enforcement mechanisms under the *CHA* depend on the "political will of federal governments to employ it."[254]

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[247] *Ibid.*
[248] CHA Annual Report 2014 - 2015, *supra* note 111 at 1.
[249] Johnstone, "After Morgentaler", *supra* note 63 at 116.
[250] *Ibid.*
[251] *Ibid.*
[252] *Ibid.*
[253] *Ibid.*
[254] *Ibid* at 115.

Shortly after the election, Johnstone says the Harper government announced it had no intention to continue with the DAR enforcement process.[255]

As discussed earlier, the claw back enforcement mechanism for extra-billing has been used in response to unfunded abortion services in New Brunswick at Clinic 554, with little success. In March of 2020 federal Minister of Health Patty Hadju wrote to New Brunswick threatening a funding clawback should the province fail to comply with the funding criteria under the *CHA*.[256] The letter asserted patient charges for surgical abortions would be considered extra-billing and user charges resulting in a claw back of the Canada Health Transfer.[257] New Brunswick responded to the threat by saying their position remained unchanged, clearly not deterred by the threat of punishment. The federal government then withheld $140,126 dollars in transfer payments, the amount corresponding to what New Brunswick women had been charged out-of-pocket for abortions performed at Clinic 554.[258] In context, New Brunswick's entitlement under the Canada Health Transfer for 2020-2021 was 860 million dollars.[259] The withheld payment is clearly a nominal amount in regards to federal contributions for New Brunswick's health care funding. However, as noted earlier, even the nominal amount was returned. According to CBC News, shortly after the claw back was withheld, the federal government "quickly reinstated the funding as New Brunswick's health-care system buckled under the stress of the COVID-19 pandemic."[260]

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[255] *Ibid* at 116.
[256] Hadeel Ibrahim, "Feds could reduce transfer payments by end of March if province doesn't fund clinic abortion" *CBC News* (26 February 2020) online: <www.cbc.ca/news/canada/new-brunswick/private-clinic-abortion-access-new-brunswick-clinic-554-1.5476517>.
[257] *Ibid.*
[258] Kerry Campbell "Group suing N.B. over abortion funding urges P.E.I. to repeal 'discriminatory' law" *CBC News* (18 January 2021) online: <www.cbc.ca/news/canada/prince-edward-island/pei-abortion-access-nb-court-action-1.5875482>.
[259] "Major federal transfers" (11 May 2021) online: *Department of Finance Canada* <www.canada.ca/en/department-finance/programs/federal-transfers/major-federal-transfers.html#NewBrunswick>.
[260] Campbell, *supra* note 258.

Not only are the enforcement remedies and mechanisms under the CHA rarely used and ineffectual, they fail to properly address the issue. While the federal government may choose to claw back $140,126 from New Brunswick as a deterrent, the money is only held with the federal government. Not only is the enforcement mechanism unsuccessful in its objective, Canadian women are still left short-changed. As discussed, those accessing abortion in Canada are predominantly younger and therefore lower-income populations. The women who paid out-of-pocket for abortions at Clinic 554 are not reimbursed for their expenses. With this in mind one must consider what objective this enforcement mechanism truly serves. Not only is it seemingly futile, but it fails to truly grasp the crux of the issue.

Documents released by Health Canada under the *Access to Information Act* reveal another inherent weakness in CHA remedies. The extra-billing enforcement mechanism under the *CHA* is only available after the prohibition has been violated. In an email from August 2014 the Assistant Director of Compliance and Interpretation of the *Canada Health Act* division, Ursula Scott, states abortions are deemed medically necessary and that further, the *CHA* "requires that all medically necessary physician and hospital services be covered by provincial/territorial health insurance plans whether they are provided in hospital or in a facility providing hospital care."[261] The email speaks to the limited recourse available, at the time, for enforcing compliance with the *CHA* after the former Morgentaler clinic closed in Fredericton. According to the email, while clinic charges under provincial legislation were in contravention of the extra-billing prohibition under the *CHA*, little could be done. The email states, "the Fredericton clinic closure actually means that extra-billing and user charges penalties under the Act are no longer possible going forward."[262]

[261] Email from Ursula Scott to Michael McAuley (12 August 2014) *Subject: CHAD input on abortion in Atlantic Canada for DM's Atlantic tour August*, document released under the *Access to Information Act* by Health Canada.
[262] *Ibid.*

Therefore, as there is currently no abortion clinic operating in either PEI or Nova Scotia, remedies for extra-billing are unavailable.

II. A Positive Rights Approach

Since the decriminalization of abortion, scholarly discussion on the topic and feminist legal activism have predominantly centred on the discussion of a positive right to abortion, arguing the government has failed to ensure access to the service.[263] Human rights are often divided into two groupings, negative and positive rights. Negative rights are also referred to as "first generation rights" and positive rights as, "second generation rights."[264] Ran Hirschl describes the difference between the two, saying negative rights are often understood to guarantee freedom from state interference,[265] such as threat of punishment resulting from criminal prohibition. A negative rights claim regarding abortion would thus focus on active state interference, such as the former criminal prohibition on abortion struck down in *Morgentaler*. In its judgment, the Court did not guarantee access to abortion, it merely sought to prevent additional barriers in access resulting from state interference.

Linda White discusses this dichotomy, asserting the judgment in effect removed legal barriers to abortion. However, she notes, "the majority of justices on the Supreme Court did not rule that women had a ''right'' to abortion; rather, the majority of justices ruled that *Criminal Code* provisions restricting abortion were so onerous as to constitute a violation of section 7 of the

[263] Rachel Johnston and Emmett Macfarlane note, "the barriers women still face in Canada absent such protections showcase the consequences of failing to acknowledge positive rights to abortion care." See Johnstone & Macfarlane, *supra* note 122 at 115 and see Erdman, "Constitutionalizing Abortion", *supra* note 24 at 247.
[264] Ran Hirschl ""Negative' Rights vs. 'Positive' Entitlements: A Comparative Study of Judicial Interpretations of Rights in an Emerging Neo-Liberal Economic Order" (2000) 22:4 Hum Rts Q1060 at 1071.
[265] *Ibid.*

Charter."[266] White's commentary touches on a clear misunderstanding in feminist activism of the implications of the 1988 *Morgentaler* judgment with the dichotomy of positive and negative rights at its core. As Joanna Erdman describes, feminist activism following *Morgentaler* "argued that abortion rights carried with them an implied right of funding, that any legal right was inseparable from the means necessary to exercise it."[267] However, White correctly identifies the implications of the *Morgentaler* judgment. The judgment does not guarantee a positive right to abortion but merely freedom from state interference with security of the person by threat of criminal sanction under a scheme which provided a defence that was "illusory or so difficult to attain as to be practically illusory."[268] The abortion rights which emerged post-Morgentaler did not ensure state guaranteed or funded access to the service, merely freedom from onerous state interference or as Erdman thoughtfully put it earlier, freedom to access the service as a commodity in a private market.

Positive rights, in contrast, Hirschl says "include freedom to act in a positive way—entailing the provision by some individual or institution of a valued service."[269] Positive rights are often argued as requiring an act on the part of the government in order to ensure access to a fundamental right. Cara Wilkie and Meryl Zisman Gary describe a positive rights claim under section 7 as made out where, "the evidence demonstrates that a lack of government action substantially impedes individuals' ability to exercise their right to life, liberty, and/or personal security."[270] For example, a positive rights argument under section 7 of the *Charter* would assert that the government has a responsibility to provide citizens with the necessary amounts of water

[266] Linda A White, "Federalism and Equality Rights Implementation in Canada" (2013) 44:1 The Journal of Federalism 157 at 163.
[267] Erdman, "Constitutionalizing Abortion", *supra* note 24 at 247.
[268] See *Morgentaler 1988, supra* note 1 at 51.
[269] Hirschl, *supra* note 264 at 1071.
[270] Cara Wilkie & Meryl Zisman Gary, "Positive and Negative Rights Under the *Charter*: Closing the Divide to Advance Equality" (2011) 30 Windsor Rev Legal & Soc Issues 37 at 46.

or food required to survive, and the failure to do so would be in breach of the right to life and security of the person.

In addition, positive rights are often thought to include social or economic rights. Hirschl says they engage government services such as healthcare, education, social security, and welfare.[271] Access to abortion is thus argued from a positive rights perspective as necessary in order to ensure the section 7 guarantees or alternatively, as Emmett Macfarlane describes the feminist discourse on the topic under section 15, linked to "women's reproductive rights to a substantive conception of equality."[272] Margot Young writes, "the text of the *Charter* provides no explicit guarantees of social and economic rights."[273] Because of this, Young – in speaking to sections 7 and 15 of the *Charter* – observes that, "legal activism has focused on one or the other of these two sections as an expandable base for textual interpretation that would allow for some specific social and economic protection."[274] While the distinction between positive and negative rights is important to examine the various approaches to challenging abortion access, as this thesis will touch on later in the chapter, some argue the distinction is superficial in certain situations and that the distinction between the two effectively collapses under close examination.

From a section 7 perspective, a positive rights argument asserts that governments' failure to ensure an accessible scheme for abortion services within each province violates section 7. As recognized in the 1988 *Morgentaler* judgment, barriers in access leading to delays in obtaining an abortion can have significant effects on a woman's mental and physical wellbeing, interfering with her bodily integrity. Therefore, a positive rights approach would argue the numerous barriers currently existing in accessing abortion in Canada result from government inaction to ensure the

[271] Hirschl, *supra* note 264 at 1071.
[272] Macfarlane, "Addressing a Dilemma", *supra* note 44 at 162.
[273] Young, "Social Justice and the Charter," *supra* note 206 at 672.
[274] *Ibid.*

service. As the current access scheme results in delays in obtaining abortion for women in rural and remote communities, as well as for those who cannot afford to pay for clinic fees out-of-pocket, the current access scheme infringes on women's security of the person and government inaction violates section 7 of the *Charter*.

In addition, *Charter*-based positive rights approaches to abortion assert that failing to ensure equitable access to abortion or reproductive health services in general, violates the substantive equality protections under section 15 of the *Charter*. The Supreme Court has on numerous occasions stated that the protections under section 15 are not only formal, but substantive in nature.[275] In recognizing that the protections under section 15 also promote substantive equality, the court has stated that this will at times require the government to act to ameliorate disadvantage.[276] Therefore, positive rights *Charter* arguments have also been grounded in the substantive equality protections under section 15.[277] A positive rights approach to a section 15 claim would then assess what reproductive health services are available to men and assert the government has a responsibility to ensure equal access to the relevant applicable service based on the identity of the group. For example, the CCLA advances a similar argument in their statement of claim for the challenge to clinic funding in New Brunswick. The section 15 argument examines access to "similar basic health services."[278] In their filed statement the CCLA claims that the challenged regulation "treats abortion services in a manner that is different from the way the

[275] See *Andrews v Law Society (British Columbia*), [1989] 1 SCR 143, [1989] 2 WWR 289 at 164 [*Andrews*] and see *Eldridge v British Columbia (Attorney General*), [1997] 3 SCR 624, [1997] SCJ No 86 at 77 [*Eldridge*] and see also *Withler v Canada (Attorney General),* 2011 SCC 12, [2011] 1 SCR 396 at 2.
[276] See *Eldridge, supra* note 275 at 73.
[277] Martha Jackman and Bruce Porter note early section 15 jurisprudence developed a notion of substantive equality that includes "important dimensions of socio-economic rights as well as positive governmental obligations to remedy disadvantage." See Martha Jackman & Bruce Porter, "Social and Economic Rights" in Peter Oliver, Patrick Macklem & Nathalie Des Rosiers, eds, *The Oxford Handbook of the Canadian Constitution* (New York, USA: Oxford University Press, 2017) at 850.
[278] *CCLA v New Brunswick, supra* note 129 at 61.

Province treats similar basic health services,"[279] comparing the barriers that men in New Brunswick face when accessing vasectomies. Therefore, the CCLA is essentially arguing that the failure to ensure equitable access to abortion across the province constitutes inequitable access to reproductive services, which violates section 15.

Rachel Johnstone advocates for governments taking additional responsibility to create and ensure a positive right to abortion access.[280] Johnstone says this is necessary if women are to be recognized as equal citizens and further, "this means not only the provision of services, but also a safe social climate in which women can exercise these choices openly."[281] Speaking to the existing barriers and privatized framework, Johnstone and Macfarlane together argue, "the barriers women still face in Canada absent such protections showcase the consequences of failing to acknowledge positive rights to abortion care."[282] According to Johnstone and Macfarlane, limiting abortion to a negative rights discussion is clearly flawed, "particularly in the context of a provincial universal health care system in Canada where publicly funded medical services are expected (and are generally delivered by way of a government monopoly)."[283]

As discussed earlier, Erdman is critical of the effect of the 1988 Morgentaler judgment. She describes the effect of the negative rights centred claim in *Morgentaler*, claiming it further exacerbated inequality. Erdman writes, "the liberal abortion right of *Morgentaler* 1988, carried forward by a liberal feminist movement, legitimized the withdrawal of the state, the privatization of abortion care, and all the social inequalities of access that followed."[284] Further, Erdman asserts this is exemplified by provincial health insurance funding regulations. She writes, "by restricting

[279] *Ibid.*
[280] Johnstone, "After Morgentaler", *supra* note 63 at 102.
[281] Johnstone, "Abortion in New Brunswick", *supra* note 59 at 84.
[282] Johnstone & Macfarlane, *supra* note 122 at 115.
[283] *Ibid* at 113.
[284] Erdman, "Constitutionalizing Abortion", *supra* note 24 at 249.

public funding to therapeutic abortions performed in hospitals settings, for example, provincial governments repurposed the criminal law to explicitly ration access on the basis of wealth."[285] Erdman says in response, feminist activism switched paths to focus on positive rights claims and access. She notes, "within this new political context, feminist activists shifted discursive strategy and sought to rework the abortion right to secure access and equality."[286]

A. Criticism of the rights dichotomy

While scholarly discourse on abortion access in Canada has examined the issue from both a positive and negative rights perspective, many scholars call for the recognition of abortion as a positive right. However, the distinction between positive and negative rights is argued by many to be superficial. Discussing the dichotomy between the two groupings of rights, Ran Hirschl writes, "several scholars have argued that a theoretical distinction between negative rights and positive rights is questionable, primarily because many rights that have been traditionally labeled as "negative" actually require some sort of public funding or state intervention.[287] Emmett Macfarlane agrees and refers to the conceptual distinction of positive and negative rights as "far from straightforward."[288] Macfarlane writes, "as advocates for positive rights point out, the enforcement of negative rights frequently requires governments to take action or spend money."[289] Further, Macfarlane says in certain health care cases, including abortion challenges, the distinction between positive rights and negative rights effectively collapses into itself.[290]

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[285] *Ibid* at 246.
[286] *Ibid* at 250.
[287] Hirschl, *supra* note 264 at at 1072
[288] Macfarlane, "Addressing a Dilemma", *supra* note 44 at 153.
[289] *Ibid.*
[290] *Ibid.*

Margot Young is also critical of the distinction, calling it ambiguous and incoherent.[291] She voices similar sentiments to Macfarlane asserting that it is "well recognized that most rights require a mix of positive and negative obligation and that the state action/inaction opposition is itself conceptually indeterminate."[292] While Young is critical of the dichotomy she recognizes Canadian courts continue to rely on this distinction.[293] Marie Eve Sylvestre agrees, claiming the distinction has been widely condemned by the legal community and in academic literature but that "the distinction is still deeply ingrained in legal consciousness and discourse."[294] Perhaps one of the clearest examples supporting these arguments that this thesis will next discuss is the fact that these rights claims can often be framed from both a positive and negative rights perspective. However, the implications of the judgment and the likelihood of success of the claim varies dependent on how it is framed.

B. Barriers to the positive rights claim

According to Johnstone, Canadian caselaw has not addressed the issue of abortion access from a positive rights perspective. She writes, "as will become evident in the cases selected, these decisions have generally protected existing levels of access or prevented extensive state interference in access but have rarely gone further in suggesting that abortion rights ought to be read as a positive right."[295] However, according to Johnstone this is not unique to the issue of abortion. She writes, **"**courts have generally avoided interpreting *Charter* rights as positive

[291] Margot Young, "Section 7: The Right to Life, Liberty, and Security of the Person" in Peter Oliver, Patrick Macklem & Nathalie Des Rosiers, eds, *The Oxford Handbook of the Canadian Constitution* (New York, USA: Oxford University Press, 2017) at 791 [Young, "Section 7"].
[292] *Ibid.*
[293] *Ibid.*
[294] Marie Eve Sylvestre, "The Redistributive potential of Section 7 of the Charter: Incorporating Socio-economic Context in Criminal Law and in the Adjudication of Rights" (2011) 42:3 Ottawa L Rev 389 at 403.
[295] Johnstone, "After Morgentaler", *supra* note 63 at 82.

rights."[296] Wilkie and Gary voice similar concerns, saying that Canadian courts have left open a positive rights interpretation for section 7 but have, "been slow to recognize positive obligations as inherent in the right to life, liberty and security of the person protected under section 7 of the *Charter*.[297] Further the two write, "[e]xisting jurisprudence under section 7 indicates that while courts pay lip service to the theoretical possibility that section 7 could be used to impose positive obligations on government, they are unwilling to turn that possibility into reality."[298] The two advance the judgments in *Gosselin v Québec (Attorney General)*[299]*[Gosselin]* and *Wynberg v Ontario [Wynberg]*,[300] to support this argument.

Although almost 20 years old, the judgment in *Gosselin* is cited by many as denoting the Supreme Court's stance on positive rights.[301] The case involved a constitutional challenge to Québec's social assistance program. The program provided a lower base payable amount for individuals under the age of 30, citing a motive to encourage young people to get job training and enter the workforce.[302] In order for an individual under 30 to receive the similar base amount as those over, they had to complete a work training program.[303] Ms. Gosselin challenged the scheme on the basis that it violated sections 7 and 15 of the *Charter*. Ms. Gosselin's section 15 challenge was a negative rights claim, that the law itself created a distinction on the basis of age. Her section 7 and 15 claims were positive rights claims. Under section 7, she argued the inadequate provisions of state welfare in Québec violated her *Charter* protections.[304] The central issue for the positive rights element of the claim was whether the government's failure to provide adequate benefits

[296] *Ibid* at 102.
[297] Wilkie & Gary, *supra* note 270 at 42.
[298] *Ibid* at 46.
[299] *Gosselin v Québec (Attorney General),* 2002 SCC 84, [2002] 4 SCR 429 [*Gosselin*].
[300] *Wynberg v Ontario*, [2006] OJ No 2732, 142 CRR (2d) 311 [*Wynberg*].
[301] See Macfarlane, "Addressing a Dilemma", *supra* note 44 at 151 and see Wilkie & Gary, *supra* note 270 at 45.
[302] *Gosselin, supra* note 299 at 2.
[303] *Ibid.*
[304] *Ibid* at 75.

constituted a deprivation by the state.[305] In its judgment, the Court acknowledged that section 7 has historically been tied to negative rights claims and active state interference with an individual's life or liberty resulting from a criminal law, but that section 7 claims were not exclusive to this domain.[306]

Writing for the majority, then Chief Justice McLachlin discussed the application of section 7 to economic or social rights, saying it had not been discussed prior. According to McLachlin CJC, even if economic rights were recognized to engage section 7, the *Charter* guarantee protected against deprivations specifically. McLachlin CJC wrote, "nothing in the jurisprudence thus far suggests that s. 7 places a positive obligation on the state to ensure that each person enjoys life, liberty or security of the person."[307] While McLachlin CJC stated that one day section 7 may be interpreted to include positive rights, a deprivation did not exist in the case at bar.[308] As stated earlier, the judgment in *Gosselin* is often characterized as representing the courts approach to positive rights, with many acknowledging that there is limited commentary from Canadian courts on the issue.[309] However, interestingly, while the court acknowledges the issue of positive rights it fails to meaningfully address the issue. While earlier in the analysis McLachlin CJC outlines one of the issues for consideration as to whether inadequate assistance constitutes a deprivation, in the end, she fails to even consider the issue. The judgment seemingly finds no deprivation of section 7, without actually examining what a deprivation is or what act on the part of the state would constitute a deprivation. There is no discussion as to whether the deprivation must be an active force or whether it can result from the effect of passive state action.

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[305] *Ibid.*
[306] *Ibid* at 78.
[307] *Ibid* at 81.
[308] *Ibid* at 81 and 82.
[309] Positive rights advocates also advance the dissenting judgment in *Gosselin* by Justice Arbour which found a positive dimension to the protections under section 7 and stressed the importance of recognizing economic rights when deeply intertwined with one's personal health and ability to survive. See *Gosselin, supra* note 299.

The claimants in *Wynberg* were denied leave to appeal at the Supreme Court of Canada after receiving an unfavourable decision at the Ontario Court of Appeal.[310] The case involved a *Charter* challenge to programming for autistic children in Ontario which was not offered to children over the age of six.[311] Along with a number of other issues, the claimants in the case argued the failure to provide the autistic programming for school-aged children violated section 7 of the *Charter*. The claimants' argument asserted that the challenged programming for school-aged autistic children, "is the one program known to provide any hope to autistic children of becoming fully realized individuals, access to such programming is fundamental to the personhood and development of autistic children."[312] In this regard, the claimants asserted, "the liberty interest protected by s. 7 is a broad concept intended to vindicate individual autonomy and personhood, and includes the right to make certain essential life decisions about oneself."[313]

Further, the claimants argued that section 7 was also engaged by placing the individuals at risk of mental suffering as "the appellant is depriving autistic children of any reasonable expectation of success in life and of any realistic possibility of meaningful participation in the community."[314] In assessing the claim under section 7, the court acknowledged the judgment in *Gosselin* and concluded that the possibility for finding positive obligations under section 7 had been "left open."[315] However similar to the judgment in *Gosselin,* without discussing what constitutes a deprivation, the court found no deprivation. The court wrote, "the appellant's actions in failing to provide intensive behavioural intervention consistent with the IEIP Guidelines to

[310] *Wynberg, supra* note 300.
[311] *Ibid.*
[312] *Ibid* at 212.
[313] *Ibid* at 213.
[314] *Ibid* at 216.
[315] *Ibid* at 219.

school-age children do not amount to *depriving* the respondents of a constitutionally protected right and therefore do not contravene s. 7 as it is now understood."[316]

C. Success in negative rights claims

In contrast, Wilkie and Zisman maintain that *Chaoulli c Québec (Procureur Général) [Chaoulli]* [317] and *Victoria (City) v Adams [Adams]* [318] demonstrate an ability to find a novel breach of section 7 where the claim involves negative rights.[319] *Chaoulli* involved a challenge to the prohibition of private health insurance in Québec. The challenger in the case, Mr. Zeliotis, argued that the ban on private insurance forced individuals to use the public system which meant enduring long wait times for health care procedures, in violation of section 7 of the Canadian *Charter* and the rights to life and to personal security, inviolability, and freedom protected by section 1 of Québec's *Charter of Human Rights and Freedoms*.[320]

One of the reasons the judgment in *Chaoulli* is a novel application, is that the findings of the court and the implications of the judgment are complex. Only seven judges of the Supreme Court heard the case at bar and the decision was split with a three-judge minority finding violations of both the Québec and Canadian *Charters*, and three judges finding it did not violate the Canadian *Charter*. A single judgment from Justice Deschamp found violations of the Québec *Charter* but declined to answer the question of the Canadian *Charter* as the legislation was therefore invalidated. In her judgment, Justices Deschamps sided with Mr. Zeliotis, finding that the prohibition on medical insurance forced Québeckers to face delays in the public system which

[316] *Ibid* at 220.
[317] *Chaoulli c Québec (Procureur général),* 2005 SCC 35, 2005 CSC 35 [*Chaoulli*].
[318] *Victoria (City) v Adams*, 2009 BCCA 563, [2009] BCJ No 2451 [*Victoria v Adams*].
[319] Wilkie & Gary, *supra* note 270 at 45.
[320] *Chaoulli, supra* note 317 at 5.

affected their personal security under the Québec *Charter*.[321] Justices McLachlin, Major, and Bastarache found the prohibition also in violation of the Canadian *Charter*, noting the deprivation was not in accordance with the principles of fundamental justice,[322] and could not be saved under section 1 of the *Charter*, as the public benefit did not outweigh the deleterious effect of the legislation.[323]

Chaoulli is therefore not determinative on the issue of the Canadian *Charter* but a persuasive and meaningful precedent for the application of section 7 regarding claims to healthcare and outside of the procedural requirements of criminal law. The claim in *Chaoulli* was rooted in a negative rights approach, as Mr. Zeilotis was not calling for funding for a healthcare service, but instead wanted the freedom from state interference to pursue private insurance, allowing him to skip the public line and access services privately. The minority judgment of Justices McLachlin, Major, and Bastarache found a section 7 Canadian *Charter* violation due to long delays infringing security of person caused by the government monopoly on Medicare.[324] Grounding a substantial portion of their analysis in the reasoning advanced by the 1988 *Morgentaler* judgment, the minority judgment wrote, "the jurisprudence of this Court holds that delays in obtaining medical treatment which affect patients physically and psychologically trigger the protection of the *Charter*."[325]

Further, speaking specifically to the application of section 7 outside of the criminal law context, the justices found while the sanctions in *Morgentaler* were criminal and the penalties here administrative, the consequences for both situations were serious.[326] Specifically the justices

[321] *Ibid* at 111.
[322] *Ibid* at 153.
[323] *Ibid* at 157.
[324] *Ibid* at 106.
[325] *Ibid* at 118.
[326] *Ibid* at 121.

noted, "it was this constraint on security, taken from the perspective of the woman facing the health care system, and not the criminal sanction, that drove the majority analysis in *Morgentaler*."[327] The minority justices opinion in *Chaoulli* is an example of willingness on the part of the Supreme Court to engage section 7, not only outside of the criminal law context, but through a lens which examines the concept of state interference through a wider lens. In addition, although the challenge in *Chaoulli* is a negative rights claim, it turns on the failure of a government service, or a positive right. In *Chaoulli* – and similarly to *Adams* as this thesis will next discuss – although the rights violation is found in interfering legislation (a negative right), infringement would not have occurred if the government offered a more effectual service (a positive right.)

Adams, a case from the BC court of appeal, involved a challenge to a municipal law in Victoria banning "taking up a temporary abode overnight" in public parks.[328] In Canadian jurisprudence, the challenge in *Adams* perhaps most aptly addresses the blurring of the dichotomy of positive and negative rights. The challengers in *Adams* asserted that the ban jeopardized the health and safety of homeless individuals who had no other options but to stay in the parks overnight. Their argument was based on the fact that the shelter system in Victoria was insufficient to accommodate all of the city's homeless individuals. Specifically, one of the intervenors, the British Columbia Civil Liberties Association asserted, "regulation of public spaces is not reasonable where it prevents the homeless, who have no access to private spaces, from engaging in necessary life sustaining activities."[329]

The BC appeal court sided with the challengers, finding the city's prohibition violated the applicants' section 7 *Charter* rights. The Court agreed with the trial judge's findings that "the

[327] *Ibid.*
[328] *Victoria v Adams*, *supra* note 318 at 12.
[329] *Ibid* at 54.

majority of homeless people in Victoria have no choice but to sleep on public property… There is no other place for them to go."[330] Further, the trial judge noted, "creating shelter to protect oneself from the elements is a matter critical to an individual's dignity and independence."[331] Lastly, the Court of Appeal affirmed the trial judge's decision that "the state's intrusion in this process interferes with the individuals' choice to protect themselves and is a deprivation of liberty within the scope of s. 7."[332] In its judgment, the Court assessed whether state action was the cause of the deprivation, considering the city's argument that state action must be the main cause of the deprivation and is not engaged where, "as a result of the state action, the claimants merely remain in a state of insecurity."[333] The Court disagreed with this argument stating an "in and of itself" causation requirement was inconsistent with previous Supreme Court judgments,[334] and observing that in *Morgentaler*, as well as *Rodriguez v British Columbia (Attorney General)*, "the impugned state action was not the sole cause of the deprivations at issue, yet the Court [in both cases] held that the causation requirement was met."[335]

The City asserted the decision of the trial judge was "founded on the failure of the government to provide sufficient shelter beds," and therefore, "the order effectively grants a right to adequate alternatives to sleeping in public spaces."[336] Addressing whether or not the claim in *Adams* was one for positive or negative rights, the Court of Appeal found the trial judge's decision did not require action on the part of the City to ensure shelter, rather it only required, "the City to refrain from legislating in a manner that interferes with the s.7 rights of the homeless."[337]

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[330] *Ibid* at 104.
[331] *Ibid.*
[332] *Ibid.*
[333] *Ibid* at 86.
[334] *Ibid* at 87.
[335] *Ibid.*
[336] *Ibid* at 90.
[337] *Ibid* at 95.

However, the Court also noted that negative rights claims, from a practical point of view, can create obligations on the City to take action in response.[338] The Court stated this kind of responsive action could be an element consistent with all *Charter* challenges. Depending on the claim, the Court stated that positive action could be required, whether it be legislative or expending public funds to ensure compliance.[339] In the case at bar the Court wrote, "that will likely take the form (as we were advised it already has) of some regulation of the overnight use of public parks, and perhaps the creation of additional shelters or alternative housing, which is consistent with the City's evidence about the initiatives it has undertaken to deal with the homeless."[340] However, according to the Court, this did not mean the claim was a positive rights claim. The Court wrote, "that kind of responsive action to a finding that a law violates s. 7 does not involve the court in adjudicating positive rights."[341]

Examining *Adams* one can see that the challenge in this case could have been framed from a positive rights perspective, asserting a positive right on the part of the government to provide shelter for homeless persons. However, as Margot Young asserts, the implications of a positive rights judgment would be vastly different, and in her opinion more meaningful in addressing the issue. For Young, "narrowing the claim to a mere negative right means that the solution or remedy to the infringement is simply government forbearance – elimination of the prohibitive bylaws."[342] However, as Young asserts, "as any advocate for the homeless will attest, resolution of homelessness requires significant government action – resources and proactive policy and planning."[343] The challengers, however, advanced a negative rights claim arguing the city's

[338] *Ibid* at 96.
[339] *Ibid*.
[340] *Ibid.*
[341] *Ibid.*
[342] Margot Young, "Rights, the Homeless, and Social Change: Reflections on *Victoria (City) v. Adams* (BCSC)" (2009) 164 BC Studies 103 at 107.
[343] *Ibid.*

prohibition contained in the bylaws interfered with homeless individuals right to life, liberty, and security of person and did so in a manner contrary to the principles of fundamental justice.[344] While Young is critical of the limited remedies available through a negative rights claim, she admits one cannot fault the claimants for approaching the claim from the angle most likely to win.

Young is also critical of the judgment in *Adams.* Quoting Martha Jackman, Young asserts that the court failed to "debunk the notion of a constitutionally meaningful distinction between negative and positive rights," and further that the, "reasoning reinforces the claimed contrast."[345] As Young writes, "[e]ven traditional "negative" rights must be supervised and supported by the state using public resources."[346] The criminal law provides a clear example of this argument, in which a vast amount of government resources are allocated just to implement and ensure negative rights. As the *Adams* decision demonstrates, it is clear that a hardline dichotomy does not exist between the two groupings of rights. The judgment clearly blurs the line between where negative rights end and positive rights begin.

However, even Young's own criticism demonstrates there are dramatically different outcomes depending on which argument is advanced. While Macfarlane claims in certain cases the two groupings effectively collapse into themselves, perhaps his most appropriate commentary describes the dichotomy as instead, two ends of a spectrum.[347] The amount of government resources which need to be expended in order to ensure the right at issue varies depending on the circumstances. With arguably, one end of the spectrum covering claims which involve minimal

[344] *Ibid* at 104.
[345] *Ibid* at 107.
[346] *Ibid.*
[347] Emmet Macfarlane, "The Dilemma Positive Rights: Access to Health Care and the Canadian Charter of Rights and Freedoms" (2014) 48:3 Journal of Canadian Studies 49 at 61 [Macfarlane, "Access to Healthcare"].

state interference and enforcement, and the other end of the spectrum involving claims to government funded services, or access to basic goods, required to ensure socio-economic rights.

In addition, it is clearly established that Canadian courts still lean more favourably towards challenges which fall on the less interventionist or negative rights side of the spectrum. Examining the four cases above, it is apparent that challengers have historically been more successful in advancing negative rights *Charter* claims, over positive rights claims. Young herself asserts the section 7 claim in *Adams* was successful because it did not engage positive obligations.[348] Wilkie and Gary attribute Canadian courts reluctance to find positive rights violations for section 7 to a deference "toward executive and legislative decisions on the allocation of scarce resource and the prioritization of competing policy concerns."[349]

Wilkie and Gary find this helps to explain the differential approach on the part of the courts to negative and positive rights claims. They write, "the courts may be willing to recognize negative rights claims, because they do not affect government allocation of resources but are wary of recognizing positive rights claims, because doing so would not only question but directly affect government distribution of resources."[350] However, as this thesis has discussed, negative rights still require the expenditure of public resources to enforce, but perhaps not to the same extent as positive rights. Further, the negative rights violations found in both *Adams* and *Chaoulli* are deeply influenced by a positive right or government expenditure. Emmet Macfarlane also attributes the varying approaches to negative and positive claims to Canadian courts deference to the legislature. According to Macfarlane, "positive rights by definition are often going to mandate specific

[348] Young, "Section 7," *supra* note 291 at 791.
[349] Wilkie & Gary, *supra* note 270 at 54.
[350] *Ibid* at 55.

remedies," and "this produces a more fundamental intrusion on the legislative decision-making process than normally arises in the negative rights context."[351]

Canadian courts reluctance to fully recognize positive rights claims may also be tied to their transformative political implications and their potential to disrupt the status quo of Canadian society. Colleen Shephard finds similar inherent issues with the recognition of substantive equality. Although the substantive equality protections are under section 15 of the *Charter*, they clearly imply positive rights obligations. Shephard says recognizing substantive equality, is "out of sync with traditional legal doctrines, steeped as they are in the assumptions of classical liberal thought."[352] Shephard writes, "[t]o carry substantive equality to its logical redistributive conclusion would be to challenge some of the fundamental economic and political pillars of modern society, something judges are unlikely to do."[353] The negative rights approach, as demonstrated in *Adams*, did not require the city to provide housing for the homeless, but merely to allow them to erect temporary shelters in the park. A positive rights claim would have required the government to provide effective shelter for homeless populations, the means of which could be a variety of different solutions including increasing shelter space, housing development, or even ensuring a guaranteed basic income. Arguably the implications of the two approaches speak to another concern guiding Canadian courts reluctance to find positive rights infringements: the fear of opening up funding floodgates.

While recognizing a positive right to abortion would be the most comprehensive approach to ensuring unbarred access to abortion, the success of such a claim would be unlikely. Recognizing a fully positive right to abortion – one which would fall at the more interventionist

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[351] Macfarlane, "Access to Healthcare", *supra* note 347 at 60.
[352] Colleen Sheppard, *Inclusive Equality: The Relational Dimensions of Systemic Discrimination in Canada* (Montreal & Kingston: McGill Queen's University Press, 2010) at 53.
[353] *Ibid.*

end of the rights' spectrum – would mean not only covering the cost of the service. A positive right to abortion could require potentially ensuring extensive funding to develop rural and remote access points, funding for travel expenses for remote populations or for those in later gestational terms, and all other associated healthcare costs, including potentially birth control. The implications would be wide-reaching, impacting the provision of a number of health services across the country. While ideal, precedent from Canadian courts has not demonstrated a willingness to engage on this level at this time.

Colleen Shephard takes this perspective in regard to a positive right under substantive equality guarantees. She writes, "while the importance of ameliorative state action may be recognized, there continues to be considerable judicial discomfort with the idea of acknowledging positive economic and social rights."[354] This is even more relevant for claims under section 7 in which recognizing a positive right could disrupt widespread government programming and policy. The implications could potentially require restructuring of our entire social benefits system, a guaranteed basic income, government subsidized housing, or comprehensive pharma care. While many scholars have critiqued the negative rights approach to challenging abortion, it is clear that while the negative/positive dichotomy is overdrawn, challenges which fall closure to the negative rights end of the spectrum have had the greatest success historically. In addition, both *Chaoulli* and *Adams* show a willingness on the part of the courts to engage section 7 when legislation interferes with access to measures essential to security of the person and liberty, and the public system is failing to provide comprehensive and adequate service. These claims also incentivize provinces to either remove the barrier or ensure more comprehensive coverage in the public system. While numerous barriers to abortion exist across the country, the unique provincial health

[354] *Ibid.*

insurance barriers in the Maritime provinces are arguably some of the most problematic and a challenge to them has a promising chance of success based on Canadian precedent.

As interfering legislation or policy, the barriers can be challenged on the negative rights end of the spectrum. By removing funding barriers this would not only prevent fee-for-service charges at clinics, but it would incentivize additional clinics to open. Historically clinics which have closed have cited the reason as funding barriers. Further, as discussed earlier, enabling access to clinic abortions helps to address many of the other barriers, such as gestational limits, wait times, and lack of service providers. As discussed at the beginning of Chapter Two, provinces with larger access frameworks that allow for clinic funding perform more abortions per capita. Lastly, from a health law perspective, this would also help to ensure greater adherence to the guiding principles of the *CHA*.

D. A claim under section 15

Claims for access to abortion can also be advanced under section 15 of the *Charter*. Abortion is a gendered issue and while men do not access the service, disproportionate access to reproductive health care in the Maritime provinces could give rise to a section 15 violation. Like section 7, the equality rights protection has its own inherent strengths and weakness. This section will touch very briefly on the arguments involved in section 15 and the obstacles inherent in the approach.

Of both sections 7 and 15 of the *Charter*, jurisprudence concerning section 15 lends itself more readily to a positive rights claim. Over the last 30 years the Supreme Court has been more willing to find in favour of claimants bringing positive rights claims under the section's obligations for substantive equality. The court has repeatedly recognized that the protections in section 15 are

substantive in nature, and that at times ensuring equality will require differential treatment.[355] As discussed earlier, a section 15 claim could be advanced in the Maritime provinces, similar to the CCLA's argument in their statement of claim, comparing the access that both men and women have to reproductive health services.

However, similar to section 7, the equality protections have their own inherent obstacles. In regard to claims for a government service, discriminatory challenges can always be addressed by levelling down or removing the increased benefit. While more open to the recognition of positive rights under section 15 than under section 7, nonetheless the jurisprudence of section 15 demonstrates a reluctance on the part of the Supreme Court to ensure positive rights. Even with recognizing substantive equality, the court repeatedly confines the scope of the *Charter* protection restricting the implications of the outcome. Statements from Justice La Forest in *Eldridge* exemplify this tempering of implications. La Forest J asserts the government has no obligation to ameliorate all disadvantage but that, "this Court has repeatedly held that once the state does provide a benefit, it is obliged to do so in a non-discriminatory manner."[356] This concept is repeated throughout section 15 jurisprudence.[357] It exemplifies the courts hesitancy to find positive obligations on the part of the government in not only section 7 claims, but section 15 as well.

[355] *See Andrews, supra* note 275 and see *Eldridge, supra* note 275 and see also *Law v Canada (Minister of Employment and Immigration),* [1999] 1 SCR 497, [1999] SCJ No 12.
[356] *Eldridge, supra note 275* at 73.
[357] *Ibid* at 75 and see *Auton (Guardian ad litem of) v British Columbia (Attorney General),* 2004 SCC 78, [2004] 3 SCR 657at 41. See also *Tétreault-Gadoury v Canada (Employment & Immigration Commission)*, [1991] 2 SCR 22 (SCC) and see *Haig v R*, [1993] 2 SCR 995 (SCC) at 1041-42 and *Native Women's Assn. of Canada v R*, [1994] 3 S.C.R. 627 (SCC) at p 655.

CHAPTER 4 - NEGATIVE RIGHTS JURISPRUDENCE FROM *MORGENTALER* (1988) TO *JANE DOE*

While previous activism and legal challenges have made progress in access to abortion in the Maritime provinces,[358] as discussed there still remain numerous barriers to accessing abortion with prohibitions on private clinic funding aggravating the problematic access framework. As noted, healthcare remedies, when used, appear to be almost completely ineffectual in creating changes in access. Johnstone acknowledges the problematic approach of viewing abortion as a health care issue. She writes, "understanding the limitations of the current treatment of abortion as a healthcare issue is necessary to create positive change."[359] For example, Johnstone writes, "extensive bureaucratic restrictions preventing women from accessing abortion care covered under provincial health insurance is a case in point."[360] From a positive rights perspective, it is clear the scholarship also appears to agree, while ideally there should be a positive obligation on the part of the government to ensure access, the jurisprudence on positive rights does not strongly support that claim.

Arguably, focussing the arguments on negative rights has greater potential for success based on the courts' approach to positive and negative rights claims, as well as the historical jurisprudence. Emmett Macfarlane speaks to this approach regarding the 1988 *Morgentaler* judgment. Macfarlane says the decision in *Morgentaler*, "refrained from even determining whether there was a right to abortion grounded in privacy, personal autonomy or "interests unrelated to

[358] For example, PEI gaining access to a hospital access point for abortion in 2016 allowing for services on the Island.
[359] Johnstone, "Abortion in New Brunswick", *supra* note 59 at 83.
[360] *Ibid.*

criminal justice."[361] Instead, Macfarlane writes, Dickson CJC's decision is rooted in "state interference with bodily integrity' and state-imposed harms, particularly psychological stress resulting from delays and unequal levels of access attributable to the *Criminal Code* provisions that constituted an infringement of security of the person."[362] Dickson CJC's decision is also rooted in the unequal access to the criminal defence available under the previous *Code* framework. In fact, Macfarlane quotes Justice Beetz's concurring decision, writing he explicitly states, there "must be state intervention for 'security of the person' in s. 7 to be violated."[363]

As discussed, the negative rights approach has garnered criticism resulting from both the access framework that emerged following the 1988 *Morgentaler* judgment and further, out of concerns for the limited potential that it carries to bring about meaningful change. However, as discussed, the negative rights claim is likely to be considered more favourably by Canadian courts. In addition, the dichotomy between the two types of rights is at times illusory. Advancing a negative rights claim to insurance barriers is a clear example of where the two categorizations of rights effectively collapse into themselves. This is especially relevant where there is clear legislative interference, like in New Brunswick and PEI. Challenging the insurance prohibition would require the state to refrain from interfering with insurance coverage of clinic abortions, but also allows for clinic billing to the provincial plan, effectively requiring the state to pay for clinic abortions.

There are numerous limitations to the negative rights approach, including the challenge becomes more difficult to advance when the legislative authority for the apparent denial of funding is unknown, such as is the case in Nova Scotia. This is because it becomes less clear as to whether

[361] Macfarlane, "Addressing a Dilemma", *supra* note 44 at 154.
[362] *Ibid.*
[363] *Ibid.*

or not there is state interference when legislation is silent, and the funding denial is commissioned through unwritten policy. A negative rights challenge will also not ensure widespread and comprehensive access to abortion, but it will improve the existing access framework allowing for more meaningful and comprehensive service. Further, even with prohibitions on clinic funding struck down, access is still dependent on the initiative of health care providers to implement and run clinics in the Maritime provinces. However, as is evident from other provinces, where the provincial plan insures clinic abortions, clinics do operate and access is increased. In addition, as discussed, barriers to clinic abortions exacerbate all other barriers, meaning that when there are more clinics that are in operation, other barriers to access decrease in severity of impact.

Jurisprudence on abortion access, including the two Supreme Court *Morgentaler* judgments, lend themselves favourably to a negative rights approach. The same can be said for a judgment from Manitoba's provincial court in the early 2000s. In 2004 a lower Manitoba court assessed a negative rights claim to insurance prohibitions on abortion in a promising judgment in *Jane Doe v Manitoba*.[364] The case was initiated by two unnamed women who had both paid for private clinic abortions in Manitoba to avoid long wait times in the hospital system.[365] The two challenged a section of the *Excluded Service Regulation,* made under the province's *Health Services Insurance Act.*[366] Former regulation 46/93 listed the following as uninsured services: "Therapeutic abortion, unless performed by a medical practitioner (a) in a hospital in Manitoba other than a private hospital licenced under The Private Hospitals Act."[367] The two applicants asserted the law was unconstitutional in that it violated the section 2(a) guarantee for freedom of

[364] *Jane Doe v Manitoba*, *supra* note 205.
[365] *Ibid*.
[366] *Excluded Services Regulation*, Man Reg 46/93.
[367] *Ibid* at s 28.

conscience, the section 15 equality rights protection, and the section 7 right to life, liberty, and security of the person.[368]

On summary judgment the justice at the provincial court agreed with the applicants, citing the 1988 *Morgentaler* judgment in the reasons. Finding the impugned legislation interfered with the women's section 7 rights, the decision drew comparisons to the situation in *Morgentaler*. The Court wrote, "the harm caused by a delay in obtaining an abortion as alluded to by Dickson CJC in *Morgentaler*, *supra*, is exactly the same type of harm Jane Doe 1 and Jane Doe 2 say is created by the delays and waiting periods faced by women wanting a therapeutic abortion paid for by the Plan which delays and waiting periods are, in turn, occasioned by the impugned legislation."[369] Continuing on with the findings the Court, similarly to *Adams*, grounded the rights infringement in the failings of the current government system. The Court stated, "[i]n my view, the effect of the impugned legislation, including the *Regulation*, is to tell every pregnant woman that she cannot submit to a safe medical procedure that might be clearly beneficial to her unless she does so at a time and place dictated by a backlogged, publicly-funded health care system."[370]

The Court commented that depriving a woman of her right to decide where and when she will undergo the procedure due to a backlogged and publicly funded system not only threatened her in a physical sense but also "the agony caused by not knowing whether an abortion will be performed in time is bound to inflict emotional distress and serious psychological harm upon her."[371] Finding the regulation was in violation of all three *Charter* sections, the Court noted, "legislation that forces women to have to stand in line in an overburdened, publicly-funded health care system and to have to wait for a therapeutic abortion, a procedure that provably must be

[368] *Jane Doe v Manitoba*, *supra* note 205 at 79, 80.
[369] *Ibid* at 33.
[370] *Ibid* at 67.
[371] *Ibid* at 68.

performed in a timely manner, is a gross violation of the right of women to both liberty and security of the person as guaranteed by s. 7 of the *Charter*."[372] The court also found the legislation to be in violations of sections 2(a) and 15 of the *Charter*. Further, agreeing with Justice Wilson's opinion in *Morgentaler,* the Court wrote, "a deprivation of a s. 7 right which has an adverse effect on a right guaranteed elsewhere in the Charter cannot be said to be in accordance with the fundamental principles of justice."[373] Lastly, the Court agreed with the two women, finding the regulation could not be saved under section 1 as it failed to pass any of the three parts of the Oakes Test.[374] The Court found the "real objective" of the impugned legislation was to prevent Dr. Morgentaler or any other such person from operating a free-standing abortion clinic in Manitoba.[375] Concluding the judgment, the Court found the legislation was not minimally impairing, rational, or fair, and lastly, that it was arbitrary in nature.[376]

The decision of the lower court was appealed to the Manitoba Court of Appeal which found that the issues engaged were too complex to be decided as a matter of summary judgment.[377] Setting aside the lower court's judgment and sending the issue back for trial the Court of Appeal wrote, "these important *Charter* issues involve complex and developing areas of the law which require a full factual underpinning based on a trial record."[378] Following the decision from the Court of Appeal, the Manitoba provincial government amended the regulations to remove the challenged section, effectively rendering moot any further challenges on this issue. It should be noted that the Court of Appeal did not agree nor disagree with the trial judge, it declined to engage on the substantive *Charter* issues. The Court of Appeal only disagreed as to whether the issue

[372] *Ibid* at 78.
[373] *Ibid* at 80.
[374] *Ibid* at 82.
[375] *Ibid* at 83.
[376] *Ibid* at 85.
[377] *Jane Doe v Manitoba*, 2005 MBCA 109, 260 DLR (4th) 149 at 20.
[378] *Ibid* at 29.

could be determined on summary judgment, leaving the *Charter* analysis open for further interpretation. The judgment of the provincial court, therefore, still remains a promising precedent for a negative rights challenge to insurance prohibitions for abortion funding.

I. A Positive or a Negative Claim?

Rachel Johnstone speaks to the importance of the precedent set by *Jane Doe*. However, Johnstone refers to the judgment as a "notable precedent in the recognition of positive rights to abortion access."[379] This is because Johnstone characterizes the impugned law to be "positive in character."[380] This, according to Johnstone, is because "the law was intended to grant some coverage, but it fell short of setting out to create universal coverage."[381] Johnstone's assertion demonstrates the overlap between positive and negative rights addressed in *Adams.* However, although outcomes can have positive implications, it doesn't necessarily make the challenge a positive rights' claim. While the claim is to economic coverage for a government benefit, the lower Court's judgment is specifically focused on the active state interference of a right caused by the impugned legislation. Further, while a challenge could be framed as an issue of positive rights – as the government's failure to ensure funding to private clinics – the actual challenge was centred on the infringing legislation.

The judgment of the Court spoke specifically to state interference: it falls at the negative end of the rights spectrum. The Court wrote, "I am convinced that psychological stress is the almost inevitable result when the impugned legislation forces women to wait for an abortion funded by the Government at a hospital."[382] Further, the Court noted, "[t]his state-imposed stress suffered by

[379] Johnstone, "After Morgentaler", *supra* note 63 at 104.
[380] *Ibid* at 105.
[381] *Ibid.*
[382] *Jane Doe v Manitoba*, *supra* note 205 at 71.

women who must wait for an abortion is, in my opinion, serious in nature."[383] Focusing the decision specifically on the interfering legislation the Court wrote, "[i]n my view, there is no reason or logic behind the impugned legislation which prevents women from having access to therapeutic abortions in a timely way."[384] Finding causation of the violation specifically resulting from the state action, the Court found, "[i]n simple terms, delayed access for a woman wishing to have a safe, state-funded therapeutic abortion is the result of the impugned legislation."[385]

The judgment in *Jane Doe v Manitoba* is illustrative of the positive rights implications resulting from a negative rights claim as discussed in *Adams*. It too demonstrates the blurring of the dichotomy and how the implications of a negative rights judgment can slide further down the spectrum towards that of a claim on the positive end. Similar to *Adams* and *Chaoulli* the negative rights infringement is in part determined by the failures of the positive right; the public system or government service. The challenge, while framed as a negative rights claim and centred on state interference, is simultaneously rooted in the prohibition of funding the service, directly engaging socio-economic interests. The outcome of which, removing the funding barrier, requires the state to fund additional services. The judgment also arguably exemplifies how while there is overlap of the rights, there still remains a distinction. As noted, the judgment is steadfast in its focus on the legislative barrier interfering with ability to access an abortion without delay.

II. An Arbitrary Law in Violation of Security of the Person

While there are numerous barriers to abortion in the Maritime provinces, resulting in an extremely problematic access scheme, the regulations prohibiting provincial health insurance are

[383] *Ibid.*
[384] *Ibid* at 73.
[385] *Ibid* at 74.

arguably the most likely to be successfully challenged. This is because of Canadian courts historic approach to positive and negative rights claims, as discussed above. Insurance regulations can be framed as a negative rights infringement because the government regulation is interfering with access, as was the case in *Jane Doe v Manitoba*. In addition, as discussed above, prohibitions on insurance funding for clinic abortions exacerbate the other barriers of wait times, gestational limits, and physical access. This is because clinics provide more access points and more comprehensive service. They prevent bottle necking in the hospital system, simultaneously allowing wait times to drop. In addition, clinics themselves often have shorter wait times as they often only perform the specialized procedure, as opposed to hospitals which address numerous other health concerns. Further, clinics often offer a more supportive environment with more flexible gestational limits.

Allowing funded access to abortion clinics not only helps to address a number of the existing barriers in the Maritime provinces, it promotes equality in access. From a section 7 perspective, legislation which limits access to clinics contributes to additional travel, longer wait times, and lack of service providers, thus creating a framework which infringes on women's rights to life, liberty, and security of person. Without clinic access points, the public system is failing to offer comprehensive and accessible service, especially after the first trimester. Because of this, insurance barriers in New Brunswick, Nova Scotia, and PEI are quite clearly in violation of section 7 of *Charter*. This is not only supported by the lower court precedent in *Jane Doe v Manitoba*, but in the historical jurisprudence surrounding abortion in Canada, including the two Supreme Court *Morgentaler* judgments.

As discussed, section 7 of *Charter* guarantees the right to life, liberty, and security of the person and the right not to be deprived thereof except in accordance with the principles of

fundamental justice.[386] Any deprivation of the right must be in accordance with the principles of fundamental justice, as Dickson CJC describes it in *Morgentaler*, "the section states clearly that those interests may be impaired only if the principles of fundamental justice are respected."[387] Therefore an initial finding of a violation of one of the section 7 guarantees does not end the inquiry but triggers an examination of whether the deprivation has occurred in accordance with the principles. In *Morgentaler*, Dickson CJC noted that the unequal operation of the abortion law itself would not necessarily violate the principles of fundamental justice, but that the most serious problems with the functioning of the former Code scheme were created by the law itself.[388] Dickson CJC asserted, "one of the basic tenets of our system of criminal justice is that, when Parliament creates a defence to a criminal charge, the defence should not be illusory or so difficult to attain as to be practically illusory."[389] Further, Dickson CJC wrote, "Parliament must be given room to design an appropriate administrative and procedural structure for bringing into operation a particular defence to criminal liability."[390] But if that structure is "so manifestly unfair, having regard to the decisions it is called upon to make, as to violate the principles of *fundamental* justice," Dickson CJC continued, "that structure must be struck down."[391] In the present case, Dickson CJC wrote, "the structure – the system regulating access to therapeutic abortions – is manifestly unfair."[392]

The principles of fundamental justice include, among other protections, protections against arbitrariness, overbreadth, and gross disproportionality.[393] A deprivation of right will be

[386] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11 s 7 [*Charter*].
[387] *Morgentaler* 1988, s*upra* note 1 at 18.
[388] *Ibid* at 43,44.
[389] *Ibid* at 51.
[390] *Ibid* at 55.
[391] *Ibid.*
[392] *Ibid.*
[393] *R v Malmo-Levine,* 2003 SCC 74, [2003] 3 SCR 571 at 83 [*Malmo-Levine*].

considered to be arbitrary where it bears no connection to the law's purpose or objective.[394] A law is overbroad if it overreaches and captures conduct not intended to be included in the legislation.[395] Laws are grossly disproportionate when the effect of the legislation on the protected rights is so grossly disproportionate to its purposes it cannot be rationally supported.[396]

A section 7 analysis as outlined by the Supreme Court in *R v Malmo-Levine*,[397] looks first to whether there has been a deprivation of one of the three guarantees, and then second to whether the deprivation has occurred in accordance with the principles of fundamental justice.[398] The second stage of the analysis can occur in two parts. First, the court will identify the relevant principle of fundamental justice and then second, the court will determine whether the violation of the three guarantees occurred in accordance with the identified principle.[399]

III. Analysis: Is There a Breach of One of the Three Guarantees?

As discussed, Canadian jurisprudence on abortion shows a clear willingness on the part of the courts to engage section 7 protections of security of the person, regarding limitations and restrictions on accessing abortion.[400] Where funding of clinics is prohibited, women who cannot afford to pay for an abortion out-of-pocket are forced to access hospitals for service. The current public system in the Maritime provinces is failing. With limited hospitals performing the service this results in mandatory travel – at times interprovincially – delays in accessing service, as well as undergoing a more invasive procedure. Many of the barriers to accessing abortion existing today, which are exacerbated by or result from the prohibition on clinic funding in the Maritime

[394] *Ibid* at 135.
[395] *Bedford v Canada (Attorney General),* 2013 SCC 72, [2013] 3 SCR 1101 at 112.
[396] *Ibid* at 120.
[397] *Malmo-Levine,* supra note 393.
[398] *Ibid* at 83.
[399] *Ibid.*
[400] See *Morgentaler* 1988, *supra* note 1 see *Jane Doe v Manitoba*, *supra* note 205.

provinces, are the same or identical to those which were documented in the Badgley report in the 1970s,[401] barriers the Supreme Court in *Morgentaler* found to be in violation of section 7.

The engagement of section 7 in *Morgentaler* resulted not from the direct prohibition of abortion, but from the effects of the administrative barriers resulting in a problematic access scheme under the designated framework. In *Morgentaler,* Dickson CJC disagreed with the Crown's assertion that the barriers existing under the current scheme were the result of administrative issues, and therefore not a result of state interference. He wrote, "it is not possible to say that delay results only from administrative constraints, such as limited budgets or a lack of qualified persons to sit on therapeutic abortion committees."[402] Dickson CJC attributed the delays directly to the impugned legislation. He wrote, "[a]lthough the mandate given to the courts under the *Charter* does not, generally speaking, enable the judiciary to provide remedies for administrative inefficiencies, when denial of a right as basic as security of the person is infringed by the procedure and administrative structures created by the law itself, the courts are empowered to act."[403] Lastly, Dickson CJC wrote, "even if the purpose of legislation is unobjectionable, the administrative procedures *created by law* to bring that purpose into operation may produce unconstitutional effects, and the legislation should then be struck down."[404]

As asserted in the CCLA's statement of claim, the effect of the ban on clinic funding in New Brunswick forces numerous women to travel to access service. This means additional financial resources, days off work, and further hoops to jump through, also resulting in delays obtaining an abortion. Dickson CJC specifically discussed the effect of requiring women to travel

[401] Barriers documented in the Badgley Report still existing today include lengthy wait times, extra-billing or additional financial costs, delays in accessing service due to limitation in service providers and misinformation as discussed in Chapter 1.
[402] *Morgentaler* 1988, *supra* note 1 at 36.
[403] *Ibid.*
[404] *Ibid* [emphasis in original].

to access service. He wrote, "[i]f women were seeking anonymity outside their home town or were simply confronting the reality that it is often difficult to obtain medical services in rural areas, it might be appropriate to say "let them travel"."[405] However, Dickson CJC said in the situation at bar it was the law itself that forced women to travel and created additional burdens for women. He wrote, "the enormous emotional and financial burden placed upon women who must travel long distances from home to obtain an abortion is a burden created in many instances by Parliament."[406]

Delays in obtaining therapeutic abortions subjected women to both psychological and physical harm or risk of harm infringing a woman's right to security of the person a clear violation of section 7's protection of security of the person in *Morgentaler*. In addressing the delays caused by the previous framework discussed in *Morgentaler* Dickson CJC wrote, "the above physical interference caused by the delays created by s. 251, involving a clear risk of damage to the physical well-being of a woman, is sufficient, in my view, to warrant inquiring whether s. 251 comports with the principles of fundamental justice."[407] However, as discussed, Dickson CJC also found the delays caused harm to women's psychological integrity. He noted, delay in accessing abortion "greatly increases the stress levels of patients, and that this can lead to more physical complications associated with abortion."[408] For Dickson CJC, this was a further violation of section 7 resulting from the scheme. It would be unreasonable to argue that requiring women to travel long distances to a limited number of services providers would not incur a delay. The very obstacle of requiring women to complete an eight-hour round trip drive, in order to access service, with a support individual, would involve coordinating two persons with time off work, booking travel, accommodation etc. It is no insignificant barrier.

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[405] *Ibid* at 54.
[406] *Ibid* at 54.
[407] *Ibid* at 28.
[408] *Ibid* at 33.

Not only do insurance barriers result in travelling long distances and additional delays, they also limit access to the procedure in general. This is in part because as discussed earlier, private clinics cannot exist within the two-tiered system. In addition, as clinics perform abortions later in pregnancy, the ban on clinic funding essentially limits abortions to the first trimester.[409] This in effect forces some women to carry a foetus to term. Restricting access to clinic abortions means also fewer service providers, in effect limiting access to abortions. Simply put, with fewer service providers there are fewer procedures. As noted earlier, this is supported by what limited statistical information there is on the number of abortions performed in Canada. Provinces with fewest access points perform the lowest number of abortions on a per capita basis.[410] Further, as discussed, previous clinics in the Maritime provinces cited lack of provincial funding as the reason for their closures. All of these various restrictions in access have dramatic impacts on a woman's mental and physical wellbeing. Being forced to carry a foetus not only has immense physical and psychological implications on a woman, it has a large financial burden, pushing women who cannot afford the procedure further into poverty.

IV. Principles of Fundamental Justice

Arguably the most relevant principle for this argument is the principle of arbitrariness. The Supreme Court summarized the principle in *Rodriguez v British Columbia (Attorney General).* [411] Justice Sopinka, writing for the majority, stated, "where the deprivation of the right in question does little or nothing to enhance the state's interest (whatever it may be), it seems to me that a

[409] For example, the hospital access points in New Brunswick offer abortion up until 13 weeks of pregnancy whereas Clinic 554 offered abortion up until 16 weeks. Throughout the rest of the country later term abortions are more commonly offered at clinics as opposed to hospitals. See ARCC List of Clinics, *supra* note 142.
[410] As evident based on the statistics previously discussed in Chapter 2.
[411] *Rodriguez v British Columbia (Attorney General),* [1993] 3 SCR 519, [1993] 7 WWR 641.

breach of fundamental justice will be made out, as the individual's rights will have been deprived for no valid purpose."[412] Continuing on with the discussion Sopinka J noted, "it follows that before one can determine that a statutory provision is contrary to fundamental justice, the relationship between the provision and the state interest must be considered."[413] Neither New Brunswick's *Medical Services Payment Act*, nor PEI's *Health Services Payment Act*, contain objective or purpose sections outlining the intent of the legislation. In addition, since minimal information is published on abortion online from Maritime government resources it makes it difficult to ascertain why the government has chosen to ban clinic funding and what purpose it serves.

Governments have historically claimed three governmental objectives in restricting access to clinic abortions. The first is restricting abortions for health and safety purposes. The second is regulating the allocation of government resources for health funding. The third is the importance of maintaining a public health care system and preventing the emergence of private clinics. Both the second and the third objectives were read into PEI's *Health Services Payment Act* in *Morgentaler v Prince Edward Island.* The PEI Court of Appeal interpreted the purpose of the *Heath Service Payment Act* to be, "to mandate the Agency to develop, operate, and administer a publicly funded health care insurance scheme for residents of the Province."[414] Joanna Erdman notes this has been the predominant response to cries for abortion funding. She writes, political responses have been, "voiced in the sustainability of Medicare and the need to ration public health care dollars."[415]

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[412] *Ibid* at 32.
[413] *Ibid.*
[414] *Morgentaler v Prince Edward Island (Minister of Health & Social Services),* 139 DLR (4th) 603, 144 Nfld & PEIR 263 at 5.
[415] Erdman, "Constitutionalizing Abortion", *supra* note 24 at 248.

Returning to the first historical objective – that abortions should be restricted to hospitals for health reasons[416] – governments have argued that hospitals are better equipped to deal with complications, and therefore more likely to protect the health and well-being of the mother.[417] Sanda Rogers maintains that these objectives are not the honest motivation for abortion funding restrictions. She writes, "while access to some health care is rationed for reasons of cost or therapeutic appropriateness, abortion is denied for reasons of inappropriate political expediency or provider morality."[418] Emmet Macfarlane also finds no valid reason for limiting abortions to a hospital setting. He writes, there is "no medical evidence as to why cost, complexity of procedure, or availability of expertise would justify limiting abortion services compared to similar procedures."[419] In addition, arguably the ban on clinic funding in reality subjects women to increased health risks. As discussed, forcing women to obtain abortions in hospital requires them to experience increased wait times or travel for service. The health risks of forcing women to experience delays in obtaining an abortion was well-documented in *Morgentaler*.

Regarding the second objective of allocating scarce health resources, Johnstone would likely find the means to be futile. Johnstone says there does not appear to be a valid reason for denying funding of abortion, viewing it as a fundamental health service. Johnstone writes, "abortions are safe, inexpensive, and require minimal physician training. In this respect, the suggestion that abortion should be treated as a core, medically necessary service is uncontroversial."[420] In addition, withholding funds for the service subjects the provinces to the mandatory deductions for extra-billing under the *CHA.* If the provinces refuse to fund clinics they

[416] This was stated as the objective of the in-hospital requirement under the former *Criminal Code* scheme in *R v Morgentaler*. See *Morgentaler 1988, supra* note 1 at 162.
[417] See *Morgentaler 1988, supra* note 1 at 153 and see also *Morgentaler 1993, supra* note 92 at 71.
[418] Rogers, *supra* note 197 at 118.
[419] Macfarlane, "Addressing a Dilemma", *supra* note 44 at 163.
[420] Johnstone, "After Morgentaler", *supra* note 63 at 112.

can still be charged the dollar-for-dollar amount of the procedures making it an equal cost for their health care resources.

Regarding the third objective of protecting the public system, the legislation likely hinders that objective. Insurance barriers to private clinics force them to operate within a private market on a fee-for-service bases. This in effect creates a two-tiered health care system effectively splintering the public system and setting a harmful precedent. Further, this is not the first time a government policy objective for legislating restrictions on abortion access was hindered by the legislation itself. In his Oakes assessment in *Morgentaler*, Chief Justice Dickson noted the former *Code* provisions were counterproductive to the objectives of the legislation. He wrote, "to the extent that s. 251(4) is designed to protect the life and health of women, the procedures it establishes may actually defeat that objective."[421]

Erdman notes the concern of a possible conflict between a *Charter*-based argument regarding access to abortion and promoting a public health care system. She writes, historically "some feminist groups shared this concern, questioning whether *Charter* litigation on abortion funding was a good idea, or whether it would lead to greater privatization in the system."[422] Karl Guebert speaks to this challenge broadly. He writes, "perhaps the most significant threat to Canada's single-tier public healthcare system as it currently exists does not come from conservative or libertarian politicians or governments; it comes from Canadians themselves. More specifically, the threat derives from Canadians seeking a right to healthcare.'[423] However, prohibiting funding of free-standing abortion clinics forces them into the private market. It

[421] *Morgentaler 1988, supra* note 1 at 61.
[422] Erdman, "Constitutionalizing Abortion", *supra* note 24 at 248.
[423] Karl Guebert, "Towards a Post-Social Right to Life, Liberty and Security of the Person Through Markets? Conceptions of Citizenship and the Implications for Health Law as Governance" (2019) 29:5 Soc & Leg Stud 609 at 610.

effectively creates a two-tiered health care system and private market for abortion. When the private clinics are in operation, this means that women who can afford to pay for private clinics can access abortion in a timely manner and at later stages of pregnancy. Those who cannot afford to pay are forced to travel long distances, carrying the foetus for longer which endangers the pregnant woman's physical as well as mental health and wellbeing. However, past experience in the Maritime provinces shows that the two-tiered system within the provinces is unsustainable. Historically, private clinics have been unable to operate without public funding, effectively forcing women to access abortions through the limited existing hospital service providers. If abortion clinics were publicly funded it would prevent splintering of abortion healthcare or further restricting Canada's access framework. In addition, funding clinics also ensures compliance with the principles of the *CHA* and promoting public health care.

In both Supreme Court *Morgentaler* decisions, the Court asserted that there is no valid reason for abortions to be performed only in hospital. In his concurring decision in *Morgentaler,* Justice Beetz found there was no medical justification for the in-hospital requirement of the former *Criminal Code* sections. Noting the objective of the law was to protect the health of women and prevent complications, Beetz J wrote, "the requirement that all therapeutic abortions be performed in eligible hospitals is unnecessary to meet that objective in all cases."[424] Finding the requirement served no real purpose, Beetz J asserted, "in this sense, the rule is manifestly unfair and offends the principles of fundamental justice."[425] Justice Sopinka affirmed this, writing for a unanimous Supreme Court in the 1993 *R v Morgentaler*. In the judgment, Sopinka J found the there was no evidence on the record as to why abortions performed in clinics would pose a greater threat to women's health. He wrote, "women may not wish to have an abortion in a hospital for any number

[424] *Morgentaler 1988, supra* note 1 at 162
[425] *Ibid* at 162.

of legitimate reasons."[426] Sopinka J specifically attributed the in-hospital requirement to the demise of the former sections of the *Criminal Code*. In addition, he wrote, "one of the effects of the legislation is consolidation of abortions in the hands of the provincial government, largely in one provincially-controlled institution. This renders free access to abortion vulnerable to administrative erosion."[427]

Macfarlane says examining the history of abortion regulation, the motives are often more ingenuine and less likely to survive *Charter* scrutiny. Macfarlane writes, "the history of provincial laws or regulations relating to abortion in the post-*Morgentaler* context strongly suggests little more than moral-based considerations on the part of governments refusing to provide full access."[428] Johnstone agrees and says the motivation appears to be more political. "It is evident that these roadblocks are not motivated by a desire to create improved health care for women," she writes, "but to block access to what is portrayed as an immoral and undesirable procedure."[429]

Information from the CCLA's statement of claim supports this perspective. According to the statement of claim, New Brunswick's health insurance plan provides coverage for out-of-hospital reproductive services, including vasectomies.[430] In addition, arguably the acts of the various provincial governments in response to funding claw backs demonstrate a hidden intent. If health care funding is the guiding concern for restricting abortion access to hospitals, then why are provincial governments unmoved by funding claw backs? It would be naïve to consider funding the dominant motive when provinces like Nova Scotia and New Brunswick have historically been unconcerned by threats of dollar-for-dollar deductions under the *CHA.*

[426] *Morgentaler 1993, supra* note 92 at 84.
[427] *Ibid.*
[428] Macfarlane, "Addressing a Dilemma", *supra* note 44 at 163.
[429] Johnstone, "Abortion in New Brunswick", *supra* note 59 at 83.
[430] *CCLA v New Brunswick, supra* note 129 at 6.

Historically the courts have recognized that hidden objectives prohibiting abortion for morality purposes are often at play behind restricting abortion access. In the 1993 *Morgentaler* judgment Sopinka J noted, "the primary objective of the legislation was to prohibit abortions outside hospitals as socially undesirable conduct, and any concern with the safety and security of pregnant women or with health care policy, hospitals or the regulation of the medical profession was merely ancillary." Further, Sopinka J noted, "this legislation involves the regulation of the place where an abortion may be obtained, not from the viewpoint of health care policy, but from the viewpoint of public wrongs or crimes."[431] As discussed, the Manitoba provincial court in *Jane Doe* found similar objectives in the case at bar. Finding the real objective was preventing Dr. Morgentaler or any other person from operating a free-standing clinic in Manitoba. The court wrote, "that objective can hardly be said to be of sufficient importance to override constitutionally protected rights such as the right to freedom of conscience, the right to liberty and security of the person or the right to equality."[432]

The complete lack of transparency regarding abortion services and regulation throughout the Maritime provinces but especially in Nova Scotia lends itself to this argument. Erdman speaks on the issue, asserting it is inconsistent with the rule of law. She writes, "as a rule of law principle, transparency speaks to the importance of law being known."[433] She continues, "where the basis for government action, let alone the action itself, is unknown, people cannot know where they stand in relation to the state and its exercise of power."[434] Further, Erdman continues, "one of the

[431] *Morgentaler 1993, supra* note 92 at 82.
[432] *Jane Doe v Manitoba*, *supra* note 205 at 83.
[433] Erdman, "Future of Abortion", *supra* note 72 at 733.
[434] *Ibid.*

first requirements of the rule of law is thus an obligation on government to be explicit in its exercises of public power."[435]

The prohibition on clinic funding in the Maritime provinces forces women who cannot afford to pay for the service out-of-pocket to experience delays in the public system. Canadian jurisprudence in *Chaoulli*, *Jane Doe,* and *Adams*, supports the argument that where legislation interferes with an individual's ability to pursue an alternative course of action which would enable their security of the person and there is no effective alternative in the public system, it constitutes a violation of the *Charter* right. Prohibitions on clinic funding are arbitrary. It is clearly established by the case law that there is no reason to limit abortions to the hospital setting. Further in that the objective is the promotion of a public health care system, concerns for safety and health of the woman, and the scarce allocation of government resources, the legislation actually hinders those objectives. Abortion is restricted for political and moral reasons, bearing no rational connection to the law's objective or purpose. Because of this, the violation cannot be considered in accordance with the principles of fundamental justice.

V. Oakes Test

Charter violations, once found, can be saved under section 1, which guarantees the rights of the *Charter* within a reasonable limit.[436] In assessing if a violation can be saved under section 1, courts apply the framework outlined in *R v Oakes*,[437] more commonly referred to as the Oakes test. The Oakes test is a two-part analysis which at the first stage examines whether there is a pressing and substantial government objective.[438] At the second stage, the government must

[435] *Ibid.*
[436] *Charter*, supra note 386 at s 1.
[437] *Oakes, supra* note 40.
[438] *Ibid* at 73.

demonstrate, “the means chosen are reasonable and demonstrably justified.”[439] The second stage of the analysis is a proportionality inquiry which considers three factors. The first consideration is that the means must be rationally connected to the objective. They must not be, “arbitrary, unfair or based on irrational considerations.”[440] The second consideration is whether the infringement is minimally impairing. Meaning that, even if the means are rationally connected, they must impede on the right as little as possible. [441] The last consideration is a weighing of the above factors. In order to pass the Oakes test, as stated in *R v Oakes*, there must be a proportionality between the *effects* of the measures which are responsible for limiting the Charter right or freedom and the objective which has been identified as of "sufficient importance.”[442]

Notably, former Chief Justice Lamer in his majority judgment in *New Brunswick (Minister of Health and Community Services) v G (J),*[443] asserted section 7 violations are not easily saved by section 1. Quoting his own judgment in *Re BC Motor Vehicles Act*, Lamer CJC wrote, “Section 1 may, for reasons of administrative expediency, successfully come to the rescue of an otherwise violation of s. 7, but only in cases arising out of exceptional conditions, such as natural disasters, the outbreak of war, epidemics, and the like.”[444] Lamer CJC explained this is for two reasons. First, the rights protected under section 7 are, “very significant and cannot ordinarily be overridden by competing social interests.”[445] Second, “rarely will a violation of the principles of fundamental

[439] *Ibid at* 74.
[440] *Ibid.*
[441] *Ibid.*
[442] *Ibid* [emphasis in original].
[443] *New Brunswick (Minister of Health and Community Services) v G (J)*, [1999] 3 SCR 46
[444] *Ibid* at 99.
[445] *Ibid.*

justice, specifically the right to a fair hearing, be upheld as a reasonable limit demonstrably justified in a free and democratic society."[446]

It is unlikely the current prohibitions on insurance funding would survive an *Oakes* test. At the first stage, it is hard to discern whether there is a pressing and substantial government objective. As discussed, there is little published and known about the government objectives and, many question the integrity of reported objectives including rationing health care funding, preventing privatization, and protecting women's health. There is sustained criticism of provincial regulation of abortion, attributing the motives for doing so to religious and moral purposes. If the objective is unknown or falsely presented, then it cannot be considered to be a valid, pressing, and substantial government objective. Further, even if the objectives are pressing and substantial, the regulations would fail the second stage of the *Oakes* Test.

As discussed earlier in regard to the principles of fundamental justice, the legislation is arbitrary and not rationally connected, in that it does not serve the assumed objective. To the extent that the objective is to promote women's health and wellbeing, promote a public health care system, and/or ration health care spending, the effect of the clinic funding regulations is to impede those objectives. In addition, clinic funding regulations are not minimally impairing. The legislation, in effect, forces women to carry a foetus for longer by limiting access to abortion services. The Supreme Court has stated that the mental and physical implications of this are potentially devastating.[447] The risks to women's health far outweigh the objectives of the legislation, especially in that the objectives are often ingenuine and not effectively served by the legislation. The importance of maintaining access to abortion cannot be overlooked. It not only

[446] *Ibid.*
[447] *R v Morgentaler*, [1988] 1 SCR 30, 82 NR 1 at 30.

influences the physical and psychological health of Canadian women but touches on women's role within society as a whole. Erdman describes this succinctly: "Abortion rights mediate the relationship between women and the state, and thereby shape the use of its power for women's security, equality, and freedom in the public interest."[448]

CONCLUSION

Although the 1988 *Morgentaler* judgment struck down the criminal prohibition it far from ensured a right to, or comprehensive access to, abortion in Canada. The judgment led to a jurisdictional movement of abortion, from the federal government's authority over criminal law to provincial jurisdiction over health care. The transition then brought new challenges for abortion rights advocates. Following decriminalization, a strong anti-abortion public sentiment in the Maritime provinces lead to provincial attempts to restrict access to service. The provinces sought to achieve this goal by enacting provincial regulations prohibiting doctors from performing abortions outside of hospitals and prohibiting insurance funding of abortions performed in clinics or outside of a designated scheme. While clinic abortions are no longer prohibited under provincial regulations, barriers to insurance funding of clinic abortions still remain in all three Maritime provinces. Funding for clinic abortions is still prohibited under New Brunswick's, *Regulation 84-20* and PEI's regulations under the *Health Services Payment Act.* As previously discussed, the funding arrangements for clinic abortions in Nova Scotia are unclear and there is currently no abortion clinic in the province. However, it is likely that if a clinic were to open it would go either fully or partially unfunded, similar to the previous Morgentaler clinic.

[448] Erdman, "Constitutionalizing Abortion" *supra* note 24 at 258.

Contemporary scholarship on the issue has predominantly focused on seeking to ensure guaranteed access to abortion as a positive right or has examined the issue through the lens of Canadian health law, arguing the failure to ensure comprehensive service is in violation of the *Canada Health Act.* However as discussed, the remedies available under the *CHA* have proven ineffectual and, in the past, have been seldom utilized. Human rights jurisprudence demonstrates an unwillingness on the part of Canadian courts to find positive rights violations. This is in part due to courts deference to the legislature on government programming or as some argue, out of fear of the economic ramifications of such a judgment and the potential to disrupt the status quo. While political and legal activism has increased access in the Maritime provinces, insurance barriers to accessing abortion still remain. Both Supreme Court *Morgentaler* judgments and the decision from the provincial court in *Jane Doe* are promising precedents for challenging insurance barriers in the Maritime provinces through a negative rights legal challenge.

While the negative rights approach has been criticized, there are arguably inherent strengths in continuing to challenge barriers to abortion access through negative rights, including that there is greater likelihood of success. Historically, Canadian courts are more likely to engage section 7 on socio-economic issues when framed as a negative rights claim. Further, although this thesis advocates for specifically challenging health insurance regulations, prohibitions on clinic funding exacerbate all of the other discussed barriers. Allowing for clinic funding would help to ensure a more comprehensive, timely, and accessible framework for abortion access in the Maritime provinces. In addition, the dichotomy between positive and negative rights is questionable. While the challenge to insurance prohibitions can be framed from a negative perspective, a favourable judgment has positive rights implications, specifically, provincial funding for abortion services.

Although the negative rights challenge can prevent insurance barriers to abortion, it is still dependent on service providers opening clinics in the Maritime provinces. Insurance barriers are also only one of numerous barriers to accessing abortion in the provinces. However, as discussed, insurance barriers exacerbate all other barriers. Further, evidence from other provinces demonstrates that provinces with more comprehensive health insurance funding, have larger and more accessible access frameworks. Whereas in contrast, historically, clinics have been unable to maintain service in provinces which deny insurance funding. This effectively forces women to either access service through the hospital system or travel outside of their home province for service.

Prohibitions on insurance funding can be challenged through a negative rights challenge where there is legislative interference. This is because the legislation actively infringes on a woman's right to security of person. Restrictions on clinic funding disincentivizes the operation of abortion clinics or effectively force existing clinics to close, restricting access to service providers. In effect, this causes women to travel great distances and incur longer waits in accessing service. Further, as clinics help to ensure comprehensive access to service after the first trimester, limitations on clinic funding also restrict abortions to the first trimester. Barriers, almost identical to the current impediments existing in the Maritime provinces, were considered by the court in *Morgentaler (1998),* to infringe the *Charter*'s section 7 guarantee of security of the person.

Although abortion is no longer criminalized, as discussed, the insurance prohibitions have a similar effect to the former criminal prohibitions in that they force women to incur longer waits or travel to access service. Judgments such as *Chaoulli* demonstrate the Supreme Court is willing to apply the protections of section 7 to state action that falls outside of the criminal law context, but still interferes with life, liberty, or security of the person. Further, the lower Manitoba court in

Jane Doe found the health insurance prohibitions which formerly existed in that province to be in violation of section 7. In addition, these barriers cannot be considered to be in accordance with the principles of fundamental justice or to be saved under the *Charter*'s reasonable limit provision. The barriers are arbitrary as they, not only do not support the purported government objectives, they actively hinder progress towards those goals. Abortion clinic funding barriers not only promote an unsustainable two-tiered or privatized health care system, they cost the provinces in *CHA* funding claw backs and most pertinently, they endanger the life of the pregnant woman. Barriers existing today in the Maritime provinces bear a striking resemblance to those documented in the 1977 Badgley Report. While abortion is no longer criminalized, provincial attempts to restrict access to service by way of health insurance regulations remain in violation of the *Charter*.

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