Fighting for Abortion Access in Canada: A Constitutional Analysis

Jordana Borzellino*

* Juris Doctor (2024), Osgoode Hall Law School. I gratefully acknowledge the help of Dr. Emily Kidd White, Professor at Osgoode Hall Law School, for her unwavering encouragement, unparalleled knowledge, and the overall supervision of this paper. All errors are my own responsibility.

ABSTRACT

Access to abortion is a controversial matter that creates a labyrinth of polarizing issues. Perspectives on abortion range from anathema to overzealous support, with stakeholders occasionally resorting to legal avenues to control access one way or another. This paper will explore the possibility of protecting and expanding access to abortion through constitutional mechanisms in the Canadian legal landscape. By analyzing Canada's current degree of access, this paper will explain that abortion services for those in need are inadequate. In order to advocate for greater access, this paper examines a multitude of legal tools and doctrines to constitutionally protect access to abortion care in Canada. These tools include recognizing positive rights under sections 7 and 15(1) of the *Canadian Charter of Rights and Freedoms*, protection under the national concern doctrine, and other conventional *Charter* challenges. However, this paper will ultimately suggest that legal protection is not the most effective strategy. Overall, political and social avenues, rather than legal ones, are more productive paths that can create lasting change in advocating for greater access to abortion.

Citation: (2024) 33 Dal Leg Stud 43

Introduction

Access to abortion is a controversial matter that creates a labyrinth of polarizing issues. Perspectives on abortion range from anathema to overzealous support, with stakeholders occasionally resorting to legal avenues to control access one way or another. This paper will explore the possibility of protecting and expanding access to abortion through constitutional mechanisms in the Canadian legal landscape. By analyzing Canada's current degree of access, this paper will explain that abortion services for those in need are inadequate. In order to advocate for greater access, this paper examines a multitude of legal tools and doctrines to constitutionally protect access to abortion care in Canada. However, this paper will ultimately suggest that legal protection is not the most effective strategy. Overall, political and social avenues, rather than legal ones, are more productive paths that can create lasting change in advocating for greater access to abortion.

Part I of this paper describes the history of regulating access to abortion in Canada, outlining how abortion moved from criminalization to deregulation. Part II tracks the current state of the law pertaining to abortion, thus discussing the relevant government bodies responsible for overseeing access. Part III examines the relevant barriers to accessing abortion, which suggests that current resources do not provide adequate access for Canadians seeking abortion services. At a high level, Part III identifies a problem that Part IV of this paper evaluates. With that, Part IV of this paper delves into three legal mechanisms that argue for protected and expanded access to abortion in Canada. Firstly, arguing for a positive right to access abortion under sections 7 and 15(1) of the *Canadian Charter of Rights and Freedoms* is the least likely solution, but would offer the greatest amount of protection for abortion access in Canada.[1] Secondly, arguing under the national concern doctrine can create a centralized approach to protecting access to abortion, but it is unlikely to result in a successful argument before the courts. Thirdly, by taking a narrower approach and challenging specific provincial laws that pertain to accessing abortion, there is potential to root a claim based on a *Charter* infringement under sections 7 and 15(1). Although the third argument is the most conventional, it is an avenue that produces an uncertain result. Overall, by engaging with a thorough constitutional analysis, it is evident that legal routes are not the most efficacious option when advocating for greater access to abortion.

i. HISTORY OF ABORTION ACCESS IN CANADA

[1] See generally *Canadian Charter of Rights and Freedoms*, Part 1 of the *Constitution Act*, 1982, being Schedule B to the Canada Act 1982 (UK), 1982, c 11 [*Charter*].

1. Early History (Pre-1988)

Historically, British law greatly influenced Canada's laws regulating abortion.[2] Before Confederation, the British legal landscape demonstrated an outright prohibition on abortion without exception.[3] In Britain, the *Offences Against the Person Act 1861* prohibited abortion at all stages of pregnancy and by all methods, with the maximum penalty being life imprisonment for women and physicians.[4] The rationale behind this harsh penalty was moral, as lawmakers viewed abortion as "destroying human life."[5] After obtaining independence from Britain through the *Constitution Act, 1867*,[6] Canada inherited the *Offences Against the Person Act 1861*.[7] The same stringent provisions criminalizing abortion were adopted into Canada's *Criminal Code* and remained unchanged until 1969.[8]

In 1939, however, the British case *R v Bourne* created some relief for women and healthcare providers in obtaining abortion services.[9] In *Bourne*, an obstetrician was charged under the *Offences to the Person Act 1861* for performing an abortion on a 14-year-old girl who was the victim of gang rape.[10] The accused raised the defence of medical necessity, arguing that the abortion was necessary to prevent the victim from mental anguish.[11] Lauded by the medical community at the time, *Bourne* suggests "that abortion could be permissible if a woman's health, including her mental health, was

---

[2] See Rachael Johnstone, *After Morgentaler: The Politics of Abortion in Canada* (Vancouver: UBC Press, 2017) at 54.

[3] See *ibid.*

[4] See *Offences Against the Person Act 1861* (UK), 24 & 25 Vict, c 100; *ibid.* For further history on the *Offences Against the Person Act 1861*, see Shelley Gavigan, "The Criminal Sanction as it Relates to Human Reproduction: The Genesis of the Statutory Prohibition of Abortion" (1984) 5:1 J Leg Hist 20.

[5] Johnstone, *supra* note 2, citing John Keown, *Abortion, Doctors and the Law: Some Aspects of the Legal Regulation of Abortion in England from 1803 to 1982* (Cambridge: Cambridge University Press, 1988) at 18–19.

[6] See generally *Constitution Act, 1867* (UK), 30 & 31 Vict, c 3 [*Constitution Act*].

[7] See Johnstone, *supra* note 2 at 55; Donald L Beschle, "Judicial Review and Abortion in Canada: Lessons for the United States in the Wake of *Webster v. Reproductive Health Services*" (1990) 61:3 U Colo L Rev 537 at 547.

[8] See *ibid.* See generally *Criminal Code*, RSC 1985, c C-46.

[9] See *R v Bourne*, [1939] 1 KB 687, [1938] 3 All ER 615 [*Bourne*]; Johnstone, *supra* note 2 at 55–56.

[10] See Gavigan, *supra* note 5 at 36.

[11] See *Bourne*, *supra* note 10 at 694.

compromised."[12] Despite the sensible precedent, the *Bourne* decision did not make much of an impact on Canadian doctors because of the significant sanctions, including the risk of life imprisonment.[13] Thus, Canadian doctors maintained the status quo for another 30 years.[14]

In 1969, Canadian Prime Minister Pierre Trudeau made significant changes to abortion legislation through the federal government's criminal law power.[15] In an effort to offer protections and legal clarity to physicians, the Trudeau administration amended the *Criminal Code* to create more forgiving abortion legislation.[16] The amended legislation authorized abortions only when they were "performed in an accredited or approved hospital and approved by a three-physician therapeutic abortion committee (TAC) from that hospital as necessary to protect the woman's life or health."[17] The Trudeau administration's amendment aligns with the *Bourne* decision, as it essentially codifies an extra layer of protection for medical professionals that deem an abortion necessary to a woman's health. The amendment was found in section 251 of the *Criminal Code*:

> **251 (1)** Every one who, with intent to procure the miscarriage of a female person, whether or not she is pregnant, uses any means for the purpose of carrying out his intention is guilty of an indictable offence and is liable to imprisonment for life.
>
> **(2)** Every female person who, being pregnant, with intent to procure her own miscarriage, uses any means or permits any means to be used for the purpose of carrying out her intention is guilty of an indictable offence and is liable to imprisonment for two years.[18]

In essence, section 251 provides a process by which a woman could apply to a TAC and a majority of three or more doctors would determine if the abortion was

---

[12] Johnstone, *supra* note 3 at 55–56, citing Jane Jenson, "The Politics of Abortion" in Janine Brodie, Shelley AM Gavigan & Jane Jenson, eds, *The Politics of Abortion* (Toronto: Oxford University Press, 1992) 15 at 24.

[13] See Johnstone, *supra* note 3 at 56, citing Melissa Haussman, "Of Rights and Power: Canada's Federal Abortion Policy 1969–1991" in Dorothy McBride Stetson, ed, *Abortion Politics, Women's Movements, and the Democratic State: A Comparative Study of State Feminism* (New York: Oxford University Press, 2001) 63 at 66.

[14] See Johnstone, *supra* note 3 at 56.

[15] See *ibid.*

[16] See *ibid.*

[17] Alister Browne & Bill Sullivan, "Abortion in Canada" (2005) 14:3 Cambridge Q Healthcare Ethics 287 at 287.

[18] *Criminal Code*, RSC 1970, c C-34, s 251 as repealed by *Criminal Code*, RSC 1985, c C-46.

necessary to that woman's life or health.[19] If the TAC determined that the woman's application was worthy of obtaining an abortion, it would issue a certificate to the woman's doctor and thus permit a legal abortion.[20]

Unsurprisingly, the Trudeau administration's amendment did not come without its perils. Section 251 created problems of access, discrimination, and unpredictability that burdened women's reproductive futures.[21] Firstly, the availability of TACs were significantly disproportionate, as only 20% of hospitals in Canada established these committees.[22] Secondly, TAC decisions were highly discretionary and subject to the biases of the panel members, creating inequities for women across Canada.[23] For example, some TACs explicitly required permission from ex-husbands or fathers (to whom the woman was not married) to provide consent for the abortion.[24] The unpredictability and bureaucracy of the TAC process led to its ultimate undoing. An onslaught of legal challenges forced the government, courts, and Canadian society to rethink the criminalization of abortion.[25]

2. The Morgentaler Effect: *R v Morgentaler*

i. Background: Dr. Henry Morgentaler

For many Canadians, the personification of pro-choice abortion advocacy is Dr. Henry Morgentaler. After graduating from the Université de Montréal with his Doctor of Medicine, Dr. Morgentaler started his practice in Montréal, which catalyzed his monumental fight against anti-abortion government intervention.[26] After being forced to turn away women seeking abortions because of the strict prohibitions under

---

[19] See *ibid*; Beschle, *supra* note 8; Moira McConnell, "Abortion and Human Rights: An Important Canadian Decision" (1989) 38:4 ICLQ 905 at 906.
[20] McConnell, *supra* note 20.
[21] See generally Judy Rebick, *Ten Thousand Roses: The Making of a Feminist Revolution* (Toronto: Penguin Canada, 2005) at 157; Shelley AM Gavigan, "*Morgentaler* and Beyond: Abortion, Reproduction, and the Courts" in Janine Brodie, Shelley AM Gavigan & Jane Jenson, eds, *The Politics of Abortion* (Toronto: Oxford University Press, 1992) 117 at 134; Johnstone, *supra* note 3 at 56; Beschle, *supra* note 8 at 548.
[22] See Johnstone, *supra* note 3 at 56. For further discussion, see McConnell, *supra* note 20.
[23] See Rebick, *supra* note 22 at 157; Johnstone, *supra* note 3 at 56.
[24] See Gavigan, *supra* note 22 at 548; Johnstone, *supra* note 3 at 56.
[25] See Johnstone, *supra* note 3 at 57; Beschle, *supra* note 9 at 548.
[26] See Johnstone, *supra* note 3 at 57; Mathieu-Robert Sauvé, "Henry Morgentaler, Feminist Doctor" (29 October 2021), online (blog): <nouvelles.umontreal.ca/en/article/2021/10/29/henry-morgentaler-feminist-doctor/> [perma.cc/B7UJ-PPM4].

the *Criminal Code*, Dr. Morgentaler felt it was against his duty as a medical professional to stand by as women attempt to self-abort and potentially cause irreparable damage.[27] This led Dr. Morgentaler to close his family practice and open an abortion clinic in Montréal by 1968.[28]

Dr. Morgentaler operated his abortion clinic in defiance of the *Criminal Code* outwardly and boldly. Dr. Morgentaler's persistent civil disobedience led to police raids of his clinic and his arrest.[29] After many attempts to prosecute Dr. Morgentaler, the Quebec government vowed to no longer take legal action against Dr. Morgentaler.[30] This decision directly resulted from a "changing social climate" in broader society, as two separate juries refused to convict Dr. Morgentaler, despite the overwhelming evidence against him.[31]

Dr. Morgentaler sought to expand his advocacy to Toronto, opening an abortion clinic alongside two colleagues.[32] In 1983, the police raided the Toronto clinic and charged the doctors.[33] The three defendants used the defence of necessity and the Toronto jury found them not guilty.[34] The decision was appealed to the Ontario Court of Appeal and was reversed, thus leading to a retrial.[35] The three doctors appealed to the Supreme Court of Canada, leading to the seminal decision decriminalizing abortion.[36]

ii. R v Morgentaler (1998)

The facts of this case follow the same disobedient and insouciant cadence as Dr. Morgentaler's previous behaviours. In operating the Toronto-based abortion clinic,

---

[27] See Johnstone, *supra* note 3 at 57.
[28] See *ibid.*
[29] In 1970, the police raided Dr. Morgentaler's Montréal clinic and subsequently arrested him. The charges were eventually dropped because of a misused search warrant. In 1973, police raided Dr. Morgentaler's clinic and arrested him again. See *ibid* at 57–58.
[30] See *ibid* at 59–60.
[31] *Ibid* at 58; *R v Morgentaler* (1973), 42 DLR (3d) 448, 1973 CanLII 1282 (QC CS).
[32] See Johnstone, *supra* note 3 at 61.
[33] See *ibid.*
[34] See *ibid*; *Regina v Morgentaler, Smoling and Scott* (1984), 12 DLR (4th) 502, 1984 CanLII 2051 (ON SC).
[35] See Johnstone, *supra* note 3 at 61; *Regina v Morgentaler, Smoling and Scott* (1985), 22 DLR (4th) 641, 1985 CanLII 116 (ON CA).
[36] See Johnstone, *supra* note 3 at 61; *R v Morgentaler*, [1988] 1 SCR 30, 1988 CanLII 90 (SCC) [*Morgentaler*].

Dr. Morgentaler and his two colleagues offered abortion services in contravention of section 251 of the *Criminal Code*.[37] What makes this fact scenario profoundly different from previous cases was the adoption of the *Charter* in 1982,[38] which "guaranteed extensive individual rights to Canadian citizens."[39] As Chief Justice Dickson suggests, the core difference in the 1988 *Morgentaler* appeal is that "Canadian courts are now charged with the crucial obligation of ensuring that the legislative initiatives pursued by our Parliament and legislatures conform to the democratic values expressed in the [*Charter*]."[40]

Overall, the appellants successfully claimed that section 251 of the *Criminal Code* infringed section 7 of the *Charter*, thus rendering it unconstitutional and of no force and effect.[41] In a 5-2 judgement, the majority drafted three separate decisions with slightly differing rationales.[42]

Writing for the majority, Chief Justice Dickson, with the signature of Justice Lamer, wrote a narrow and cautious judgement, ensuring that the interpretation of section 7 did not extend beyond the facts presented in the case.[43] The Chief Justice focuses solely on security of the person in his analysis, recognizing that "[t]he law has long recognized that the human body ought to be protected from interference by others."[44] Further, the Chief Justice finds that "state interference with bodily integrity and serious state-imposed psychological stress…constitute a breach of security of the person."[45] In supporting this assertion and applying it to the case, Chief Justice Dickson further elaborates:

> At the most basic, physical and emotional level, every pregnant woman is told by the section that she cannot submit to a generally safe medical procedure that might be of clear benefit to her unless she meets criteria entirely unrelated to her own priorities and aspirations. Not only does the removal of decision-making power threaten women in a physical sense; the indecision of knowing whether an abortion will be granted inflicts emotional stress. Section 251 clearly interferes with a woman's bodily integrity in both a physical and emotional sense. Forcing a woman, by threat

[37] See *Morgentaler*, *supra* note 36 at 50; *Criminal Code*, *supra* note 19, s 251.
[38] See generally *Charter*, *supra* note 2.
[39] Johnstone, *supra* note 3 at 61.
[40] *Morgentaler*, *supra* note 37 at 46.
[41] See *ibid* at 50–51.
[42] See generally *ibid*.
[43] See *ibid* at 51.
[44] *Ibid* at 53.
[45] *Ibid* at 56.

> of criminal sanction, to carry a foetus to term unless she meets certain criteria unrelated to her own priorities and aspirations, is a profound interference with a woman's body and thus a violation of security of the person.[46]

Another significant issue the Court cites is the lengthy delays before a woman can see a physician, which was purportedly about eight weeks.[47] The delays in receiving adequate medical care and the concomitant uncertainty of the TAC process created compounded stress that led to more physical complications.[48] The Chief Justice finds that "[section] 251 is a law which forces women to carry a foetus to term contrary to their own priorities and aspirations and which imposes serious delay causing increased physical and psychological trauma to those women who meet its criteria."[49]

Justice Beetz writes a concurring opinion that aligns with Chief Justice Dickson's reasoning. Justice Beetz explains that section 7 of the *Charter* must protect a "right to access medical treatment for a condition representing a danger to life or health without fear of criminal sanction."[50] Quite notably, Justice Beetz's decision is the only judgement to recognize a right of access to treatment when a woman's health or life is in danger, thus placing an obligation on the government.[51] Moira McConnell posits that Justice Beetz's judgement "provides a basis for developing a right to service: i.e. a constitutional right of access implies that there exists a service to have access to."[52] On the contrary, Justice Beetz attenuates the scope of his statements regarding access by placing them squarely within matters that pertain to criminal law.[53] In other words, Justice Beetz stresses the ability to access medical treatment without fear of *criminal sanction* rather than conferring a broad right to access. [54]

Justice Wilson offers the third concurring opinion. The core difference in Justice Wilson's decision is the discussion of the liberty *and* security of the person's interests.[55] Justice Wilson outlines that the right to liberty is inextricably linked to the notion of

---

[46] *Ibid* at 56–57.
[47] See *ibid* at 57 citing Canada, Government of Canada, *Report of the Committee on the Operation of the Abortion Law* (1977) (Chair: Robin Badgley).
[48] *Morgentaler*, *supra* note 37 at 60.
[49] *Ibid* at 63.
[50] *Ibid* at 81.
[51] See McConnell, *supra* note 20 at 909–910.
[52] *Ibid.*
[53] See *Morgentaler*, *supra* note 37 at 90.
[54] See *ibid.*
[55] See *ibid* at 161–184.

human dignity, in which Canadian citizens reserve the "right to make fundamental decisions without interference from the state."[56] To round out her discussion, Justice Wilson suggests that a woman's decision to terminate her pregnancy falls within the type of personal decision that the liberty interest protects.[57] Despite her illuminating discussion on the liberty interest and abortion generally, Justice Wilson's comments are obiter dicta.

In their joint dissenting opinion, Justices McIntyre and La Forest orient their reasoning around the notion that the Court must demonstrate some constraint and refrain from trying to solve the abortion debate.[58] Furthermore, the dissenting justices note that Chief Justice Dickson's and Justice Wilson's reasonings presuppose that women have the right to abortions.[59] The dissenting judges note that the express language of a positive right to an abortion is not in the *Charter*.[60] Finally, the dissenting judges suggest that all laws have the potential to interfere with individual priorities and aspirations.[61] In a somewhat obtuse manner, the dissenting justices draw an analogy to the *Income Tax Act*, which they cite as "frequently interfering with the priorities and aspirations" of individuals, yet is not unconstitutional.[62] Overall, the dissenting justices posit that the claimant must show something more than state interference to engage the security of the person interest.[63]

Overall, the *Morgentaler* decision suggests that section 251 of the *Criminal Code* infringes the security of the person interest under section 7 of the *Charter* in a way that cannot be justified in a free and democratic society.[64] Although the *Morgentaler* decision is one of the most impactful decisions discussing abortion and the *Charter*, it does not end the debate.

II. CURRENT STATE OF THE LAW

[56] *Ibid* at 165–166.
[57] See *ibid* at 171.
[58] See *ibid* at 138.
[59] See *ibid* at 142.
[60] See *ibid* at 143.
[61] See *ibid* at 142.
[62] *Ibid.*
[63] See *ibid* at 142, 146–147.
[64] See *Morgentaler*, *supra* note 37; McConnell, *supra* note 20 at 906.

The aftermath of the *Morgentaler* decision created a legal lacuna in regulating abortion.[65] Canada does not have any *legal* restrictions on accessing abortions.[66] *Morgentaler* is the seminal authority exploring the contours of abortion access; however, "the decriminalization of abortion access led to its reclassification as a healthcare issue, shifting jurisdiction over the procedure from the federal government to the provinces."[67]

This section seeks to untangle the shift in jurisdiction from the federal to provincial governments in regulating abortion as a derivative of healthcare. Part II begins by discussing federalism as a core constitutional concept, thus parsing out the division of powers for healthcare. Secondly, this part will discuss the current policy landscape concerning abortion, thus highlighting the *Canada Health Act* and its impact on provincial regulatory powers.[68] Finally, this part will discuss the *CHA*'s effect on abortion regulation as an interest defined in the healthcare realm.

1. Who Regulates Health? Federalism and the Distribution of Powers

The *Constitution Act, 1867* is the overarching document that guides the relationship between provinces and the federal government in regulating health.[69] Sections 91 and 92 of the *Constitution Act, 1867* are responsible for distributing relative legislative powers between Parliament and provincial legislatures.[70] Health does not fit squarely under any of the classes of subjects listed under sections 91 or 92 of the *Constitution Act, 1867*.[71] Rather, health is an amorphous matter that takes a hybrid approach between the provincial and federal heads of power, with both levels of government asserting power within the health space.[72]

Both the federal and provincial governments may encroach on dealing with health-related matters through multiple constitutional avenues. Most relevant to the scope of this paper, Parliament can regulate health as it pertains to the federal spending power and the ability to provide economic incentives for provinces to

---

[65] See generally Rachel Johnstone & Emmett Macfarlane, "Public Policy, Rights, and Abortion Access in Canada" (2015) 51 Intl J Can Studies 97 at 98.
[66] See *ibid*; Peter W Hogg & Wade Wright, *Constitutional Law of Canada*, revised ed, (Toronto: Carswell, 2021) at 590.
[67] Johnstone & Macfarlane, *supra* note 66 at 103.
[68] See generally *Canada Health Act*, RSC 1985, c C-6 [*CHA*].
[69] See *Constitution Act*, *supra* note 7, ss 91–92.
[70] See *ibid*.
[71] See *ibid*; Hogg & Wright, *supra* note 67 at 817.
[72] See Hogg & Wright, *supra* note 67 at 817.

maintain a specific national standard of healthcare insurance.[73] From a provincial perspective, legislatures can regulate health as they pertain to matters of a local or private nature,[74] the maintenance and management of provincial hospitals,[75] and the insurance industry.[76] As confirmed by the Supreme Court of Canada in *Canada (Attorney General) v PHS Community Services Society*, the overlapping federal and provincial jurisdiction over health makes it impossible to compartmentalize relative responsibilities in a system with such widespread diversity.[77]

2. Cooperative Federalism in Action: the Canada Health Act

Provinces can regulate health insurance within their relative jurisdictions, while the federal government can provide economic incentives to maintain a certain standard of insured services.[78] The *CHA* embodies the amalgam of these responsibilities.[79] The *CHA* is a federal spending statute that "establishes national criteria that provincial health insurance plans must satisfy to qualify for federal contributions."[80]

Section 4 of the *CHA* states that its overarching purpose is to "establish criteria and conditions in respect of insured health services and extended healthcare services provided under provincial law that must be met before a full cash contribution may be made."[81] At a broader level, the *CHA* articulates that the "primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."[82] In order to be eligible for a full federal cash contribution pursuant to the *CHA*, provinces must ensure they satisfy the five core pillars of the statute: public administration, comprehensiveness, universality, portability, and accessibility.[83] Furthermore, provincial healthcare insurance plans

---

[73] See *Constitution Act*, *supra* note 7, ss 91(3), (1A). To note, the federal spending power is not a literal power, but it can be inferred from the classes of subjects listed in this citation. For further information, see generally Hogg & Wright, *supra* note 67.
[74] See *Constitution Act*, *supra* note 7, s 92(16).
[75] See *ibid*, s 92(7).
[76] See *ibid*, s 92(13).
[77] See 2011 SCC 44 at para 68 [*Insite*].
[78] See Hogg & Wright, *supra* note 67 at 821.
[79] See generally *CHA*, *supra* note 69.
[80] Joanna N Erdman, "Constitutionalizing Abortion Rights in Canada" (2017) 49:1 Ottawa L Rev 221 at 250 [Erdman, "Constitutionalizing Abortion"].
[81] *CHA*, *supra* note 69, s 4.
[82] *Ibid*, s 3.
[83] *Ibid,* s 7. For more information on each of these pillars, see *ibid*, ss 8–12.

must ensure that all medically necessary services are universally accessible.[84] Determining which services fall into the nebulous category of "medically necessary" services falls to the provinces.[85]

3. Abortion and the *CHA*

According to Joanna Erdman, the interests secured under the *CHA* are not a legal obligation or a positive right to healthcare for an individual – it is mainly a societal stance on universal healthcare that reflects social democratic values.[86] With that said, provinces still hold the ultimate decision-making power regarding whether abortion should be deemed a medically required service.[87] After the *Morgentaler* decision, many provinces refrained from funding abortion services, thus creating tension with the federal government under the requirements of the *CHA*.[88] Although the federal government did not have the constitutional ability to deem abortion services "medically necessary" unanimously, the *CHA* provided financial incentives to do so. However, given that the penalty for contravention of the *CHA* was only losing monetary support, some provinces suffered the financial repercussions to preserve their anti-abortion stances.[89] This attitude, however, did not withstand the test of time. At present, abortion is deemed a medically required service in all provinces.[90]

Although the current landscape concerning abortion seems to present Canadians with accessible options, that is a far cry from reality. The next part of this paper discusses the particular barriers to *accessing* abortion.

III. BARRIERS LIMITING ACCESS TO ABORTION

Although there are no legislative or judicial restraints on abortion in Canada, this does not necessarily equate to widespread access to abortion services.[91] In Canada, the present healthcare structures do not provide an adequate amount of access to ensure those requiring abortion services receive them in a safe, timely, and efficient

---

[84] Joanna N Erdman, "In the Back Alleys of Heath Care: Abortion, Equality, and Community in Canada" (2007) 56:4 Emory LJ 1093 at 1150 [Erdman, "Back Alleys"].
[85] See generally Canada, Health Canada, *Canada Health Act Annual Report 2014-2015* (Ottawa: Minister of Health, 2015).
[86] See "Constitutionalizing Abortion", *supra* note 81 at 250–51. See also *Chaoulli v Quebec*, 2005 SCC 35.
[87] See "Constitutionalizing Abortion", *supra* note 81 at 251.
[88] See *ibid.*
[89] See *ibid.*
[90] See Johnstone & Macfarlane, *supra* note 66 at 109.
[91] See Browne & Sullivan, *supra* note 18 at 287.

manner. This section aims to describe the various political and legal pressures contributing to inadequate access to abortion services in Canada. Furthermore, this section will discuss the obstacles that impede sufficient access to abortion services. Finally, this part will evaluate the varying levels of access to abortion-related care across the provinces and territories.

1. Barriers to Accessing Abortion in Canada

A significant number of non-legal barriers impede access to adequate abortion services in Canada. These barriers include political, geographical, financial, medical, moral, and temporal obstacles. A brief overview of each of these barriers is below.

i. Political

Abortion has always been, and will likely continue to be, a controversial topic in political circles. At the federal level, Parliament absolves itself of difficult discussions about regulating abortion services. By avoiding discussions related to abortion, Parliament has effectively passed the baton of responsibility to the courts to carve out the contours of reproductive rights through litigation.[92] Parliament effectively deemed itself an inappropriate body to discuss abortion-related matters, thus outsourcing decision-making to the judiciary and provincial governments.[93]

Federalism offers additional complexity, as each province and territory occupy a distinct stance on the access to abortion debate. After the *Morgentaler* decision, each province took a unique approach to regulating abortion.[94] For instance, some provinces, such as Quebec, took a liberal approach to improving access.[95] On the other hand, some provinces, like New Brunswick, attempted to create similar restrictions to access that were struck down in *Morgentaler*.[96] As Rachael Johnstone notes, the incongruity amongst the provincial regulation of abortion "demonstrates the instability of the federal-policy vacuum" surrounding abortion.[97] With federal policymakers reluctant to take action and courts reluctant to tread on Parliamentary authority, substantive protection of abortion access is unlikely.[98] Overall, the political

[92] See Johnstone, *supra* note 3 at 52.
[93] See *ibid.*
[94] See *ibid* at 80.
[95] See *ibid.*
[96] See *ibid.*
[97] *Ibid.*
[98] See *ibid* at 80, 52–53.

landscape in Canada is one of avoidance, thus leaving the issue of abortion regulation underdeveloped.

ii. Geographical

Access to abortion services is a privilege for those living in populated cities. Living in rural or remote areas of Canada creates significant challenges for those seeking timely and safe abortion services.[99] This is especially true for those living on reserves, as there is little to no access for Indigenous peoples.[100] In fact, only one in six hospitals in Canada provide abortion services, and most private abortion clinics are concentrated along the United States-Canada border, making access very difficult for those living outside urban communities.[101] A study conducted in 2013 investigating the spatial disparities in accessing abortion clinics in Canada found that "18.1 percent of women traveled more than 100 kilometres to access abortion, with Indigenous women being three times more likely than white women to have travelled this distance."[102]

Access to abortion services is not only an intra-provincial issue. Up until 2017, residents of Prince Edward Island (PEI) did not have access to intra-provincial abortion services. Accordingly, an individual seeking an abortion in PEI before 2017 would need to travel outside the province for access while paying for the travel out-of-pocket.[103] Although abortion services have expanded nationwide in recent years, access is still sparse for those in specific geographical regions.

iii. Financial

In recent years, most provincial health insurance fully covers the cost of abortion services regardless of what medication or procedures are involved. While all provinces

---

[99] See Kyra Keer, Kayla Benjamin & Roma Dhamanaskar, "Abortion in Canada is legal for all, but inaccessible for too many", (18 August 2022) online: <policyoptions.irpp.org/magazines/august-2022/abortion-access-canada/> [perma.cc/9QQF-RP23].
[100] See *ibid.*
[101] See *ibid.*
[102] *Ibid*, citing Christabelle Sethna & Marion Doull, "Spatial disparities and travel to freestanding abortion clinics in Canada" (2013) 38 Women's Studies Intl Forum 52 at 55, 57.
[103] See Rachael Johnstone, "Between a Woman and Her Doctor? The Medicalization of Abortion Politics in Canada" in Shannon Stettner, Travis Hay & Kristin Burnett, eds, *Abortion: History, Politics and Reproductive Justice After Morgentaler* (Vancouver: UBC Press, 2017) 217 at 225.

cover abortion services in hospitals, some provinces, such as New Brunswick, still exclude private clinic services from being eligible under provincial insurance. This is problematic from a financial perspective because the cost of abortions in Canada can range from $400 to $1425, depending on the location and procedures required.[104] Also, seeking abortion services through private clinics has become increasingly popular in Canada, with approximately 60% of abortions occurring in private clinics.[105]

Inevitably, denying public funding for a medical procedure such as abortion disproportionately affects low-income women, thus rendering safe and timely access to abortion services a privilege of the wealthy.[106] Denying public funding for abortion pushes the burden onto the patient, as they are required to "return to overburdened hospital providers or delay receiving care until they can obtain required funds."[107] Not only does this exacerbate financial strain, but delayed care also increases the risk of physical and psychological complications.[108] As Joanna Erdman comments, "…denied funding does not necessarily prevent poor and low-income women from accessing care, [though] it does prevent their safe and timely access."[109]

iv. Medical

The medical barrier that prevents safe and timely access to abortion services in Canada is two-fold. Firstly, gestational limits placed on abortion treatments vary by province, thus creating time limits on abortion services depending on how far along the pregnancy is.[110] Secondly, the education of many physicians in Canada creates significant constraints, as abortion procedures are not a part of the basic curriculum in many medical schools.[111]

---

[104] See Jocelyn Downie & Carla Nassar, "Barriers to Access to Abortion through a Legal Lens" (2007) 15 Health LJ 143 at 153.
[105] See Frances E Chapman & Tracy Penny Light, "Functionally Inaccessible: Historical Conflicts in Legal and Medical Access to Abortion" in Shannon Stettner, Travis Hay & Kristin Burnett, eds, *Abortion: History, Politics and Reproductive Justice After Morgentaler* (Vancouver: UBC Press, 2017) 175 at 190.
[106] See Erdman, "Back Alleys", *supra* note 85 at 1096.
[107] *Ibid.*
[108] See *ibid.*
[109] *Ibid.*
[110] Chapman & Light, *supra* note 106 at 189.
[111] See Johnstone, *supra* note 3 at 119.

According to the Centre for Reproductive Rights, gestational limits are specific points within a pregnancy where termination is still legally permissible.[112] As with many other elements of abortion procedures, prescribed gestational limits vary by province.[113] This is mainly because the gestational limits are prescribed at the discretion of doctors in the province, often influenced by the extent of training, funding regulations, and the capacity of available facilities.[114] With that said, gestational limits further restrict access, as the foetus' gestational age places a time stamp upon which an insurable abortion procedure is possible.[115] For instance, New Brunswick places a gestational limit of 12 weeks to obtain a legal abortion, whereas Ontario's limit is 24 weeks.[116] As Downie and Nassar point out, "[w]here gestational limits are demonstrably justifiable in relation to medical concerns…a legal challenge to these policies will be difficult to mount. However, limits might be the result of provincial regulations or hospital policies that are grounded in moral or political concerns."[117] Echoing these concerns, the World Health Organization outlines that gestational limits should be evidence-based and used cautiously, as they may have negative consequences for women who exceed these limits and thus seek alternative and unsafe avenues.[118]

Concomitantly, abortion access suffers at the hands of medical schools that refuse to teach the procedure to the next generation of doctors. At present, not all medical schools in Canada teach how to perform abortion procedures, whether it be in the classroom or throughout residency, which creates a pervasive gap in reproductive knowledge for Canada's medical profession.[119] Moreover, "on average, more class time is dedicated to Viagra than to abortion procedures, pregnancy options counselling, or abortion law and policy."[120] In purely economic terms, the shortage of doctors graduating from Canadian medical schools creates downward pressure on the

---

[112] See Centre for Reproductive Rights, "Law and Policy Guide: Gestational Limits" (2022), online: <reproductiverights.org/maps/worlds-abortion-laws/law-and-policy-guide-gestational-limits/> [perma.cc/68GA-AZLD] ["Gestational Limits"].
[113] See Johnstone & Macfarlane, *supra* note 66 at 107.
[114] See *ibid*; Johnstone, *supra* note 3 at 122.
[115] See Johnstone & Macfarlane, *supra* note 66 at 107.
[116] See *ibid*.
[117] Downie & Nassar, *supra* note 105 at 163.
[118] See "Gestational Limits", *supra* note 113.
[119] See Johnstone, *supra* note 3 at 119.
[120] *Ibid*, citing Atsuko Koyama & Robin Williams, "Abortion in Medical School Curricula" (2005) 8:2 McGill J Medicine 157 at 159.

supply of services, which undoubtedly leaves the corresponding high demand for abortion services unsatisfied.

v. Moral

The shortage of professionals who can perform abortion procedures is constrained when considering a doctor's ability to refuse services that would require them to act against their morals.[121] Put simply, "…there is no legal requirement that the medical sector make such a procedure available in an accessible and timely manner. This model takes the onus off physicians to ensure that their patients receive care and creates unreasonable barriers for [individuals] attempting to access a safe and legal medical procedure."[122] The ability to turn patients away based on the moralization of a legislatively defined healthcare procedure aggravates the already limited supply of abortion services in Canada.

In response to a doctor's right to religious or conscience objection, some provincial regulators have enacted policies that require physicians to provide referrals to accessible and non-objecting healthcare professionals for controversial procedures such as abortion.[123] Although these policies were recently challenged in *Christian Medical* for violating sections 2(a) and 15 of the *Charter*, the Ontario Court of Appeal found that the impugned policies only infringe section 2(a), but are justified under section (1).[124] In obiter dicta, the Court highlights that since physicians are gatekeepers to a public healthcare system, there is a duty to put patient interests and decisions above their own.[125] The *Christian Medical* decision offers some amelioration with respect to the moral barriers that prevent access to abortion. However, the referral process further aggravates the temporal barrier associated with accessing abortion, as discussed immediately below.

---

[121] See Johnstone, *supra* note 3 at 120.
[122] *Ibid.*
[123] See *Christian Medical and Dental Society of Canada v College of Physicians and Surgeons of Ontario*, 2019 ONCA 393 at para 2 [*Christian Medical*].
[124] See *ibid* at paras 1-8.
[125] See *ibid* at para 102.

vi. Temporal

Obtaining timely abortion services in the Canadian healthcare system is difficult due to the lack of training, available facilities, and funding.[126] Unfortunately, overburdened hospitals encounter lengthy delays in administering abortion services, thus running the risk of pushing beyond mandated gestational limits.[127] For example, abortion services in Quebec, the national leader in progressive abortion policy, operate with up to four-week long waitlists.[128] Moreover, the COVID-19 pandemic exacerbated hospital resources, thus creating negative implications for accessing abortion services broadly.[129] Overall, as wait times to accessing abortions increases, so does the likelihood of complications, thus creating undue hardships for those wishing to utilize abortion services.[130]

2. Charting Access by Province and Territory

The following table provides a comprehensive summary of access to abortion by geographical jurisdiction in Canada. It is vital to refrain from conflating the optics of availability with accessibility.

Table 1: Abortion Access by Jurisdiction[131]

[126] See Downie & Nassar, *supra* note 105 at 150.

[127] See *ibid.*

[128] See CBC News "Long wait times for abortion 'unacceptable,' Quebec Premier Legault says" (27 October 2019), online: <www.cbc.ca/news/canada/montreal/abortion-access-1.5337471> [perma.cc/Q4CB-CUYC] ["Long Wait Times"].

[129] See Action Canada for Sexual Health & Rights "Trends in barriers to abortion care" (14 December 2022), online (blog): <www.actioncanadashr.org/resources/reports-analysis/2022-12-14-trends-barriers-abortion-care> [perma.cc/3B4X-PPBE].

[130] Abortion Rights Coalition of Canada, "Abortion Is a 'Medically Necessary' Service and Cannot Be Delisted" (March 2021), online (pdf): < https://www.arcc-cdac.ca/media/position-papers/01-Abortion-Medically-Required.pdf> [perma.cc/V42B-2JFP].

[131] For further information, see National Abortion Federation of Canada, "Abortion Coverage by Region" online: <nafcanada.org/abortion-coverage-region/> [perma.cc/XGW4-U9WN] ["Abortion Coverage by Region"].

Province/ Territory	Number of Hospital Providers[132]	Number of Clinics[133]	Gestational Limits[134]	Notes[135]
British Columbia	26 / 90 hospitals perform abortions.	7	Up to 24 weeks and 6 days.	Provincial health insurance covers the full cost of abortion services in hospitals and clinics. There is "bubble zone" legislation that protects legally defined parameters around abortion clinics to prevent disruptive protesting and harmful activities.
Alberta	6 / 100 hospitals perform abortions.	4	Up to 24 weeks.	Provincial health insurance covers the full cost of abortion services in hospitals and clinics. There is "bubble zone" legislation that protects legally defined parameters around abortion clinics to prevent disruptive protesting and harmful activities.
Saskatchewan	4 / 68 hospitals perform abortions.	4	Up to 18 weeks and 6 days.	Provincial health insurance covers the full cost of abortion services in hospitals and clinics.
Manitoba	2 / 52 hospitals	3	Up to 19 weeks and 6 days.	Provincial health insurance covers the full

[132] See Michelle Siobhan Reid, "The Morgentaler Decision: Access by Province" online: <www.morgentaler25years.ca/the-struggle-for-abortion-rights/access-by-province/> [perma.cc/2EKY-Z5WX].
[133] See Abortion Rights Coalition of Canada, "Abortion Clinics and Services in Canada" (23 March 2023), online (pdf): <www.arcc-cdac.ca/media/2020/08/list-abortion-clinics-canada.pdf> [perma.cc/2V38-JT3F].
[134] See "Abortion Coverage by Region", *supra* note 132.
[135] See *ibid.*

	perform abortions.			cost of abortion services in hospitals and clinics.
Ontario	33 / 194 hospitals perform abortions.	26	Up to 24 weeks.	Provincial health insurance covers the full cost of abortion services in hospitals and clinics. There is "bubble zone" legislation that protects legally defined parameters around abortion clinics to prevent disruptive protesting and harmful activities.
Quebec	31 / 129 hospitals perform abortions.	12	Up to 23 weeks.	Provincial health insurance covers the full cost of abortion services in hospitals and clinics. There is "bubble zone" legislation that protects legally defined parameters around abortion clinics to prevent disruptive protesting and harmful activities.
New Brunswick	1 / 28 hospitals perform abortions.	1	Up to 16 weeks.	Provincial health insurance covers the full cost of abortion services in hospitals *only* (excludes clinics).
Newfoundland	3 / 14 hospitals perform abortions.	1	Up to 15 weeks.	Provincial health insurance covers the full cost of abortion services in hospitals and clinics. There is "bubble zone" legislation that protects legally defined parameters around abortion clinics to prevent disruptive

				protesting and harmful activities.
Nova Scotia	4 / 30 hospitals perform abortions.	4	Up to 16 weeks.	Provincial health insurance covers the full cost of abortion services in hospitals *only* (excludes clinics). There is "bubble zone" legislation that protects legally defined parameters around abortion clinics to prevent disruptive protesting and harmful activities.
Prince Edward Island	1 / 7 hospitals perform abortions.[136]	0	Up to 12 weeks and 6 days.	Provincial health insurance covers the full cost of abortion services in hospitals *only* (excludes clinics). Travel costs to receive an abortion from out-of-province hospitals are not covered.
Nunavut	1 / 1 hospitals perform abortions.	0	Up to 12 weeks.	Provincial health insurance covers the full cost of abortion services in hospitals *only* (excludes clinics).
Yukon	1 / 2 hospitals perform abortions.	1	Up to 12 weeks and 6 days.	Provincial health insurance covers the full cost of abortion services in hospitals and clinics.
Northwest Territories	2 / 3 hospitals perform abortions.	0	Up to 19 weeks and 6 days.	Provincial health insurance covers the full cost of abortion services in hospitals *only* (excludes clinics).

[136]Health PEI, "Abortion Services" (22 January 2023), online: <www.princeedwardisland.ca/en/information/health-pei/abortion-services> [perma.cc/E6CK-6CWH].

Iv. WHAT IS THE FUTURE OF ABORTION ACCESS IN CANADA?

Advocating for greater access to abortion services is an uphill battle. The legal dimension of this battle is no exception. Using available legal tools to create avenues for greater access to abortion is no simple feat within the Canadian constitutional landscape. Part V addresses the abovementioned problems by discussing the legal mechanisms that can potentially aid in increasing access to abortion services in Canada. This part will outline three potential tools to widen access: the possible recognition of positive rights through trial-level precedent, the national concern doctrine, and a *Charter* challenge based on a breach of sections 7 and 15(1). Each tool attracts different levels of efficacy. The first tool argues for a positive right to access abortion under sections 7 and 15(1) of the *Charter*. This tool offers the most effective solution, as it obligates the government to grant reasonable and substantial access. The second tool, imposing the national concern doctrine, may also increase access, creating a centralized approach to regulating access. The third tool argues for a *Charter* challenge on provincial governments that provide inadequate access to abortion care. The third tool is the least viable, as it challenges provincial governments individually based on their relative regulations with no guarantee of success. To clarify, these tools are not organized in terms of likelihood of success. On the contrary, they are organized in terms of effectiveness at achieving the end goal of broadening access to abortion. As this analysis proceeds, it will be obvious that significant barriers impede each tool's effectiveness.

1. Tool #1: Recognizing Positive Rights to Access Abortion Under Sections 7 and 15(1) of the Charter

Courts in Canada refrain from recognizing positive *Charter* rights under sections 7 and 15(1). However, recent jurisprudence and literature point to the persuasive possibility of opening up positive obligations in certain circumstances.[137] In order to grant citizens the full benefit of *Charter* protections, there is a strong argument that the courts should recognize positive rights.

To be clear, recognition of positive rights in the Canadian constitutional context imposes an obligation on the government to abide by a particular order. Historically, courts in Canada have not widened the ambit of *Charter* rights, specifically under

[137] See e.g., Michael Da Silva, "Positive Charter Right: When Can We Open the Door?" (2021) 58:3 Osgoode Hall LJ 669.

sections 7 and 15, to include positive dimensions.[138] However, some elements of sections 7 and 15 jurisprudence outline that the possibility is not off the table.[139]

i. Positive Rights Under Section 7

Section 7 states, "[e]veryone has 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."[140] Section 7 and the concept of access to healthcare have an established connection in the decriminalization context, however, it has yet to translate to healthcare regulation generally.[141] As demonstrated in *Morgentaler*, the Court will strike down criminal law prohibitions that prevent timely and safe access to healthcare under section 7, but this still remains true to the trend of recognizing negative rights.[142]

In *Chaoulli*, the Supreme Court of Canada is unequivocal in stating that Canadians do not have a freestanding right to healthcare.[143] However, Chief Justice McLachlin previously wrote in *Gosselin v Quebec (Attorney General)*, "[n]othing 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. Rather, s. 7 has been interpreted as restricting the state's ability to deprive people of these…*one day s. 7 may be interpreted to include positive obligations*."[144] As Da Silva outlines, "the basic lesson of *Gosselin* and *Chaoulli* remains operative, and lower courts likewise continue to deny that section 7 includes a positive component, while recognizing that the 'door' to positive rights recognition remains 'slightly ajar.'"[145]

One instance in which it might be arguable that the Supreme Court of Canada recognized a positive obligation is in *Insite*.[146] In *Insite*, a safe injection facility operated in Vancouver to provide medical services to intravenous drug users.[147] The safe injection facility's ability to operate stemmed from an exemption from the criminal

---

[138] See *ibid* at 675.
[139] See *ibid* at 676–77.
[140] *Charter*, *supra* note 2, s 7.
[141] See Martha Jackman, "*Charter* Review as a Health Care Accountability Mechanism in Canada" (2010) 18 Health LJ 1 at 18.
[142] See generally *Morgentaler*, *supra* note 37.
[143] See *Chaoulli*, *supra* note 87.
[144] *Gosselin v Québec*, 2002 SCC 84 at paras 81–82.
[145] Da Silva, *supra* note 135 at 676–77.
[146] See *Insite*, *supra* note 78.
[147] See *ibid* at paras 4–20.

laws under the *Controlled Drugs and Substances Act*, which was subject to expiry.[148] The outcome of *Insite* followed the Supreme Court of Canada instilling an order of mandamus, a highly unusual remedy compelling the Minister of Health to issue another exemption.[149] Although it is possible to frame the remedy in *Insite* as a positive obligation, Justice Mactavish pushes back on this interpretation in *Canadian Doctors for Refugee Care v Canada (Attorney General)*.[150] Justice Mactavish attenuates the expansive interpretation offered in *Insite* by drawing a line between "requiring the state to grant an exemption that would allow a health care provider to provide medical services funded by others and requiring the state itself to fund medical care."[151] Although not entirely out of the question, section 7 jurisprudence shows a pejorative attitude toward recognizing positive rights.

ii. Positive Rights Under Section 15

Section 15(1) states, "[e]very individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability."[152] As with section 7 jurisprudence, a very narrow margin of case law provides a hook to argue a positive right associated with section 15. Within section 15 jurisprudence, there is a push-and-pull dynamic between two cases: *Eldridge v British Columbia (Attorney General)*[153] and *Auton v British Columbia (Attorney General)*.[154]

Eldridge dealt with three deaf individuals that failed to receive medical interpretation services at a hospital.[155] The appellants sought a declaration that failing to provide public funding for sign language interpreters when receiving medical care violates section 15(1).[156] The Supreme Court of Canada finds that the failure to provide sign language interpreters violated section 15(1) in a manner that is not demonstrably justified.[157] In arriving at this finding, Justice La Forest outlines that

---

[148] See *ibid*.
[149] See *ibid* at para 150.
[150] See 2014 FC 651 at para 536.
[151] *Ibid* at para 538.
[152] The *Charter*, *supra* note 1, s 15(1).
[153] See [1997] 3 SCR 624, 1997 CanLII 327 (SCC) [*Eldridge*].
[154] See 2004 SCC 78 [*Auton*].
[155] See *Eldridge*, *supra* note 150 at paras 5–10.
[156] See *ibid* at para 11.
[157] See *ibid* at para 97.

"[t]he principle that discrimination can accrue from a failure to take positive steps to ensure that disadvantaged groups benefit equally from services offered to the general public is widely accepted in the human rights field."[158] Moreover, the Court suggests that a government *may* be required to take positive steps to guarantee the equality of groups that fall under the enumerated categories in section 15(1).[159]

The Supreme Court of Canada recognizes the potential for positive rights claims within the section 15 ambit and creates a pathway for health services claims that are distributed inequitably across certain groups.[160] The effects of *Eldridge* were short-lived, however, as *Auton* came after to constrict its effects.

Auton follows a challenge against the province of British Columbia under section 15(1) due to the province's failure to fund applied behavioural therapy for autistic infants.[161] Specifically, the government did not provide funding because applied behavioural therapy was not a core service protected by the *CHA* and relevant British Columbia legislation.[162] This distinguishing factor led the Supreme Court of Canada to specifically dictate that the legislative healthcare scheme in the relevant province and the *CHA* "does not promise that any Canadian will receive funding for all medically required treatment."[163] Furthermore, the Court clarifies that the government was under no obligation to provide social benefits generally, but when it does provide them, they must not be provided in a discriminatory manner.[164] Since certain applied behavioural therapy was not a core service, and the *CHA* only purports to fully fund core services, excluding non-core services cannot be a discriminatory distinction based on enumerated grounds.[165] Therefore, the unanimous Court found no discrimination under section 15(1).[166]

Overall, under sections 7 and 15, there have been apparent ebbs and flows in the case law that suggests the *potential* to root a claim for positive rights. When the courts seem to expand the ambit of section 7 or 15, a decision to attenuate its scope soon follows. In the access to abortion context, the question remains open as to whether it is possible to root an argument under section 7 or 15. A lower-level court in Manitoba

---

158 *Ibid* at para 78.
159 See *ibid.*
160 See *ibid* at para 73.
161 See *Auton*, *supra* note 151 at paras 4–18.
162 See *ibid.*
163 *Ibid* at para 35.
164 See *ibid* at para 41.
165 See *ibid* at para 43.
166 See *ibid.*

has challenged the right to access abortion, however, the matter remains unresolved.[167]

iii. Doe et al v The Government of Manitoba

Jane Doe tests the boundaries for challenging abortion legislation that chills access to abortion services. Not only does this case provide persuasive arguments to ensure greater access to abortion services, but it also posits a very progressive approach to recognizing positive dimensions to both sections 7 and 15(1) of the *Charter*.

The facts of *Jane Doe* are relatively simple, as the case follows two pregnant women who wished to terminate their pregnancies.[168] Before Jane Doe 1 received an abortion from a private clinic, she sought the public services of a Winnipeg hospital.[169] Jane Doe 1 was seven and a half weeks pregnant at the time.[170] The Winnipeg hospital told Jane Doe 1 there would be a six to eight week delay in receiving the procedure.[171] Given the additional health risks associated with delays in abortion services and the corresponding deleterious psychological effects, Jane Doe 1 opted for the private clinic procedure.[172] Jane Doe 1 had to pay $375 for the procedure.[173] The other plaintiff, Jane Doe 2, was told there would be a four to six week delay in obtaining an appointment at a Winnipeg hospital.[174] On top of the delay in obtaining the first appointment, Jane Doe 2 needed two subsequent appointments before the procedure could be completed.[175] For similar reasons to Jane Doe 1, Jane Doe 2 opted to seek an abortion at a private clinic.[176]

Jane Doe 1 and Jane Doe 2 commenced an action against the province of Manitoba, claiming that the relevant provincial regulations and legislation were inconsistent with the *Charter*.[177] At the time of the case, the provincial insurance

[167] See *Doe et al v The Government of Manitoba*, 2004 MBQB 285 [*Jane Doe*].
[168] See *ibid* at paras 5–24.
[169] See *ibid* at para 6.
[170] See *ibid*.
[171] See *ibid* at para 8.
[172] See *ibid* at para 9.
[173] See *ibid* at para 5.
[174] See *ibid* at para 11.
[175] See *ibid*.
[176] See *ibid* at para 15.
[177] See *ibid* at para 1.

scheme excluded funding private clinic abortions.[178] Jane Doe 1 and Jane Doe 2 argued that the relevant legislation violates sections 2(a), 7, and 15(1) of the *Charter*.[179]

In his analysis, Justice Oliphant does not separate each *Charter* claim into their respective tests, but rather deals with the matters collectively. Justice Oliphant clarifies that the obiter dicta in *Morgentaler* are "so powerfully conclusive" that its application to the matter at hand is "beyond dispute."[180] The Court concludes that the relevant legislation violates all three *Charter* rights, having little regard for the principles of fundamental justice or the section 1 analysis.[181]

On appeal, the Manitoba Court of Appeal found that the plaintiffs did not provide adequate evidence to support a summary judgement, and that a full hearing was necessary.[182] Therefore, the trial judgement was overturned.[183] Years later, the plaintiffs attempted to commence an action once again, thus seeking certification of a class action.[184] The class action was certified but no trial followed.[185]

Although the Manitoba Court of Appeal overturned Justice Oliphant's decision based on evidentiary matters, it offers a refreshing reading of sections 7 and 15(1) that has the potential to articulate a positive right to access abortion.[186] The *Jane Doe* decision also takes access to abortion out of the decriminalization context, thus extending *Morgentaler*'s reach. Despite the *Jane Doe* decision failing to offer much precedential weight, it is an interesting reference point for future claims.

iv. Summary

A brief analysis of sections 7 and 15(1) case law highlights a general reluctance to recognize positive rights. With that said, narrow hooks within the jurisprudence provide the potential for an argument. This argument is unlikely to be successful, however, as courts are unwilling to overstep their boundaries and impose legislative requirements upon Parliament, especially regarding funding decisions.[187]

---

[178] See *ibid* at para 18.
[179] See *ibid* at para 31.
[180] *Ibid* at para 66.
[181] See *ibid* at paras 78–81.
[182] See *Jane Doe et al v Manitoba*, 2005 MBCA 109 [*Jane Doe 2*].
[183] See *ibid.*
[184] See *Jane Doe 1 and Jane Doe 2 v Manitoba (The Government of)*, 2008 MBQB 217.
[185] See *ibid* at para 19.
[186] See Johnstone & Macfarlane, *supra* note 65 at 111; Johnstone, *supra* note 2 at 104.
[187] See generally Jackman, *supra* note 138.

2. Tool #2: National Concern Doctrine

i. Overview of the National Concern Doctrine

The second legal tool, the national concern doctrine, is an exceptional principle under the federal government's "Peace, Order and Good Government" power.[188] The national concern doctrine affords the federal government jurisdiction over matters of inherent national concern.[189] For example, the court invoked the national concern doctrine in contexts related to marine pollution[190] and greenhouse gas pricing.[191] In essence, "the national concern doctrine does not allow Parliament to legislate in relation to matters that come within the classes of subjects assigned exclusively to the provinces…[t]he national concern test is a mechanism by which matters of inherent national concern, which transcend the provinces, can be identified."[192]

The courts have significant reservations about overzealous applications of the national concern doctrine, as it has the potential to erode provincial autonomy and disrupt the balance of federalism.[193] A vital attribute of the national concern doctrine is the ability of the federal government to permanently gain "exclusive jurisdiction of a plenary nature to legislate in relation to that matter, including its intra-provincial aspects."[194] Accordingly, in a recent Supreme Court of Canada judgement, Chief Justice Wagner narrowly prescribed the contours of the national concern doctrine to ensure that the federal government does not encroach on provincial autonomy to a problematic degree.[195]

Through the national concern doctrine, the federal government could hypothetically create a unified response to the access to abortion crisis in Canada. Since abortion regulation is a provincial healthcare matter, there are very few ways to create a unified response to guarantee access to abortion. Of course, this analysis assumes that the federal government aligns itself with a broad ability to access abortion.

---

188 See *Constitution Act, 1867*, *supra* note 6, s 91.
189 See *References re Greenhouse Gas Reference*, 2021 SCC 11 at para 89 [*Greenhouse Gas Reference*].
190 See *R v Crown Zellerbach Canada Ltd*, [1988] 1 SCR 401, 1988 CanLII 63 (SCC) [*Crown Zellerbach*].
191 See *Greenhouse Gas Reference*, *supra* note 186.
192 *Ibid* at para 89.
193 See *Re Anti-Inflation Reference*, [1976] 2 SCR 373, 1976 CanLII 16 (SCC) at 421.
194 *Crown Zellerbach*, *supra* note 187 at para 34.
195 See *Greenhouse Gas Reference*, *supra* note 186.

ii. Analysis

In order to argue for the application of the national concern doctrine, a piece of federal legislation must be drafted and challenged. To apply the national concern doctrine to the access to abortion context, Parliament must pass legislation that addresses this issue.

Step 1: Pith & substance

The first step in the division of powers analysis asks the court to analyze the pith and substance of the legislation.[196] The pith and substance analysis is heavily evidence-based. The court will look to intrinsic and extrinsic evidence, the purpose of the legislation, and its practical and legal effects.[197] Although no discrete piece of legislation exists in the access to abortion context, there are a few matters to note at the outset of this analysis. Firstly, it is imperative to be precise in the purpose of the legislation to capture the law's "essential character" and ensure that there is a prescribed scope in which to encroach on the provincial government's sphere of jurisdiction.[198] The ambit of the legislation should be sufficiently precise to ensure that it does not cast a net too wide that it hinders the province from regulating healthcare generally.

Step 2: National concern test

After the pith and substance analysis, the next step is to conduct the national concern test as expressed in the *Greenhouse Gas Reference*.[199] The national concern test is three steps: the threshold question, the singleness, distinctiveness, and indivisibility analysis, and the scale of impact test.[200]

Step 2a: The threshold question

The first question in the national concern test asks whether the matter identified through the pith and substance analysis is "of sufficient concern to Canada as a whole

[196] See *ibid* at paras 51–88.
[197] See *ibid.*
[198] See *ibid* at paras 51–52.
[199] See *ibid* at paras 132–166.
[200] See *ibid* at para 132.

to warrant consideration under the doctrine."[201] The Supreme Court of Canada qualifies this question by noting it invites a "common-sense inquiry into the national importance of the proposed matter."[202] At this point in the analysis, the federal government must provide evidence to convince the court that the matter is of inherent national concern.[203] The evidence must show that the matter exceeds mere importance.[204] This portion of the national concern test is clarified in the *Greenhouse Gas Reference* to limit the doctrine, thus protecting the integrity of cooperative federalism and the division of powers.[205]

Application

Although the threshold question is difficult to answer without a discrete piece of legislation to analyze, a few key pieces of evidence support a finding of sufficient concern. Parliament must convey the magnitude of the access to abortion problem, showing that it is a pervasive risk to the health and livelihood of people seeking abortions. Although the issue of access to abortion is not as ubiquitous as matters in previous case law (for example, greenhouse gas emissions), it is possible to argue about the extensive medical threat that a lack of access creates. Additionally, the legislation must not purport to regulate abortion broadly – it must have a prescribed and narrow scope to carve out matters that are sufficiently of national concern, for instance, funding and physical access.[206]

Another important aspect of this part of the analysis is relying on international instruments that recognize the magnitude of the matter. Relevant to accessing abortion care, the *International Covenant on Civil and Political Rights* provides commentary that suggests no jurisdiction should jeopardize the lives of women who seek abortions or "subject them to physical or mental suffering."[207] Moreover, the World Health Organization declares that safe abortion care should be readily accessible to the "full extent of the law."[208] This stipulation requires that safe abortion services must be

---

[201] *Ibid* at para 142.
[202] *Ibid.*
[203] See *ibid* at para 144.
[204] See *ibid.*
[205] See *ibid.*
[206] See *ibid* at paras 168–69.
[207] 999 UNTS 171, Art 6.
[208] "Law and Policy Guide: Availability, Accessibility, Acceptability and Quality Framework" (2022), online: *Centre for Reproductive Rights* <reproductiverights.org/maps/worlds-abortion-laws/law-and-policy-guide-availability-accessibility-acceptability-and-quality-framework/>,

within reach of the entire population.[209] Given these international standards and the exigent access to abortion problem in Canada, it is at least arguable that this issue can pass the threshold question. However, it will be difficult to mount an argument that proves access to abortion should be classified beyond a matter of mere importance.

Step 2b: Singleness, distinctiveness, and indivisibility

According to Justice Le Dain in *Crown Zellerbach*, this portion of the analysis asks whether the matter has a "singleness, distinctiveness and indivisibility that clearly distinguishes it from matters of provincial concern."[210] This inquiry further breaks down into two sub-tests. Firstly, "to prevent federal overreach, jurisdiction based on the national concern doctrine should be found to exist only over a specific and identifiable matter that is qualitatively different from matters of provincial concern."[211] In order to show that a matter is qualitatively different, the court will look to the following, "whether the matter is predominantly extra provincial and international in its nature or its effects," whether there are any "international agreements in relation to the matter," and "whether the matter involves a federal legislative role that is distinct from and not duplicative of that of the provinces."[212]

The second test embedded within this analysis investigates whether federal jurisdiction exists because there is a provincial inability to deal with the matter.[213] In order to show a provincial inability to handle the matter, the federal government must show three indicia. Firstly, "the legislation should be of a nature that the provinces jointly or severally would be constitutionally incapable of enacting."[214] Secondly, "the failure to include one or more provinces or localities in a legislative scheme would jeopardize the successful operation of the scheme in other parts of the country."[215]

---

citing "Safe abortion: technical and policy guidance for health systems" (2012), online (pdf): *World Health Organization* <apps.who.int/iris/bitstream/handle/10665/70914/9789241548434_eng.pdf?sequence=1&isAllowed=y>.

[209] See *ibid.*

[210] *Crown Zellerbach*, *supra* note 187 at 432.

[211] *Greenhouse Gas Reference*, *supra* note 186 para 146.

[212] *Ibid* at para 151.

[213] See *ibid* at para 152.

[214] *Ibid.*

[215] *Ibid.*

Thirdly, "a province's failure to deal with the matter must have grave extra provincial consequences" in which there is serious harm to life, health, or the environment.[216]

Application

The first principle of the singleness, distinctiveness, and indivisibility test poses issues for the access to abortion argument. It will be incredibly difficult to mount an argument that shows access to abortion services are an extra provincial issue that is distinct rather than duplicative. Given the fact that the national concern test creates a high bar for the federal government, the courts will be reluctant to consider the matter passing this portion of the test.

The second and third principles may have more potential considering that the failure of one province to regulate access to abortion adequately can affect the operation of other provincial healthcare mechanisms, as people are forced to travel and overburden other provinces' facilities in order to access abortion services. To this end, one province's inability to adequately regulate may impact the successful operation of another province's abortion scheme. However, a cautionary note is necessary here, as the access to abortion argument struggles to reach the threshold the case law requires regarding extra provincial consequences. For instance, the claim in *Schneider v The Queen*, which dealt with provinces failing to provide treatment facilities for heroin users, was found not to compromise the interests of other provinces. [217] Therefore, the majority in *Schneider* determined that the facts did not warrant grave enough consequences that the national concern test demands.[218] Although actual harm is very plausible with limited access to abortion, arguing that the consequences of a disjointed provincial approach has intolerable repercussions is unreasonable.

Step 2c: Scale of impact

The third and final requirement of the national concern test requires the federal government to show that the matter has "a scale of impact on provincial jurisdiction that is reconcilable with the fundamental distribution of legislative power under the Constitution."[219] This portion of the test signals a balancing exercise, as the court

[216] *Ibid* at para 155.
[217] See *Schneider v The Queen,* [1982] 2 SCR 112, 1982 CanLII 26 (SCC) [*Schneider*].
[218] See *ibid* at 113–15.
[219] *Crown Zellerbach*, *supra* note 187 at 432.

must weigh "the intrusion upon provincial autonomy that would result from empowering Parliament to act" against "the extent of the impact on the interests that would be affected if Parliament were unable to constitutionally address that matter at a national level."[220] Rendering a matter of national concern is only permissible if the former outweighs the latter.[221]

Application

Once again, the analysis for this section greatly relies on the discrete legislation at issue. A recurring theme throughout national concern doctrine jurisprudence is the ability to carefully carve out the purpose and reach of the legislation at issue, thus impacting the rest of the analysis. Suppose the federal government drafted legislation in a way that has minimal impact on the provinces' freedom to legislate on broader aspects of abortion. In that case, the impact on provincial healthcare will not be significant. On the other hand, it will be difficult to argue that the interests affected if Parliament could not address the matter nationally outweigh the encroachment on provincial jurisdiction. The consequences for people that need accessible abortion services are dire, however, they do not reach the threshold of irreversible harm that the jurisprudence calls for.[222]

iii. Summary

Overall, the national concern doctrine provides the opportunity for a unified legislative solution to widen abortion access across Canada. However, the stringent judicial framework that the federal legislation must measure up to does not lend itself to a strong position. Arguing the access to abortion issue is ill-suited for the national concern doctrine, as it does not reach the adequate level of severity to justify disrupting the distribution of powers. Although the outcome of a national minimum standard can be theoretically beneficial, it is unlikely.

3. Tool #3: Charter Challenge Rooted in Sections 7 and 15

The third tool requires challenging individual provinces on their abortion policies, thus arguing infringements of sections 7 and 15(1). The caveat is that this tool will not be effective against provinces that do not have any restrictions on abortion care. In other words, only the provinces that restrict funding for private

[220] *Greenhouse Gas Reference*, *supra* note 186 at para 161.
[221] See *ibid.*
[222] See *ibid* at para 206.

clinics may be plausible defendants. The active limitation on funding can be the hook to attach a *Charter*-based argument. The same hook does not exist for other provinces that do not restrict funding, but rather operate within a legal lacuna. This leaves five possible defendants: New Brunswick, Nova Scotia, Prince Edward Island, Nunavut, and the Northwest Territories.

Engaging in a *Charter* challenge by jurisdiction is not the most practical nor efficient means to increase access to abortion in Canada. It will likely take significant time to work through the courts and will come at a steep price. There is also no guarantee that challenges of this kind will be successful, as the court has not dealt with accessing abortion since *Morgentaler*. Thus, the argument outlined in this section is novel, and there is a stark risk that courts across Canada vary in their analysis and interpretation of the issues.

This section will proceed by hypothetically challenging the jurisdictions outlined above based on the restriction to fund services provided by private abortion clinics. Due to the limitations in this analysis, this section does not merit a discussion of the principles of fundamental justice under section 7 and the section 1 analysis for both rights.

i. Section 7: Life, Liberty, and Security of the Person

Justice La Forest articulates the framework for the section 7 analysis in *R v Beare*.[223] According to the Court, "[t]o trigger [section 7] there must first be a finding that there has been a deprivation of the right to 'life, liberty and security of the person' and, secondly, that the deprivation is contrary to the principles of fundamental justice."[224] Therefore, if the claimant does not meet the threshold question, the analysis cannot proceed.[225] In answering the first prong of the section 7 test, the claimant must bring concrete evidence of a causal link between the challenged government action and the alleged deprivation.[226] Since the lack of causal evidence was a weakness in *Jane Doe*, collecting current and topical evidence is paramount to

[223] See [1988] 2 SCR 387, 1988 CanLII 126 (SCC).
[224] *Ibid* at 401.
[225] *Blencoe v British Columbia (Human Rights Commission)*, 2000 SCC 44 at para 47 [*Blencoe*].
[226] Patrick Macklem et al, *Canadian Constitutional Law*, 5th ed (Toronto: Edmond Montgomery, 2017) at 1186–87.

bolster a strong legal argument under section 7.[227] All three of the section 7 interests are analyzed below.

The right to life

The court narrowly interprets the right to life as the right not to die at the hands of the government.[228] The Supreme Court of Canada in *Carter* suggests that the right to life is engaged "where the law or state action imposes death or an increased risk of death on a person, either directly or indirectly."[229] It is essential not to conflate the right to life with the right to liberty or security of the person, as the protection of personal autonomy or the quality of life falls outside the ambit of the right to life.[230] In the healthcare context, the Supreme Court of Canada has grappled with the right to life on many occasions. Two relevant examples are the decisions in *Insite* and *Chaoulli*.[231] In *Insite*, the Supreme Court of Canada determined that the right to life is engaged where the government deprives people of the right to potentially lifesaving medical care.[232] Further, the Court in *Chaoulli* found that the right to life is engaged where a lack of timely healthcare may result in death.[233] In broad terms, "[s]ection 7 is rooted in a profound respect for the value of human life."[234]

Application

For this argument to be persuasive, causal, and quantitative evidence is required. However, some high-level observations warrant discussion. For instance, citizens in provinces that do not provide fully funded abortions in private clinics, or do not have private clinic services at all, are left to seek care at overburdened hospitals. The lack of access to private clinics, whether for socioeconomical, geographical, or other reasons, in effect creates an inability for people to seek safe and timely access to

---

[227] See *Jane Doe 2*, *supra* note 179. It is important to note that the provincial and federal governments have failed to research access to abortion in recent years. Especially with the overwhelming toll COVID-19 took on healthcare systems across Canada, there has been a lack of data collection. Inevitably, a lack of government data on access to abortion pushes data-gathering to private bodies.
[228] *Carter v Canada*, 2015 SCC 5 at para 61.
[229] *Ibid* at para 62.
[230] See *ibid.*
[231] See *Insite*, *supra* note 77; *Chaoulli*, *supra* note 86.
[232] See *Insite*, *supra* note 77 at para 91.
[233] See *Chaoulli*, *supra* note 86 at paras 38, 50, 123, 191, 200.
[234] *Carter*, *supra* note 225 at para 63.

abortion services. Narrow gestational limits derived by these provinces compound this issue, as they range from about 12 to 19 weeks.[235] For example, access to abortion services in Nova Scotia has an approximate wait time of six weeks minimum to obtain an abortion.[236] However, on average, women are usually not aware they are pregnant until about five to six weeks into their pregnancy.[237] This leaves an incredibly narrow margin to obtain a legal abortion.

Each of these issues connects to the right to life under section 7; with an increase in delay to receive abortion care comes an increased risk to the life of the person seeking an abortion.[238] According to a study in the Canadian Medical Association Journal from 2019, "complications and severe adverse events associated with surgical abortion increase markedly with increasing gestational age."[239] In simple terms, people who have to wait to obtain abortions will encounter greater frequencies of potentially life-threatening complications that are avoidable through free access to more efficient private clinics. Moreover, the same study found that fatality rates increase in the following manner:[240]

- **8 weeks gestation or less**: 0.3 per 100,000 abortions
- **9-10 weeks gestation**: 0.7 per 100,000 abortions
- **11-12 weeks gestation**: 1.1 per 100,000 abortions
- **13-15 weeks gestation**: 2.2 per 100,000 abortions
- **16-20 weeks gestation**: 6.9 per 100,000 abortions

There is a stark increase in fatalities as gestational age increases. The government's failure to address delays in abortion services that private clinic services can alleviate arguably engages the right to life.

A significant drawback to the right to life argument is that fully funded private clinics in other provinces still experience similar delays. As mentioned previously,

---

[235] See "Abortion Coverage by Region", *supra* note 128.
[236] See Brett Bundale, "Wait times for abortions in Nova Scotia 'unconscionable,' advocate says" *CTV News* (15 August 2017), online: <www.ctvnews.ca/health/wait-times-for-abortions-in-nova-scotia-unconscionable-advocate-says-1.3547222>.
[237] See Amy M Branum & Katherine A Ahrens, "Trends in Timing of Pregnancy Awareness Among US Women" (2016) 21 Maternal Child Health J 715.
[238] See generally Laura Schummers & Wendy V Norman, "Abortion services in Canada: access and safety" (2019) 191:19 Can Medical Association J 517 at 517–18.
[239] *Ibid.*
[240] *Ibid.*

Quebec is a province that offers some of the most robust abortion care in the country, however, delays in obtaining services still plague the system.[241] Therefore, the lack of functional differences in delays erodes the causal connection between the government action and the right to life. Another significant drawback to this argument stems from previous jurisprudence that dictates the right to life is usually engaged when there are no other viable options but to operate under government action that threatens one's life. For instance, in *Chaoulli*, a Quebec law that prohibited the existence of private healthcare options was challenged.[242] A narrow reading of the case points to the notion that delay in wait times for public healthcare options jeopardizes the right to life *because* there were no alternatives Quebec residents could opt for.[243] That is not necessarily the case here. The legislative scheme that offers private services at a cost promotes greater access because it is a faster alternative to hospital services. Ironically, this is the exact outcome the plaintiffs in *Chaoulli* argued for – the ability to pay for faster and more efficient healthcare.[244] With respect to provinces that do not offer private services at all, the argument that a lack of private clinic options may *prima facie* align with the ratio from *Chaoulli* is not necessarily accurate either. A closer look will show that the situation can still be differentiated – provinces that do not offer private abortion services do not have a prohibition on private clinics, as in *Chaoulli*.[245]

Given the drawbacks, the lack of data in the area, and its narrow interpretation in previous jurisprudence, it is evident that arguing a right to life may be difficult in the context of challenging the lack of coverage for private abortion services.

Right to liberty

The right to liberty is twofold. It includes the right to be free of physical restraint and the right to be free from interference with fundamental personal decisions.[246] The liberty interest safeguards personal autonomy by extending protection to inherently private choices that "by their very nature…[go] to the core of what it means to enjoy individual dignity and independence."[247] To recall, Justice Wilson's decision in Morgentaler thoughtfully touched upon the liberty interest in the context of accessing

---

[241] See "Long Wait Times", *supra* note 125.
[242] See *Chaoulli*, *supra* note 86.
[243] See *ibid.*
[244] See generally *ibid.*
[245] See generally *ibid.*
[246] See *Blencoe*, *supra* note 222 at paras 49–54.
[247] *Godbout v Longueuil (City)*, [1997] 3 SCR 844, 1997 CanLII 335 (SCC) at para 66.

abortion. Justice Wilson aptly recognizes that a woman's decision to obtain an abortion is "a central part of the sphere of liberty that our law guarantees equally to all."[248] Justice Wilson further recognizes that the decision to obtain an abortion is one of personal autonomy and profound privacy.[249]

Application

At this threshold stage, it is difficult to make a compelling argument that select provincial governments violate the right to liberty in failing to adequately fund private clinic abortion services, as this framing of the access issue fits incongruently with liberty interest jurisprudence. Accessing abortion is no longer prohibited anywhere in Canada – the crux of the issue is creating *greater* access. With that said, the liberty interest is not appropriately engaged, as the decision to obtain an abortion is not directly infringed by government action or inaction. People seeking abortion services can exercise their personal autonomy and choose to terminate a pregnancy. The caveat is that there may be barriers after that decision. The liberty interest does not confer any protection over these additional barriers as they fall outside the ambit of the right.

Although Justice Wilson's dicta in *Morgentaler* made significant strides in understanding the fundamental aspects of abortion, it is inapplicable in expanding access to abortion. Justice Wilson's argument hits its stride when discussing the decision to obtain an abortion when criminal sanctions are in order. The discussion in this paper is not about the broad choice to obtain an abortion – it pertains to the aftermath of that choice and the subsequent inhibitors. Therefore, the liberty interest does not provide a persuasive constitutional vessel to bring a claim related to accessing fully funded private clinic abortion services.

Right to security of the person

First and foremost, the Supreme Court of Canada in *New Brunswick (Minister of Health and Community Services) v G(J)* clarifies that the protections afforded under the security of the person interest are applicable beyond the criminal law context, thus bringing the interest within the sphere of healthcare regulation.[250] The security of the

[248] *Morgentaler*, *supra* note 36 at 171.
[249] See *ibid.*
[250] See *New Brunswick (Minister of Health and Community Services) v G(J),* [1999] 3 SCR 46, 1999 CanLII 653 (SCC) at para 58 [*G(J)*].

person interest protects against "state interference with bodily integrity and serious state-imposed psychological stress."[251] For the purposes of this argument, state-imposed psychological stress is the most relevant vantage point to root a claim. The notion of psychological integrity has somewhat unclear boundaries. The Court in *G(J)* describes it as an "inexact science" that seems to import a minimum degree of harm necessary to be deemed an infringement.[252] According to Chief Justice Lamer:

> For a restriction of security of the person to be made out, then, the impugned state action must have a serious and profound effect on a person's psychological integrity. The effects of the state interference must be assessed objectively, with a view to their impact on the psychological integrity of a person of reasonable sensibility. This need not rise to the level of nervous shock or psychiatric illness, but must be greater than ordinary stress or anxiety.[253]

Therefore, to determine if a particular state interference creates "serious state-imposed psychological stress,"[254] the claimant must meet two requirements.[255] The Court in *Blencoe* delineates the requirements as follows, "[f]irst, the psychological harm must be state imposed, meaning that the harm must result from the actions of the state. Second, the psychological prejudice must be serious."[256]

Application

When challenging select provincial healthcare regimes based on a failure to fund private clinic abortions, arguing an infringement of the security of the person interest will likely be the most effective option. In examining the first requirement of the test, whether the psychological harm was state imposed, it is crucial to examine any direct links between the harm and government interference.[257] The lack of funding for private clinics prevents people seeking abortions from receiving timely and adequate care for similar reasons canvassed under the life interest argument. Furthermore, the practical operation of the failure to provide full funding to private clinics forces women who cannot afford timely services to jeopardize the efficacy of their procedure by waiting for the public system to catch up to their needs. As Justice Oliphant

---

[251] *Blencoe*, *supra* note 222 at para 55.
[252] *G(J)*, *supra* note 247 at para 59; Erdman, "Back Alleys", *supra* note 84 at 1106.
[253] *G(J)*, supra note 247 at para 60.
[254] *Morgentaler*, *supra* note 36 at 56.
[255] *Blencoe*, *supra* note 222 at para 57.
[256] *Ibid.*
[257] See generally, *ibid* at paras 307, 350.

eloquently dictates in *Jane Doe*, the effect of the lack of funding for private clinics in Manitoba "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."[258]

The second requirement is relatively uncontroversial, as the case law and research suggest that the impact of delayed abortion access causes exigent concerns for those seeking to terminate their pregnancy. As Chief Justice Dickson outlines in *Morgentaler*, "[i]n the context of abortions, any unnecessary delay can have profound consequences on a woman's physical and emotional well-being."[259] According to a 2008 study completed by the American Psychology Association, women who obtained abortions in their first trimester faced fewer mental health problems than women who continued with their pregnancies, thus illuminating the importance of improving access to timely abortion care.[260] Moreover, another study found that women who were denied abortion care reported more significant mental health issues and lower life satisfaction than those who were able to obtain abortions.[261] Overall, a person's ability to obtain accessible and timely abortion services unencumbered by financial burdens is imperative to their social, political, and economic futures.

Many of the counterarguments that erode the security of the person argument are articulated in the life interest section and do not warrant significant discussion. Firstly, adjacent case law, including *Chaoulli* and *Morgentaler*, successfully finds that the government infringed the security of the person interest because the state interference was prohibitive in nature.[262] In the case of accessing fully funded abortion services in private clinics, there is no comparable legislative prohibition that makes this argument analogous. Furthermore, the security of the person interest, and section 7 more broadly, has never been interpreted to impose a duty on the government to provide

---

[258] *Jane Doe*, *supra* note 164 at para 67.
[259] *Morgentaler*, *supra* note 36 at 57.
[260] See Zara Abrams, "The Facts About Abortion and Mental Health" (2008) 53:6 American Psychology Association 40.
[261] See M Antonia Biggs et al, "Women's Mental Health and Well-Being 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study" (2017) 74:2 JAMA Psychiatry 169.
[262] See Erdman, "Back Alleys", *supra* note 84 at 1110–11. See generally *Chaoulli*, *supra* note 86; *Morgentaler*, *supra* note 36.

fully funded healthcare services.[263] In this regard, *Jane Doe* is the only case to make this leap, albeit the precedential weight of the case is questionable.[264]

Although an argument challenging select provincial healthcare regimes based on the failure to fund private abortion clinics seems like a fruitful avenue with some compelling arguments, it is unclear whether it would succeed.

Summary

Significant and overwhelming barriers exist to rooting arguments within each interest outlined in section 7. In order to maximize the potential for the success in a section 7 claim, there is a dire need for more recent and targeted data to help illustrate the consequences of failing to provide fully funded abortion services in each province.

ii. Section 15(1): Equality Rights

On multiple occasions, the Supreme Court of Canada articulates that the purpose of section 15(1) is twofold.[265] Firstly, section 15(1) "expresses a commitment deeply ingrained in our social, political and legal culture – to the equal worth and human dignity of all persons."[266] Furthermore, section 15(1) promulgates "the promotion of a society in which all are secure in the knowledge that they are recognized at law as human beings equally deserving of concern, respect and consideration."[267] The second distinct purpose of section 15(1) relates to "a desire to rectify and prevent discrimination against particular groups 'suffering social, political and legal disadvantage in our society.'"[268]

The leitmotif that underscores section 15(1) jurisprudence is the notion of substantive equality, which ensures "equality in the formulation and application of the law."[269] In other words, the Supreme Court of Canada in *Andrews* disavows the overly

---

[263] Colleen M Flood, "Just Medicare: The Role of Canadian Courts in Determining Health Care Rights and Access" (2005) 33:4 JL Med. & Ethics 669 at 671; Erdman, "Back Alleys", *supra* note 84 at 1114.
[264] See generally *Jane Doe*, *supra* note 164; Erdman, "Back Alleys", *supra* note 84 at 1115.
[265] See *Eldridge*, *supra* note 150 at para 54.
[266] *Ibid.*
[267] *Andrews v Law Society of British Columbia*, [1989] 1 SCR 143, 1989 CanLII 2 (SCC) at 171 [*Andrews*].
[268] *Eldridge*, *supra* note 150 at para 54, citing *R v Turpin*, [1989] 1 SCR 1296, 1989 CanLII 98 (SCC) at 1333.
[269] *Andrews*, *supra* note 264 at 171.

formalistic approach to equality that propagates sameness in treatment rather than accommodating differences.[270] Another important concept evolving through the case law is the notion of adverse effects discrimination. In the Supreme Court of Canada's most recent articulation, adverse effects discrimination "occurs when a seemingly neutral law has a disproportionate impact on members of groups protected on the basis of an enumerated or analogous ground."[271] Adverse effects discrimination is usually more sinister than *prima facie* discriminatory, as it functions in a manner that indirectly places protected groups at the hands of increased disadvantage.[272] Adverse effects discrimination becomes especially relevant in the healthcare context, as not many laws relating to the distribution of healthcare are outwardly discriminatory.[273]

The framework for a section 15(1) claim involves two key steps. Firstly, the "claimant must demonstrate that the impugned law or state action on its face or in its impact, creates a distinction based on enumerated or analogous grounds."[274] Under this prong of the test, adverse effects discrimination is relevant.[275] In order to meet this requirement, the Court in *Auton* stipulates that the claimant must show they failed to receive a benefit that the law provided to others or that they endured a greater burden that the law did not inflict on others.[276] Secondly, a claimant must show that the impugned law or state action "imposes burdens or denies a benefit in a manner that has the effect of reinforcing, perpetuating, or exacerbating disadvantage."[277] The Court clarifies the second step of the section 15(1) analysis in *Fraser*, outlining that its primary function is to "examine the impact of the harm caused to the affected group."[278] Furthermore, the second step of the analysis is highly contextual and fact-specific, as "[t]here is no 'rigid template' of factors relevant to this inquiry."[279]

Step 1: Does the law in the relevant province that excludes private clinic abortions from funding, on its face or in its impact, create a distinction based on enumerated or analogous grounds?

---

[270] See generally *ibid.*
[271] *Fraser v Canada (Attorney General)*, 2020 SCC 28 at para 30 [*Fraser*].
[272] See *ibid.*
[273] See generally *Eldridge*, *supra* note 150.
[274] *Fraser*, *supra* note 268 at para 27.
[275] See *ibid* at paras 50-55.
[276] See *Auton*, *supra* note 151 at para 27.
[277] *Fraser*, *supra* note 268 at para 27.
[278] *Ibid* at para 76.
[279] *Ibid.*

In using a similar line of reasoning to the claimants in *Jane Doe*, it is plausible to argue that the provincial laws that exclude private clinic abortions from funding place an undue burden on women to pay for efficient, timely, and accessible healthcare services that are distinct from the rest of the population in that province.[280] Although the law does not amount to a *prima facie* violation of section 15(1) by singling out women, it places women at an inherent disadvantage in its practical effect.

In settling on the enumerated ground of sex, two relevant counterarguments should be addressed and rebutted. Firstly, it is possible to argue that the broad umbrella group of "women" may not adequately demonstrate the adverse effects of these provincial laws. Thus, a more defined subgroup of "pregnant women" would offer a more poignant evidentiary focus to root the claim. This line of reasoning imitates the failed adverse effects discrimination claim in *Symes v Canada* that distinguished women and potentially single mothers demonstrating the disproportionate burden of childcare expenses.[281] In response, the Supreme Court of Canada recognizes pregnancy as a derivative of sex as an enumerated ground. As Chief Justice Dickson notes in *Brooks v Canada Safeway Ltd*, "[d]iscrimination on the basis of pregnancy is a form of sex discrimination because of the basic biological fact that only women have the capacity to become pregnant."[282] The second counterargument surrounds the notion of choice. It is possible to argue that burdens are not incurred by the failure to fund private clinics *because* the clients are women; burdens are incurred because women *choose* to terminate their pregnancies.[283] This argument, however, is dissonant with section 15(1) precedence, as "differential treatment can be discriminatory even if it is based on choices made by the affected individual or group."[284] In this regard, sex as a protected ground is an appropriate category to root this claim.

To show adverse impacts discrimination concerning the failure to fund private abortion clinics in select provinces, it will be helpful for claimants to bring forth evidence of statistical disparity or other disadvantages to ground this claim.[285] This verification includes "evidence about the circumstances of the claimant group *and*

---

[280] See generally Erdman, "Back Alleys", *supra* note 84 at 1118; *Jane Doe*, *supra* note 165 at para 56.
[281] See [1993] 3 SCR 624, 1997 CanLII 327 (SCC).
[282] [1989] 1 SCR 1219, 1989 CanLII 96 (SCC) at 1241.
[283] See *Fraser*, *supra* note 268 at paras 85–86.
[284] *Ibid* at para 86.
[285] "Section 15 – Equality Rights" (14 April 2022), online: *Charterpedia* <www.justice.gc.ca/eng/csj-sjc/rfc-dlc/ccrf-ccdl/check/art15.html>.

about the results produced by the challenged law."[286] Thus, this evidence will be unique to each claim and each province. From a broader perspective, however, the crux of the argument lies in showing that women face additional burdens that others in society do not face in trying to obtain fully funded abortion services. At its core, the laws that do not allow for funding private clinic abortions impose a burden on women to pay for timely and safe care that can have potentially life-altering consequences that others in society do not have to deal with. Abortion services are deemed medically required under the relevant federal and provincial healthcare legislation, and by failing to fund such services based on the location of the procedure imposes an unnecessary constraint on women seeking abortions. By effectively forcing women to wait for fully funded services under hospital providers, they are subject to avoidable delays that can aggravate psychological, physical, and emotional harm.

Although meritorious in certain aspects, the argument outlined above will run into pushback on two major grounds. Firstly, many healthcare-related arguments within section 15(1) jurisprudence are successful because there is an overall failure to provide specific services. For example, the Court in *Eldridge* finds a violation of section 15(1) because of British Columbia's outright failure to provide interpreter services for all deaf persons.[287] The argument concerning accessing abortion does not take the same framing. Rather, the access to abortion argument is more analogous to the one raised in *Auton*, in which the challenged scheme was one of funding under *certain* circumstances.[288] The Court in *Auton* finds that the *CHA* "does not have as its purpose the meeting of all medical needs."[289] More specifically, the Court holds that the *CHA* does not promise the benefit of funding for all medically required services.[290] As a corollary, the second weakness in the access to abortion argument stems from the fact that hospital abortions remain available. There are plenty of other parallel procedures offered in the private healthcare sector that offer administrative efficiencies and more pleasant experiences by virtue of their payment, however, this does not necessarily root a claim under section 15(1).

---

[286] *Fraser*, *supra* note 268 at para 60.
[287] See *Eldridge*, *supra* note 150.
[288] See *Auton*, *supra* note 151.
[289] *Ibid* at para 43.
[290] See *ibid* at para 35.

Step 2: Do the select provincial laws impose burdens or deny benefits in a manner that has the effect of reinforcing, perpetuating, or exacerbating disadvantage?

The inability to access safe and timely abortion services effectively erodes a woman's personal autonomy, self-determination, and future. As Justice Oliphant explains in *Jane Doe*, "[t]he impugned legislation limits and impairs a woman's freedom to assert her autonomy and to exercise self-determination thereby affecting a woman's human dignity in an adverse manner."[291]

Abortion has always been a contentious topic in society's eyes. This attitude is evident from the disproportionate and aggressive approach to regulating abortion through criminalization in the pre-*Morgentaler* era. There is a connection between the ability to terminate pregnancies with minimal barriers and the parity of women on a relative social scale. A study done in 2017 on the impact of unplanned birth on women's lives found significant adverse outcomes that greatly impacted a woman's ability to participate in society.[292] Out of the women tested from ages 18 to 44, many found that proceeding with an unplanned pregnancy would harm educational plans (65.7%), maintenance and success in a job (58.4%), earning an income (63.2%), a general motivation to achieve their individual life goals (33.1%), physical health (40.7%), mental health (58.6%), and their relationship with their partner (28.1%).[293] Many of these perceived negative impacts are linked to areas where women already represent a disproportionate societal group. Overall, the discriminatory impact of inaccessible abortion services has multi-faceted consequences for women who wish to terminate their pregnancies. Not only do inaccessible abortion services exacerbate disadvantage for women at a micro-level considering the tumultuous history of abortion, but it also perpetuates women's disadvantage at a macro-level, as it augments deep-rooted societal issues of subordination and systemic sexism.

Summary

---

[291] *Jane Doe*, *supra* note 164 at para 57.

[292] See Emily M Johnston et al, "Beyond Birth Control: Family Planning and Women's Lives – Prevalence and Perceptions of Unplanned Births" (March 2017), online: (pdf) *Urban Institute* <www.urban.org/sites/default/files/publication/88801/prevalence_and_perceptions_of_unplanned_births.pdf>; Lawrence B Finer et al, "Reasons US Women Have Abortions: Quantitative and Qualitative Perspectives" (2005) 37:3 Perspectives on Sexual and Reproductive Health 110.

[293] Johnston, *supra* note 289.

Although the argument demonstrated under the second prong of the section 15(1) test is quite strong, there are fairly significant barriers at the first stage of the analysis that will likely impede a claimant's ability to pursue a successful claim. With significant barriers and persuasive case law that points to a contrary result when rooting a healthcare claim under section 15(1), it is unlikely that this avenue will assist in creating greater access to abortion in select provinces that fail to fund private clinic services.

Conclusion

Overall, access to abortion services in Canada is desperately inadequate to meet the demands of those in need. As a result, increased protection and expansion of abortion services are necessary. Unfortunately, due to the constitutional structures in place, a lack of recent data collection, and the lack of government regulation, pursuing legal action to protect access to abortion is unlikely an effective solution. Other avenues, such as political or social advocacy, are a more efficacious and realistic method of expanding access to abortion in Canada.

In summary, since the *Morgentaler* decision, abortion has operated within a statutory lacuna in Canada. A lack of regulation, however, does not necessarily mean that access to abortion is abundant. This notion is evident when surveying the various barriers and levels of access to abortion services in each jurisdiction in Canada. To promote greater access, constitutional routes are likely to be unsuccessful advocacy methods, as outlined in Part IV of this paper. Specifically, *Charter* challenges and the use of novel doctrines, like the national concern test, are unsuitable for expanding or protecting access to abortion. Although the arguments discussed in this paper are unlikely to succeed in the current Canadian constitutional landscape, that is not to say that raising these arguments is impossible. Different variables, such as data collection, research, and causal evidence, will be germane in rooting a legal claim and may potentially strengthen the arguments outlined in this paper.

Although the potential constitutional routes discussed in this paper may not offer fruitful paths forward in obtaining greater access to abortion, all hope is not lost. Through political and social activism, the federal government increased funding for abortion services in 2022 by over $1,000,000 nationally.[294] Though there is much work

[294] Health Canada, News Release, "Government of Canada Strengthens Access to Abortion Services" (11 May 2022), online: *Government of Canada* <www.canada.ca/en/health-canada/news/2022/05/government-of-canada-strengthens-access-to-abortion-services.html>.

to be done, the confines of constitutional legal mechanisms in Canada are not the only effective means to propagate potential progress in increasing access to abortion.