Drifting Apart: the Evolution of Contemporary Abortion Policies across Canada

by

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Abstract

This thesis takes an innovative approach to examining health care policy by applying the concept of policy drift to the issue of access to abortion across Canada through analyzing three explanations: the structure of Canadian federalism, women’s organizations, and rights litigation. The Supreme Court of Canada ruled that section 251 of the Criminal Code of Canada was unconstitutional in R v. Morgentaler (1988). Section 251 forced women to secure the approval of a panel of medical experts in order to gain legal consent to seek an abortion. As a result of this decision, women are now able to undergo a therapeutic abortion procedure without facing criminal sanctions. However, the issue of equitable access to abortion services across Canada is still unresolved. For example, women living in Prince Edward Island have to travel out of province at their own expense to undergo an abortion procedure. Meanwhile, women in Ontario are able to undergo an abortion procedure at a number of hospitals and private clinics with provincial insurance subsidizing the financial burdens. Abortion is a time-sensitive procedure and different from other health care procedures because it is also gender-sensitive. Findings within this thesis suggest that the model of Canadian federalism contributes to the inability of women’s organizations to gain audience from the federal government and inhibits the courts from assisting in expanding provincial access, which further facilitates policy drift. Recognizing policy drift concerning access to abortion is significant because it is an issue that involves gender equity at its core as well as discussions over what society deems is a right and what society deems is fair.
Acknowledgements

The process of writing this thesis on access to abortion has been one of the most difficult, but rewarding experiences of my life. For as long as I can remember I have prioritized education above all else and it is extremely inspiring to finally be able to offer a contribution back to society to repay the gracious opportunities provided to me by the University of Guelph. Guelph truly is one of the best communities a student could hope to undertake their studies.

However, I would not have been able to complete this project without a tremendous amount of help and support from some of the most wonderful people in the world (and who I have drawn inspiration from over the years) including my friends (Tim, Justin, Andrew, Tristan, and John); my family (Mom and Dad; Kara and Rob); and my thesis committee (Professor Julie Simmons and Professor Byron Sheldrick).

Finally, I would like to offer a special acknowledgement to my advisor, Professor Candace Johnson, who worked tirelessly to help me cultivate this project over the last year and a half.

“It is in fact a part of the function of education to help us escape, not from our own time — for we are bound by that — but from the intellectual and emotional limitations of our time.”

-T.S. Eliot
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Introduction

The existing abortion policy landscape in Canada is dramatically different from one province to the next. The Supreme Court of Canada ruled more than two decades ago that it was unconstitutional for Canadian law to require a woman to gain approval from a panel of health care professionals prior to obtaining an abortion. Nonetheless, the federal government did not create a national policy on abortion and left the decision to each provincial legislature as the Constitution Act of 1867 grants health care jurisdiction to provinces. As such, there exists a great deal of variance in contemporary abortion policy across Canada. In provinces like Ontario and British Colombia, there are a number of public and private facilities offering abortion procedures and the government lists the service as one that must be subsidized by the respective provincial public health care systems. However, in other provinces, such as P.E.I., there exists no provincially or privately-run facilities that provide abortion services.

The policy vacuum in the absence of federal abortion legislation after the 1988 Supreme Court decision has spawned a confusing patchwork of access to abortion for women across Canada. This patchwork hampers women’s ability to gain equal access to a health care service that is unique to women as is the capacity to give birth. Given that the issue of abortion is gender specific and time sensitive (doctors will not perform abortions in Canada beyond a gestation limit of 21 weeks or 23 weeks in instances of imminent maternal health threats), it seems illogical and inequitable that a woman in Ontario would be able to have readily available
access to abortion services while a woman in Prince Edward Island faces restrictions and barriers.

This thesis argues that this patchwork of services is attributable to the absence of federal policy and the resultant policy ‘drift’ in this area. Utilizing drift in Canada as a lens for analysis is an innovative approach concerning health care issues, such as abortion, because policy drift is a concept that has traditionally been associated with American policy analysis.¹ Jacob Hacker defines drift as, “changes in the operation or effect of policies that occur without significant changes in those policies’ structure.”² In essence, the policy itself may not change in any significant way, but the impact or consequences felt by recipient groups of the policy do change over time.

Jones and Baumgartner, define drift slightly differently: “when many small factors impinge on the course of public policy, the result will be an incremental pattern of change often characterized by policy scholars as ‘policy drift’.”³ Streeck and Thelen argue that, “since drift is an informal process that may have serious societal consequences, it may explain the paradox of change as experienced by a popular social program in the absence of formal decisions; otherwise known as ‘change without change.’”⁴ Streeck and Thelen’s characterization of policy drift clarifies how a policy may come to differently impact a portion of the population without significant change to the language and structure of the original policy.

Thus, looking at the issue of abortion policy in Canada, one may observe a certain degree of ‘drift’ occurring after the Supreme Court ruled that section 251 of the Criminal Code of Canada contravened constitutional rights. This decision struck down the legal requirement that a woman gain consent from a panel of three doctors before qualifying as a viable candidate for an abortion procedure. The Supreme Court of Canada ruled that this requirement infringed on a woman’s fundamental rights, under section 7 of the Charter of Rights and Freedoms (the right to life, liberty, and security) to maintain control over her own reproductive capacity. But, the Supreme Court decision left a policy vacuum concerning specific legislation regulating equitable access to abortion across Canada. It also spawned further debate over health care as an entrenched right.

Jacob Hacker suggests that, “an appealing option that can facilitate the achievement of the same policy goals for a government, without negative political repercussions, is to permit policy drift.” When provinces like New Brunswick or Prince Edward Island intentionally chose to largely ignore the absence of certain kinds of health services (like abortion) in their jurisdictions, the political consequences are limited for the federal government as the decisions appear to exceed the capabilities of the federal government to act.

Hacker’s assessment of the intentionality associated with drift is significant because it provides a distinction from the phenomenon of incremental-policy-change and provides another reason for analyzing abortion policy through a lens of policy drift. The absence of federal policy has created intentional opportunities for drift and neglect by both the federal and provincial governments. Despite the existence of health care as a provincial jurisdiction, policy drift

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concerning access to abortion seems to be occurring at the federal level of government as well. The federal government no longer engages provinces in discussion concerning their non-compliance with the Canada Health Act – in this case limited access to abortion services – and a lack of funding to women’s organizations has further subverted the issue of abortion. The unwillingness of the federal government to aggressively pursue provinces in non-compliance with the Canada Health Act and demonstrate consistent fiscal support for women’s organizations diminishes the opportunity for women to voice concerns and experiences concerning abortion procedures.

Policy drift concerning access to abortion across Canada seems to be occurring not just at the federal level of government, but in some provinces as well, such as Prince Edward Island and New Brunswick, but not in other provinces like Ontario and British Colombia. This thesis argues that this drift is intentional, but appears inadvertent. Provinces such as New Brunswick and Prince Edward Island claim that budgetary constraints concerning health care limit the capacity to fund or expand access to a variety of health care initiatives, including, but not limited to abortion procedures. Thus, provincial legislatures in New Brunswick and Prince Edward Island seem to be achieving a specific policy outcome concerning abortion by intentionally maintaining the status quo while espousing that such a decision is beyond institutional control and a change in the impact felt by women is inadvertent.

This thesis also argues that the inability of various women’s organizations to gain favourable court outcomes in provinces such as New Brunswick seems to reinforce the legislature’s position on maintaining the status quo on abortion policy. Further, New Brunswick and Prince Edward Island governments have actively challenged court cases involving abortion
policy indicating an element of intentionality on behalf of the provincial legislatures in Prince Edward Island and New Brunswick to restrict abortion access.

In order to gain deeper understanding of the application of drift to abortion policy in Canada, it is important to apply the contributions of Jacob Hacker on the definition of social policy drift. According to Hacker, “the hallmark of change of this sort is that it occurs largely outside the immediate control of policymakers, thus appearing natural or inadvertent.”\(^6\) Thus, the change in policy effect and its seemingly organic manifestation implies that there is still a question of key explanations culpable for this drift to address. Again, Hacker makes the significant argument that while active initiatives to reduce the coverage of social policies are unsuccessful, it is comparatively simple to block the adaptation of existing policies.\(^7\) Heclo demonstrated this line of arguing as well by suggesting, “the easiest way to change a policy is to fail to make a program to accord with the movement of events.”\(^8\)

Subsequently, Hacker asserts that the questions for policymakers become whether or not and how to address the growing gap between intent and reality concerning the creation of public policy. Abortion in Canada reflects this dispute between intent and reality as evidenced by the gap between the intended reasoning for Parliament choosing not to pursue further criminal sanctions and social reality concerning a patchwork of abortion services. Perhaps, following the Supreme Court decision in 1988, the federal government could have immediately started a campaign to secure compliance with the Canada Health Act provision of equality while emphasizing abortion as a unique case because of gender and time sensitivity.

\(^7\) Hacker, 2004, p. 247.
Lastly, Hacker points-out that policy drift typically occurs when there has been insufficient updating, which facilitates a lack of responsiveness in policy changes that have occurred.\(^9\) The evolution of contemporary abortion policies across Canada reflects policy change as well as the impact felt by women in different provinces. However, The Harper Government announced in 2006 that abortion would no longer be a priority discussion with the provinces, which seems to reflect the notion of insufficient updating alluded to by Hacker. In the context of the Harper government’s preferred brand of conservative ideology policy in-action may seem like drift has positive implications for abortion. However, a lack of action from the federal government subverts the issue of access to abortion even further and removes pressure on provinces like New Brunswick and Prince Edward Island from complying with the Canada Health Act.

Certainly, one must also address the issue of why abortion procedures pose a case deserving a greater degree of attention when most areas of health care across Canada are a patchwork and represent the same sort of interprovincial variation as evidenced in abortion policy. Abortion policy warrants this type of treatment largely because it is highly gendered and involves the issue of gender equity at its core. The existence of policy drift concerning access to abortion in Canada seems to indicate that abortion has been subverted on the list of priorities for social and political society to discuss. However, abortion remains an issue of gender equity with the capacity to marginalize groups of Canadian women, which merits continued analysis and discussion. The ability to give birth exclusively belongs to a woman, which ought to suggest that women have the ability to choose to give birth or not to give birth. However, the political landscape in Canada reflects a much different reality as many women are marginalized and not

granted equal opportunities to choose, let alone have their voice heard in debates over the issue of choice.

The goal of the following research project is to analyze key explanations for policy drift and identify and understand how these explanations interact in a way that may contribute to a gender equality deficit. The first key explanation to consider within this research project would be the institutional layout of Canadian federalism. Federalism is an important explanation to analyze because of the significant relationship between health care services and federal-provincial jurisdiction and constitutional guarantees. Additionally, this explanation could facilitate some significant questions concerning abortion policy and subsequent drift across Canada. For example, how does the institutional arrangement impact abortion policy development in the provinces and territories across Canada? Moreover, does the structure of Canadian federalism enable intentional policy change or drift? These are key questions to explore that may help to identify barriers preventing more equitable access to abortion services across Canada.

The second key explanation under consideration in this research project is the impact of the courts and pursuit of legal avenues using the Charter of Rights and Freedoms. This explanation is important to analyze because the initial Supreme Court decision that ruled criminal legislation on abortion as unconstitutional comprises the beginning of the period of policy drift concerning access to abortion across Canada. Further, this explanation is important to explore because of the lack of success women have had in using the courts to gain more equitable access to abortion services. Additionally, from this second explanation, more important questions concerning abortion policy drift arise. For example, how have certain court decisions influenced the development of abortion policy across Canada? Identifying potential
influences and the limitations of judicial authority may help to explain abortion policy drift and the issue of gender equality. Additionally, the issue of access to abortion may have broader significance for gender equality issues as a whole. Restricting access to abortion in provinces like Prince Edward Island and New Brunswick and subsequently marginalizing groups of women seems to reflect a pattern of legislatures failing to be inclusive of the perspectives of some groups of women on various gender-sensitive issues.

The third and final key explanation that this research project will explore is the influence of competing women’s organizations and their interaction with the federal and provincial governments. This is an important explanation to analyze because it may help to provide an understanding of the influence that certain women’s groups had on those movements striving for greater access, but also provide an understanding of the limited ability of social movements to influence the federal policy-process. Once again, there are some key questions that the exploration of this movement can facilitate. For example, have competing women’s organizations (such as those striving for in-vitro fertilization and reproductive rights) distracted policymakers from abortion issues? Further, does the federal government decision to rarely consult social movements on policy decisions and/or its decision to treat them as constituents, inhibit the expansion of access to abortion services across Canada?

Ultimately, each of the three key factors is significant in explaining policy drift concerning access to abortion across Canada. However, it seems that federalism is the most significant explanation for drift concerning access to abortion across Canada as the institutional-structure associated with Canadian federalism facilitates rights litigation and competition among women’s groups, which in turn, contributes to policy drift in abortion policy.
Chapter one: The Institutional Structure of Canadian Federalism

An Introduction to Federalism and Drift

When discussing concepts such as federalism and ‘drift’ it is important to understand that the 1988 Supreme Court decision indicated uniformity by stating that enforcement of criminal restrictions on abortion was unconstitutional. However, while the Supreme Court of Canada may have indicated uniformity concerning criminal sanctions, the model of federalism in Canada is supposed to allow for variation as health care falls within provincial jurisdiction as stipulated in the Constitution Act, 1867. (Table 1 provides a dichotomy of provinces and territories with full insurance subsidies for abortion procedures and provinces and territories with no or limited subsidies for abortion procedures.) Policy drift, as argued by Hacker, can be distinguished from policy change by the notion of intent. This thesis argues that policy drift is intentional concerning access to abortion across Canada. Subsequently, the structure of Canadian federalism provides one explanation for abortion policy drift because of the complications concerning federal and provincial jurisdiction in health care policy, political ideology, the structure of the health care system in Canada, a lack of concern for women’s perspectives and fundamental justice concerning gender equity in the policy process, and the confusing patchwork of bi-lateral agreements between provinces.

Table 1

<table>
<thead>
<tr>
<th>Full Subsidies for</th>
<th>Policy</th>
<th>Limited or No</th>
<th>Policy</th>
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<tr>
<th>Abortion Procedures</th>
<th>Subsidies for Abortion Procedures</th>
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<tr>
<td><strong>Ontario</strong></td>
<td><strong>Prince Edward Island</strong></td>
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<tr>
<td>- Women have the option of accessing services from a private clinic or one of a number of public hospitals. - Provincial health insurance plans subsidize the entire cost accrued by a woman receiving the abortion services in both private and public healthcare facilities. - 6 private facilities and approximately 76 of the 210 public hospitals provide access to abortion services for women.</td>
<td>- Women have nowhere within the province to seek an abortion procedure. - 7 public hospitals, but none offer abortion services. - No private clinics exist. - A woman can make a claim for out-of-province insurance reimbursement, but requires the support of a panel of practitioners and the consent of the province.</td>
</tr>
<tr>
<td><strong>Newfoundland</strong></td>
<td><strong>New Brunswick</strong></td>
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<td>- Two of the 15 public hospitals in operation provide women with abortion services as well as one private clinic. - Provincial health insurance completely subsidizes the costs of abortion services at the two public hospitals and the private clinic.</td>
<td>- A woman must gain consent from two practitioners before a publicly funded abortion at a public hospital even becomes an option. - 2 public hospitals perform abortion operations. - Women must absorb the service fees and travel expenses for attending the lone private clinic.</td>
</tr>
<tr>
<td><strong>British Columbia</strong></td>
<td><strong>Nova Scotia</strong></td>
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<tr>
<td>- All trips made by women to both public and private healthcare facilities are covered by provincial health insurance. - 37 of the 100 public hospitals offer abortion services for women. - Additionally, there are 3 private facilities offering abortion services.</td>
<td>- The provincial health insurance will completely cover costs to women at the 5 public hospitals performing the procedure. - Nova Scotia has only listed partial insurance reimbursement for women using the services at the lone private abortion facility.</td>
</tr>
<tr>
<td><strong>Quebec</strong></td>
<td><strong>Saskatchewan</strong></td>
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<tr>
<td>- Provincial health insurance completely subsidizes costs for women at public hospitals and health centres and costs private facilities. - 30 of the 155 public hospitals in operation provide women with access to abortion services. - Additionally, 5 private clinics exist, but also</td>
<td>- Provincial health insurance plans subsidize the costs at public hospitals. - However, only 2 public hospitals perform abortion procedures. - No private clinics exist in the province should a woman have the financial resources to afford such services.</td>
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CLCS facilities (Community Health Centres) and WHC facilities (Women’s Health Centres).

**Territories**

- In the Yukon, 1 of 2 public hospitals provides abortion services and the government subsidizes service fees and travel costs for women attending clinics.
- In the Northwest Territories, both of the public hospitals provide abortion services and the government subsidizes service fees and travel costs.
- In Nunavut, 1 public hospital provides abortion procedures and the government subsidizes travel and service fees.

**Manitoba**

- Provincial health insurance subsidizes costs at public hospitals.
- 2 public hospitals perform abortion procedures and 1 private facility.
- Provincial health insurance only partially subsidizes service fees and travel expenses to the private facility.

**Alberta**

- 3 of the 99 public hospitals provide abortion services and there are 2 private facilities.
- Provincial health insurance subsidizes travel and service fees at public and private facilities.

Additionally, in order to conceptualize the potential dangers and discrimination towards women living in provinces where contemporary legislation places restrictions on access to abortion, such as Prince Edward Island and New Brunswick, it is crucial to understand how the restrictions on abortion that existed under the previous statute, section 251 of the Criminal Code of Canada, were oppressive. For example, the provision that a women had to appear in front of a panel of doctors and gain consent from each doctor on the panel in order to gain access to abortion services essentially privileged women possessing more wealth while women in lower
socio-economic demographics were disadvantaged.\textsuperscript{11} Wealthier women had the resources to attend the committee hearings and seek-out a suitable clinic or hospital within the safe gestation limit of 21 weeks.\textsuperscript{12} This type of discrepancy seems to reflect marginalization of a group of women because of socioeconomic status and not a lack of access based on government resource availability.

Further, wealthier women tended to have better relationships with their doctors and also had the resources to navigate the legislation.\textsuperscript{13} This also seems indicative of too much authority concentrated with doctors, which ultimately subjected women to doctors or health care professionals who may have had personal and moral reasons to use the legislative provisions under section 251 of the Criminal Code of Canada to actively dissuade or a prevent a woman from obtaining access to abortion services.\textsuperscript{14} The 1988 Supreme Court of Canada ruling that such provisions under section 251 of the Criminal Code of Canada were unconstitutional and deprived a woman of her fundamental rights under section 7 of the Charter of Rights and Freedoms (the right to life, liberty, and security) emphasized the oppressive nature of the previous legislation governing access to abortion across Canada. Women were denied the capacity for choice over their own reproductive system and personal health. Nonetheless, presently, provinces such as New Brunswick refuse to fund access to abortion and Prince Edward Island offers no access to abortion services and will only accommodate travel expenses on the condition that a woman gain consent from a committee of doctors. This condition or restriction seems to parallel provisions under the previous Criminal Code of Canada legislation.

\footnotesize{\textsuperscript{11} Center for Reproductive Rights. Whose Choice: How the Hyde Amendment Harms Poor Women. 2010.}
\footnotesize{\textsuperscript{14} Gavigan, 1992. P. 121.}
section 251, which was ultimately deemed to be unconstitutional by the Supreme Court of Canada.

Under the Constitution Act, 1867, section 92 grants the provinces exclusive jurisdiction concerning the establishment, maintenance and management of hospitals. Section 91 of the Constitution Act guarantees that, “it shall be lawful for the Queen, by and with the advice and consent of the Senate and House of Commons, to make laws for the peace, order, and good government of Canada, in relation to all matters not coming within the classes of subjects by this act assigned exclusively to the legislatures of the provinces.” Section 92 of the Constitution Act guarantees provincial jurisdiction over the, “establishment, maintenance, and management of hospitals, asylums, charities, and eleemosynary institutions in and for the province, other than marine hospitals.” Taken together, these provisions give the provinces primary constitutional responsibility for health care and health care services in Canada. However, the federal government also has jurisdiction over specific facets of health care. For example, the federal government is responsible for: setting and administering national principles for the health care system through the Canada Health Act, assisting in the financing of provincial/territorial health care services through fiscal transfers, delivering health care services to specific groups (e.g. First Nations and Inuit and veterans), and providing other health-related functions such as public health and health protection programs and health research.

Health Care as a Provincial and Federal Jurisdiction

15 The Constitution Act, 1867, 30 & 31 Victoria, c 3, Section 92.
16 The Constitution Act, 1867, 30 & 31 Victoria, c 3, Section 92.
17 The Constitution Act, 1867, 30 & 31 Victoria, c 3, Section 92.
In order to gain a complete understanding of Canadian federalism pertaining to health care, it is also crucial to recognize the extent of and limitations to federal jurisdiction. Howard Palley points out strong contradictions between the legislation of the provinces and the central governing legislation, the Canada Health Act. Palley notes that, in return for federal financing to offer medically necessary services, the Canada Health Act requires provinces and territories to provide equal access to such services. Nonetheless, Palley is quick to assert that constitutionally, under both the 1867 North America Act and the current 1982 Constitution, the operation of health care delivery systems in Canada is primarily reserved for the provinces—allowing the federal government to only sanction provincial violations of the Canada Health Act (CHA) with financial penalties. The federal government constitutionally may, but usually does not, intervene more directly in territorial matters. Further, the growth of provincialism over time, and the federal government’s wavering financial commitment to health care since the mid-1990s may be significant in explaining the federal government’s reluctance to more aggressively sanction non-conforming provinces. Thus far, Palley’s research seems to reflect the variation in provincial health care policies, and the limitations on federal jurisdiction, concerning abortion services, within the context of a broad constitutional analysis.

In order to understand the limitations on federal jurisdiction it is prudent to understand the constitutional jurisdiction granted to the federal government (through the federal spending power). The federal spending power in Canada refers to, “the power of Parliament to make payments to people or institutions or governments for purposes on which it (Parliament) does not


20 Palley, p. 566.

necessarily have the power to legislate.”

Karine Richer points-out that the conditional grants come with certain ‘strings attached,’ as provinces are required to meet federal standards in order to receive the federal transfers. Since 2004, the main conditional federal grants have been the Canada Social Transfer (CST) and the Canada Health Transfer (CHT), which are also known as ‘block transfers.’ To receive these block-transfers in the area of health care, the provinces must demonstrate compliance with the provisions of the Canada Health Act. The auditor general’s 1999 report stated, “Parliament cannot readily determine the extent to which each province and territory has satisfied the five criteria (i.e. universality, comprehensiveness, accessibility, portability and non-profit public administration) and the two conditions (i.e., the bans on extra-billing and user fees) of the Act.”

Thus, the notion of securing national standards concerning access seems to go against the provinces that interpret their constitutional right to legislate in the areas of health care.

Palley is an important academic contributor to the literature on federalism because he utilizes the case study of abortion to point-out the lack of resources and leverage available to the federal government to change the status-quo in provinces that currently do not comply with the CHA. According to Palley, there appears to be insufficient political resources for federal intervention in provincial affairs to occur in the first place. Also, the federal government has not utilized financial penalties, which are influential enough to ameliorate such a substantial lack of compliance with respect to the provision of abortion services in many of Canada's provinces.

Provinces, such as Nova Scotia, willingly pay an annual penalty for breaching the federal

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26 Palley, p. 566.
legislation, providing an illustration of the federal government’s ineffectiveness to reign-in provinces without aggressive tactics. Palley asserts that, “such non-compliance may reflect the dynamics of Canadian federalism.” Moreover, Palley seems to be implying that variability in policy may result from various provinces’ resistance to the notion of federal imposition (of regulations) over what they believe to be their sole jurisdiction. Therefore, there seems to be a rift between provinces that interpret the Constitution Act so as to have the capacity to make final decisions concerning health care matters within their province and provinces that interpret the Constitution Act to include the federal capacity to ensure a standard quality of health care for all Canadians.

In June 1989, the Nova Scotia legislature passed the Act to Restrict Privatization of Medical Services (called the Medical Services Act), which proposed a range of medical procedures to be set by regulation that could be performed only in hospitals. Although the Nova Scotia Medical Services Act regulations covered other procedures as well as abortion, it was widely considered that the timing of the legislation was influenced by Dr. Henry Morgentaler's public announcements that he intended to establish an abortion clinic in Halifax. Dr. Morgentaler is among the most prominent pro-choice advocates and responsible for establishing the Morgentaler Clinic (a private abortion clinic operating in 5 cities across Canada) and received the Order of Canada in 2008 for his devotion to women’s freedom to choose to give birth. Nonetheless, in using the courts to combat this legislation in Nova Scotia Dr. Morgentaler gained access to the Supreme Court of Canada in 1993, which ruled that provinces have the right

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27 Palley, p. 566.
to maintain the integrity of their health policies, but penalizing abortion under criminal legislation provides an example of provinces overstepping their jurisdictional authority.\textsuperscript{30}

In order to regulate abortion procedures and services in a way that was consistent with constitutional rights, the government of Nova Scotia needed to demonstrate that its abortion-policy was based on health care concerns. Instead, when the court looked at the background and surrounding circumstances, including the Hansard for the period when the legislation was debated, health care concerns were largely absent. Ultimately, the court ruled that, “the Nova Scotia legislation was invalid because the primary objective of the legislation was to prohibit abortions outside hospitals as socially undesirable conduct, and any concern with the safety and security of pregnant women or with health care policy, hospitals or the regulation of the medical profession was merely ancillary.”\textsuperscript{31}

**Ideology, Federalism, & Drift**

Ideology, with respect to political decisions involving provincial abortion policies, is another important aspect to explore because of the potential for ideological-orientation to influence the decisions of a provincial legislature. According to Christian Bjørnskov, spending on public health in the Canadian provinces appears to be driven by government ideology.\textsuperscript{32} Further, “in a Canadian context and other consensus-oriented polities, this means that ideological effects on political outcomes would follow not only from the ideological position of the

\textsuperscript{30} Gudel, P. 158.
incumbent government, but the average ideological position of the provincial legislature.” This perspective may be significant in gaining further insight into why some provinces seem appear to have more restrictions on access to abortion than other provinces.

For example, Prince Edward Island comprises the most apparent provincial case concerning restrictions on access to abortion. No abortion services are currently provided on the island and Medicare (the insurance system provided by the Canada Health Act and the health insurance legislation(s) in individual provinces and territories) will only subsidize the costs of a woman travelling to a different province for an abortion with the consent of multiple general practitioners. This is the only province where a specific medical reason is required in order for taxpayers to absorb the costs of an abortion procedure. There were as many as 143 abortions performed on women from PEI in 2004 and 10 that gained approval through committee. These women had to travel to the private clinic in Fredericton, New Brunswick or mainland hospitals in Ontario or Quebec. Subsequently, the government of Prince Edward Island will pay for abortion procedures at mainland hospitals, but will not subsidize the cost of travel expenses to these locations. Social society in Prince Edward Island is heavily conservative and there is a large influence present from the Catholic Church. As such, the very last abortion performed on the island occurred in 1982 prior to the merging of Catholic and Protestant hospitals in Charlottetown, who agreed to put an end to offering the procedure.

Despite a recent surge of pressure in Prince Edward Island from pro-choice groups, the province’s Health Minister, Doug Currie, stated that the province has no intention of

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33 Bjørnskova and Potrafke, P. 144.
renegotiating its current abortion policy. Christabelle Sethna from the University of Ottawa points-out that by refusing to perform the procedure on the Island, P.E.I. is trying to shift the issue to other parts of the country, as she said, “In the 1960s and ’70s women had to leave the country to get abortion and people said, ‘what’s the problem?’ ‘Leave the country.’ Now people are saying, ‘what’s the problem?’ ‘Leave the province.’ All that does is down-load the issue that the individual provinces have to deal with onto the backs of other provinces and that’s unfair.”

The issue of abortion has garnered little attention in Prince Edward Island since Dr. Morgentaler sought to challenge the legislation in the mid-1990s and the Court of Appeal upheld a ruling to allow the province to continue to restrict funding at provincial hospitals. Marie Tomlins, past-president of the Right to Life Association in P.E.I. claimed it would be ‘political suicide’ for either of the province’s major parties to come out in favour of abortion as most Islanders, she contends, are against abortion. Tomlins also stated that having to get multiple doctor referrals and travel out-of-province gives pregnant women extra time to reconsider their decision. Colleen MacQuarrie, a psychologist at the University of P.E.I., additionally suggested in a study that a significant number of women are turning to self-induced abortions because of prohibitive travel costs and the strong possibility that doctors in nearby provinces will not perform the operation.

Health Care Structure & Drift

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37 Erdman, P. 1095.
38 Erdman, P. 1095.
40 Browne and Sullivan. P. 257.
41 Browne and Sullivan. P. 258.
Health Care spending during the 1990s (immediately after the Supreme Court ruled Section 251 to be unconstitutional) is also important to analyze. Carolyn Tuohy points out that public health care spending in the 1990s in Canada set the stage for a broad consideration of reform options, but also, “established hurdles to be overcome in taking action.”\(^{42}\) Tuohy notes that, “by moving health care to the centre of the federal-provincial agenda, reconfiguring the internal politics of medical and hospital groups, and heightening a public sense of the need for improvement, the legacy of the 1990s prepared the ground for reforms that would ‘modernize’ the Canadian model.”\(^{43}\) Nonetheless, Tuohy clarifies that this groundwork yielded a degree of federal-provincial hostility and provided demands for ‘catch-up,’ which made the process of achieving change even more complex.\(^{44}\) Therefore, Tuohy argues that decision-making in the health care arena is path dependent.

Throughout some of the prairie provinces, one will also observe cases of traditionally lower levels of access to abortion services, such as Manitoba, which provides an example of the gap between policy and reality discussed by Tuohy. Timely, safe abortions are unavailable to many women in Manitoba due to either the referral requirement, financial burdens, or because it is an extensive bureaucratic procedure that is often intimidating to women.\(^{45}\) In March 1993, Dr. Morgentaler successfully challenged the Progressive Conservative government’s decision not to fund private clinics, but the government responded by enacting the Health Services Insurance Amendment Act, which excluded payment of induced abortions in non-hospital settings.

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Abortion is typically about terminating an unplanned or unwanted pregnancy. A moral divide exists within the views of Manitobans much like it does with the general Canadian population.  

Winnipeg judge Jeffrey Oliphant ruled that the failure to pay for private clinic abortions was a “gross violation” of women’s rights. The decision was overturned in 2006 by the province’s Court of Appeal because the judge had not heard any evidence on the issues involved. An appeal to the Supreme Court of Canada was refused.

In 1991, the province of Saskatchewan, led by the Progressive Conservative government, undertook a provincial referendum in which approximately 63 per cent of respondents voted to defund abortion procedures. However, the Progressive Conservative party lost the following election and the in-coming (NDP) government chose to commission an expert panel to study the legislation and decided that making changes would constitute a poor policy decision because it would discriminate against women on the basis of sex. Further, in a challenge involving the Freedom of Informed Choice Act, the Saskatchewan Court of Appeal held that the province could not make it an offence to perform an abortion without the prior written consent of a pregnant woman's husband or parents, because the law's objective was to ‘stiffen’ criminal law in relation to abortions, which would constitute a matter for exclusive federal jurisdiction. Despite the provinces having wide powers in the field of health, the courts have found a number of provincial attempts to regulate abortion under the guise of health care legislation to be unconstitutional.

When the federal government altered how it used its spending power with the introduction in 1995 of the CHST, it lost some of the leverage it had previously to manipulate provincial abortion policy. Pat Armstrong points out that, “…In 1995, the federal government drastically cut social spending (by one-third) with the introduction of the Canada Health and Social Transfer (CHST).” The CHST was block funding to provinces for all the areas previously covered by both the Canadian Assistance Plan (CAP) and the Established Programs Financing (EPF). As a result, Armstrong notes that, “…Provinces were forced to take a substantially larger financial responsibility for social policies, including health, which resulted in restructuring with pronounced gendered impacts.” Nonetheless, in a 2001 Parliament session, the Senate announced that it believed the federal government could maintain control of constitutional issues arising from provinces with more restrictive abortion policies, such as New Brunswick. Armstrong suggests that with women being the largest consumers of the health care services in Canada, they are disproportionately affected.

For the purpose of demonstrating the institutional and fiscal jurisdictional-arrangements associated with Canadian federalism, as well as how the limitations on federal spending power may have influenced the development of the various provincial abortion policies, it is prudent to continue to examine the political circumstances in which existing abortion policies were created. New Brunswick consistently ranks among provinces traditionally associated with the lowest levels of abortion services available to women. In June of 1994, shortly after Dr. Henry Morgentaler opened his first abortion clinic in Fredericton, the provincial government invoked

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54 Armstrong. P. 14.
legislation to prohibit doctors from performing abortions outside of medically-approved facilities and decreed that Medicare would only subsidize women who have an abortion performed at a hospital. New Brunswick’s stance on abortion since the Supreme Court decision of 1988 in R v. Morgentaler clearly provides an example of a province invoking its jurisdictional authority to set restrictions on the funding of abortion procedures at private clinics.

To fortify the illustration of a province determined to control its own jurisdictional-fate, the same year, the New Brunswick Court of Queen’s Bench ruled that the province could not order women to have abortions exclusively at hospitals. Despite this ruling, the province of New Brunswick sought to challenge the judgement in the appellate court, but again lost the decision as the Court of Appeal upheld the Lower Court’s decision to point-out provincial legislation was unconstitutional and the Supreme Court of Canada decided not to hear the case. In 1999, then Premier of New Brunswick, Bernard Lord, denied funding to the Morgentaler clinic after Dr. Morgentaler’s requests for the province to comply with the provisions of the CHA. Despite the courts insisting that the provincial restrictions on abortion were unconstitutional the province of New Brunswick was determined to maintain its position.

Subsequently, in 2001 then Federal Health Minister Allan Rock warned the province of New Brunswick (as well as other provinces) to fund abortions in clinics. To further impress upon the province of New Brunswick the gravity of the situation, Health Minister Anne McLellan, stated that the federal government was willing to withhold health-transfer-payments if abortion legislation did not comply with the CHA. Adding to this pressure, Dr. Morgentaler

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56 Moulton, P.701.
57 Moulton, P.701.
threatened to file a lawsuit against the province, which then New Brunswick Justice Minister Brad Green promised to fight all the way to the Supreme Court with Premier Lord insisting provincial legislation conformed to the Charter of Rights and Freedoms and the CHA.\(^{58}\) This disagreement between the province and the federal government is significant to the concept of Canadian federalism because it shows that the federal government indeed has the capability to pressure provinces to comply with federal legislation irrespective of jurisdictional provisions.

In court during August of 2003, the New Brunswick government filed a statement of defence in the Morgentaler lawsuit, which decreed that funding abortions in private clinics would create an "unnecessary financial burden;" that medically necessary, Medicare-funded abortions are provided at several hospitals in the province; and that access would not be "meaningfully enhanced" by extending funding to abortions at the Morgentaler clinic.\(^{59}\) Anti-choice group, Coalition for Life also had an application as an intervener in the court case dismissed on the grounds that they sought to discuss moral implications associated with abortion and not the issue of access.\(^{60}\) In 2005, Federal Health Minister Ujjal Dosanjh, sent a letter to the New Brunswick Department of Health and Wellness to initiate an official dispute avoidance resolution process to attempt to settle the issue of funding Dr. Morgentaler’s private clinic. In response, New Brunswick’s Health Minister claimed he would not bow to threats from the federal government.\(^{61}\) Again, the province’s insistence that pressure from the federal government to comply with the Canada Health Act was a perceived ‘threat’ is indicative of the provincial will

\(^{60}\) McTavish, P. 123.
of New Brunswick to control its own policy on abortion and interpret the constitution as health care representing an exclusive provincial jurisdiction.

Upon giving the Province of New Brunswick a period of time to officially acknowledge the requests of the federal government, Federal Health Minister Ujjal Dosanjh suggested that New Brunswick ignored his statements and he would send a panel of three officials to hear arguments from both sides of the issue.62 New Brunswick’s Health and Wellness Minister Elvy Robichaud made it clear that he would defend the province’s existing abortion legislation before the federally-appointed panel.63 However, with new Federal Health Minister Tony Clement taking over in 2006 the issue lost significant traction as the federal government, led by the Conservative Party of Canada, was reluctant to address the issue or the dispute resolution mechanism previously proposed.64 Finally, in 2007, Tony Clement announced that the issue of abortion was off of the radar of the federal government and the issue of funding private clinics in New Brunswick would not be pursued any further. Although the Liberal government at the federal level made some attempts to secure provincial compliance with the CHA, the transition of power to the Conservative Party of Canada and subsequent dismissal of the issue, were ultimately indicative of the trend of federal government jettisoning responsibility for health care funding issues.

Women’s Perspectives, Fundamental Justice & Drift

63 Kaposy and Downie, P. 287.
64 Kaposy and Downie, P. 288.
There exists an array of perspectives of women’s groups on the issue of access to abortion across Canada. Christopher Manfredi believes that the old policy concerning abortion under section 251 of the Criminal Code of Canada was a means of liberalizing a policy in reaction to public demand, while allowing provinces to dictate control over such services and also reflect the wishes and autonomy of their constituencies. Furthermore, Manfredi argues that the Supreme Court decision striking down section 251 as unconstitutional (in R v. Morgentaler, 28 January, 1988) rejected provincial diversity in policymaking. Manfredi’s commentary certainly seems to support the principles of Canadian federalism (such as the division of jurisdictional authority, equity, and constitutional responsiveness). However, there exists almost no regard for the perspectives of various women impacted by barriers to and provincial variation in access to abortion services.

However, it is important to consider the views of the Supreme Court of Canada concerning fundamental justice versus constitutional jurisdiction. Janet Hiebert points out that former Chief Justice of the Supreme Court of Canada, the Honourable Brian Dickson, felt that the federal government should only override provincial policymaking decisions if they were contradictory to fundamental justice. This is a significant statement considering that the Supreme Court struck down section 251 as unconstitutional (and a violation of fundamental justice under Section 7 of the Charter) and provinces such as New Brunswick still have restrictive abortion policies that closely resemble the oppressive regulations of section 251.

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66 Maioni and Manfredi, pp. 45-47.
67 Maioni and Manfredi. P. 47.
Nevertheless, the federal government has yet to intervene in a provincial health care policy dispute concerning abortion as previously mentioned.

In his judgment, Chief Justice Dickson held that, “forcing a woman, by threat 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.” He also concluded that delays faced by women seeking abortions, which increased the level of complication and risk in the procedure, amounted to an infringement of both the physical and psychological aspects of the right to security of the person. Nevertheless, there are still oppressive regulations attached to legislation in some provinces, such as Prince Edward Island, which requires the approval of separate doctors within a narrow window of time.

Quebec provides perhaps the most compelling provincial case to dissect concerning debate on the extent of provincial autonomy versus preservation of constitutional rights. In 2002, Federal Health Minister Anne McLellan tried to initiate the same dispute-resolution mechanism, comprised of a panel of three-members (albeit on a broader scale) that Dosanjh would later attempt once more with the province of New Brunswick. All of the provinces consented to this mechanism except for Quebec. However, in 2006, a class-action lawsuit filed by the Association for the Access to Abortion against the province of Quebec was heard by the Superior Court and the government defended its legislation by claiming that by offering abortions in hospitals and public-clinics that services were accessible. Doctors Henry Morgentaler and Claude Paquin, two members of the Association for Access to Abortion filed a

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69 Hiebert, p. 138.
70 Hiebert, p. 139.
motion alleging that the Government of Quebec had intentionally violated the Health Insurance Act. The claim asked the Government to reimburse women who had had to pay for an abortion.

Accordingly, in 2006, Quebec Health Minister Philippe Couillard announced an amendment to Quebec’s legislation on abortion to allow abortions to be funded at private clinics should timely service be denied at a hospital or community clinic. In the class action Association pour l'accès à l'avortement v. Québec (Procureur général) the province of Quebec was ordered to refund women who were required to pay additional fees for abortion services. In this case the judge was asked to rule on the legality of provincial funding policies, which could inhibit a woman's choice to have an abortion by making them pay for the procedure.\(^73\)

In Alberta, pro-life activists have sought, albeit unsuccessfully thus far, to lobby the provincial legislature to make amendments to the provincial abortion policy by extending the Fetal Insurance law to the case of abortions. The Fetal Insurance Law, otherwise known as the ‘Rowega’ Law of 1999, allows children to sue their parents for injuries incurred in the womb. Brooklyn Rowega’s family lobbied for this legislation after she was left with permanent blindness and neurological disorders as a probable result of injuries obtained in a car accident four months prior to birth.\(^74\) Nonetheless, the College of Physicians and Surgeons in Alberta, recognize under Canadian law, that the unborn fetus does not have status or rights as a person.\(^75\)

In 2001, Alberta Pro-Life sent around information packages trying to sway public opinion to defund abortion policies by attempting to utilize legal arguments demonstrating that abortion procedures are not medically necessary.\(^76\)

\(^73\) Association pour l'accès à l'avortement c. Québec (Procureur général), 2006 QCCS 4694.
\(^75\) Richer, 2008.
\(^76\) Richer, 2008.
Nonetheless, Alberta’s Premier at the time, Ralph Klein, derailed any momentum for defunding abortion services as he stated in the provincial legislature that he believed abortion should not be debated politically as it is a matter for a woman, her doctor, and her God.\textsuperscript{77} Klein also countered the pro-life line of argument dealing with medical necessity by suggesting that abortion is covered under the Canada Health Act.\textsuperscript{78}

**Bi-lateral Discussions & Drift**

The disagreement on how to interpret health care rights and administer service provision between the federal and provincial governments provides yet another barrier for women seeking to expand access to abortion through policy discussions. Candace Johnson argues in support of the conclusions of Howard Palley concerning the issue of barriers created by federalism for women seeking abortion services in the provinces and territories across Canada. According to Johnson, the provinces are concerned with autonomy in policymaking and securing enough money to adequately fund health care, and the federal government should be concerned with cost control and compliance with national standards.\textsuperscript{79} Furthermore, Johnson points to the conclusions of Carolyn Tuohy, who suggests that federal-provincial disagreement in the field of health care consumes a significant amount of creative energy.\textsuperscript{80} This means that there are many reforms, improvements, and innovations that do not receive adequate consideration.

Another barrier to further political discussion concerning access to abortion is the lack of attention at the macro-level of policy analysis. As such, Tuohy states, “an inordinate amount of

\textsuperscript{80} Johnson, p. 13.
attention devoted to intergovernmental processes, disputes, and historical patterns and grievances, many macro-level discussions, through which policy is created and understood, are rendered irrelevant by more immediate concerns.”

Johnson adds to this that policy discussions at the macro-level rarely occur because of the federal-provincial deadlock and the stability of government and group relations usually do not facilitate dramatic policy change. The 2004 Health Accords involved Prime Minister Paul Martin’s 10-year plan to strengthen health care, which suggested, “physical and mental well-being as inextricably linked and equally important to the efficiency and quality of health care systems.” As recent as 2012, a review of the 2004 Health Accords conducted by the Standing Senate Committee on Social Affairs, Science, and Technology made no less than 46 recommendations involving the increased action of the federal government to facilitate and achieve the aforementioned goal outlined in the 2004 Health Accords. Further, despite certain additional macro-level discussions recently occurring, such as Prime Minister Harper’s funding plan, these discussions are typically about funding and not necessarily the contours of health care per se as the role of the federal government has played since 2004 in distributing health care is smaller. Additionally, it is important to note that the "bilateral discussions" between former Federal Health Minister Rock and the obstinate provinces did not result in any form of policy changes concerning abortion when the federal government appeared keener to enforce health-transfer penalties prior to the 2006 election of the Canadian Conservative Party. This is significant because it is indicative of a change in policy and the espousal of intent to no longer discuss abortion with provinces in non-compliance with the CHA.

81 Johnson, pp. 15-17.
However, it also demonstrates the intent of provincial governments to maintain the status quo on abortion policy even in cases where legislation has been criticized for non-compliance with federal legislation. It seems likely that the lack of success in the federal government attempting to penalize non-complying provinces provided a window of opportunity for the Harper Government to contribute to the subversion of the issue of access to abortion in bi-lateral policy discussions.

Pro-life activists in Newfoundland have not been able to gain much momentum in lobbying the provincial legislature to have abortion procedures defunded as recent advertisements opposing abortion on the public transportation vehicles were pulled from display after an onslaught of public criticism. In 1995, after Federal Health Minister Diane Marleau announced the intended enforcement of the CHA concerning abortion procedures, Newfoundland remained static for two years of up to $11,000 in lost transfer payments for non-compliance with the CHA. However, after enduring these fiscal penalties for two years, the government of Newfoundland chose to comply with the CHA and eliminated user-fees for abortion clinics. Thus, the case of Newfoundland illustrates the ability of the federal government to secure provincial compliance with the CHA concerning abortion policy with aggressive tactics. However, there are obvious limitations to this type of action with provinces, such as the case of Nova Scotia, New Brunswick, and Prince Edward Island willing to accept current and past fiscal penalty rates to maintain restrictions on abortion.

Billing agreements between provinces for health care procedures can be crucial if a patient is expected to require travel arrangements. Applying this statement to abortion makes

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86 Ryan, P. 861.
things even more difficult for women as the gestational limit for obtaining a hospital-based abortion vary from ten to twenty weeks. Currently only two hospitals perform the procedure up to 23 weeks (and only in circumstance involving immediate maternal health threats). Many provinces list abortion on their ‘excluded list’ for reciprocal billing under Medicare, which means that a woman’s abortion obtained outside of her home province may not be listed under insurance coverage.\(^{87}\) Jocelyn Downie and Carla Nassar point out that the Inter-provincial Health Insurance Agreements Coordinating Committee (IHIACC) is responsible for the determination of what is included and excluded from the Interprovincial Reciprocal Billing Agreement. It is comprised of federal, territorial and provincial health officials and all provinces participate in reciprocal hospital billing agreements and all provinces and territories except Quebec participate in reciprocal physician services billing agreements. Abortion is on a list of services excluded from the Interprovincial Reciprocal Billing Agreement along with the other medical procedures excluded from the agreement that are considered elective procedures, experimental, or not time-sensitive procedures. According to these authors, the fact that abortion is on this list may reflect a perception that the procedure is not medically necessary and ignores the fact this it is incredibly time-sensitive.\(^{88}\) However, this point is contestable as previous federal governments have recognized abortion as a medically necessary procedure and there is a great deal of support for this claim pursuant to the Supreme Court of Canada and the Charter. Ignoring the importance of time concerning gestation limits would seemingly constitute a violation of a woman’s rights under section 7 and section 15 of the Charter.

\(^{88}\) Downie and Nassar, P.144.
It is also important to consider the Canadian Territories as their situation concerning constitutional jurisdiction is not unlike that of the provinces. Section 16 of the Northwest Territories Act and section 17 of the Yukon Territory Act authorize the territorial Councils to legislate in relation to ‘property and civil rights’ and ‘hospitals’ within each territory.\(^9\) In 1992, barriers to abortion procedures and services in the Northwest Territories were identified in a report sent to the territorial government, which included the fact that all procedures were being performed exclusively at one hospital in the capital city of Yellowknife, which made it excessively difficult in terms of time and fiscal resources for women to gain equitable access.\(^9\) In the Yukon Territory, responsibility for the delivery of health services and health insurance was transferred from the federal government to the Yukon Ministry of Health in 1997. Further, section 73 of the Nunavut Act provides for the transfer of health insurance and health care services from the Northwest Territories to Nunavut upon agreement between the two territories.\(^9\)

The ambiguous network of billing agreements between various Canadian provinces makes it even more difficult for women to access abortion services depending on the province in which a woman is seeking an abortion procedure. Downie and Nassar point out that some jurisdictions appear to have negotiated bilateral agreements outside the Interprovincial Reciprocal Billing Agreement. This has resulted in a confusing patchwork, where for example, Quebec has arranged inter-provincial billing for some hospital and physician services in Ottawa and North Bay but beyond that, residents often have to pay upfront for out-of-province medical

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\(^9\) Richer, 2008.

services. Additionally, residents are only reimbursed for the Quebec-fee for the service, and so often end-up paying for a significant portion of their own health care. If a woman from Saskatchewan has an abortion in the Kensington Clinic in Alberta, the clinic will directly bill the Saskatchewan provincial government, but if she has an abortion at the Peter Lougheed Hospital, she will have to pay for it herself and apply for reimbursement. Thus, the lack of a seamless approach to reciprocal billing agreements facilitates a confusing and fragmented network of agreements that contribute to the overall pattern of some women receiving health care advantages while others remain marginalized.

For example, women living in Ontario comprise an example of the best access to abortions services yielded by a province. The case of (Attorney General) v. Dieleman, where it was claimed that Morgentaler (1988) validated, "a woman's right to make a decision concerning abortion without governmental intrusion," was important for ensuring abortion procedures received funding under provincial legislation. As recent as 2011, a report from an Abortion Expert Panel noted that procedures performed in Ontario are safe and also necessary to the safety and well-being of women. Further, while the report noted the necessity for hospitals to continue to offer services to meet demands of women in rural areas, the report also suggests the importance of funding private facilities because of a noticeable trend of heavier reliance on such facilities. Further, the Ontario Human Rights Commission explicitly protects a woman’s right to abortion services by dictating that employers are required to accommodate special needs

92 Downie and Nassar, P. 144.
93 Downie and Nassar, P. 145.
In British Colombia, the Access to Abortion Services Act of 1995 is the key piece of legislation guaranteeing women timely access to abortion services with freedom from public and professional harassment. The British Columbia Hospital Act mandates that all listed hospitals must provide abortion services. As recent as 2008, the courts upheld both pieces of legislation in the wake of challenges from anti-choice advocates trying to establish a challenge on the grounds that Charter rights to expression and lawfully protest were infringed. The Act was found to strike an appropriate balance between the rights of anti-abortion protesters and the rights of women and abortion service providers to equality, privacy and security of the person. It is viewed as a means of protecting not only doctors and patients, but nurses assisting in any part of the process as well as family and friends that might accompany a patient for emotional support. It is the provision to establish protected-zones around abortion clinics in British Colombia to mitigate the consequences of pro-life activists harassing potential patients and doctors that makes the legislative arrangement for abortion somewhat unique. Thus, women living in British Colombia derive a disproportionate advantage as support for provincial legislation enables them the opportunity for some of the best access to abortion services in Canada.

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99 Lambertson, P. 82.
A Return to Federalism & Drift

By observing the abortion policies across the provinces and territories in Canada one will notice a great deal of variation. While there is a degree of variability to be expected pursuant to provincial jurisdiction and the limitations on federal spending power, it is also quite possible that the notion of inherent variability masks the opportunity that is provided for genuine policy drift to occur in the issue-area of abortion. While there are other explanations to consider for drift, such as the impact of the Charter of Rights and Freedoms, and women’s organizations, the variation in policy as facilitated by Canadian federalism provides a compelling platform for intentional action or in-action that is characteristic of policy drift and as evidenced in the provinces with more restrictive policies and the least accessible abortion services.

New Brunswick and Prince Edward Island comprise two key examples that help to explain how policy drift is a unique concept from that of federalism and its subsequent institutional arrangement. These two maritime provinces insist that they are not hampering a woman’s control over her own reproductive autonomy since there are no criminal legislations preventing women from seeking-out abortion services. Further, since the provinces are constitutionally guaranteed jurisdiction over health care these legislatures believe that they are in no jeopardy of infringing on fundamental rights and freedoms in designing and maintaining their own policy governing access to abortion. Despite this perspective, women’s experiences and the facts that the procedure is time-sensitive and the capacity to give birth exclusive belongs to women seem to be consistently overlooked or ignored.

Nevertheless, the CHA guarantees the principle of universality within its legislative provisions and with a great deal of other provinces across Canada, most notably Ontario,
Quebec, and British Colombia offering no or few restrictions on access to abortion, provinces like Prince Edward Island and New Brunswick are engaged in non-compliance with the central legislation. Moreover, the intentionality to maintain the status quo is a hallmark of Jacob Hacker’s description of policy drift where the best way for a government to achieve a certain policy outcome is to do nothing at all, which seems to be the case concerning abortion policy in provinces like New Brunswick, Prince Edward Island, and Nova Scotia. The decision to engage in policy-inaction when many other provinces have documented change to expand access to abortion services seems to reflect the notion of ‘change without change’ that is another indication of the existence of policy drift. Thus, while on the surface variation in a health care policy such as abortion seems to be an inadvertent by-product of the federal structure, a deeper analysis reveals that the non-compliance with the CHA of provinces restricting access to abortion may be intentional, and therefore, indicative of policy drift.
Chapter Two: Women’s Organizations

Women’s Organizations as an Explanation for Drift

Women’s organizations like the National Action Committee on the Status of Women and the Abortion Rights Coalition of Canada play an important role in analyzing the evolution of contemporary abortion policies across Canada. It would be naïve to assume that women’s organizations across Canada all share a primary goal of lobbying to ensure more equitable access to abortion. Within this chapter of the thesis it will be important to examine the role of the provincial and federal governments concerning interaction with and responsiveness to women’s organizations. This will facilitate an opportunity to consider the influence that the degree of governmental responsiveness to women’s organizations may have on policy drift concerning access to abortion across Canada. This thesis argues that the inability of woman’s organizations to gain favourable responses from the federal government contributes to drift concerning access to abortion as evidenced by the difficulties demonstrated in women seeking artificial reproductive technology rights, women’s organizations striving for abortion rights and the responsiveness of the federal government (or lack thereof).

To determine the potential impact of women’s organizations on policy initiatives it is important to examine which factors comprise a measure of effectiveness in attempting to achieve such initiatives. The effectiveness of women’s organizations in achieving policy goals will depend on a variety of factors, including the strength of the women's organizations, the activities
and characteristics of women’s organizations and the subsequent policy environment.\textsuperscript{100} The legal status of women’s rights to safe abortion is often a measure or barometer of the effectiveness of feminism and respect for women’s citizenship, in that abortion is safest where women are more respected as citizens of the countries in which they live.\textsuperscript{101} This last point is significant because the success of women’s organizations in attempting to secure equitable access to abortion services is a gauge for effectiveness in achieving responsiveness from federal and provincial governments. This would seem to be the case because in provinces with more restricted access to abortion one would expect a lower degree of effectiveness of women’s organizations.

In general, women's organizations, such as the National Action Committee on the Status of Women (NAC), tended to be remote from power and low in resources. The nature of their mandate appears to matter more directly than resources in their capacity to confer insider status on women's movement forces.\textsuperscript{102} The most important aspect of the women's movement in gaining insider status was its closeness to left-wing parties and the political strength of those parties.\textsuperscript{103} This is an important argument to consider in terms of explaining drift concerning access to abortion across Canada as the provinces with more restricted access tend to espouse a right-wing-oriented ideology.

Further, the unwillingness of the current Harper Government to continue dispute-resolution mechanisms with provinces in non-compliance with the Canada Health Act lends credence to the aforementioned scenario involving right-wing orientation. The Harper

\begin{thebibliography}{99}
\bibitem{101} Findlay, P. 44.
\bibitem{103} Shaver, P. 870.
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Government refuses to assert itself by engaging in discussions with provinces in the way the previous Liberal government favoured. On September 25, 2006, the Conservative government announced a five million dollar cut (a 38.5 per cent cut in funding) to Status of Women Canada (SWC). The goals of SWC were changed from promoting and protecting gender equality or promoting political justice to, "facilitating women's participation in Canadian society by addressing their economic, social and cultural situation."104 With the central-governing authority avoiding the issue of abortion, and with the prior knowledge that the NAC forged greater opportunities to perpetuate policy initiatives with more left-wing governments, it becomes more apparent that the ideology espoused by government can contribute to policy drift concerning abortion. The most salient characteristic of policy drift is for a government to intentionally engage in in-action so as to perpetuate the status-quo. The Harper Government is making an intentional decision to avoid discussing abortion with policy agencies and provincial legislatures when previous governments chose to aggressively pursue provinces in non-compliance with the CHA.

Cohesion within women’s organizations is also extremely important in attempting to facilitate a cogent lobbying effort for a favourable policy alternative. For example, the unity of the women's movement and the priority it gave to the abortion issue were also very important in the successes of decriminalizing the procedure and gaining access in provinces without restrictions on the procedure.105 Women's organizations do appear to be necessary to the movement's success in influencing the content of policy and gaining participation in policymaking processes.106 Nonetheless, there must be cohesion in order for policymakers to

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105 Shaver, P. 871.
106 Shaver, P. 872.
have a clear concept of what it is that a woman’s organization would like to see specifically reflected in the policy process. However, this seems to be true only of those lobbyists’ efforts to have criminal sanctions removed on abortion and in the provinces where access is currently better. In provinces such as New Brunswick and Prince Edward Island, lobbying efforts have had no impact on the provincial legislatures in either province as access to abortion remains restricted. Thus, women’s organizations are important in provinces where provincial access to abortion services is less-restricted and perhaps not as important in provinces where access remains restricted.

Overcome with Artificial Reproductive Technologies (ARTs)

As discussed before, the women’s health movement utilized women’s organizations to help promote the policy aspirations associated with issues such as ARTs and abortion rights. In the 1970s, several observers of Canadian politics saw the creation and development of the NAC as an effective way to improve women's presence in policy-making processes.107 The NAC provides a key example of a women’s organization that was instrumental in lobbying the federal government for a policy stance on artificial reproductive technologies (ARTs). Nonetheless, the NAC also yields an example of how a lack of cohesion across women’s organizations and within them hinders the ability to lobby the government effectively.

As such, it must be recognized the influence of vessels, such as the NAC, over abortion policy and any subsequent drift, is a complex notion and not as straightforward as one group achieving the exact same goal or policy solution. Giving voice to different perspectives and

recognizing different forms of knowledge eventually harmed the NAC’s capacity to present policy makers with a coherent position on ARTs in Canada.\textsuperscript{108} Such discursive principles, adopted by several social movement organizations, are often incompatible with the continued need for advice by state actors mandated to make timely decisions. When social movement organizations are incapable of providing advice, policy makers look for alternative sources.\textsuperscript{109} The case of ARTs reveals how the NAC’s organizational practices undermined its capacity to influence government policy and opened a space for the dominance of individual feminist experts in official deliberations on reproductive technologies.\textsuperscript{110} Thus, as the case of social movement struggle for a federal policy regulating ARTs demonstrates social cohesion within a movement is extremely important in gaining a policy that is responsive to all of the significant goals of the movement.

Facilitating an opportunity for different groups to voice different perspectives and recognizing different forms of knowledge inhibited the NAC’s capacity to present policy makers with a cohesive and cogent policy position. This lack of cohesion is often incompatible with the continued need for advice by state actors mandated to make timely decisions.\textsuperscript{111} Further, when social movement organizations are incapable of providing advice, policy makers will often look for alternative sources, which are typically experts, thereby altering the legitimacy basis of policy choices.\textsuperscript{112} This shift or change in the basis of the policy is a result of the policy reflecting expert testimony rather than the collective ambitions of a women’s organization. During the early 1990s, the NAC was increasingly criticized for the lack of representation of minority and

\textsuperscript{108} Scala et al., P.581.
\textsuperscript{109} Scala et al., P.582.
\textsuperscript{110} Scala et al., P. 583.
\textsuperscript{111} Scala et al., Pp. 585-587.
\textsuperscript{112} Scala et al., P. 587.
disabled women on its executive.\textsuperscript{113} The appointment of a prominent visible minority woman, such as Sunera Thobani to NAC's Executive Committee, and the allocation of executive positions to members of particular identity groups reflected a growing commitment to, "be more inclusive of women of colour, lesbians, women with disabilities, and poor women."\textsuperscript{114} The NAC's recognition of diversity entailed greater participation on the part of member groups in the direction of a policy agenda.\textsuperscript{115} After four years of deliberation, the Royal Commission published its final report, Proceed with Care, in 1993. The report recommended that the federal government introduce a regulatory agency to licence and monitor fertility clinics and research institutes working in the area of biotechnology.\textsuperscript{116} It also recommended that the federal government prohibit and criminalize some of the most controversial aspects of reproductive technologies, including human cloning, creating human-animal hybrids, commercial surrogacy, and the commercialization of human gametes.\textsuperscript{117} The federal government responded in June 1995 by calling for a voluntary moratorium on several of these practices. In June 1996, the Human Reproductive and Genetic Technologies Bill (Bill C-47) was tabled in Parliament.

In the case of reproductive technologies the greater involvement of member groups in the development of the NAC's policy agenda would significantly alter the organization's position, which it presented during the bill C-47 hearings. While the organization's expert-written brief to the royal commission contained a stern critique of these technologies and characterized them as ‘anti-woman,’ its stance on C-47 during the committee hearings was more favourable as abandoning its previous oppositional stance against ARTs, the NAC's brief on C-47 emphasized

\textsuperscript{113} Scala et al., Pp. 588-589.
\textsuperscript{115} Young and Everitt, 2004. Pp. 87-89.
\textsuperscript{116} Young and Everitt, 2004. P. 90.
women's reproductive autonomy and followed the principle of ‘equality of result’. The NAC's policy agenda during the C-47 debate constituted a compromise among the plurality and multiplicity of perspectives held by members groups. However, the group failed to achieve consensus on a number of issues, including the appropriate mechanism for attaining ‘equality of results’ and the use of criminal sanctions to regulate the development and practice of reproductive technologies, a central feature of C-47. Clearly, failing to achieve a consensus on a number of issues, including a salient consideration like a barometer for judging equality of results, demonstrates the complexity involved in creating cogent policy initiatives within a women’s organization like the NAC.

A great deal of criticism was directed against Bill C-47 from a number of groups, including the Canadian Medical Association, the Canadian Bar Association and the National Association of Women and the Law. There emerged a consensus among these organizations that criminal sanctions were not the best mechanism to use in this context, given that they could stymie useful genetic and reproductive research. The NAC’s attempts to be more inclusive of diversity and its inability to reach a consensus on reproductive technologies inadvertently opened a space for professional experts to dominate policy deliberations on ARTs. This had an important impact on the type of issues that would inform the committee’s report. The overriding concerns of the report submitted by the Standing Committee on Health in 2001 were the interests of children born of ARTs as well as the interests of the scientific community and biotechnology.

industry. The central recommendation of the report concerned the right of children conceived through in vitro fertilization or artificial insemination to know the identity of donors (Standing Committee on Health, 2001). In the end, women's health and well-being, the issue that had first galvanized the NAC and the women's movement to launch a public debate on reproductive technologies, largely disappeared in the latest round of deliberations on ARTs. Thus, one can observe the difficulties and complexities involved with a women’s organization attempting to produce a cohesive policy agenda that will provide timely information to policy makers for the policy process. One can also observe that the NAC was predominantly focused on securing a legislative framework for ARTs, after the decriminalization of abortion procedures in 1988 and throughout the 1990s and early part of the 21st century and less-so on the issue of abortion. Even within the movement for ART legislation itself there were a number of competing and contrasting ideas that led to policy experts providing the basis of information as a result of the lack of cohesion on the part of the NAC.

However, as previously mentioned, it is not simply about the process of policy creation for women’s organizations involved with the women’s health movement. There is also an aspect of changing the minds of the collective. Susan Phillips suggests that as, “identity-based organizations, these movements are also engaged in ‘symbolic’ politics, which entails the articulation of a collective identity and the building of solidarity and loyalty within one's group.” Phillips describes the competing values and agendas that social movement

125 Scala et al., P. 589.
organizations must contend with when attempting to influence policy makers.\textsuperscript{127} She argues that social movement organizations are engaged in two action fields, instrumental action and expressive action. Instrumental action is dedicated to achieving strategic, policy-oriented ends while expressive action is directed towards the more emotional task of shaping a collective identity through solidarity-building and consciousness-raising.\textsuperscript{128} Reconciling these two types of activities poses a challenge for these organizations as they struggle to influence government action while still adhering to democratic principles.\textsuperscript{129} As demonstrated by the case of ARTs, reconciling these two concepts can become immensely difficult. However, this issue also exists with the movements attempting to achieve greater access to abortion as evidenced by their tenuous relationship to the federal government in Canada.

It is important to acknowledge that women’s organization lobbying and interest group lobbying may not be as robust in Canada as the United States, which means that there may not be as many inherent battles occurring in Ottawa as there are in Washington, D.C. Nonetheless, it is crucial to consider the notion of a shift in issue-attention from access to abortion in order to determine whether a lack of responsiveness from the federal government and provincial governments contributes to abortion policy drift. Analyzing newspaper articles provides one piece of evidence of a shift in attention largely from abortion to ARTs. For example, from 1989 until 2012, the Toronto Star newspaper produced a combined 140 news articles on the issue of abortion in Canada. In contrast, within the same period, the Toronto Start produced 553 news articles on the issue of assisted reproductive technologies in Canada. This evidence seems to suggest that the Toronto Star, one of Canada’s most widely-circulated newspapers, emphasized a

\textsuperscript{127} Phillips, Pp. 861-862.
\textsuperscript{128} Phillips, P. 862.
\textsuperscript{129} Phillips, P. 863.
significantly larger portion of attention on ARTs than abortion after the Supreme Court of Canada ruling that the criminalization of abortion procedures was an unconstitutional practice.

A further example of a shift in issue attention away from abortion and towards ARTs may be found in analyzing the contemporary priorities of related women’s organizations. As previously documented, the NAC spent a large volume of the 1990s and 2000s attempting to achieve a legislative framework to regulate ARTs. However, women’s organizations too have adjusted their priorities in a way that no longer places abortion at the centre of their policy ambitions. For example, Ottawa-based National Association of Women and the Law, acknowledges abortion rights for women, but is currently emphasizing issues such as equal pay for equal work and insuring equal rights for immigrant and aboriginal women and previously secured funding of approximately $350 000 annually to try and resolve these issues.130 Further, the Feminist Alliance for International Action, which seeks to reflect the equity of international covenants within Canadian policies, no longer lists abortion as an ‘issue’ on its main website.131 Similarly, the National Council of Women of Canada (NCWC) was involved in lobbying for the decriminalization of abortion procedures, but has since engaged in lobbying for a wide variety of issues beyond the scope of abortion.132 The NCWC website-archives document particular success in the field of ARTs in 2000 with its recommendation to encourage public consultation concerning genetic engineering.133 Therefore, with a noticeable attention shift away from abortion in one of Canada’s most-circulated newspapers and a shift away from abortion rights in some of the more seminal women’s organizations, it seems likely that the issue of abortion

would subsequently move further away from the apex of the federal and provincial governments’ list of policy priorities.

Returning to the NAC, it becomes clear how fragmented ideas and goals served to hinder the goal of gaining a favourable ART policy. While the group's previous anti-science position rejected reproductive technologies altogether the equality of result principle opened a space for the use of some technologies, but the organization recognized the broader social and ethical concerns of these technologies, even though it ultimately chose to base its position on women's rights, especially in the area of reproduction. As the NAC spokesperson stated, "in terms of equality rights for women, this does not mean just equality of access or equality of treatment; it means equality of the results. By this we mean there should be no judicial intervention into pregnancy and birth and that we as an organization must have full support for women's reproductive autonomy". The NAC's policy agenda during the C-47 debate constituted a compromise among the plurality and multiplicity of perspectives held by members. The NAC had to agree on a general compromise to support women’s reproductive autonomy, but not all of the interests were met because of the noted differences in perspective and experience.

The previous example demonstrates the inability of a women’s organization to reconcile the notions of strategic policy goals with re-shaping the collective identity. Thus, while key issues have come to light since the inception of the women’s health movement, such as decriminalizing abortion procedures, there are still many areas in which a lack of consensus may be providing an inability for groups to positively influence legislation, such as access to abortion in provinces with more restrictive policies. Despite only two provinces currently funding IVF as an ART,

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134 Scala et al., P. 583.
135 Scala et al., P. 583.
136 Scala et al., P. 583.
there still seems to be an indication of the provincial and federal governments reflecting a shift in attention towards ARTs, which further sidelines the issue of abortion. While provinces are slowly starting to consider access to ARTs progress seems to be stalled concerning groups advocating access to abortion as restrictions remain in place in multiple provinces and court cases have been long, drawn-out and largely unsuccessful in influencing legislation. Additionally, the federal government has created a legislative framework for ARTs, compared to abortion, where a policy vacuum filled the void of in-action after the 1988 Supreme Court decision rendered existing legislation unconstitutional. The federal government, as previously mentioned, has jettisoned prior attempts to engage provincial governments on the issue of abortion pursuant to non-compliance with the CHA. These combined factors seem to be indicative of intent associated with policy drift as the federal government has made a deliberate decision to move away from discussions on abortion with the provinces and progress on access to abortion in provincial legislatures and courts has come to an impasse.

It is also useful to take another look at the fragmentation across the different interests involved in the women’s health movement. There emerged a consensus among these organizations that criminal sanctions were not the best mechanism to use in this context, given that they could inhibit useful genetic and reproductive research and a regulatory regime was regarded as a more appropriate approach since it afforded government officials some flexibility.\textsuperscript{137} In response to this criticism the newly re-elected Liberal government asked Health Canada to prepare a new bill in 1997. Health Canada transferred the preparation of the bill from the Health Policy Division to a Special Project Division primarily staffed with ‘fresh faces.’\textsuperscript{138}

\begin{footnotesize}
\textsuperscript{138} Basen, P. 10.
\end{footnotesize}
Another round of consultations was held with interest groups and provincial governments across the country. Given the federal-provincial jurisdictional issues involved consultations were held with provincial agencies, such as health and justice departments, as well as regional offices of the Status of Women.

In 2001, when the legislative consultation process began again, the House of Commons Standing Committee on Health heard testimony from various stakeholders. Mona Greenbaum spoke to this committee on November 26, 2001 as the representative of the Lesbian Mothers Association. She described the exclusion that she and other lesbian mothers have faced, the health risks associated with exclusion, and concerns about further marginalization that lesbian mothers may experience under the new law. Ms. Greenbaum argued for inclusion stating, "all women in Canada must have equal access to fertility clinics and sperm banks, regardless of their sexual orientation, marital status or fertility status." She also described the fact that a woman cannot receive testing in Quebec fertility clinics, let alone insemination, unless she is a wife. The difficulties in finding doctors and the necessity of importing sperm often cause women to seek donors about whom women may not have all the necessary medical knowledge, which thus can expose women to the risk of contracting HIV and other conditions. The Assisted Human Reproduction Act was drafted in response to the House of Commons Standing Committee on Health's Report. In 2002, the Minister of Health introduced Bill C-56, which established a legislative and regulatory framework addressing issues relating to assisted human reproduction.

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140 Harris, P.45.
141 Harris, Pp. 45-46.
However, as previously mentioned, despite those involved with the women’s health movement dedicated to ART rights gaining a federal regulatory policy they did not achieve universal financial coverage or status as a medically necessary service. Ontario is the only province to fund IVF treatments, but only in cases of bilateral blockage of the fallopian tubes in accordance with recommendations of the Royal Commission on New Reproductive Technologies. The provinces do cover several other forms of assisted reproduction and fertility restoration, such as intrauterine insemination, non-IVF ovarian stimulation and surgical repair of the fallopian tubes. In 1999, a Nova Scotia couple argued that infertility is a disability under section 15 of the Charter, making it discriminatory to exclude intracytoplasmic sperm injection from Medicare coverage.”¹⁴² The discrimination question remains unsettled as the trial court noted that other infertility treatments are available to infertile people. Both trial and appellate courts affirmed the provincial right to limit Medicare coverage of specific procedures on the grounds of expense, effectiveness and medical necessity.¹⁴³ The argument that provinces should maintain the right to restrict health care provisions on the grounds of financial considerations parallels the provincial government arguments espoused from legislatures in P.E.I. and New Brunswick concerning the funding of abortion procedures.

**Women’s Organizations and Abortion**

In Canada, there is a persistent underrepresentation of women within legislative bodies. It reached a high of 25% in the recent federal election, up from 22% in 2009.¹⁴⁴ As well, the

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¹⁴² Harris, Pp. 47-48.
¹⁴³ Harris, P. 49.
work by Jane Jenson and Susan Phillips on the Women’s State and its undoing during the late 1980s and 1990s tells a story of women’s groups enjoying a brief period as ‘outsiders’ deliberately brought into the channels of law and policy making and then equally deliberately being barred and recast as illegitimate ‘interest groups’ that interfere with the access of individual citizens to Parliament.\textsuperscript{145} The picture also should include the general defunding of women’s organizations by the Canadian government and the decision not to fund organizations that facilitate access to abortion in the Harper Government’s 2010 global maternal health initiative, the continual ripple of anti-abortion private members bills through the House of Commons, and the more successful and ongoing efforts of provincial governments to curtail abortion access.\textsuperscript{146} Thus, there is a considerable amount of resistance from the federal government for women’s organizations seeking access to abortion to deal with in order to have a positive impact on legislation. Additionally, this indicates that the experiences and perspectives of many groups of women remains absent from the policy process.

The motivations for the provinces’ actions began with clashes between individuals and small, concentrated interest groups and continue to this day. Abortion has been the responsibility of the provinces for over twenty years and should be handled like any other healthcare concern; unfortunately, this may not be the case.\textsuperscript{147} Part of the reason for this may be the resistance provided by other groups. For example, anti-choice activists are highly organized in Canadian politics and driven by a singular focus.\textsuperscript{148} This focus on the re-criminalization and social demonization of abortion by lobbyists is difficult to counter as the goals of the pro-choice

\textsuperscript{146} Macdonald, P. 20.
\textsuperscript{148} Luxton, P. 30.
movement cover a spectrum of issues surrounding reproductive choice from birth control to daycare.\textsuperscript{149} The division of focus combined with a lack of perceived urgency on behalf of the pro-choice movement given the legal precedent on their side, has meant that the anti-choice movement has become a strong lobbying group that operates subtly and without strong opposition.\textsuperscript{150} This is an important point because it suggests that anti-choice momentum may contribute to the intent of a particular government to engage in policy in-action or the deliberate attempt to restrict access in the case of some provincial legislatures.

A specific example of the preceding argument would be the case of New Brunswick. The convictions of anti-choice lobbyists and members of parliament on a subject which is still socially taboo, but presumed safeguarded, has allowed the anti-choice movement strong footholds in New Brunswick.\textsuperscript{151} The constant threat to women’s autonomy that has been the result of this means that New Brunswick women lack the access Ontario and Quebec women possess on issue of access to abortion.\textsuperscript{152} Conversely, this is indicative of policy drift in the provinces with more restricted access to abortion, such as New Brunswick, as the strength of anti-choice groups and the intent of the government to refuse pro-choice lobbyists efforts to conform to the standards of the CHA reflect the characteristics of drift. Further, even stronger and more-organized groups have failed to rally the current Conservative government at the federal level to more aggressively enforce compliance with the federal legislation as other Liberal governments endeavoured to accomplish in the past. It seems highly unlikely that the federal government would risk compromising future electoral outcomes and public confidence

\textsuperscript{149} Luxton, P.30.  
\textsuperscript{150} Luxton, P. 35.  
\textsuperscript{152} Rebick, Pp. 39-40.
and act more aggressively on the issue of abortion (in the manner that they did with same sex marriage) as abortion remains too controversial for any government to get ‘voter mileage’ from advancing access. Therefore, the government chooses to avoid the issue of abortion regardless of how well movements and organizations are organized, which can also be a characteristic of drift as sometimes intent can be reflected in a government’s decision to follow a course of inaction.

The Abortion Rights Coalition of Canada (ARCC) is currently supporting Dr. Morgentaler's 2003 lawsuit, which was meant to force the government of New Brunswick to fund abortions performed in clinics as well as hospitals. In 2001, the federal government began insisting that New Brunswick fully fund abortion services, but was slow to take official steps toward remedying the situation. In April 2005, then-Federal Health Minister Ujjal Dosanjh began a dispute avoidance resolution process with the government of New Brunswick, but it lost momentum. With the recent election of a Conservative government, it seems clear that women's right to fully funded abortion will no longer be supported at the federal level. At least 63 percent of the Conservative caucus is publicly anti-choice, and new Federal Health Minister Tony Clement has yet to take a public stand on the issue. This seemingly points toward a general lack of success facing women’s organizations that are hoping to persuade the federal government to aggressively enforce compliance with the CHA.

Perhaps one of the more salient women’s organizations that is pressuring for the expansion of access to abortion services is the ARCC. One of the ARCC’s most well-known members, Joyce Arthur, admits that abortion access improved after 1988, but there is still an up-

\[153\] McTavish, P. 124.
\[155\] Cook, Pp. 19-20.
hill battle in provinces like New Brunswick where funding to private clinics is not mandated under provincial legislation.\textsuperscript{156} A 2009 position paper authored by the ARCC, entitled, “The Case for Repealing Anti-Abortion Laws” suggests that achieving expanded access in New Brunswick through lobbying both the federal and provincial governments is a top priority in promoting the CHA principle of equality.\textsuperscript{157} Another prominent women’s organization that is lobbying for expanded access to abortion in provinces with restrictions in place is the National Abortion Federation (NAF). The NAF website suggests that access to abortion is guaranteed under the CHA and also emphasizes the restrictions placed on abortion in New Brunswick may, “violate the Canada Health Act and the intent of decriminalization of abortion procedures in Canada.”\textsuperscript{158} Again, even the most cogent women’s organizations have failed to achieve responsiveness from the federal government to reign in non-complying provinces, which also indicates the presence of policy drift as the current federal government chooses policy-in-action despite more aggressive lobbying efforts.

Another specific example would be the province of Saskatchewan. It should also be realized that the general weakness of the feminist movement in Saskatchewan reduced the pressure on the provincial government to take aggressive stances on women’s issues.\textsuperscript{159} During the 1990s, the SAC (The Saskatchewan Action Committee on the Status of Women) was centred mostly in Regina and had a small membership while most other Saskatchewan women’s groups were concentrated on community organizing and did not lobby the provincial government.\textsuperscript{160} In spite of the election of several female Members of the Legislative Assembly to the provincial

\textsuperscript{160} McGrane, Pp. 185-186.
legislature, the weakness of Saskatchewan's feminist movement and moderate nature of women's policies of the NDP and other parties reflected the continued existence of a patriarchal political culture in Saskatchewan during the 1990s.\textsuperscript{161} The case of Saskatchewan demonstrates another example of the intent associated with drift that can be at the core of some abortion policy decisions as it is apparent that a strong pro-choice movement is required to pressure a government to consider less-restrictive and more gender-inclusive policies. With a change of government and subsequent ideological perspective the Saskatchewan legislature went against public opinion on funding abortion procedures, which could also be said to demonstrate policymaker intent in favour of less-restrictive policies. This instance occurred when the 1991 provincial Progressive Conservative government issued a plebiscite through which 63\% of respondents indicated they wished to bring an end to publicly-funded abortion. However, when the NDP was elected into power later-on the same year the government declared that creating a policy reflective of the plebiscite results lacked agency because it was not constitutionally possible to follow such instructions.\textsuperscript{162} Again, this seems to be indicative of the sort of intent associated with policy drift as the more left-wing-oriented NDP intentionally acted against the public opinion to protect the constitutional rights of women. However, as some procedures were already funded in the province the decision to continue funding does not fulfill the criteria for intentionality associated with Hacker’s description of drift or Sidney Tarrow’s description of the autonomy to act through, but not limited to individual motives (ideological, moral, or otherwise).\textsuperscript{163}

\textsuperscript{161} McGrane, P. 187.
\textsuperscript{162} McGrane, P. 187.
Responsiveness of the Federal Government

It is necessary to take a more in-depth look at the specific interactions between some key women’s organizations and the federal government in order to gain a better understanding for how these women’s organizations help to explain abortion policy drift. In 2000, Health Canada developed a Gender-Based Analysis (GBA) policy. The policy confirms the department's commitment to the implementation of GBA and outlines ways in which it is being integrated into the policies and programs of Health Canada.\(^{164}\) The Bureau of Women's Health and Gender Analysis is central to this initiative. The bureau coordinates the implementation and evaluation of GBA and ensures that women's health concerns are integrated and responded to appropriately by Health Canada.\(^{165}\) Therefore, at first-glance, it appears as though the federal government does have an interest in being responsive to the gendered issues pressed forward by the women’s health movement and subsequent groups. However, a deeper analysis will reveal that this has not necessarily entailed more equitable access to abortion services in each Canadian province.

Nevertheless, observing different women’s organizations interacting with the federal government reveals that much of the interest in women’s needs appears to be a token effort to placate such groups and subsequently maintain the integrity of a potentially large portion of the Canadian electorate. As such, GBA has not been consistently incorporated into health policy development, implementation, or evaluation.\(^{166}\) Many policy makers in a variety of branches in Health Canada simply do not recognize the relevance of GBA and resist having to undertake any

\(^{164}\) Cook, Pp. 20-21.  
\(^{165}\) Cook, P. 31.  
additional work that they perceive is associated with a gender analysis.\(^{167}\) Although the Bureau of Women's Health and Gender Analysis does provide progress reports on the process and implementation of GBA across Health Canada, the Women's Health Strategy and the Gender-Based Analysis Policy have not undergone any formal evaluation. Arguably then, a commitment to GBA within the federal health sector is not by itself a guarantee of meaningful change.\(^{168}\) The 2009 Spring Report from the Auditor General of Canada directly noted that the, “[level of GBA implementation varies greatly and gender impacts were not regularly reported in the documents for Cabinet we reviewed.”\(^{169}\) Additionally, there is no government-wide policy requiring that GBA be performed.”\(^{170}\) The reports continues by stating that, “officials in departments expressed concern over the leadership of the central agencies in promoting GBA and noted the need for better guidance and clearer communication of expectations from the centre to improve the reporting of gender impacts.”\(^{171}\) Finally, the Auditor General’s report notes that the, “1995 commitment called for a five-year phased-in implementation of GBA throughout the federal government. Despite this, we observed considerable variation in our sample departments’ GBA frameworks. We also found that the departments rarely perform gender-based analysis and that, based on the evidence provided, documents for Cabinet often omit information on gender impacts.”\(^{172}\) Thus, the women’s health movement and various organizations attempting to utilize policy initiatives still meet resistance to their concerns.

The deliberate avoidance of being more inclusive of women’s experiences also indicates the in-action associated with policy drift. The federal government as well as the provinces have

\(^{167}\) Hankivsky, P.54.  
\(^{168}\) Hankivsky, P.54.  
\(^{169}\) Hankivsky, p. 55.  
\(^{170}\) Hankivsky, p. 55.  
\(^{171}\) Hankivsky, p. 55.  
\(^{172}\) Hankivsky, p.55.
a commitment to undertake gender sensitive policy and program development with at the very least uneven results.\textsuperscript{173} Provincial governments may have identified women as a priority population, produced a women's health plan or set up Women's Health departments, but without much effect on care.\textsuperscript{174} Despite a 2002 Royal Commission on Health Care Report that clearly demonstrated the support for and superiority of the Canadian Medicare system action is missing in reflecting the ambitions for women-centred models of health care.\textsuperscript{175} This so-called missing-policy action in the wake of independent commission reports and lobbying from women’s groups through various policy initiatives could also be regarded as policy-inaction associated with intent and subsequent policy drift.

Moreover, another macro-scale example of a lack of consideration for the voices of women’s organizations is the report of the 2002 Royal commission on Health Care. The Health Accord that was derived from the Romanow Report and signed by the provinces and federal government in February 2003 was also void of any kind of gender analysis.\textsuperscript{176} Further, the First Minister's ten-year plan to strengthen health care (2004) makes no specific mention of gender. This can be partly explained by the fact that although almost all health care is provided by women and women are most of those who receive care; women are a minority of those making policy decisions about health care.\textsuperscript{177} This may also be a result of the widespread belief that universality does not require differentiation predicated on unique characteristics of males and females. Women’s organizations have few means of influencing how major policy decisions are

\textsuperscript{174} Agnew, Pp. 10-11.
\textsuperscript{175} Agnew, P. 12.
\textsuperscript{177} Austin et al., P. 42.
made even though their daily practices bring so many of them into direct contact with the health care system.\textsuperscript{178} Despite how organized a women’s movement or organization may appear, it is often difficult to gain the necessary influence to progress policy initiatives. Additionally, the lack of responsiveness to include more Canadian women’s voices in the policymaking process seems to reflect the inaction associated with policy drift as well.

Again, the intentionality that is characteristic of policy drift is represented by the lack of support for GBA and defending other gender-based initiatives. It is also important to recognize those women’s organizations and women who are both providers and users of the health care system are rarely consulted.\textsuperscript{179} Most community-based women's and health groups remain unaware of GBA, and, not surprisingly, activists and other health care professionals remain skeptical about GBA and its ability to affect health policy, programs, and services or other policy areas that directly affect health.\textsuperscript{180} As well, the infrastructure for women and equity seeking groups have been reduced significantly thereby decreasing the likelihood of the ongoing monitoring required to support change.\textsuperscript{181} While the preceding point does not reflect in-action it still may point at policy drift because of the active effort to defund policy initiatives such as the federal government cutting over a quarter of the budget allocated to the Status of Women Canada (SWC) that enables more women’s voices to be heard in the policymaking process. As the 2009 Auditor General’s Report noted the SWC, “works with federal departments and agencies to help them take into account gender impacts when developing policies and programs. It has encouraged departments to carry out GBA pilot projects and other targeted efforts. Its support

\textsuperscript{178} Austin et al., Pp. 42-43.
\textsuperscript{179} Austin et al., P. 44.
\textsuperscript{180} Austin et al., P. 44.
\textsuperscript{181} Austin et al., P. 45.
has included knowledge transfer, training, assistance, and GBA capacity building.”

Therefore, defunding one of the most important platforms for women to express their voices in the policy process seems like an intentional act to coax policy in a certain direction or to simply maintain the status-quo concerning policy issues that are specifically sensitive for women, such as abortion.

Further, many of the challenges and barriers to successful GBA application in health and beyond have been further entrenched by recent political decisions at the federal level. Again, a salient example occurred on September 25, 2006, when the Conservative government announced a five million dollar cut to Status of Women Canada (SWC). Also, the goals of SWC were changed from promoting and protecting gender equality or promoting political justice to, "facilitating women's participation in Canadian society by addressing their economic, social and cultural situation through Canadian organizations.”

There is no longer any formal commitment to helping women's organizations participate in the public policy process or increasing the Canadian public's understanding of the importance of gender equality issues. On September 27th, the government announced that the Women's Program of SWC will no longer fund any advocacy or lobbying or general research and that for-profit organizations are now eligible to apply for this program's funding. Therefore, the case of SWC funding yields another example of the government’s intent to suppress perspectives on issues that are most important to women, such as abortion and ARTs.

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184 Rankin and Vickers, Pp. 35-36.
185 Rankin and Vickers, P.40.
The erosion of our publicly-funded, not-for-profit health insurance system and the accelerating growth of a two-tiered health system is a significant women's health issue. Though women and men are both affected by government cutbacks and rising health care expenditures, they do not have the same financial resources to cope with them and the impacts are different.\textsuperscript{186} Women earn less than men on average and are less likely to have supplementary health insurance coverage through their paid employment, and are more likely to live in poverty.\textsuperscript{187} As a result, women face a greater burden when health care costs are privatized. No action has ever been taken to build in-health impact assessments that would evaluate new policies or programs as possible causes of inequities in women's health.\textsuperscript{188} Further, although the privatization of health care has potentially harmful consequences for women, private clinics are typically encouraged for abortion procedures as services offered at these clinics are only in-relation to the abortion process. Additionally, public hospitals are concerned with a wide variety of procedures and may not treat the issue with the gender sensitivity commanded by private facilities that only perform abortion procedures. Private abortion clinics also offer counselling services to ensure the mental health of the patient as well as freedom from moral and personal biases of doctors and staff at a public hospital. This additional example of in-action on behalf of the federal government demonstrates the intention to formulate policies that are largely missing the perspectives of many women’s groups as there is a clear unwillingness to acknowledge and assess inequalities emphasized by such groups.

Once again, it is crucial to consider how the institutional layout of federalism disguises the intent (associated with policy drift) of the federal government to avoid insisting on a

\textsuperscript{186} Rankin and Vickers, P.41.
\textsuperscript{188} Armstrong, P. 29.
consistent access scheme for abortion services. Melissa Haussman draws on the successes of women’s activist organizations in Canada concerning in-vitro fertilization and other technology facets of reproductive rights, such as abortion.\(^{189}\) According to Hausman, activism in its various forms coupled with the ideology of conservative governments that use federalism to prevent a consistent access scheme leaves reproductive rights in jeopardy of only being of “consequence” to wealthier demographics in society.\(^{190}\) In other words, regardless of how well-organized a social movement may be the federal government accords very little legitimacy to social movement as far as consultation for devising policy or responsiveness in treating movements as legitimate constituents.\(^{191}\) Further, it seems as though the federal government uses the policy-variation inherent in the layout of Canadian federalism to disguise the intent associated with policy-inaction and policy drift concerning access to abortion across Canada.

**Advocacy leading to Policy Drift**

The fragmentation that exists within women’s organizations and across movements prevents the necessary cohesion from province-to-province to successfully influence the policymaking process at the federal level of government. Nonetheless, this lack of cohesion amongst women’s organizations causing a substantial weakness (as demonstrated by the case of ART rights) certainly could allow the intentions of the government in one province to support funding abortion procedures and allow the intentions of government in another province (with weaker lobbying efforts) to produce a more restrictive policy. Additionally, even in cases where


\(^{190}\) Haussman, P. 80.

organizations and movements are well-prepared the federal government shows intent associated with policy drift through inaction and through cutting the budgets for many of the policy initiatives that these groups are dependent-on. Whether it is because of voter-mileage or the ideology of the governing party, the federal government demonstrates the intent indicative of policy drift when it comes to social movement organizations and abortion policy across Canada.
Chapter Three: Right’s Litigation

Rights Litigation as an Explanation for Policy Drift

Since the Supreme Court of Canada’s decision in the R v. Morgentaler case ruled criminal legislation on abortion as unconstitutional there have been some unsuccessful attempts at the federal level of government to re-criminalize the procedure or at the very least establish a legislative framework for foetal rights in hopes of an avenue to re-criminalize abortion. The Conservative Party of Canada’s Member of Parliament for Kitchener-Centre, Stephen Woodworth, has recently endeavoured in another attempt to restrict and re-recriminalize abortion procedures within the context of human-rights and modern-medical-technological-capacity. Mr. Woodworth is attempting to apply to the foetus the human rights arguments afforded to those living outside of the womb already. Further, Mr. Woodworth’s arguments suggest that with an increased capacity for medical technology and biological-knowledge there is an increased capacity for sympathy towards the foetus so that it may be accorded the same rights as any other human being. If Parliament agrees to Mr. Woodworth’s request, a special committee will review Section 223 of the Criminal Code of Canada, which dictates that a child becomes recognized as, “A human being…when it has completely proceeded, in a living state, from the body of its mother.” Since the CPC now has a majority government in their grasp, both the means and the motive exist to move towards a discussion of recriminalizing abortion procedures.

Perhaps on the surface, it would appear difficult to discern any negative repercussions from Mr. Woodworth’s motion as it seems to have legitimate human-rights concerns at its core. However, a closer analysis reveals the potential dangers of such a motion like threatening
maternal health and infringing upon women’s fundamental rights, which galvanizes a shift of attention away from abortion procedures that was evidenced in the movement towards a focus on assisted reproductive technologies. Further, as Joyce Arthur has noted, bestowing two sets of fundamental human-rights on one human body creates inherent conflicts between the foetus and the mother, in which the rights of a woman are being subordinated beneath the rights of the foetus as well as fostering an entirely new set of social and legal complexities.

 Nonetheless, there have been a number of court cases in various provinces since the initial Morgentaler (1988) decision in which women have attempted to utilize the Charter of Rights and Freedoms to gain access to abortion in places where procedures are more restricted. The most widely-used argument in such cases involves section 7 of the Charter, the right to life, liberty and security. However, there is also building-momentum within scholarly circles of debate encouraging women to pursue arguments focused-on section 15 of the Charter (the right to equality) as a more effective medium to gain favourable outcomes in the courts concerning access to abortion. Therefore, the most significant objective for this section of the thesis is to determine the extent to which legal outcomes in the courts (via Charter of Rights claims) can account for the concept of policy drift concerning access to abortion across Canada.

 In order to find an answer to this question it is important to first turn to the academic literature to gain an understanding and conception of rights as well as prominent debates on the efficiency of utilizing different sections of the Charter. This will be followed by an analysis of key court cases that will provide evidence of the efficiencies and failures of various Charter claims involving women attempting to gain access to abortion across Canada. Evidence emanating from the court decisions will facilitate the opportunity to provide an analysis of rights claims as a potential explanation for policy drift. In provinces where restrictions remain in place
concerning abortion unfavourable court decisions may have reinforced the government’s intention to maintain the status-quo, which is characteristic of policy drift. Further, provinces such as New Brunswick seemingly resist court orders by instinctively challenging such rulings in the appellate courts. This is not the case in Quebec, where the Legislative Assembly chose not to pursue a challenge ordering the government to expand access to abortion.

Rights

As indicated, R. v. Morgentaler (1988) offers the most efficient starting-point for rights analysis because it was the policy vacuum left by the Supreme Court decision that made debates and discussions concerning rights more prominent. R. v. Morgentaler (1988) involved a Charter challenge to provisions of the Canadian Criminal Code that criminalized abortion unless certain requirements were met. Specifically, the impugned provision required a woman seeking an abortion to appear before a three member therapeutic abortion committee, obtain a certificate authorizing the abortion and find a physician other than one on the committee to perform the abortion. Because of this process many women faced significant delays in obtaining abortion services particularly in areas outside large urban centres. The majority of the Supreme Court of Canada found that this criminal scheme was an unjustifiable violation of the Charter. One judge stated that the Charter right to, “security of the person must include a right of access to medical treatment for a condition representing a danger to life or health without fear of criminal

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sanction.” The decision to rule existing criminal legislation on abortion as unconstitutional left the regulation of abortion procedures to provincial legislatures as the procedure falls under the constitutional jurisdiction of health care. Nonetheless, there are still some provinces with more restricted access to abortion procedures, which has led to a number of court challenges concerning women and the argument that their fundamental rights are infringed-upon in instances where access to the abortion procedure may be restricted.

However, there is a great deal of discussion and debate surrounding the concept of a right and if it is reasonable to conclude that restricting abortion comprises an infringement on a woman’s rights. Mary Ann Glendon argues that the Supreme Court of Canada's decision in R. v. Morgentaler, which declared unconstitutional the federal abortion law in 1988, is an example, "of the combination of interest and caution that many Anglophone judges manifest toward American rights ideas.” She commends the decision because it was decided on narrow terms, leaving room for Parliament to enact new legislation as it saw fit. Despite the Supreme Court facilitating an opportunity for Parliament to draft legislation concerning abortion, no federal government has since taken the opportunity to create such a policy. This hints at policy drift as a result of constant policy in-action, but that strand of analysis will be explored more in-depth later in this chapter of the thesis. Nevertheless, the significance of Glendon’s commentary is in the emphasis on caution exorcized by judges towards the notion of rights. There was and still is an aversion the courts seem to have to explicitly referencing rights discussions in rendering any decisions concerning abortion.

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Subsequently, it seems to follow that the political spheres, both provincially and federally, would also have an aversion to an explicit discussion of rights in the drafting of policy concerning abortion procedures. The federal government supplements any rights discourse with the central piece of health legislation (the CHA). Efforts from past federal governments to remove restrictions on abortions have focused more on obtaining a measure of compliance with the principles of the CHA rather than on a premise of fundamental rights. According to F.L. Morton, the failure of new legislation to pass in the immediate aftermath of the decision, "suggests that the polarizing effects of rights talk is at work in the Canadian body politic."196 As such, Morton also questions the extent to which legislative in-action on abortion is the result of issue avoidance or simply satisfaction with the status quo.197 In either scenario, there seems to be sufficient evidence to suggest that policy drift is at work.

Emphasizing rights discourse in the realm of abortion policy and broader health care concerns seems highly ineffective. Mary Ann Glendon's assertion made only a few years after Morgentaler is that the decision served to foster compromise and reflected a less absolutist understanding of rights in the Canadian context.198 That no attempt has been made since 1990 to address the policy vacuum left by the decision suggests that a compromise has not been reached.199 Again, this lack of compromise is significant because it has led to the in-action deemed to be characteristic of policy drift. Additionally, the lack compromise seems to provide an indication of the ineffectiveness of placing rights discourse at the centre of arguments in favour of removing restrictions on abortion procedures in certain provinces.

Further, as Emmett Macfarlane points out, the Liberal party's ability to use abortion as a wedge issue against the Canadian Alliance or Conservative party in consecutive elections, even at times when it was not on any party's agenda, lends some support to Morton's argument concerning the polarizing effect of rights-debate in Canadian politics. During the 2006 campaign Paul Martin raised the spectre of abortion in the context of his promise to abolish federal use of the notwithstanding clause so that Stephen Harper could not, "pick and choose which rights Canadians will keep and which will be taken away." This example provides insight into the way invoking rights can inhibit, or in this case pre-empt, genuine debate. Nonetheless, as the news coverage reflects, the abortion issue is subject to the crippling impact of rights talk. This confirms Peter Russell's assertion that court decisions such as this recast these issues, "in less compromising and more strident terms--making consensual resolution of the issues more difficult than before." Thus, once again, the reliance on rights discourse seems as though it may not be the most expedient avenue for women given the diminished capacity to reach compromise under such auspices and given the federal government’s traditional reliance on securing compliance with the CHA rather than the Charter of Rights and Freedoms.

There are other reasons that exist, which limit the effectiveness of rights discourse as absolute rights discussion signals that something should or should not exist and there is no or little opportunity for concessions. Health policy commentators Christopher Manfredi and Antonia Maioni argue that the, “rights discourse narrows the range of feasible policy alternatives,” particularly in the health care policy context. This concern echoes the government’s argument in the Auton case that a ruling in favour of the claimants would

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‘constitutionalize’ certain health care treatments and consequently restrict the policy options that might otherwise be considered. Advancing rights claims under the Charter, “narrows the scope of policy discussion by equating legally enforceable rights with a single, ‘correct’ policy choice.”

Thus, there is a considerable amount of academic support opposed to the concept of a rights-based argument gaining traction in the courts concerning access to certain health care provisions (such as abortion).

The Charter of Rights and Freedoms

Individuals or groups may use the Charter or human rights laws to argue the government has a legal obligation to fund specific health care services. Although the Charter does not specifically protect a right to health care it protects rights to life, liberty and personal security (section 7) and equality rights (section 15), which encompass the right to equal benefit of government benefit programs without discrimination on grounds such as disability and age. Similarly, human rights laws across Canada protect the right to access public services, such as health care, without discrimination.

Section 7 of the Canadian Charter of Rights and Freedoms, the right to life, liberty, and security is a crucial passage in the overall document for ensuring that a certain standard of life is guaranteed to all Canadian citizens. As such, the language in section 7 of the Charter has become the preferred court argument for women attempting to remove restrictions on abortion.

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procedures across Canada. However, it is also the language in section 7 of the Charter that can lead to interpreting rights in absolute-terms, which complicates and inhibits the possibility of reaching compromise and issue-resolution. Peter Russell warned about the dangers of some of the simplistic language used to promote the Charter during the entrenchment debate leading-up to the 1982 decision, which entailed intense debate concerning the implementation of constitutional rights as would be entrenched in the Charter. According to Russell, “protecting rights and freedoms,” is a deceptively simple idea. Further, Russell notes that while the simplistic language undoubtedly assisted in winning public support for the Charter it is not very helpful in understanding the real political consequences and implications. The trouble with this language is that it tends to reify fundamental rights and freedoms by treating them as things which people either possess in their entirety or not at all. Nevertheless, society will not encounter these rights and freedoms in such a zero-sum fashion. Once again referring to rights, Russell contends, “we enjoy more or less of them. What we have to settle about these rights and freedoms is not whether or not we will ‘have’ them, but what limits it is reasonable to attach to them and how decisions about these limits should be made.” Without any compromise on decisions or how to formulate decisions on what restrictions on abortion procedures would comprise a reasonable course of action it is futile to utilize a rights-based argument in the courts.

There exists a great deal of debate concerning whether or not specific sections of the Charter indicate health care provisions as an absolute right. Therefore, according to Macfarlane, a significant question becomes whether s. 7 entitles a person to specific forms of health care, or whether it could be used to compel government to add certain benefits to a schedule of insured

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health services. This question comprises the crux of a complex issue. If the idea of health care is posited as a social right - that it is part of human welfare at its most basic social level, similar to, for example, public education - there is a possible case to be made. 210 In Canada, this is supported by the fact that Medicare has solidified its place in the social fabric so that subsidized health care has arguably become a basic right of Canadian citizenship. 211 In other words, the provision of a government service can (over a period of time) become a fundamental right, as a part of a national history of decision-making. This view also fits within a growing acknowledgment of social and economic rights developed in international commitments. 212 A arguing under section 7 of the Charter for improved access to abortion procedures seems like a cogent strategy. On the other hand, a closer analysis of the issue reveals inherent dangers, such as the ‘slippery-slope’ mentality whereby it becomes difficult to determine a point at which to stop funding one procedure over another. Indeed, it becomes most difficult to pick and choose which procedures a Canadian citizen is entitled to as a health care right.

However, there also instances where the position of interpreting health care as a right becomes substantially weakened by scholarly research. For example, Macfarlane argues that it seems apparent that some individual rights are more fundamental than those of health such as the rights to food and water that are not included in the Charter and to somehow read any of these rights into the Constitution is unlikely. 213 Thus, it becomes extraordinarily difficult to support the line of arguing that health care is an entitled right when survival necessities are not explicitly institutionalized in the Constitution. Moreover, Macfarlane suggests that the same reasoning can be used today to draw the opposite conclusion that government is as much a force for reducing

social programs as it is for introducing and promoting them, which by implication sends a message that any form of guaranteed government program is a reflection of past policies.\textsuperscript{214} Again, taking Macfarlane’s argument and applying it in the context of access to abortion across Canada fosters an understanding of the inefficiencies and complex barriers associated with using a rights-based argument in the courts in attempts to reduce restrictions on provincial access to the procedure.

As the 1988 Morgentaler judgment makes plain these types of adverse medical outcomes constitute a clear violation of both the physical and the psychological aspect of the security of the person protected by section 7 of the Charter. In essence, such violations include not allowing a woman to have control over her own reproductive capability and physical and mental health as well as shrinking the period in which a woman can safely obtain the procedure (recalling that the maximum gestation limit is 21 weeks or 23 in instances where maternal health is at immediate risk). In Morgentaler (1988), the Supreme Court of Canada decided that when a government-induced delay in obtaining medically necessary services increases the risk of adverse medical consequences, there is a violation of security of the person. Moreover, the Court ruled that the stress associated with waiting for medically necessary care violates the psychological aspects of security of the person, which is also a value protected under section 7. Where governments institute measures that delay or impede access to medically necessary services and where that delay increases medical risks or otherwise results in adverse health consequences the violation of security of the person is clear.\textsuperscript{215} This conclusion is consistent with the underlying approach of Chief Justice Dickson's 1988 decision in R v Morgentaler, which emphasized that the state's

\textsuperscript{214} Macfarlane, 2008. P.320.
impeding access to timely abortion services violated section 7 of the Charter.\textsuperscript{216} Chief Justice Dickson specifically noted that the fact that patients may be able to access services in another jurisdiction, such as the United States, does not negate or eliminate the violation of security of the person.\textsuperscript{217} In effect, what Justice Dickson decided is that Canadians have a right to expect that medically necessary services are available in Canada.\textsuperscript{218}

However, applying similar logic in more-recent cases that attempt to expand provincial access to abortion procedures becomes a much more difficult task, especially concerning rights arguments utilized under section 7 of the Charter of Rights and Freedoms. Of course, a deprivation of security of the person does not in itself automatically lead to the conclusion that the deprivation is contrary to section 7 of the Charter as it requires further inquiry to determine whether the deprivation has been imposed in a manner consistent with the, "principles of fundamental justice."\textsuperscript{219} But before turning to that inquiry, the court must consider whether the existing restrictions on access to medical care also constitute a deprivation of an individual's ‘liberty’ interest under section 7.\textsuperscript{220} Thus, in attempting to apply the same rights-based reasoning as the Morgentaler (1988) decision to cases involving provincial access to abortion procedures there are significantly greater barriers and complexities to overcome to achieve the same favourable results from the courts. In particular, it seems as though it is more difficult to prove the deprivation of security and liberty are imposed in a way that is a contradiction of fundamental justice when criminal sanctions are no longer providing a barrier for a woman to seek-out an abortion procedure.

\textsuperscript{216} Hartt and Monahan, 2002.
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One final approach under s. 7 may be available to women seeking to improve access to abortion procedures. This strategy would be to rely on the legislative provisions of the CHA itself. Under the CHA, services to be included under Medicare are those, "medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability." Richard Haigh argues that, “rather than simply delisting items by regulatory fiat, fundamental justice, as entrenched under the Charter, could require open, public discussion of the treatment modality and other health policy decisions that reverberate through a number of professions and therapies.” This argument also seems like an improved strategy for gaining traction as it is closer in proximity to the federal government’s traditional approach of attempting to secure reasonable compliance with the CHA while steering clear of absolute rights discussions. A discussion of rights would only exist in the capacity to secure compliance with the CHA as opposed to fulfilling demands for access to abortion as entitlement or constitutional-rights obligation of the federal or provincial governments.

It is also possible to utilize section 7 of the Charter to interpret health care rights in a manner that does not limit an individual’s choices for treatment. As Professor Martha Jackman states, “an individual whose health-related interests are at risk would also have the right to discuss fully the health service or treatment decision with the physician or other health care provider actually responsible for making it. To meet the requirements of fundamental justice, such a discussion should enable the person affected to thoroughly understand and assess the entire spectrum of treatment choices available, including those of a non-medical nature, and fully convey his or her own particular priorities and concerns....” Clearly, Jackman is a proponent

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of using the Charter as an instrument to assist in securing compliance with central legislation. However, Jackman has also questioned the expediency of utilizing section 7 in-terms of framing health care as a constitutional entitlement in the courts concerning access to abortion.

Instead, another section of the Charter is also receiving consideration to utilize as an argument in the courts. Martha Jackman has focused some of her efforts on arguing for the use of section 15 of the Charter as a more suitable host for rights discussions in the context of access to abortion procedures across Canada. Under the Canadian Charter of Rights and Freedoms, section 15 guarantees the right to equality for each and every Canadian citizen. Jackman suggests that the path of least resistance to a favourable court outcome would be to utilize equality based arguments to secure similar treatment for citizens, irrespective of gender, as opposed to the argument that access to abortion qualifies as an entitlement that if not met, is an infringement of section 7, the right to life, liberty, and security. Further, framing discussions concerning access to abortion with equality arguments also lends support to the federal government’s status quo mentality of haphazardly, in certain instances, attempting to secure compliance with central legislation. Securing such compliance offers the purpose of attempting to ensure that federal legislation is interpreted for and applied to each Canadian citizen in an equitable manner and pursuant to the principles of the CHA. Thus, Jackman’s strategy posits that if each Canadian citizen has the right to equality under section 15 of the Charter it would seem to follow that each Canadian would have the right to have legislation interpreted and applied equally including the provisions of the CHA. Additionally, if the goal of Canadian law

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is to point towards a right to health care for the purpose of the enforcement of egalitarian
principles then section 15 may be the most suitable rights-based argument.\textsuperscript{225}

The lack of success using section 7 arguments from the Charter may be contributing to
abortion policy drift across Canada. Considering that intentionality is an important precondition
for drift provinces like New Brunswick that actively challenge court rulings and tend to gain
favourable outcomes (on the grounds that there are no criminal sanctions on abortion) may serve
to galvanize or reinforce the initial intent or ambitions of the legislature. Failure to obtain
expanded access in the courts also fosters a richer precedent each time an unfavourable outcome
is rendered in a province with restricted access to abortion. Although a stronger strategy to
deploy would involve equality rights under section 15 of the Charter, which would be aimed at
securing compliance with the CHA, the recent emergence of this strategy may be too late as the
precedent seems to have been set for rights-based litigation in provinces like New Brunswick.

\textbf{Court Decisions}

Since Morgentaler (1988), the issue of whether provinces should reimburse the entire
cost of abortion services under the public health care system has been the contestation in a
number of court cases. Many provinces have sought to avoid paying for abortions by often
refusing payment in full for abortions performed in private clinics rather than in hospitals. One
case that is particularly important to examine is the case of Jane Doe 1 v. Manitoba, where a
judge ruled in a summary judgment that the province of Manitoba's Health Services Insurance
Act, which denied funding to abortions performed in private clinics, violated various sections of

\textsuperscript{225}Haigh, 1999. P. 163.
the Charter of Rights and Freedoms. The plaintiffs argued that there was a significant delay in obtaining abortions in hospitals (which were covered by the Health Services Insurance Act) and so sought the procedure at private clinics. The judge agreed that forcing women to wait for an abortion in the public system violated Charter guarantees of liberty and security of the person. This judgment was overturned on appeal in 2005 when it was held that a summary judgment was insufficient to resolve the complex issues of the case. This case comprises a significant case to analyze because it demonstrates the complex barriers involved with attempting to utilize rights based arguments for provincial access to abortion policies in a similar manner that rights-based reasoning was included in the Morgentaler (1988) decision. The appellate court clearly indicated that the circumstances created complex issues that would prevent a summary court from making a ruling on the grounds of rights-based reasoning.

The case of Morgentaler v. Prince Edward Island (Minister of Health and Social Services) also upheld a province's decision to refuse public funding for abortions performed in clinics. In this ruling, the judge declared that, "this application does not decide whether Island women will, or may, obtain legal abortions. Many now exercise that choice. Permission is not in issue." The judge appears to have accepted the government's position that the, "proceeding is confined to the issue of whether abortion will be paid for, there being no regulation in existence that denies a woman the choice of whether to obtain an abortion". This argument makes a distinction between exercising the choice to obtain an abortion and having that abortion

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paid-for. Once again, because the criminal prohibitions on abortion were removed as a result of the Morgentaler (1988) outcome it is increasingly difficult to legitimize a rights-based argument for access to abortion as the Judge in P.E.I. pointed out that there is no legal obstacles preventing a woman from obtaining an abortion. Entitlement to abortion funding through rights-based arguments in the various provinces is a sticking-point for the courts and provincial and federal governments because it limits the autonomy governments have to make decisions concerning health care.

This example further demonstrates the lack of awareness of barriers to the exercise of choice even in the absence of criminal prohibitions. Thus, this distinction is deeply problematic since the inability to pay for abortion and the province's refusal to cover the procedure will certainly have an effect on whether a woman will be able to exercise choice. As noted above, Prince Edward Island has no abortion providers and a woman may have to travel over 400 km to reach the nearest center providing abortion. In situations in which a woman must incur the costs of travel to access an abortion, take time off work or school and overcome the difficulty of coming up with excuses for her absence the fact that she must additionally pay for the abortion out of her own pocket could work in concert with these other barriers to deny the choice to terminate a pregnancy. The judge's remarks in this case thus exhibit a striking lack of awareness of the barriers that impede reproductive choice. Therefore, this lack of awareness may also contribute to a lack of expediency concerning rights-based arguments and enhancing provincial access to abortion procedures across Canada.

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Recently, in the class action litigation brought forward by Association pour l'accès à l'avortement v. Québec (Procureur général) the province of Quebec was ordered to refund women who were required to pay additional fees for abortion services.\footnote{Association pour l'accès à l'avortement c. Québec (Procureur général), 2006 QCCS 4694 (CanLII), 2006-08-17.} In these cases judges were asked to rule on the legality of provincial funding policies which could inhibit a woman's choice to have an abortion by making them pay for the procedure. This case comprises a significant piece of information to consider because the outcome eventually forced the Legislative Assembly in Quebec to fund abortion procedures without limitations or restrictions beyond those recommendations provided by the college of doctors, which did not occur in the Manitoba case or the Prince Edward Island example. The court was more concerned with ensuring compliance with the CHA and ultimately decided that any constitutional rights had not been infringed upon and less concerned with sorting out complexities related to jurisdiction. The Legislative Assembly in Quebec has complied with the courts and resisted aggressively appealing decisions on abortion. However, provinces like New Brunswick have aggressively and successfully appealed court decisions ordering the provincial restrictions on abortion to be unconstitutional. Quebec adhering to court rulings and New Brunswick immediately and vigorously challenging a similar decision seems to suggest that there is intent in certain provincial legislatures to maintain the status quo on abortion policy, which is indicative of policy drift.

Additionally, the aforementioned court decisions seem to indicate that provincial governments tend to focus on the immediate cost impacts of funding a new service as well as the financial liability they may face by setting a precedent for other funding requests.\footnote{Ries and Caulfield, 2004.} Individuals who seek to expand health care coverage often emphasize the wider cost savings that may result
from funding a service as well as psychological and social costs incurred when some groups are
excluded from accessing an important benefit program like Medicare. In Eldridge (1997), the
government focused on the expense of a medical sign language interpretation program, and was
particularly concerned with the possible long-term financial impact of requests for language
interpretation services by other groups.237 However, the Supreme Court criticized the
government for its lack of evidence to substantiate this speculative concern.238 The Supreme
Court’s criticism in Eldridge (1997) should be applied to cases involving the expansion of
provincial funding to abortion services as it seems there is little evidence to support government
arguments of this same fiscal variety. Eldridge (1997) involved the necessity for the hearing-
impaired to receive financial subsidization for special equipment as the disability of being
hearing impaired interferes with some Canadians’ ability to receive health care that is equitable
to care received by Canadians without a hearing disability and in a manner that complies with the
principles of the CHA. In the case of abortion policy, the abortion procedure itself is gendered
and according to the Supreme Court of Canada in Morgentaler (1988), it is crucial that women
have control over their capacity to give birth in order to preserve constitutional rights to life,
liberty, and security. Provinces that restrict access to abortion inhibit the equitable interpretation
of the CHA and sections 7 and 15 of the Charter. Further, the aforementioned court rulings in
New Brunswick and Nova Scotia as well as Eldridge (1997) point-out a lack of evidence to
support an argument for fiscal restraint in either area of sign language interpretation or abortion
procedures. Therefore, with a lack of substantial evidence to deny abortion funding in certain
provinces there is evidence of intentionality that is indicative of policy drift. Recall that Jacob
Hacker points out that drift occurs when there is a failure to change a program to match societal

movements or when there has been insufficient updating. In Eldridge (1997), the Supreme Court of Canada pointed out that budget allocation concerns were speculative. Provincial governments (like New Brunswick) using financial stability as reasoning to restrict access to abortion is short-sighted and reflects a lack of updating on the number of abortions being performed and their subsequent cost in reality.

**Legal Cases, Rights & Drift**

To the extent that a generalized conclusion can be reached it is not only that rights-based argument seems ineffective, but court challenges in general have been ineffective thus far. Legal avenues likely do not offer the best approach to health system reform.\(^{239}\) While individuals seem increasingly willing to pursue legal action in the health care context the reality is that litigation is an expensive and time-consuming process that may be extremely draining especially for individuals who are themselves ill or responsible for the care of others.\(^{240}\) Subsequently, this course of action is most likely only available to those who have financial and other resources to fight-out the legal battle.

Further, because of the polarizing nature of right-talks there is little opportunity to reach a compromise on something as highly politicized as access to abortion procedures. With little possibility of reaching a compromise and setting a dangerous precedent concerning the future application of health care rights-entitlement rights-based challenges through the court seem like a

poor option for women seeking the expansion of abortion services. Both the courts and the federal government are more willing to secure compliance with the central legislation as a matter of adhering to its principle of universality and have traditionally steered away from absolute-rights guarantees in the reasoning for subsequent decisions. Although Martha Jackman suggests that women attempt to use the equality-rights argument (under section 15) of the Charter as a more suitable mechanism to expand access to abortion services there has not been a successful attempt to date using this approach.

Finally, the provincial governments in provinces with restrictions on access to abortion, such as New Brunswick, have been traditionally occupying courtrooms with arguments focusing on applying reasonable limits to health care resource allocation. These provinces typically argue that since there are no criminal sanctions impeding women from seeking-out an abortion procedure they are within reasonable and justifiable limits to maintain the status-quo policy on access to abortions. Thus, as previously mentioned, utilizing a rights-based argument in the courts has been particularly ineffective since certain provincial governments suggest that they are not imposing legal barriers for women to obtain an abortion. However, the Supreme Court criticizing provincial legislatures laying claim to arguments of fiscal restraint in health care spending and challenging them to provide more evidence to substantiate such positions has done little to force provincial legislatures to retreat from these arguments.

As suggested from the outset of this chapter dissecting academic analysis and evidence to determine the extent to which court decisions and Charter of Rights claims may account for policy drift concerning abortion is a complex task. It is clear that there is no compromise in the debates over health care entitlement as a guaranteed right and to force this concept as an absolute right inevitably polarizes perspectives on the issue and removes the clarity and certainty of health
care provisions as an equal right. Further, utilizing section 7 and 15 of the Charter to formulate rights-based arguments in the courts seems to be an ineffective strategy that is often successfully countered by provincial legislatures with fiscal concerns and the absence of criminal legislation impeding choice. Despite challenges from the Supreme Court to substantiate these claims and provinces, such as Quebec, resisting the appeal process provinces like New Brunswick and Prince Edward Island have explicitly ignored these issues and maintained the status-quo. This type of policy in-action and intent to maintain the status-quo seems indicative of the conditions necessary for policy drift in the realm of provincial abortion policies. Recall that the necessary conditions for policy drift, according to Jacob Hacker, revolve around the concept of intentionality or achieving a specific policy-outcome by means of purposefully choosing not to act.\textsuperscript{241} Moreover, policy drift appears to reflect the notion of change without change.\textsuperscript{242} Subsequently, in the case of provinces such as New Brunswick and Prince Edward Island, there have been no changes to policies that follow similar procedural rigours to those of the previous criminal code regulation governing abortion that was deemed to be unconstitutional. However, the impact or consequences felt by constituent groups has significantly changed as women in other provinces (such as Ontario or British Colombia) do not face the same barriers and obstacles that become crucial factors in a time-sensitive procedure.

Martha Jackman and women’s organizations are hopeful that section 15 of the Charter may be harnessed to support women’s endeavours in the courts to expand access to abortion across Canada. This is a new possibility for women that may be assisted by the federal government’s traditional prerogative of preferring to secure compliance with the CHA as opposed to galvanizing health care as a guaranteed right. One of the key principles of the CHA

\textsuperscript{242} Hacker, 2004. P. 245.
is equality, which would be addressed with section 15 arguments and without assigning guaranteed rights. However, there is no indication that this strategy would successfully apply to accessing abortion procedures or that it would be able to supersede provincial governments arguing for reasonable resource allocation. There is far more evidence to suggest that the courts and rights based arguments comprise an inefficient method of expanding access as the intent to defy court decisions and maintain the status-quo suggests policy drift may be at work and itself indicative of the incapacity of the courts to contribute to an expansion of access to abortion services.
Conclusion

Applying the concept of policy drift to abortion policies across Canada is a unique research process because drift is a concept that is typically utilized to study health care policies in the United States of America. However, drift can also be applied to the case of access to abortion across Canada as demonstrated in the preceding thesis. While the Supreme Court of Canada decision in Morgentaler (1988) ruled that requiring a woman to submit to the will of a panel of doctors in order to seek an abortion was unconstitutional there still exists the issue of unequal access to the procedure in provinces such as Nova Scotia, Prince Edward Island, and New Brunswick. Access to abortion comprises a unique case concerning health care provisions as compared to other services such as cardiac care. Abortion is unique because it is a gender sensitive issue as only women have the capacity to give birth, but do not have the collective autonomy to choose whether to give birth because of the unequal access to abortion procedures across Canada. Further, abortion is a time-sensitive procedure, which emphasizes the necessity of equitable access to the procedure across Canada.

In the context of the United States, policy scholars describe drift as a phenomenon that reflects little change in the structure of a policy or policies, but a significant change in the impact felt by constituent groups. Further, Jacob Hacker offers that policy drift can be distinguished from incremental policy change by the feature of intentionality as it is often best for a government to achieve a specific policy outcome by choosing to deliberately engage in a course of in-action or maintaining the status quo concerning a certain policy. Finally, an informal

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process like drift is a result of the change felt by constituent groups in the absence of formal
decision-making, otherwise known as ‘change without change.’

There are three key explanations that contribute to an explanation for policy drift
concerning access to abortion across Canada including the structure of Canadian federalism,
women’s organizations and rights litigation. While variation in provincial health care policies is
an expected by-product of federalism it would be naïve to assume that such institutional layout is
the only reason drift is occurring with such a unique, gender-based and time sensitive procedure.
A more holistic analysis reveals the intentionality associated with policy drift reflected in the
provincial legislatures in non-compliance with the CHA and also the federal government in
failing to aggressively pursue such provincial legislatures and subverting the issue of abortion by
removing it from a list of priority policy issues to discuss in the House of Commons. Despite
other provinces, such as Ontario, British Columbia, and Quebec slowly expanding access to
abortion services since the Morgentaler (1988) decision, New Brunswick, Nova Scotia, and
Prince Edward Island have intentionally maintained the status quo on abortion policy and
aggressively resisted bi-lateral discussions aimed at forcing provinces to comply with the CHA.

The federal government, under the Harper Conservatives, made a significant contribution
to drift concerning abortion policy as Hacker points-out that permitting policy drift is an
appealing option for governments hoping to achieve a specific policy outcome without negative
political repercussions. Since abortion is considered a morally and personally controversial
subject, policymakers are often unwilling to engage in explicit policy discussions concerning
abortion because of the potential to change the collective will of the electorate prior to elections.

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Thus, the Harper Government’s decision to remove abortion from the agenda of policy discussions subverted the issue of access and contributed to policy drift.

Women’s organizations also comprise a key explanation that assists in explaining the phenomenon of policy drift concerning abortion policies across Canada. Competing interests and goals within women’s organizations inhibit the collective ability to produce cogent policy advice as demonstrated by the case of ARTs. However, it is unlikely that abortion is competing with the issue of ARTs within internal agendas of women’s organizations and more likely that attention has already shifted away from abortion and towards ARTs. Since the Morgentaler (1988) decision, woman’s organizations have engaged in an attention shift away from the issue of abortion and towards the expansion of ART rights. This contributes to drift because it subverts the issue of access to abortion in a significant manner as key organizations (such as the NAC) act as the voice of women seeking to influence the policy process in accordance with their personal experiences as women in Canada are no longer focused on the issue of access to abortion.

The lack of women’s experiences and input into policy decisions also subverts the issue of access to abortion and reflects the intention to achieve a certain policy outcome through choosing not to act on the experiences of Canadian women. A lack of responsiveness to women’s organizations also exists at the provincial level of government as organizations in provinces like Quebec have gained a measure of success in lobbying the policy process while organizations in provinces with restrictive abortion policies like New Brunswick and Prince Edward Island have not gained any legislative success to date. Ideology, too, contributes to this responsiveness (or lack thereof) as demonstrated in Saskatchewan with the NDP ignoring the
public plebiscite to defund abortion services. As such, ideology can serve as a basis for intentional policy action or in-action; the latter is an important condition for drift.

Women’s organizations may not be the strongest explanation for policy drift concerning abortion policies across Canada. Interest group litigation in Ottawa is not as robust in its presence as it is in Washington, which suggests another institutional weakness. The lack of pressure in-terms of interest group litigation advocating the expansion of abortion services reflects another example of pressure not being put on the state to be more inclusive of women’s needs in policymaking.

The last explanation contributing to policy drift concerning abortion policies across Canada is rights litigation. Rights-based court challenges to restrictive abortion policies have not been an efficient medium for women attempting to expand access to abortion. Litigation requires a significant amount of resources in terms of both time and financing, which also serves to make it a less-appealing option. Applying the concept of rights (under section 7 of the Charter of Rights and Freedoms) to abortion inevitably invokes a debate over the absolute nature of such rights and whether they are applicable to issues involving health care policy. Subsequently, the federal government and the courts both prefer to attempt to interpret the CHA and compliance with the legislation rather than interpreting the Charter of Rights Freedoms.

There is potential for a renewed possibility of rights-based court challenges for expanding access to abortion under section 15 of the Charter of Rights and Freedoms that would involve interpreting an equitable application of the CHA to all provinces. However, provinces such as Prince Edward Island and New Brunswick have been successful in defending restrictive abortion policies by arguing that expanding access to abortion would set a dangerous precedent for
funding other health care initiatives that would exceed the provincial capacity for resource allocation in the field of health care policy.

Nonetheless, court rulings in these two provinces have also noted that there is insufficient evidence to make such resource-based conclusions. Despite these statements, the provincial legislatures have maintained their position and aggressively challenged such arguments at the appellate level. The provincial legislatures in New Brunswick and Prince Edward Island challenging court rulings concerning access to abortion demonstrates the intent indicative of policy drift to maintain the status quo on restrictive abortion policies. In broad terms, the inability for women to expand access to abortion using rights litigation has galvanized the position of provinces with restrictive abortion policies as women cannot rely on judicial oversight on this issue.

The institutional structure of Canadian federalism allows for variation in health care policies because health care is a constitutionally guaranteed jurisdiction of the provinces of Canada. However, this structure also contributes to policy drift concerning abortion because the autonomy each province enjoys in the field of health care creates the political opportunity for legislatures to espouse the intentionality associated with drift in maintaining the status quo on restrictive abortion policies. Further, since health care is a provincial jurisdiction there is also a political opportunity created for the federal government to avoid the issue as the Harper Government has or claim that it is beyond the constitutional authority and political resource capacity of the federal government to intervene more aggressively in securing compliance with the CHA.
These provincial and federal government contributions to drift based on jurisdictional responsibility stipulated in the constitution subsequently facilitate space for the lack of responsiveness to women’s organizations based on a measure of intentionality associated with provincial ideological orientation. Further, women’s organizations are fragmented into provincial organizations, which inhibit better mobilization at the national level. Further, this created the opportunity for the federal government, under the Harper Conservatives, to eliminate discussions with provinces in non-compliance with the CHA concerning abortion policies because it is a provincial issue and not one the federal government ought to be involved in intervening. Woman’s organizations shifting attention away from abortion and towards ARTs also contributes to the larger societal trend of a shift away from attention on access to abortion as evidenced by the Toronto Star article headlines since 1989 and serves to reinforce provincial and federal governments intentionally choosing policy in-action, which is a hallmark of drift.

The institutional layout of federalism also enables rights litigation to help in the explanations of policy drift concerning abortion policies across Canada. The constitutional guarantee of provincial jurisdiction over health care and health care resources has enabled provinces with restrictive abortion policies to intentionally resist federal pressure to comply with the CHA and to intentionally and aggressively challenge court rulings under the auspices of jurisdiction and projected resource constraints. These court challenges, in-turn, have resulted in the failure of women to rely on judicial oversight as an additional pressure on both federal and provincial governments to interpret fundamental rights and central legislation in an equitable manner, which has further subverted the issue of abortion.

The complexities involved with policy drift concerning abortion leaves an ambiguous future for access to abortion services across Canada. In the global context, there still exist a
number of countries that do not offer any form of abortion services and place heavy criminal sanctions on the procedure. When one places the case of abortion in Canada within the global context, abortion seems like a relatively secure issue. The preceding point indicates a contribution to drift as well because the relative security of abortion appears to have subverted discussion of the issue in political arenas. However, despite abortion seeming relatively secure, access is still a significant and unresolved issue across Canada. This thesis offers a contribution to scholarly debates because it emphasizes the need for continuity in political discussions on access to abortion. MP Woodworth recently gaining access to debate in the House of Commons to discuss a committee to study the legal definitions of life in Canada reflects the point that the security of and access to abortion services has been taken for granted.

Further, additional or more aggressive federal government intervention to secure the compliance of provinces with restrictive abortion policies with the CHA ought to happen, but has not and likely will not occur. Nonetheless, the CHA is still active legislation and should guide the policymaking process concerning health care, but once again, federal involvement is not a part of any current discussions on abortion services expansion. Therefore, perhaps with respect to the Canadian abortion case, there is a need for a different type of discussion concerning policies across Canada. This new type of conversation should be based on political philosophy and the issue of injustice. Perhaps it is time that the discussion on abortion shifted from arguments focused on rights to discussions focused more on what is fair. The fabric of democracy entails open and frank political discussion and debate on how society should handle an issue when it does not seem fair. Perhaps it is time to extend this democratic courtesy to the issue of access to abortion and repair the damage of drifting apart.
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