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IN THE BACK ALLEYS OF HEALTH CARE: ABORTION, EQUALITY, AND COMMUNITY IN CANADA

Joanna N. Erdman[*]

In 2002, the Commission on the Future of Health Care in Canada surveyed Canadians on the sustainability of their universally accessible, publicly funded health system.[1] The Commission reported that Canadians "still strongly support the core values on which our health care system is premised—equity, fairness and solidarity."[2] Canadians believe that "equal and timely access to medically necessary health care services on the basis of need [is] a right of citizenship, not a privilege of status or wealth."[3] Unfortunately, health systems do not exist in belief alone. For many Canadian women seeking to terminate their pregnancies, access to medically necessary health care is, in fact, a privilege of status and wealth.

In 1988, the Canadian Supreme Court struck down the therapeutic abortion provisions of the Criminal Code as unconstitutional.[4] An attempt to enact a revised law was unsuccessful.[5] Abortion in Canada is therefore no longer uniquely subject to criminal restriction. Abortion services can be legally integrated into the health system and governed by the laws, regulations, and medical standards that apply to all health services. Abortion can be a health service like any other, but it is not.

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[1] *See* COMM'N ON THE FUTURE OF HEALTH CARE IN CAN., BUILDING ON VALUES: THE FUTURE OF HEALTH CARE IN CANADA (2002), http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/HCC_Final_Report.pdf. In 2001, Parliament established the Commission to recommend policies and measures required to ensure the sustainability of Canada's universally accessible, publicly funded health system. The Commission delivered its final report on November 28, 2002. *Id.* at iii.

[2] *Id.* at xvi.

[3] *Id.*

[4] R v. Morgentaler, [1988] 1 S.C.R. 30, 32 (Can.).

[5] An Act Respecting Abortion, C-43, 2d Session 34th Parliament, 38 Elizabeth II (1989) (as defeated by Senate, Jan. 31, 1991).

Immediately following decriminalization, provinces enacted laws and regulations that impeded women's access to abortion services.[6] All provinces, with the exception of Ontario and Quebec, restricted or withdrew funding for abortion under public health insurance schemes.[7] British Columbia and Prince Edward Island, for example, limited public funding to "medically necessary" abortions performed in hospitals.[8] Manitoba amended its health insurance regulations to exclude "[t]herapeutic abortions, unless performed by a medical practitioner in a hospital in Manitoba other than a private hospital."[9] Nova Scotia and New Brunswick prohibited the performance of all abortions outside of hospitals.[10] Many of these laws and regulations were challenged on jurisdictional grounds. Some survived scrutiny,[11] while others were defeated.[12] In response to invalidation, some provinces enacted amended versions of laws and regulations to overcome courts' objections.

The decriminalization of abortion thus ensured neither its availability nor accessibility as an integrated and publicly funded health service. As of 2003,

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[6] Following decriminalization, Canadian provinces and territories regulate abortion as a health care service pursuant to their primary constitutional jurisdiction over the administration of health care under section 92(7) (jurisdiction regarding the establishment, maintenance, and management of hospitals) of the Constitution Act 1867, 30 & 31 Vict. Ch. 3 (U.K.), *as reprinted in* R.S.C., No. 5 (Appendix 1985), and sections 92(13) and 92(16) (jurisdiction regarding "property and civil rights" and "local or private" matters respectively).

[7] MICHAEL MANDEL, THE CHARTER OF RIGHTS AND THE LEGALIZATION OF POLITICS IN CANADA 292 (1989).

[8] Medical Service Act, B.C. Reg. 54/88, R.S.B.C. 1979, ch. 255; General Regulations, P.E.I. Reg. EC453/96, § 1(d)(iv) enacted pursuant to Health Services Payment Act, R.S.P.E.I. 1988, ch. H-2.

[9] Excluded Services Regulation (Man.), Reg. 46/93, schedule H, § 28(a) enacted pursuant to Health Services Insurance Act, R.S.M. 1987, ch. H-35; C.C.S.M., c. H-35, s. 113(1).

[10] Under amended regulations enacted pursuant to the Medical Act, abortions performed outside of a hospital constituted professional misconduct in New Brunswick. *See* Medical Act, S.N.B. 1981, ch. 87. Nova Scotia prohibited the performance of abortions outside of hospitals and denied public funding for abortions performed in violation of the prohibition. *See* Medical Services Act, N.S. Reg. 152/89, R.S.N.S. 1989, ch. 281.

[11] *See, e.g.*, Morgentaler v. Prince Edward Island (Minister of Health and Social Services), [1996] 139 D.L.R. (4th) 603, 609 (P.E.I.C.A.) (upholding a regulation that restricted public funding for abortion services on the finding that the statute allowed the province to limit payment for medical services based on "the circumstances of the performance of the services") (quoting Health Services Payment Act, R.S.P.E.I., ch. H-2 § 5(s) (1988)).

[12] *See, e.g.*, B.C. Civil Liberties Ass'n v. British Columbia (Attorney General), [1988] 49 D.L.R. (4th) 493, 498 (Can.) (declaring a regulation that restricted public funding for abortion services *ultra vires*, and "inconsistent with the statute, and with common sense"); R. v. Morgentaler, [1993] 3 S.C.R. 463, 464 (Can.) (striking down the prohibition on the performance of abortions outside of hospitals and denied public funding for abortions performed in violation of the prohibition as an indivisible attempt by the province of Nova Scotia to legislate in the area of criminal law, a federal jurisdiction); Morgentaler v. New Brunswick (Attorney General), [1995] 121 D.L.R. (4th) 431, 432–33 (N.B.C.A.).

only 17.8% of Canadian hospitals provided abortion services.[13] Less than 5% of hospitals in Alberta, Saskatchewan, and Manitoba performed abortions.[14] In 2006, the New Brunswick hospital that performed 400 of the 404 publicly funded abortions in 2005 announced that it would no longer provide the service.[15] Abortion services are entirely unavailable in Prince Edward Island[16] and Nunavut.[17] Where hospital services are formally available, access is often restricted by quotas, gestational limitations, and mandatory family physician referrals. These barriers contribute to longer wait times for hospital services.

As a result, at least in part, Canadian women are increasingly referred to or seek abortion services from single-purpose clinics that function separately from the primary health care system. In 1994, 32% of abortions in Canada were performed in private clinics.[18] By 2003, this figure rose to 46%.[19] As compared to hospitals, clinics are widely held to offer more supportive and higher quality care. Unfortunately, clinic services are neither available nor accessible to all Canadian women. Clinics do not exist in all provinces,[20] and even where clinic services are available, financial barriers often render them inaccessible. With the exception of New Brunswick, all hospital abortion services are insured under provincial health plans.[21] The same is not true respecting clinic services, which are partially or fully excluded under certain public health insurance plans.

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[13] CAN. ABORTION RIGHTS ACTION LEAGUE (CARAL), PROTECTING ABORTION RIGHTS IN CANADA: A SPECIAL REPORT TO CELEBRATE THE 15TH ANNIVERSARY OF THE DECRIMINALIZATION OF ABORTION 47 (2003), http://www.caral.ca/uploads/caralreporti.pdf.

[14] *Id*. at 12.

[15] *Doctors Step in to Fill Abortion Service Void*, CANADIAN BROAD. (2006), http://www.cbc.ca/canada/new-brunswick/story/2006/05/25/nb-abortiondocs20060525.html.

[16] Provincial hospitals stopped providing abortions before decriminalization. Since 1983, the province has failed to report any abortions to Statistics Canada. MELISSA HAUSMAN, ABORTION POLITICS IN NORTH AMERICA 2 (2005).

[17] *See* CAN. ABORTION RIGHTS ACTION LEAGUE, *supra* note 13, at 16; CHILDBIRTH BY CHOICE TRUST, ABORTION IN CANADA TODAY: THE SITUATION PROVINCE-BY-PROVINCE (2006), http://www.cbctrust.com/provincebyprovince.php.

[18] STATISTICS CANADA, CATALOGUE NO. 82-223, XIE: INDUCED ABORTION STATISTICS 2003, 10–11 (2006).

[19] *Id.*

[20] Private abortion clinics do not exist in Saskatchewan, Nova Scotia, Prince Edward Island, the Yukon Territory, Northwest Territories, and Nunavut.

[21] *See* Medical Services Payment Act Regulation, N.B. Reg. 84-20, enacted pursuant to the Medical Services Payment Act, R.S.N.B. 1973, ch. M-7. Under New Brunswick law, hospital abortions are eligible for public funding only when performed in the first twelve weeks of pregnancy by a specialist in the field of obstetrics and gynecology and certified as "medically required" by two medical practitioners. *Id.*

Denied public funding for private clinics renders safe and timely access to abortion services a privilege of wealth. The exclusion of clinic services from public health insurance disparately affects poor and low-income women who must return to overburdened hospital providers or delay receiving care until they can obtain required funds. Delayed care increases the risk of physical complications, psychological distress, and exceeding gestational limitations. While denied funding does not necessarily prevent poor and low-income women from accessing care, it does prevent their safe and timely access.

Denied access on the basis of wealth is, however, only part of the inequity. Abortion is a health service that responds to reproductive and sexual health needs distinctive to women. Only members of the female sex can become pregnant.[22] The exclusion of clinic services from a public health insurance plan thus affects exclusively poor and low-income *women*. The inequity of the exclusion resides at the intersection of wealth, sex, and gender.[23]

The conditioning of public funding on the place where a health service is provided—hospital or clinic—treats abortion services differently than other health services. Given the sex-specific nature of abortion services, its treatment raises the specter of unequal rather than merely different treatment. In other words, a difference in treatment that violates the equality guarantee under the Canadian Charter of Rights and Freedoms.[24] It is thus unsurprising that the constitutionality of denied funding for clinic abortion services has been the subject of a series of legal challenges across Canada. The governments of New Brunswick, Québec, and Manitoba have all been called to account for the different treatment of abortion services under their provincial health insurance plans.

In New Brunswick, clinic abortions are excluded by regulation from provincial health insurance coverage.[25] Women in the province pay as much

[22] *See* Nancy Krieger, *A Glossary for Social Epidemiology*, 55 J. EPIDEMIOLOGY COMMUNITY HEALTH 693, 694–95 (2001) ("[S]ex is a biological construct premised upon biological characteristics enabling sexual reproduction."). Reproductive capacity is not an essential biological attribute of women; in other words, persons need not have the capacity to become pregnant in order to be recognized as female. Rather reproductive capacity is distinctive to women insofar as only persons of the female sex can become pregnant.

[23] *Id.* ("Gender refers to a social construct regarding culture-bound conventions, roles, and behaviors for, as well as relationships between and among, women and men . . . .").

[24] Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982, ch. 11 (U.K.).

[25] *See* Medical Services Payment Act Regulation, N.B. Reg. 84-20, enacted pursuant to the Medical Services Payment Act, R.S.N.B. 1973, ch. M-7.

as $750 (CAN) for the service.[26] In July 2003, an action claiming the unconstitutionality of the regulation was initiated against New Brunswick.[27] The case is still pending and is vigorously contested by the provincial government.[28]

In August 2006, in *Association pour l'accès à l'avortement c. Québec (Procureur général)*,[29] a provincial Superior Court ordered the Québec government to reimburse almost 45,000 women out-of-pocket expenses paid for private clinic abortion services between 1999 and 2006.[30] During this period, the province publicly funded physician fees but only partially covered facility fees.[31] While the *Association pour l'acces l'avortement* (Association for Access to Abortion) argued that the public insurance plan was unconstitutional, the Court decided the case on alternative grounds.[32]

In *Jane Doe 1 v. Manitoba (Jane Doe I)*,[33] the Court of Queen's Bench of Manitoba squarely addressed the question of constitutionality. The Manitoba challenge concerned a provincial regulation that excluded clinic abortions from

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[26] *N.B. Premier Says Province Stands by Policy Not to Pay for Private Abortions*, CANADIAN PRESS, Jan. 27, 2005, http://www.medbroadcast.com/health_news_details.asp?news_id=5827&rss=67&rid=999999.

[27] *See, e.g.*, *Morgentaler Takes New Brunswick to Court over Access to Abortion*, CAN. BROAD. CORP., Aug. 19, 2003, http://www.cbc.ca/news/story/2003/08/19/morgentaler030811.html. Dr. Morgentaler alleges that Regulation 84-20, to the extent that it excludes abortions performed in nonhospital settings from the definition of "entitled services" under the provincial health insurance plan, violates sections 7 and 15 of the *Canadian Charter of Rights and Freedoms*.

[28] *Id.* The claim further asserts that Regulation 84-20 is in conflict with the Canada Health Act, R.S.C. 1985, c. C-6, and the Medical Services Payment Act.

[29] [2006] QCCS 4694.

[30] The Association *pour l'acces l'avortement* (Association for Access to Abortion) initiated a class action against the Québec government on behalf of "all women covered by the Quebec Health Insurance plan who disbursed a sum of money in order to obtain an abortion in the Province of Quebec." The Government of Québec has not appealed the ruling of the Québec Superior Court.

[31] Under Québec's Health Insurance Act R.S.Q. c. A-29, the *Régime d'Assurance Maladie du Québec* (RAMQ) reimbursed a total of $144 per first trimester abortion, which covers physician fees and $40 toward facility fees. *See also* CAN. ABORTION RIGHTS ACTION LEAGUE, *supra* note 13, at 29; Robert P. Kouri, *The Actualization of Reproductive Rights Through Access to Emergency Oral Contraception and Abortion in Quebec*, *in* JUST MEDICARE: WHAT'S IN, WHAT'S OUT, HOW WE DECIDE 168 (Colleen Flood ed., 2006) (describing how facility fees cover expenses for drugs, counseling, nursing services, clinic administration, and overhead costs, and how women in Quebec may access publicly funded abortion services through *Centre Locaux de Services Communautaires*).

[32] *Association pour l'accès à l'avortement c. Québec (Procureur général)*, [2006] QCCS 4694. The Court decided the case on the basis of statutory duties under the Quebec Health Insurance Act and related regulations. *Id.* The Court also relied on article 1376 of the Civil Code of Quebec. *Id.* Given no evidence of harm, the Court held that there was no breach of the Quebec Charter or the Canadian Charter. *Id.*

[33] [2004] 248 D.L.R. (4th) 547 (Can.).

public health insurance.[34] Although the government opted to insure clinic services while the challenge was pending[35] and subsequently amended its regulation,[36] the government maintained that it was under no legal obligation to do so.

On summary judgment, the Court disagreed with the government's position and affirmed that the Charter obligates the province to fund clinic abortion services. Judge Oliphant held that the exclusion of clinic services from provincial health insurance violated women's fundamental freedom of conscience under section 2(b) of the Charter; their right to life, liberty, and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice under section 7; and their equality rights under section 15. He viewed a trial of the issues unnecessary as there was "nothing more than a theoretical possibility of the Government's succeeding" in the face of such "a gross violation of the rights guaranteed . . . by the Charter."[37] On review, the Manitoba Court of Appeal set aside the judgment of the Court of Queen's Bench on the basis that this was an inappropriate case for summary judgment and that a trial of the issues was warranted.[38] In February 2006, the Supreme Court of Canada dismissed an application for leave to appeal, thereby returning the case to Manitoba for trial.[39]

The judgment of the Court of Queen's Bench in *Jane Doe I* nevertheless remains significant in Canadian constitutional jurisprudence. The court affirmed that denied access to safe and timely abortion services is a violation of women's equality rights.[40] A law that tells "every pregnant woman . . . she

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[34] *See* Excluded Services Regulation (Man.), Reg. 46/93, schedule H, § 2(28)(a), enacted pursuant to Health Services Insurance Act, R.S.M. 1987, ch. H-35; C.C.S.M., ch. H-35, § 113(1).

[35] *Province Pays for Jane's Clinic Abortions*, CBC NEWS, July 8, 2004, http://www.cbc.ca/manitoba/story/mb_abortion20040708.html. On July 1, 2004, the government began funding clinic abortion services through the Winnipeg Regional Health Authorities.

[36] As amended in November 2005, the Regulation provides that therapeutic abortion services, performed by a medical practitioner in a facility approved by the minister, are not excluded as insured services. *See* Excluded Services Regulation (Man.), Reg. 46/93, schedule H, § 2(28)(c).

[37] *Jane Doe I*, 248 D.L.R. (4th) at 565.

[38] Jane Doe 1 v. Manitoba (*Jane Doe II*), [2005] 260 D.L.R. (4th) 149 (Man. C.A.).

[39] *Id.*; 2006 CanLII 5401 (S.C.C.) (Feb. 23, 2006) (No. 31225) (appeal denied). Given the Supreme Court's refusal to hear an appeal, the case was returned to Manitoba for trial. For a history of the procedural developments in this litigation, see Supreme Court of Can., Information on Cases, *Jane Doe 1, et al. v. Government of Manitoba*, http://205.193.81.30/information/cms/docket_e.asp?31225.

[40] *See Jane Doe I*, 248 D.L.R. (4th) at 564. Although the violation of equality rights was argued in *Morgentaler*, in which the therapeutic abortion provisions of the Criminal Code were struck down as unconstitutional under the rights to liberty and security of the person, no member of the Supreme Court

cannot submit to a safe medical procedure that might be clearly beneficial to her unless she does so at a time and place dictated by a backlogged, publicly-funded health care system,"[41] the Court concluded, "is a gross violation of . . . equality rights as guaranteed to women."[42] Unfortunately, Judge Oliphant offered little more than this statement to support his finding. His reasoning is at best gleaned from a recitation of the claimants' submissions.

The brevity of Judge Oliphant's equality rights analysis risks undermining its significance. In an effort to protect against the risk, this Article seeks to construct a comprehensive account of denied access to safe and timely abortion services as a violation of women's equality rights. This account is premised on a model of equality that emphasizes the dignity of equal community membership.

Equality rights, as guaranteed by section 15(1) of the Charter, are intended to protect and affirm human dignity.[43] A law thus violates equality rights if its purpose or effect demeans human dignity. While human dignity encompasses the values of autonomy, freedom, and self-determination, it is not confined to these principles. Dignity also includes the self-respect and self-worth attained through relationships with others and by the recognition of others. Human dignity is demeaned when individuals and groups are marginalized, ignored, or devalued as less capable, less deserving, or less worthy of recognition as members of Canadian society. Human dignity, as defined under Canadian equality rights, thus encompasses a sense of community; a mutual commitment to treat individuals and groups as capable, deserving, and worthy of full and equal membership in Canadian society. Membership in Canadian society is in turn reflected by the legal recognition of individuals and groups as equally deserving of concern, respect, and consideration.

Canada's comprehensive and universally accessible health system—premised on the core values of equity, fairness, and solidarity—is the quintessential symbol of community. In the domain of health care, all Canadians are supposed equals. Public health insurance as a legal institution of collective responsibility and shared risk is intended to reflect equal concern,

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commented on the impact of the law on section 15(1). *See* R v. Morgentaler, [1988] 1 S.C.R. 30 (Can.). Moreover, the lower court that addressed Section 15(1) held that the criminal law on abortion did not itself violate the guarantee of equality. *See, e.g.*, R v. Morgentaler, [1985] 11 O.A.C. 81, 90–95 (Can.).

41 *Jane Doe I*, 248 D.L.R. (4th) at 562.

42 *Id*. at 564.

43 Law v. Canada (Minister of Employment and Immigration), [1999] 1 S.C.R. 497, 500 (Can.).

respect, and consideration for all Canadians without discrimination on the basis of status or wealth.

Consider therefore the effect on human dignity of restricting access by law to a fundamental social institution of community membership, the Canadian health care system. The purpose of this Article is to demonstrate that when a public health insurance plan denies coverage for health services that respond to women's distinctive reproductive and sexual health needs, women are not treated as equal in the domain of health care. They are not equal beneficiaries of a supposed comprehensive and universally accessible health system. Moreover, given the status of Canadian Medicare as a right of citizenship, provincial governments' selective divestment from the health of women implies a selective divestment from women themselves.[44] Denied funding for abortion services conveys the message that women are less deserving or less worthy of public support and expenditure. Women are neither respected nor valued as full and equal members of Canadian society.

Part I of this Article examines Judge Oliphant's Charter rights analyses in *Jane Doe I*. Access to abortion services historically has been protected in Canadian law as a security of the person or liberty interest under section 7 of the Charter. In *Jane Doe I*, Judge Oliphant did not stray from this orientation. He decided the case primarily as a violation of section 7. In his section 15(1) analysis, Judge Oliphant tethered his equality rights analysis to a conception of dignity rooted in the liberty-based values of reproductive freedom, autonomy, and self-determination.[45] Part I is intended to demonstrate that the liberty-based approach adopted by Judge Oliphant is ill-suited to the abortion funding context. In an effort to offer an alternative approach, Part II develops a conception of equality under section 15(1) based on the self-respect and self-worth—the social dignity—of equal community membership. This model is developed with reference to the work of U.S. constitutional scholar Kenneth Karst and his principle of equal citizenship. Part III returns to the section 15(1) analysis in *Jane Doe I* to evaluate denied funding for clinic services according to the proposed community-membership model of equality. Part III demonstrates that the exclusion of clinic abortion services from a universally accessible, publicly funded health system perpetuates and promotes the view

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[44] *See* M. Giacomini et al., *The Many Meanings of Deinsuring a Health Service: The Case of In Vitro Fertilization in Ontario*, 50 SOC. SCI. & MED. 1485, 1497 (2000).

[45] *Jane Doe I*, 248 D.L.R. (4th) at 564 (accepting the argument that limiting a woman's autonomy adversely affects women's dignity and violates equality rights under section 15).

that women are less worthy of concern, respect, and consideration as members of Canadian society.

While this Article is primarily concerned with the conception of Charter rights and their infringement, Part IV briefly considers how a community-membership model of equality may affect the Court's analysis under the Charter's section 1 Limitation Clause. Under section 1, state action that infringes a right will be upheld as constitutional if the government demonstrably justifies the infringement as a reasonable limitation in a free and democratic society.

I. THE CASE OF *JANE DOE 1 V. MANITOBA*

In 2001, two women—Jane Doe 1 and Jane Doe 2—commenced a class action against the government of Manitoba. At the time the claim was initiated, clinic abortion services were excluded by regulation as insured services under Manitoba's Health Services Insurance Plan.[46] Under this policy, Jane Doe 1 and Jane Doe 2 both privately paid for clinic services after learning of the significant wait times required for a publicly funded hospital abortion. At seven-and-a-half weeks pregnant, Jane Doe 1 was informed that she would be required to wait six to eight weeks to receive a publicly funded abortion at a Manitoba Hospital.[47] Concerned about health risks and emotional stress associated with the delay, Jane Doe 1 paid $375 for a clinic abortion and received the service fifteen days after her positive pregnancy test.[48] Jane Doe 2 was similarly informed that she was required to wait four to six weeks for a first appointment and that two further appointments were required before a publicly funded hospital abortion could be performed.[49] Fearing physical risk

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[46] *See* Health Services Insurance Act, C.C.S.M., ch. H35 (1993). The Manitoba Health Services Insurance Plan provides:

> The minister may make regulations . . . for the purpose of [designating the benefits to which an insured person is entitled under this Act in relation to services rendered by medical practitioners, and respecting the manner of, and other details relating to, payments of those benefits to or on behalf of insured persons], requiring as a condition of entitlement to receive benefits that services be provided in a specified hospital or facility or any class of hospitals or facilities.

§ 116(1)(h)(i). The Manitoba Excluded Services Regulation further provides: "The following services are not insured services: Therapeutic abortion, unless performed by a medical practitioner in a hospital in Manitoba other than a private hospital licensed under The Private Hospitals Act." Excluded Services Regulation, Man. Reg. 46/93, § 2(28)(a), enacted pursuant to Health Services Insurance Act, C.C.S.M., ch. H35 (1993).

[47] *Jane Doe I*, 248 D.L.R. (4th) at 552.

[48] *Id.* at 551–52.

[49] *Id.* at 552.

and emotional stress, Jane Doe 2 also arranged for a clinic abortion.[50] Jane Doe 2 was receiving social assistance at the time of her pregnancy, and therefore a substantial portion of the clinic fee was covered through this government program. She paid the remaining fees out of pocket.[51]

Jane Doe 1 and Jane Doe 2 sought a declaration from the Court that the exclusion of clinic abortion services from the Manitoba Health Services Insurance Plan was inconsistent with and in violation of the Charter. Although the provincial government opted to insure clinic abortion services while the class action was pending[52] and subsequently amended its regulation,[53] it maintained that the Charter imposed no legal obligation on the province to fund the service.[54] On summary judgment, Judge Oliphant of the Court of Queen's Bench declared that the exclusion of clinic services from public health insurance was a gross violation of women's rights to liberty and security of the person as guaranteed by section 7, as well as a violation of the right to freedom of conscience under section 2(a) and women's equality rights under section 15(1).

Jane Doe 1 and Jane Doe 2 were not the first claimants to challenge the constitutionality of denied funding for abortion services in the province of Manitoba. They were, however, the first to do so successfully. In 1988, following the decriminalization of abortion, the Manitoba Provincial Health Services Commission amended its health insurance regulations to exclude "[t]herapeutic abortions, unless performed by a medical practitioner in a hospital in Manitoba other than a private hospital."[55] In 1993, Lexogest Inc., then owner and operator of the sole abortion clinic in the province, challenged the exclusion as a violation of sections 7 and 15(1). In *Lexogest Inc. v. Manitoba (Attorney General) (Lexogest I)*, a majority of the Court of Appeal declared the regulation restricting public funding to hospital abortion ultra

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50 *Id.* at 552–53.

51 *Id.* at 553.

52 *Manitoba to Pay for Abortions at Clinic*, CBC NEWS, July 8, 2004, http://www.cbc.ca/canada/story/2004/07/08/abort_manitoba040708.html. In April 2004, Jane's Clinic Inc., a nonprofit entity with a community-based board, purchased the former Morgentaler Clinic. On July 1, 2004, the government began funding abortions at the clinic through the Winnipeg Regional Health Authorities, allowing Jane's Clinic to function as the abortion arm of a new and expanded Women's Health Clinic. *Id.*

53 As amended in November 2005, the Regulation provides that therapeutic abortion services, performed by a medical practitioner in a facility approved by the minister are not excluded as insured services. *See* Excluded Services Regulation (Man.), Reg. 46/93, schedule H, § 2(28)(c).

54 *Jane Doe I*, 248 D.L.R. (4th) at 551.

55 Health Services Insurance Act Regulations (Man.), Reg. 506/88, schedule H, § 26 enacted pursuant to Health Services Insurance Act, R.S.M. 1987, ch. H-35; C.C.S.M., ch. H-35, § 113(1).

vires.[56] While the Commission was authorized to exclude medical services from the insurance plan, the Health Services Insurance Act did not authorize the Commission to impose limitations or conditions on excluded medical services.[57] The majority of the court dismissed the Charter as having no application to the proceedings.[58] Only Chief Judge Scott, writing in dissent, considered the Charter claims. He held that the exclusion violated neither section 7 nor section 15(1).[59]

The Manitoba government responded to legal defeat in *Lexogest I* by enacting the Health Services Insurance Act, which gave Cabinet the authority to exclude insured services according to the location where they are provided.[60] Pursuant to this authority, Cabinet promulgated a new regulation that excluded clinic abortions from provincial health insurance. Lexogest again challenged the exclusion as a violation of equality rights under section 15(1). In *Lexogest Inc. v. Manitoba (Lexogest II)*, the Court of Queen's Bench dismissed the claim because "the issue of whether the new regulation violates [section] 15 of the *Charter* . . . is the same issue litigated and decided by the Court of Appeal in the previous proceedings [*Lexogest I*]."[61]

The regulation that survived Lexogest's second challenge is the same regulation impugned in *Jane Doe I*. For this reason, the government in *Jane Doe I* argued that the claims pertaining to sections 7 and 15(1) of the Charter had been previously decided. It thus sought an order that the statement of claim be struck as an abuse of process, or in the alternative, that summary judgment be granted dismissing the Charter claims. Judge Oliphant rejected the government's motions; a holding affirmed by the Court of Appeal. Both courts held that the government failed to establish a prima facie basis for its claim. Chief Judge Scott's dissenting opinion in *Lexogest I* could not alone ground an abuse of process claim.[62] Given that *Lexogest II* relied on Chief Judge Scott's opinion in *Lexogest I*, it, too, was of no assistance.

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56 [1993] 101 D.L.R. (4th) 523, 562 (Man. C.A.).

57 *Id*. at 559.

58 *Id*. at 549, 555.

59 *Id.* at 547–48 (Scott, C.J.M.; Lyon, J., dissenting). On the question of jurisdiction, Chief Judge Scott and Judge Lyon held that the Health Services Insurance Commission was authorized to exclude a medically necessary service solely on the basis of its physical location. *Id.* at 540.

60 Health Services Insurance Act, C.C.S.M., ch. H35 (1993).

61 [1994] 91 Man. R.2d 260, 267 (Man. Q.B.).

62 *See* [1993] 101 D.L.R. (4th) at 561.

Chief Judge Scott's dissenting opinion is not, however, without value. His Charter analysis is an important comparison for evaluating Judge Oliphant's sections 7 and 15(1) analyses in *Jane Doe I*. Despite their differing outcomes, the judges' approaches are more similar than different. Both judges emphasized liberty-based values of autonomy, freedom from government constraint, and self-determination in their analyses.

Judge Oliphant's focus on liberty-based values also renders his approach comparable to the opinions of the United States Supreme Court on the constitutionality of denied Medicare funding for abortion services in *Maher v. Roe*[63] and *Harris v. McRae*.[64] *Maher* and *Harris* tested the limitations of the landmark 1973 decision, *Roe v. Wade*, in which the Court held that the right of privacy "founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action . . . is broad enough to encompass a woman's decision whether or not to terminate her pregnancy."[65] In 1976, following *Roe v. Wade*, Congress enacted the Hyde Amendment, which forbade the use of federal Medicaid funds for abortion services except when necessary to avert a threat to the pregnant woman's life.[66] Under the Medicaid program, federal and state governments share the cost of necessary medical care for many of the poorest Americans, in particular indigent pregnant women and women who receive welfare benefits on behalf of their children. In 1977 and 1980, in *Maher* and *Harris* respectively, the Court upheld the constitutionality of the Hyde Amendment and similar state funding restrictions.[67] In both cases, a majority of the Supreme Court reasoned that because a woman could access abortion services with private funds, her constitutionally protected liberty and

[63] 432 U.S. 464 (1977) (holding that a state Medicaid program that excluded all nontherapeutic abortions from coverage but funded all childbirth related services did not violate the Equal Protection Clause of the Fourteenth Amendment of the United States Constitution, U.S. CONST. amend XIV, § 1). This case was decided on the same day as two other cases in which the Court upheld similar restrictions on funding. *See* Beal v. Doe, 432 U.S. 297 (1980); Poelker v. Doe, 432 U.S. 438 (1977).

[64] 448 U.S. 297 (1980) (holding that the Hyde Amendment, which at the time prohibited the use of Federal Medicaid funds for abortion except when necessary to preserve the life of the pregnant woman, did not violate the "liberty" or "equal protection" components of the Due Process Clause of the Fifth Amendment, nor the Establishment Clause of the First Amendment of the United States Constitution).

[65] 410 U.S. 113, 153 (1973) (holding that state criminal abortion laws that except from criminality only a life-saving procedure on the mother's behalf without regard to the stage of her pregnancy and other interests violate the Due Process Clause of the Fourteenth Amendment). Government may limit this right only where regulation is justified by a "compelling state interest" and is narrowly tailored to express only the legitimate state interests at stake. *Id.* at 155 (quoting Kramer v. Union Free Sch. Dist., 395 U.S. 621, 627 (1969)).

[66] Hyde Amendment, Pub. L. No. 94-439, § 209, 90 Stat. 1418, 1434 (1976) (applicable for fiscal year 1977). The Hyde Amendment came into effect in August 1977. Congress has renewed the Hyde Amendment every year since, albeit with modifications either expanding or restricting the exemptions.

[67] *See Maher*, 432 U.S. at 464; *Harris*, 448 U.S. at 297.

equality interests were not impaired.[68] The Hyde Amendment remains in effect today and forbids the use of federal funds for all abortions except in cases of life endangerment, rape, or incest.[69]

Drawing on Chief Judge Scott's dissenting opinion in *Lexogest I* and the opinions of the Court in *Maher* and *Harris*, this Part evaluates the strengths and weaknesses of Judge Oliphant's liberty-based analysis of sections 7 and 15(1). Access to abortion services historically has been protected in Canadian law as a security of the person or liberty interest under section 7 of the Charter. In *Jane Doe I*, Judge Oliphant did not stray from this orientation. He decided the case primarily as a violation of section 7. Even under section 15(1), Judge Oliphant tethered his equality rights analysis to a conception of dignity rooted in the liberty-based values of reproductive freedom, autonomy, and self-determination. This Part demonstrates that a liberty-based approach is especially ill-suited to the abortion funding context.

A. Section 7: The Right to Life, Liberty and Security of the Person

Section 7 of the Charter provides, "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."[70] In both *Lexogest I* and *Jane Doe I*, the claimants relied on the majority opinions of the Supreme Court of Canada in *Morgentaler* as the basis of their section 7 claims.[71] *Morgentaler* concerned a criminal code provision that prohibited all abortions except when performed in an accredited hospital and approved by a therapeutic abortion committee as necessary to protect the life or health of the pregnant woman.[72] Unlike the justices deciding *Roe v. Wade*, Chief Justice Dickson and Justice Beetz expressly did not decide *Morgentaler* on the basis of a liberty

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68 *Maher*, 432 U.S. at 474; *Harris*, 448 U.S. at 316–17.

69 *See* GUTTMACHER INST., STATE POLICIES IN BRIEF: STATE FUNDING OF ABORTION UNDER MEDICAID 1 (Oct. 1, 2006), http://www.guttmacher.org/statecenter/spibs/spib_SFAM.pdf. At present, thirty-two states and the District of Columbia follow the Federal Medicaid law. *Id*. at 1–2. States may also choose to fund abortions for low-income pregnant women with state funds in more circumstances than the Hyde Amendment allows. *Id*. at 1. Seventeen states fund all or most medically necessary abortions; thirteen of these states do so under Court order. *Id*. at 1–2. Courts have held that state constitutions and equal rights amendments prohibit the exclusion of medically necessary abortions from medical assistance programs.

70 Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982, ch. 11 (U.K.).

71 *See* Lexogest Inc. v. Manitoba (Attorney General) (*Lexogest I*), [1993] 101 D.L.R. (4th) 523, 523 (Man. C.A.); Jane Doe 1 v. Manitoba (*Jane Doe I*), [2004] 248 D.L.R. (4th) 547, 547 (Man. Q.B.).

72 R v. Morgentaler, [1988] 1 S.C.R. 30, 47–49 (Can.) (citing Criminal Code, R.S.C. 1970, ch. C-34, § 251).

interest.[73] Rather, the Justices reasoned that delays caused by the procedural requirements of the criminal provision violated women's section 7 right to security of the person in a manner that did not accord with the principles of fundamental justice.[74]

In a subsequent decision, *Blencoe v. British Columbia (Human Rights Commission)*, the Supreme Court delineated "two requirements that must be met in order for security of the person to be triggered."[75] Evidence must be adduced of physical or serious psychological harm, and the physical and psychological harm must result from state action.[76] These requirements represent the threshold inquiry necessary to establish a prima facie violation of the right to security of the person.[77] Section 7 further requires that the right to security of the person be deprived in a manner that fails to accord with the principles of fundamental justice.[78] Given substantial barriers encountered at the threshold inquiry, this Article will not consider the latter inquiry (accordance with the principles of fundamental justice).

1. Physical or Serious Psychological Harm

In *Morgentaler*, Chief Justice Dickson introduced the first triggering requirement of the right to security of the person: "State interference with bodily integrity and serious state-imposed psychological stress, at least in the criminal law context, constitutes a breach of security of the person."[79] As subsequently elaborated by the Supreme Court in *New Brunswick (Minister of Health and Community Services) v. G. (J.)*,[80] this requirement conveys something about the degree or type of psychological harm necessary to constitute an infringement of the right:

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73 *Compare Morgentaler*, [1988] 1 S.C.R. at 51 (Dickson, C.J.) (holding that "it is neither necessary nor wise in this appeal to explore the broadest implications of [section] 7"), and *Morgentaler*, [1988] 1 S.C.R. at 113–14 (Beetz, J.) (holding that "it is nevertheless possible to resolve this appeal without attempting to delineate the right to 'liberty' in [section] 7 of the *Charter*"), *with* Roe v. Wade, 410 U.S. at 153 (holding that the right of privacy is founded in the Fourteenth Amendment's concept of personal liberty, which is broad enough to encompass a woman's decision whether or not to terminate her pregnancy).

74 *Morgentaler*, [1988] 1 S.C.R. at 79–80.

75 [2000] 2 S.C.R. 307, 344 (Can.) (holding that in the circumstances of this case state-caused delays in human rights proceedings did not engage Section 7 rights to liberty or security of the person).

76 *Id.*

77 *See id.* at 339.

78 *Id.* (quoting R v. Beare, [1988] 2 S.C.R. 387, 401 (Can.)).

79 [1988] 1 S.C.R. at 32.

80 [1999] 3 S.C.R. 46, 56–57 (Can.) (holding that State removal of a child from parental custody without the provision of state-funded counsel constituted a serious interference with psychological integrity, and thus security of the person).

> For a restriction of security of the person to be made out, then, the impugned state action must have a serious and profound effect on a person's psychological integrity . . . . This need not rise to the level of nervous shock or psychiatric illness, but must be greater than ordinary stress or anxiety.[81]

The majority opinions in *Morgentaler* easily concluded that the delay caused by the mandatory committee procedure had "profound consequences on the woman's physical and emotional well-being"[82] that were sufficient to satisfy the threshold requirement. Their finding was supported by "encyclopedic factual submissions" that established beyond any doubt the harmful effect of the criminal law.[83] These submissions included extensive government-commissioned reports, such as the 1987 *Report on Therapeutic Abortion Services in Ontario* (the Powell Report)[84] and the 1977 *Report of the Committee on the Operation of the Abortion Law* (the Badgley Report).[85]

In *Jane Doe I*, the claimants expressly asserted that the "delays . . . faced by women wanting a [publicly funded] therapeutic abortion" caused physical risk and serious psychological harm of a similar magnitude as described in *Morgentaler*[86] and submitted supporting personal affidavits and transcripts of cross examination. Unlike in *Morgentaler*, however, no expert evidence respecting either the relative safety of employed procedures or the physical or psychological effects of delay was before the Court. Judge Oliphant compensated for this lack of evidence by relying on the "statements of fact . . . in *Morgentaler*," which he viewed as "so powerfully conclusive that they are beyond dispute":[87]

> I accept as a fact that depriving a woman of her right to decide when and where she will undergo the procedure of a therapeutic abortion threatens the woman in a physical sense and that the agony caused by

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81 *Id*. at 77–78.

82 [1988] 1 S.C.R. at 57.

83 *Id.* at 56.

84 ONT. MINISTRY OF HEALTH, REPORT ON THERAPEUTIC ABORTION SERVICES IN ONTARIO (1987) (Powell Report).

85 CAN. DEP'T OF JUSTICE, REPORT OF THE COMMITTEE ON THE OPERATION OF THE ABORTION LAW (1977) (Badgley Report). The mandate of the Committee was to "conduct a study to determine whether the procedure provided in the Criminal Code for obtaining therapeutic abortions is operating equitably across Canada." *Morgentaler*, [1988] 1 S.C.R. at 65 (internal quotation marks omitted). In addition to data from Statistics Canada, the Committee conducted its own research, meetings with officials from the departments of the provincial attorneys general and of health, and visits to 140 hospitals throughout Canada. The Committee also commissioned national hospital, hospital staff, physician, and patient surveys." *Id.*

86 Jane Doe 1 v. Manitoba *(Jane Doe I)*, [2004] 248 D.L.R. (4th) 547, 556 (Man. Q.B.).

87 *Id.* at 562.

> not knowing whether an abortion will be performed in time is bound to *inflict emotional distress and serious psychological harm upon her*.[88]

Later in the opinion, Judge Oliphant reiterated the seriousness of the psychological harm and attributed it directly to the impugned regulation:

> I am convinced that psychological stress is the almost inevitable result when the impugned legislation forces women to wait for an abortion funded by the Government at a hospital . . . . This state-imposed stress suffered by women who must wait for an abortion is, in my opinion, serious in nature.[89]

Judge Oliphant thus sought to compensate for the lack of an extensive evidentiary record by accepting physical and serious psychological harm as the inevitable result of the challenged law. Although the Manitoba Court of Appeal did not comment on whether Judge Oliphant was entitled to take judicial notice of the effect of delay, it did emphasize the inadequacy of the evidentiary record in setting aside the summary judgment: "[O]ne would expect the record to be based on *viva voce* evidence and be as ample as possible to provide the necessary factual underpinning for these complex Charter challenges."[90] In denying the section 7 claim in *Lexogest I*, Chief Judge Scott seized upon the same lack of expert evidence to distinguish *Morgentaler* from a case of abortion funding. He stated that although "therapeutic abortions may sometimes be performed more quickly and conveniently at the Clinic, there is no evidence in these proceedings that women have had their health or safety jeopardized by delay in obtaining a hospital abortion."[91] Noting Chief Judge Scott's observation in *Lexogest I*, the Court of Appeal in *Jane Doe I* concluded that "[t]hese important Charter issues involve complex and developing areas of law which require a full factual underpinning based on a trial record."[92]

The type of expert evidence before the court in *Morgentaler* set an onerous evidentiary burden under the threshold requirement of section 7. Comparative expert evidence of the physical or serious psychological effects of delay became a central preoccupation in the abortion funding cases. Since 1994,

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[88] *Id*. (emphasis added).

[89] *Id.* at 563.

[90] Jane Doe 1 v. Manitoba (*Jane Doe II*), [2005] 260 D.L.R. (4th) 149, 158 (Man. C.A.).

[91] Lexogest Inc. v. Manitoba (Attorney General) (*Lexogest I*), [1993] 101 D.L.R. (4th) 523, 546 (Man. C.A.) (Scott, C.J.M.; Lyon, J., dissenting).

[92] *Jane Doe II*, 260 D.L.R. (4th) at 158.

however, no Canadian government, either federal or provincial, has commissioned a comprehensive study of access to abortion services.[93] This task has fallen to nongovernmental, privately financed organizations.[94] In 1999, Health Canada tabled a report recommending that abortion surveillance in Canada be conducted collaboratively with all clinics and hospitals in order to improve the scope and quality of reporting and that particular emphasis be given to the different components of access, including time, distance, and availability of service.[95] The 2003 Women's Health Surveillance Report did not include an expanded set of data on abortion service access.[96] Given the lack of government initiative in abortion surveillance and reporting, *Morgentaler* may have established a burden of evidentiary proof that few claimants, including Jane Doe 1 and Jane Doe 2, can satisfy.

2. *State-Imposed Harm*

The attribution of harm to government action poses a second barrier to the effective application of section 7. In *Blencoe*, Justice Bastarache affirmed that "a significant connection between the harm and the impugned state action [is required] to invoke the *Charter*."[97] The facts of *Morgentaler*, he noted, satisfied this requirement insofar as they concerned "direct state interference with a woman's bodily integrity in that the delays in obtaining therapeutic abortions were caused by the mandatory procedures . . . of the *Criminal Code*."[98] Throughout the majority opinions of *Morgentaler*, the justices emphasized that the delay resulting in physical and psychological harm was "caused by," "created by," "traced to," or "attributed to" the procedures

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[93] The most recent provincial report was conducted in British Columbia. *See* B.C. MINISTER OF HEALTH & MINISTER RESPONSIBLE FOR SENIORS, REALIZING CHOICES: REPORT OF THE BRITISH COLUMBIA TASK FORCE ON ACCESS TO CONTRACEPTION AND ABORTION SERVICES (1994).

[94] In 1998 and 2003, the Canadian Abortion Rights Action League (CARAL) conducted and issued reports on access to abortion services in Canada. *See* NANCY BOWES, VARDA BURSTYN & ANDREA KNIGHT, CARAL, ACCESS GRANTED, TOO OFTEN DENIED: A SPECIAL REPORT TO CELEBRATE THE 10TH ANNIVERSARY OF THE DECRIMINALIZATION OF ABORTION (1998); CAN. ABORTION RIGHTS ACTION LEAGUE, *supra* note 13.

[95] HEALTH CANADA, ADVISORY COMM. ON WOMEN'S HEALTH SURVEILLANCE, *WOMEN'S* HEALTH SURVEILLANCE: A PLAN OF ACTION FOR HEALTH CANADA 70, 73, 96–97 (1999), http://www.phac-aspc.gc.ca/publicat/whs-ssf/pdf/whs0200.pdf. The report explained that while data is collected in terms of number of abortions performed, there is a lack of data from clinics, demographic information (who is having abortions and why), on timing from decision to procedure, distance traveled to obtain services, and the abuse that some women endure to obtain the procedure.

[96] HEALTH CANADA, WOMEN'S HEALTH SURVEILLANCE REPORT: A MULTIDIMENSIONAL LOOK AT THE HEALTH OF CANADIAN WOMEN (2003), http://www.phac-aspc.gc.ca/publicat/whsr-rssf/pdf/CPHI_WomensHealth_e.pdf.

[97] Blencoe v. British Columbia (Human Rights Comm'n), [2000] 2 S.C.R. 307, 350 (Can.).

[98] *Id.*

mandated by the law "itself."[99] Chief Justice Dickson, for example, acknowledged that the "[u]nfair functioning of the law could be caused by external forces which do not relate to the law itself,"[100] but in this case, "the most serious problems with the functioning of [section] 251 are created by procedural and administrative requirements established in the law."[101]

The majority opinions of *Morgentaler* also emphasized the criminal nature of the impugned provision—in particular, its prohibitive, preclusive, or preventative character.[102] Justice Dickson affirmed that section 7 is engaged where "the administrative structures and procedures established by [section] 251 *itself* . . . in practice *prevent* the woman from" accessing timely services.[103] The prohibitive character of impugned state action under section 7 was again emphasized in the recent Supreme Court of Canada case, *Chaoulli v. Quebec (Attorney General)*,[104] wherein a majority of the court held that a provincial prohibition on private health insurance violated the rights to life and personal security under the Quebec Charter of Human Rights and Freedoms.[105] In their concurring judgment that the provincial law violated section 7, Chief Justice McLachlin and Justice Major stressed the law's prohibitive character: "In *Morgentaler*, as in this case, the legislative scheme denies people the right to access alternative health care . . . . [I]n both cases, care outside the legislatively provided system is effectively *prohibited*."[106] Affected persons "have no choice but to accept the delays imposed by the legislative scheme and the adverse physical and psychological consequences this entail[ed]."[107]

The "negative" character of rights protected under section 7—freedom from legal restriction or prohibition on life, liberty, and security of the

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[99] R v. Morgentaler, [1988] 1 S.C.R. 30, 59–62, 65, 71 (Can.).
[100] *Id.* at 65.
[101] *Id.*
[102] *See, e.g.*, *id.* at 101.
[103] *Id.* at 70–71 (emphasis added). In a later passage, Chief Justice Dickson expressly noted that "the evidence establishes convincingly that it is the law itself which in many ways prevents access to local therapeutic abortion facilities." *Id.* at 71.
[104] [2005] 1 S.C.R. 791 (Can.).
[105] Quebec Charter of Human Rights and Freedoms, R.S.Q., ch. C-12., s.1 (1975) ("Every human being has a right to life, and to personal security, inviolability and freedom.").
[106] *Chaoulli*, [2005] 1 S.C.R. at 848 (McLachlin, C.J. & Major, J., concurring) (emphasis added).
[107] *Id.* at 848–49.

person—was explicitly acknowledged by a majority of the Supreme Court of Canada in *Gosselin v. Quebec (Attorney General)*.[108]

> Nothing in the jurisprudence thus far suggests that [section] 7 places a positive obligation on the state to ensure that each person enjoys life, liberty or security of the person. Rather, [section] 7 has been interpreted as restricting the state's ability to <u>deprive</u> people of these.[109]

In *Lexogest I*, Chief Justice Scott relied on the negative character of section 7 to distinguish denied public funding from criminalization. Unlike the law in *Morgentaler*, he stated, "the Manitoba regulation does not prohibit or restrict abortions or mandate where they are performed. It merely deals with payment."[110] Chief Justice Scott reasoned that imposing a positive obligation on the state to fund abortion services "once a choice has been made by a woman to terminate her pregnancy"[111] was a novel application of section 7 and would move the Court "beyond the judicial domain."[112]

The logic of Chief Justice Scott's opinion prevailed in the abortion funding cases before the U.S. Supreme Court. In *Maher*, Justice Powell, on behalf of the majority, distinguished funding restrictions from the imposition of "severe criminal sanctions [that] . . . drastically limit[ed] the availability and safety of the desired service."[113] He held that denied Medicare funding did not violate the right of privacy insofar as the regulation

> places no obstacles—absolute or otherwise—in the pregnant woman's path to an abortion . . . . [The state] has imposed no restriction on access to abortions that was not already there. The indigency that may make it difficult—and in some cases, perhaps, impossible—for some women to have abortions is neither created nor in any way affected by the . . . regulation.[114]

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108 [2002] 4 S.C.R. 429 (Can.) (holding that provincial social assistance regulations that provided reduced benefits to individuals under the age of thirty, unless they participated in training or education programs, did not violate sections 7 or 15).

109 *Id.* at 491.

110 Lexogest Inc. v. Manitoba (Attorney General) (*Lexogest I*), [1993] 101 D.L.R. (4th) 523, 546 (Man. C.A.).

111 *Id.* at 547.

112 *Id.*

113 Maher v. Roe, 432 U.S. 464, 472 (1976).

114 *Id.* at 474.

In *McRae*, a majority of the Court affirmed the negative character of the right recognized in *Roe v. Wade*.[115] In upholding the constitutionality of the Hyde Amendment, Justice Stewart reasoned, in a manner akin to Chief Judge Scott in *Lexogest I*, that a woman's freedom of choice does not necessarily entail an "entitlement to the financial resources to avail . . . the full range of protected choices."[116] To the contrary, he explained that

> although government may not place obstacles in the path of a woman's exercise of her freedom of choice, it need not remove those not of its own creation. Indigency falls in the latter category. The financial constraints that restrict an indigent woman's [access] . . . are the product not of governmental restrictions . . . but rather of her indigency.[117]

Unlike in *Morgentaler*, the unfair functioning of the Hyde Amendment was understood to result from an external factor—indigency—that was not attributable to the law itself.[118] The law did not prohibit or restrict access to abortion.[119] It merely addressed payment.[120] Echoing Chief Justice Scott in *Lexogest I*, Justice Stewart concluded that to translate a limitation on governmental power into an affirmative funding obligation "would mark a drastic change in our understanding of the Constitution."[121]

The dissenting opinions in *Maher* and *McRae* adopted a very different approach, rejecting as artificial the distinction between state-imposed and independent or external barriers to access. The opinions focused instead on the effect of the law as experienced by women themselves. In *McRae*, Justice Marshall chastised the majority for avoiding "the undeniable fact that . . . denial of a Medicaid-funded abortion is equivalent to denial of legal abortion altogether. By definition, these women do not have the money to pay for an abortion themselves."[122] Justice Blackmun similarly noted in *Maher* that "[f]or the individual woman concerned, indigent and financially helpless . . . the result is punitive and tragic."[123] Regardless of its purpose or design, the

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115 Harris v. McRae, 448 U.S. 297, 316 (1980).
116 *Id.*
117 *Id.*
118 *See id.*
119 *See id.* at 301–03.
120 *See id.*
121 *Id.* at 318.
122 *Id.* at 338 (Marshall, J., dissenting).
123 Beal v. Doe, 432 U.S. 454, 462 (1976) (Blackmun, J., dissenting). *Maher* and *Beal* were decided together.

funding restriction, in effect, impedes women's safe and timely access to abortion services. The majority justices in *Morgentaler* exhibited a strong sympathy with this perspective. Justice Dickson insisted that "[i]n order to understand the true nature and scope of [section] 251, it is necessary to investigate the practical operation of the provisions."[124] The majority analysis in *Morgentaler* was driven by "the perspective of the woman facing the health care system, and not the criminal sanction."[125]

In *Jane Doe I*, Justice Oliphant employed the same effect-based approach, as used in *Morgentaler* and the dissenting opinions of *Maher* and *McRae*, to attribute evidenced harm to impugned state action. Justice Oliphant did not contest the characterization of the Manitoba regulation as merely dealing with payment. Rather, he considered its practical effect from the perspective of "a woman who wishes to have a safe therapeutic abortion without having to undergo the physical risks and psychological harm associated with delay."[126] He asked: what is the effect of denying women public funding for safe and timely abortions? What is the effect of requiring women to pay for the same out of their own pockets? The effect of the impugned law, Justice Oliphant explained, "is to tell every pregnant woman that she cannot submit to a safe medical procedure that might be clearly beneficial to her unless she does so at a time and place dictated by a backlogged, publicly funded health care system."[127] The law "forces women to have to stand in line in an overburdened, publicly funded health care system and to have to wait for a therapeutic abortion, a procedure that provably must be performed in a timely manner."[128] In simple terms, Justice Oliphant concluded, "delayed access for a woman wishing to have a safe, state-funded therapeutic abortion is the result of the impugned legislation."[129] An indigent woman has no choice but to accept the delays imposed by the legislative scheme and the adverse physical and psychological consequences this entails.

While an effect-based approach enabled Justice Oliphant to establish a relationship between the harm and state action, it could not fully address the Supreme Court of Canada's equally important emphasis on the prohibitive,

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[124] R v. Morgentaler, [1988] 1 S.C.R. 30, 65 (Can.).

[125] Chaoulli v. Quebec (Attorney General), [2005] 1 S.C.R. 791, 849 (Can.) (McLachlin, C.J. & Major, J., concurring).

[126] Jane Doe 1 v. Manitoba *(Jane Doe I)*, [2004] 248 D.L.R. (4th) 547, 563 (Man. Q.B.).

[127] *Id.* at 562.

[128] *Id.* at 564.

[129] *Id.* at 563.

preclusive, or preventative character of impugned laws. While Justice Oliphant emphasized the prohibitive effect of the law, describing the legislative scheme as *forcing* women to stand in line or telling pregnant women that they *cannot* submit to a safe medical procedure, the challenged law remained nevertheless positive in character. It established the terms of a public health insurance plan. The legislative scheme, it may be argued, did not deny access to abortion services. On the contrary, it provided women with the very opportunity to stand in line in an overburdened, publicly funded health care system to receive abortion services. Without the public health insurance plan, a woman seeking a safe and timely abortion was required in all circumstances to pay for the same out of her own pocket. The legislative scheme thus arguably facilitated rather than impeded access to abortion by funding services in some circumstances.

The impugned legislative scheme violated section 7 only if the rights protected therein obligated the state not merely to refrain from depriving individuals of their life, liberty, and security of the person, but placed a positive obligation on the state to ensure that individuals enjoy life, liberty, and security of the person. Access to safe and timely health services is thus not merely a privilege of government largesse but an entitlement of right under section 7.

To date, however, section 7 has "been interpreted in a way so that governments do not have a duty to provide publicly-funded health care."[130] Publicly funded health care is regarded neither as an individual right nor government obligation. *Jane Doe I* is the lone exception in this regard, and its standing remains uncertain following the Supreme Court's more recent decision in *Chaoulli*.[131] In *Brown v. British Columbia (Minister of Health)*,[132] for example, the British Columbia Supreme Court upheld the government's decision not to subsidize the costs of an AIDS drug treatment regime on the

[130] Colleen M. Flood, *Just Medicare: The Role of Canadian Courts in Determining Health Care Rights and Access*, 33 J.L. MED. & ETHICS 669, 671 (2005). Donna Greschner similarly notes that "[t]he courts have not interpreted the rights in section 7 in a manner sufficiently broad to encompass a general right to health, or, except in exceptional circumstances, a right to access health care services." Donna Greschner, *How Will the Charter of Rights and Freedoms and Evolving Jurisprudence Affect Health Care Costs?* 9 (Commission on the Future of Health Care in Canada, Discussion Paper No. 20, 2002), *available at* http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/20_Greschner_E.pdf.

[131] *See* Jane Doe 1 v. Manitoba (*Jane Doe II*), [2005] 260 D.L.R. (4th) 149, 156 (Man. C.A.) ("*Chaoulli* was released after the hearing of this appeal, and we have not had the assistance of counsel on what, if any, implications *Chaoulli* may have on the plaintiffs's [section] 7 challenge in this case.").

[132] [1990] 66 D.L.R. (4th) 444 (B.C. S.C.).

basis that section 7 does not guarantee benefits to enhance life, liberty, or security of the person.[133] In *Cameron v. Nova Scotia (Attorney General)*,[134] the Supreme Court of Nova Scotia similarly dismissed a claim under section 7 for public funding of fertility treatments. The claim was not pursued on appeal. As the Supreme Court of Canada noted in *Gosselin*, the imposition of a positive state duty is a novel application of section 7.[135]

Justice Oliphant neither acknowledged nor justified his novel application of section 7 in *Jane Doe I*. The Court of Appeal seized upon this aspect of the judgment as the second basis for setting it aside, noting that the "*Charter* issues in this case are complex and involve developing areas of the law, with important policy implications."[136] Following the release of Justice Oliphant's judgment, the Manitoba government emphasized these implications, describing the decision as "reach[ing] far beyond the abortion debate . . . [to potentially] affect the way governments handle long waiting lists for other procedures."[137] The government admonished that "[w]e can't turn over to individual people the planning of the health-care system, no matter how strongly we might feel about their rights to the procedure."[138] A narrow interpretation of constitutional rights in the health care context is routinely defended by evoking fears of judicial meddling in the complexities of health budgeting and allocation, and related concerns of institutional competence and political accountability. In the words of Chief Justice Scott in *Lexogest I*, courts should not meddle "beyond the judicial domain."[139]

B. Section 15: Equality Rights

Equality rights can potentially overcome the judicial reluctance to impose positive state obligations by distinguishing between rights to public benefits and rights to equality in the distribution of benefits. In *Maher*, for example, the majority of the U.S. Supreme Court held that while "[t]he Constitution imposes no obligation on the States to pay . . . any of the medical expenses of

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133 *Id.* at 467–69.

134 [1999] 177 D.L.R. (4th) 611 (N.S. C.A.).

135 Gosselin v. Quebec (Attorney General), [2002] 4 S.C.R. 429, 492 (Can.).

136 *Jane Doe II*, 260 D.L.R. (4th) at 156.

137 Press Release, Canadian Press, Manitoba Appeals Abortion Ruling to Protect Right to Set Spending Priorities (Jan. 27, 2005), http://www.medbroadcast.com/health_news_details_pf.asp?news_id=5831&news_channel_id=1000; *see also* Press Release, Government of Manitoba, Manitoba Defends Right to Set Health Care Priorities (Jan. 27, 2005), http://www.gov.mb.ca/chc/press/top/2005/01/2005-01-27-01.html.

138 *Id.*

139 [1993] 101 D.L.R. (4th) at 547.

indigents[,] . . . when a State decides to alleviate some of the hardships of poverty by providing medical care, the manner in which it dispenses benefits is subject to constitutional limitations."[140] Justice Stevens drew heavily on this distinction in his dissent in *McRae*. The government, he asserted, "must use neutral criteria in distributing benefits. It may not deny benefits to a financially and medically needy person simply because he is a Republican, a Catholic, or an Oriental."[141] Nor, Justice Stevens reasoned, may the government deny benefits to a financially and medically needy woman simply because she seeks to terminate her pregnancy.[142]

By focusing on the equitable distribution of government benefits, the dissenters in *McRae*, in the language of Seth Kreimer, respecified the "acceptable baseline" against which to assess the effect of government action.[143] Unlike the majority of the Court, the dissenting justices did not consider whether "the Hyde Amendment leaves an indigent woman with at least the same range of choice . . . as she would have had if Congress had chosen to subsidize no health care costs at all."[144] Rather, they assessed the effect of the Hyde Amendment in the context of the Medicaid program to which it was appended. Abortion was the only category of medically necessary services excluded under Medicaid. Justice Brennan observed that while "[n]on-pregnant women may be reimbursed for all medically necessary treatments[,] . . . [p]regnant women . . . will be reimbursed only if the treatment involved does not happen to include an abortion."[145] The government, the dissenting opinions asserted, failed to use neutral criteria in the distribution of public benefits and thus ran afoul of the Constitution.

The distinction between a right *to* health care and a right *in* health care is well recognized in Canadian law. The objective of the equality rights under the Charter is precisely to ensure that benefits and burdens are distributed on a nondiscriminatory basis. Section 15(1) provides that

> [e]very individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without

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[140] Maher v. Roe, 432 U.S. 464, 469–70 (1976).

[141] Harris v. McRae, 448 U.S. 297, 356 (1980) (Stevens, J., dissenting).

[142] *See id.* at 356–57.

[143] *See* Seth F. Kreimer, *Allocational Sanctions: The Problem of Negative Rights in a Positive State*, 132 U. PA. L. REV. 1293 (1984). "[T]he distinction between liberty-expanding offers and liberty-reducing threats turns on the establishment of an acceptable baseline against which to measure a person's position after imposition of an allocation." *Id.* at 1352.

[144] *McRae*, 447 U.S. at 317 (majority opinion).

[145] *Id.* at 331 n.4 (Brennan, J., dissenting).

> discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.[146]

The distinction between a right to health care and a right to equitable distribution of health care benefits is affirmed in *Eldridge v. British Columbia (Attorney General)*[147] and *Auton (Guardian* ad litem *of) v. British Columbia (Attorney General)*.[148] In *Eldridge*, the Supreme Court of Canada held that a provincial government's failure to fund sign language interpretation for deaf persons when communicating with health care providers infringed section 15(1).[149] The Court affirmed that "once the state does provide a benefit, it is obliged to do so in a nondiscriminatory manner . . . . In many circumstances this will require governments to take positive action, for example, by extending the scope of a benefit to a previously excluded class of persons."[150] In *Auton*, the Supreme Court considered whether a provincial government's failure to fund applied behavioral therapy for children with autism violated section 15(1) on the basis of disability.[151] As understood by the Court, the case did not concern "what the public health system should provide," but "whether the British Columbia Government's failure to fund these services . . . amounted to an unequal and discriminatory denial of benefits."[152] Compared against a substantive claim for public funding, Canadian law supports "a procedural claim anchored in the assertion that benefits provided by the law were not distributed in an equal fashion."[153]

The claimants in both *Lexogest I* and *Jane Doe I* asserted that a denial of funding for clinic abortions violated women's equality rights under section 15(1).[154] Chief Justice Scott and Justice Oliphant again reached opposite conclusions on the claims, with neither justice fully articulating reasons to support his holding. Chief Justice Scott provided a truncated equality rights analysis rejecting the claim. Justice Oliphant simply concluded "that the impugned legislation is a violation of the . . . equality rights as guaranteed to

146 Part I of the Constitution Act, being Schedule B to the Canada Act 1982, ch. 11, s. 15 (U.K.).

147 [1997] 3 S.C.R. 624 (Can.).

148 [2004] 3 S.C.R. 657 (Can.).

149 *Eldridge,* [1997] 3 S.C.R. 624 at 624–31.

150 *Id.* at 678.

151 *Auton*, [2004] 3 S.C.R. at 658–60.

152 *Id.* at 663.

153 *Id.* at 677.

154 *See supra* notes 55–59 and accompanying text.

women."[155] His detailed recitation of the claimants' submissions, however, suggests his supporting reasons.

The remainder of this Part examines Justice Oliphant's equality rights analysis under the section 15(1) analytical guidelines developed by a unanimous Supreme Court of Canada in *Law v. Canada (Minister of Employment and Immigration)*[156] and adopted in subsequent case law. The guidelines address three broad inquiries:

> (a) whether a law imposes differential treatment between the claimant and others, in purpose or effect;
> (b) whether the differential treatment is based on a personal characteristic associated with an enumerated or analogous ground of discrimination; and
> (c) whether the law in question has a purpose or effect that is discriminatory within the meaning of the equality guarantee.

1. Whether the Manitoba Regulation Imposes Differential Treatment Between Jane Doe 1 and Jane Doe 2 and Others in Purpose or Effect

Differential treatment under the law may result from either the failure to receive a benefit that the law provides to others or the imposition of a burden that the law does not impose on others. As described by the Supreme Court in *Auton*, the purpose of section 15(1) "is to ensure that when governments choose to enact benefits or burdens, they do so on a non-discriminatory basis."[157] Section 15(1) claims are thus confined "to benefits and burdens imposed by law."[158]

In *Jane Doe I*, the claimants argued that the Manitoba regulation "imposes an unfair burden on women by forcing them to pay for medical services to be received in a safe and timely fashion as distinct from the rest of the population."[159] Chief Justice Scott rejected a similar claim in *Lexogest I.* He reasoned that because "[t]he impugned regulation does not deny women coverage for therapeutic abortions, that are medically required," women were

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[155] Jane Doe 1 v. Manitoba *(Jane Doe I)*, [2004] 248 D.L.R. (4th) 547, 564 (Man. Q.B.).

[156] [1999] 1 S.C.R. 497 (Can.) (holding that the Canada Pension Plan, which denied full entitlement to survivor's pensions to those under 35 years of age, did not violate Section 15(1) on the basis of age).

[157] *Auton*, [2004] 3 S.C.R. at 671.

[158] *Id.*

[159] *Jane Doe I*, 248 D.L.R. (4th) at 556 (internal quotation marks omitted).

not denied benefits or otherwise treated unequally under the law.[160] The Manitoba government adopted the same position in *Jane Doe I*. Under Manitoba's Health Services Insurance Act, pursuant to which the challenged regulation was enacted, benefits are limited to "services rendered by a medical practitioner that are *medically required* but does not include those services excepted by the regulations."[161] The government argued that clinic abortions are not medically required and thus do not qualify as benefits under the law. If the service is not a benefit under the law, there is no entitlement to equal distribution.

On the facts of the case, however, it is difficult for the government to persuasively maintain this position. The Manitoba regulation does not expressly deny funding for clinic services on the basis of medical necessity. Rather, the funding restriction relates solely to the location where the service is performed.[162] As compared to hospital services, clinic services do not differ in the treated condition, patient risk, or practitioner skill. In Manitoba, there are no restrictions as to the "medical necessity" of hospital abortions.[163] Nor does the regulation provide exceptions for "medically necessary" clinic abortions.

Nonetheless, these difficulties are not fatal to the government's position given that medically necessary services can also be disqualified as benefits under the law. Under the Health Services Insurance Act, "medically required" services that are "*excepted by the regulations*" are excluded from the definition of benefits.[164] In fact, the Health Services Insurance Act was enacted with the express purpose of providing Cabinet the authority to exclude otherwise insured services according to the location where they are provided. The government may thus argue that because clinic services are excepted by the Manitoba regulation, regardless of whether they are medically necessary, they do not qualify as benefits to be equally distributed by law.

In *Auton*, the Supreme Court of Canada considered a similar line of reasoning in affirming the constitutionality of denied public funding for applied behavioral autism therapy. *Auton* did not turn on the "medical necessity" of the therapy. Rather, health services qualified as benefits under

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160 Lexogest Inc. v. Manitoba (Attorney General) (*Lexogest I*), [1993] 101 D.L.R. (4th) 523, 548 (Man. C.A.) (emphasis added).

161 Health Services Insurance Act, R.S.M., ch. H 35, s. 2 (1987) (Can.) (emphasis added).

162 *See supra* text accompanying note 60 (discussing *Lexogest II*).

163 In New Brunswick, for example, the government funds hospital abortions only when certified as "medically required" by two medical practitioners. *See supra* note 21.

164 Health Services Insurance Act, R.S.M., ch. H 35, s. 2 (emphasis added).

the impugned legislation only when delivered by a physician.[165] Applied behavioral autism therapy is not provided by a physician, and thus the service did not qualify as a benefit under the law.[166] The Court explained that provincial health insurance schemes do not promise to any Canadian that he or she will receive funding for all medically required treatment.[167] Chief Justice Scott in *Lexogest I* similarly remarked that a public health insurance plan does not guarantee "equal access to all physicians regardless of location and availability."[168] The benefit claimed—funding for all medically necessary services—is simply not provided by the law.[169] This reasoning leads to the troubling conclusion in *Jane Doe I* that the exclusion of *any* service by regulation under Manitoba's Health Services Insurance Act is immune from Charter review. In other words, where a differential effect results from the designation of a benefit rather than its distribution, equality rights are of no avail.

Given such an enfeebled interpretation of the reach of equality rights, the Court in *Auton* acknowledged that the equal distribution of formally designated benefits cannot end the inquiry. Equality rights under section 15(1) are not confined to the "equal benefit of the law." Section 15(1) also guarantees the right to equality "before and under the law." The phrase "under the law" was specifically intended to expand the Supreme Court's narrow interpretation of the phrase "before the law" under the Canadian Bill of Rights.[170] In *Canada (Attorney General) v. Lavell*,[171] the Supreme Court held that a law depriving only aboriginal women of status upon marriage to a nonaboriginal person did not deny women equality before the law.[172] All aboriginal women were deprived of their status, and thus all aboriginal women were treated equally.[173] The Court accepted the definition of benefits and burdens as drawn and inquired simply whether the law as constructed granted equal benefits and imposed equal burdens on all persons to whom it applied.[174] The Court reasoned that while aboriginal women may not have been equal *under* the law,

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165 Auton v. British Columbia (Attorney General), [2004] 3 S.C.R. 657, 676 (Can.).

166 *Id*. at 676–77.

167 *Id.* at 673.

168 Lexogest Inc. v. Manitoba (Attorney General) (*Lexogest I*), [1993] 101 D.L.R. (4th) 523, 542 (Man. C.A.).

169 *Id.* at 676.

170 Canadian Bill of Rights, 1960 S.C., ch. 44 *reprinted in* R.S.C. 1985, app. III.

171 [1974] S.C.R. 1349 (Can.).

172 *Id.* at 1373.

173 *Id.*

174 *Id.* at 1363–64

they were equal *before* it.[175] The decision in *Lavell* was heavily criticized and formed the basis of a successful claim before the Human Rights Committee of the United Nations.[176] To avoid such rigid formalism under the *Charter*, the Court in *Auton* moved beyond the legislative definition of "benefit" to examine whether the legislative scheme—the very categories of benefit created by law—is itself discriminatory.[177]

In this regard, it is noteworthy that Jane Doe 1 and Jane Doe 2 made no explicit claim to the "equal benefit of the law." The claimants did not challenge the equal distribution of benefits under the legislative scheme. Rather, they challenged the legislative definition of benefits under the law—the design of the insurance plan itself—as imposing an unfair burden on women. In other words, the claimants in *Jane Doe I* sought "equality *under* the law."

As the Court affirmed in *Auton*, in designing a public health insurance plan, "[i]t is not open to . . . a legislature to enact a law whose policy objectives and provisions single out a disadvantaged group for inferior treatment."[178] Under the separation of powers, the judiciary is thus tasked with the responsibility of determining whether the statutory definition of benefits and burdens under the law is a legitimate exercise of legislative power or the inferior treatment of a group in purpose or effect. This distinction requires consideration of the purpose of the legislative scheme and the overall needs it seeks to address. As the Supreme Court explained,

> If a benefit program excludes a particular group in a way that undercuts the overall purpose of the program, then it is likely to be discriminatory: it amounts to an arbitrary exclusion of a particular group. If, on the other hand, the exclusion is consistent with the overarching purpose and scheme of the legislation, it is unlikely to be discriminatory. Thus, the question is whether the excluded benefit is one that falls within the general scheme of benefits and needs which the legislative scheme is intended to address.[179]

In *Auton*, the Court reasoned that the impugned insurance scheme did not have as its purpose the meeting of all medical needs. Its only promise was to provide funding for core services, defined as physician-provided services.

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[175] *Id.* at 1367–72.
[176] *See* Lovelace v. Canada, 1 CAN. HUM. RTS. Y.B. 305 (1983).
[177] *See* Auton v. British Columbia (Attorney General), [2004] 3 S.C.R. 657, 675 (Can.).
[178] *Id.*
[179] *Id.* at 676.

Beyond this, the province funded services at its discretion.[180] The Court thus explained that because the health insurance scheme was "by its very terms, a partial health plan . . . exclusion of particular non-core services cannot, without more, be viewed as an adverse distinction . . . . Rather, it is an anticipated feature of the legislative scheme."[181] To hold otherwise would effectively "amend the . . . scheme and extend benefits beyond what it envisions—core physician-provided benefits plus non-core benefits at the discretion of the Province."[182] The Court therefore concluded that "the benefit claimed, no matter how it is viewed, is not a benefit provided by law."[183]

The same is not true with respect to clinic abortion services. The regulation in *Jane Doe I* saddles abortion services, and by extension women who seek to terminate their pregnancies, with a burden not imposed on others. While the Health Services Insurance Act authorizes Cabinet to exclude services from the insurance coverage according to the location where they are provided, Cabinet cannot exercise its authority in a manner that arbitrarily excludes or otherwise singles out a particular group for inferior treatment in purpose or effect. Abortion services are the only medically necessary services for which funding is conditioned on the type of facility where the service is performed. Clinic abortion services do not differ from hospital abortion services either in the health care need they address or the type of professional that provides the service. Neither hospital nor clinic abortions are premised on the satisfaction of any medical or other defined criteria. The majority of physician services funded under the provincial health insurance plan are performed outside of hospitals. All physician services, other than abortion services, provided in clinic contexts are core services under the insurance plan. The exclusion of clinic abortion is not an anticipated feature of the legislative scheme, but an anomaly—a difference in treatment. The provincial health insurance excludes women who wish to terminate their pregnancies in a way that undercuts rather than supports the overall purpose of provincial health insurance.

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[180] *Id.*
[181] *Id.*
[182] *Id.* at 677.
[183] *Id.*

2. *Whether the Differential Treatment Is Based on a Personal Characteristic Associated with an Enumerated or Analogous Ground of Discrimination*

Equality rights prohibit, in particular, discrimination based on "race, national or ethnic origin, colour, religion, sex, age or mental or physical disability."[184] In *Lexogest I*, Chief Justice Scott held without elaboration that the "regulation simply does not discriminate on the basis of the grounds listed in [section] 15."[185] The claimants in *Jane Doe I* emphasized the sex-specific character of abortion services to demonstrate that differential treatment under the regulation was based on sex, an enumerated ground of discrimination under section 15(1).[186] Justice Oliphant accepted their claim, noting that "because women are the only persons who can access abortion services, any legislated restrictions on women's ability to access abortion services uniquely affects women as opposed to the general population."[187] Moreover, the fact that not all women are adversely affected by the Manitoba Regulation, or that some women may even benefit from the exclusion, does not defeat the claim.[188] In *Brooks v. Canada Safeway Ltd.*,[189] for example, the Supreme Court of Canada held that a company accident and sickness plan which exempts pregnant women from benefits during a seventeen-week period discriminates on the basis of sex. Writing for the majority of the court, Chief Justice Dickson explained:

> While pregnancy-based discrimination only affects part of an identifiable group, it does not affect anyone who is not a member of the group. Many, if not most, claims of partial discrimination fit this pattern. As numerous decisions and authors have made clear, this fact does not make the impugned distinction any less discriminating.[190]

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184 Part I of the Constitution Act, being Schedule B to the Canada Act 1982, ch. 11, s. 15 (U.K.).

185 Lexogest Inc. v. Manitoba (Attorney General) (*Lexogest I*), [1993] 101 D.L.R. (4th) 523, 548 (Man. C.A.).

186 Jane Doe 1 v. Manitoba *(Jane Doe I)*, [2004] 248 D.L.R. (4th) 547, 556 (Man. Q.B.).

187 *Id.*

188 As noted by Martha Minow, "Not all women, at all times, are pregnant; indeed, some women will never become pregnant, and some who already have been never will be again . . . . Some women may argue that health benefits for pregnancy are far less relevant to their needs than [other benefits]" such as home care or pharmaceutical coverage, which are also excluded from provincial health insurance plans. MARTHA MINOW, MAKING ALL THE DIFFERENCE: INCLUSION, EXCLUSION, AND AMERICAN LAW 231 (1990).

189 [1989] 1 S.C.R. 1219 (Can.). Although this case was decided under the Human Rights Act, R.S.C., ch. H-6 (1985), rather than the Charter, the reasoning is equally relevant.

190 *Id.* at 1247; *see also* Symes v. Canada, [1993] 4 S.C.R. 695, 775 (Can.) (holding that childcare expenses are not deductible as business expenses). In the United States, the Supreme Court refused to

The disfavored treatment under the Manitoba regulation flows entirely from the state of unintended pregnancy, a condition distinctive to the female sex.[191] The fact that only women are affected by denied funding for clinic abortion services is thus sufficient to ground a claim for discrimination on the basis of sex.

3. *Whether the Manitoba Regulation Has a Purpose or Effect that Is Discriminatory Within the Meaning of the Equality Guarantee*

In the first Charter equality case, *Andrews v. Law Society of British Columbia*,[192] the Supreme Court of Canada confirmed that "not every distinction or differentiation in treatment at law . . . will transgress the equality guarantees."[193] For this reason, "a bad law will not be saved merely because it operates equally upon those to whom it has application. Nor will a law necessarily be bad because it makes distinctions."[194] Persons differ in important respects, and therefore, similar treatment regardless of difference may exacerbate rather than mitigate inequality. Distinction based on claimed difference has, however, historically served as the very justification for marginalization and the imposition of disadvantage.

Unlike other judicial actors, the Supreme Court of Canada did not seek to escape this "dilemma of difference"—that "stigma of difference may be recreated both by ignoring and by focusing on it"[195]—through the criterion of *relevance*. A law will not be saved under section 15(1) simply because its objective is substantially or rationally related to an identified difference. Rather, the court recognized that the relevance of a distinction often follows necessarily from the characterization of a law's objective.[196] In *Miron v.*

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recognize differential treatment on the basis of pregnancy as sex-based for the purpose of the equal protection guarantee. *See* Geduldig v. Aiello, 417 U.S. 484, 497 (1974). "While it is true that only women can become pregnant, it does not follow that every legislative classification concerning pregnancy is a sex-based classification." *Id.* at 496 n.20. This holding presents a major barrier for sex equality based challenges to abortion restrictions under the U.S. Constitution. *See* Sylvia A. Law, *Rethinking Sex and the Constitution*, 132 U. PA. L. REV. 955 (1984).

[191] *See Brooks*, [1989] 1 S.C.R. at 1242.

[192] [1989] 1 S.C.R. 143 (Can.) (holding that a citizenship restriction on admission to the Law Society of British Columbia violated section 15(1) and was not justified under section 1).

[193] *Id.* at 168.

[194] *Id.* at 167.

[195] MINOW, *supra* note 188, at 20.

[196] Denise G. Réaume, *Discrimination and Dignity*, 63 LA. L. REV. 645, 660 (2003).

Trudel,[197] for example, Justice McLachlin eschewed the arid circularity of "relying on the formal test of logical relevance as proof of [equality]."[198] Equality rights demand more than rational laws. Section 15(1) seeks to ensure equality in the effect of laws.

The Supreme Court of Canada affirmed in *Andrews* and *Law v. Canada* that "[t]o approach the ideal of full equality before and under the law . . . the main consideration must be the *impact* of the law on the individual or the group concerned."[199] Under section 15(1), a law is discriminatory within the meaning of the equality guarantee if its *purpose or effect* demeans *human dignity*.[200] A discrimination inquiry thus seeks to determine whether the distinction created by law demeans the human dignity of affected individuals and groups. Differential treatment of abortion services under a public health insurance plan, for example, constitutes discrimination insofar as the denial of funding demeans women's dignity.

Lexogest I was decided before *Law v. Canada*, and therefore Chief Justice Scott's equality rights analysis did not examine whether the Manitoba regulation in purpose or effect demeaned women's dignity. This inquiry, however, was central to the holding in *Jane Doe I*. Justice Oliphant characterized the discrimination claim in the following manner:

> [T]he right to equality as granted by [section] 15 of the *Charter* was intended to preserve and protect human dignity. . . . [T]he right to reproductive freedom is central to a woman's autonomy and dignity as a person. The ability to assert that autonomy and to exercise self-determination regarding one's own body is fundamental to the preservation and protection of a woman's dignity.
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> . . . [T]he impugned legislation limits and impairs a woman's freedom to assert her autonomy and to exercise self-determination thereby affecting a woman's human dignity in an adverse manner with the result that it violates the right to equality as guaranteed by [section] 15 of the *Charter*.[201]

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[197] [1995] 2 S.C.R. 418 (Can.) (holding that a provision of the Ontario Insurance Act that distinguished between married and unmarried partners with respect to uninsured claims violated section 15(1) and was not justified under Section 1).

[198] *Id.* at 489.

[199] Andrews v. Law Soc'y of B.C., [1989] 1 S.C.R. 143, 165 (Can.). (emphasis added); Law v. Canada, [1999] 1 S.C.R. 497, 530 (Can.).

[200] *Law v. Canada*, [1999] 1 S.C.R. at 539.

[201] Jane Doe 1 v. Manitoba (*Jane Doe I*), [2004] 248 D.L.R. (4th) 547, 557 (Man. Q.B.).

Judge Oliphant's conception of dignity, rooted in the liberty-based values of reproductive freedom, autonomy, and self-determination, again evidenced a strong reliance on *Morgentaler*.

According to Chief Justice Dickson and Justice Wilson, the flaws of the impugned criminal provision in *Morgentaler* extended beyond the physical and psychological harm of delayed care. The mandated committee procedure denied women the ability to assert their autonomy and to exercise self-determination regarding their own bodies. The provision, Justice Wilson explained, violated the right to security of the person by declaring "[i]n essence . . . that the woman's capacity to reproduce is not to be subject to her own control. It is to be subject to the control of the state."[202] Chief Justice Dickson similarly located the provision's flaw in its command to every pregnant woman "that she cannot submit to a generally safe medical procedure that might be of clear benefit to her unless she meets criteria entirely unrelated to her own priorities and aspirations."[203]

In *Jane Doe I*, Judge Oliphant emphasized women's same loss of freedom, autonomy, and self-determination. In consciously imitative language, he wrote that "the effect of the impugned . . . *Regulation*[] is to tell every pregnant woman that she cannot submit to a safe medical procedure that might be clearly beneficial to her unless she does so at a time and place dictated by a backlogged, publicly funded health care system."[204]

It is Justice Wilson's analysis of the right to liberty in *Morgentaler*, however, that most strongly articulates a liberty-based conception of dignity. Unlike Chief Justice Dickson and Justice Beetz, Justice Wilson held that the impugned criminal provision violated not only the right to security of the person, but also the right to liberty—a right "inextricably tied to the concept of human dignity."[205] Justice Wilson reasoned that

> an aspect of the respect for human dignity on which the *Charter* is founded is the right to make fundamental personal decisions without interference from the state. This right is a critical component of the right to liberty . . . . In my view, this right, properly construed, grants

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[202] R v. Morgentaler, [1988] 1 S.C.R. 30, 173 (Can.).

[203] *Id.* at 56.

[204] *Jane Doe I,* 248 D.L.R. (4th) at 562.

[205] *Morgentaler*, [1988] 1 S.C.R. at 164. Justice Wilson also held that the deprivation of section 7 under the impugned law infringes section 2(a) of the Charter, freedom of conscience and religion, on the basis that "the decision whether or not to terminate a pregnancy is essentially a moral decision, a matter of conscience." *Id.* at 175.

> the individual a degree of autonomy in making decisions of fundamental personal importance.[206]

A woman's decision to terminate her pregnancy, she concluded, is a decision of fundamental personal importance and is thus protected by the right to liberty.

A liberty-based conception of dignity under the Charter is therefore defined by the enjoyment of a degree of autonomy in making decisions of fundamental personal importance free from state interference. This conception, as Justice Wilson noted, is "consistent with the American jurisprudence on the subject."[207] Respect for human dignity through the limitation on government intervention reflects the very same negative conception of liberty endorsed by the U.S. Supreme Court in *Maher* and *McRae*. Charter rights, according to Justice Wilson, "erect around each individual, metaphorically speaking, an invisible fence over which the state will not be allowed to trespass. The role of the courts is to map out, piece by piece, the parameters of the fence."[208]

In the reproductive health context, women have greatly benefited from the construction of a metaphoric space into which others may not trespass. Religious, moral, and social codes have interfered for too long with women's reproductive decision making according to criteria unrelated to a woman's own priorities and aspirations. Nevertheless, as well recognized in feminist theory, respect for human dignity requires more than freedom from the imposition of others. The North American "language of possessive individualism"[209] in the abortion context "fails to recognize the inherently social nature of human beings . . . [that] [w]e come into being in a social context that is literally constitutive of us."[210] An individual cannot but make decisions, even of fundamental personal importance, in a social context and through interaction with others.

Justice Wilson acknowledged the importance of social situatedness with her observation in *Morgentaler* that "[a]n individual is not a totally

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[206] *Id.* at 166.

[207] *Id.* at 167.

[208] *Id.* at 164.

[209] JULIA S. O'CONNOR, ANN SHOLA ORLOFF & SHEILA SHAVER, STATES, MARKETS, FAMILIES: GENDER, LIBERALISM AND SOCIAL POLICY IN AUSTRALIA, CANADA, GREAT BRITAIN AND THE UNITED STATES 52 (1999).

[210] Jennifer Nedelsky, *Reconceiving Autonomy: Sources, Thoughts and Possibilities*, 1 YALE J.L. & FEMINISM 7, 8 (1989).

independent entity disconnected from the society in which he or she lives."[211] For this reason, she explained, a woman's decision to terminate her pregnancy often "reflects the way the woman thinks about herself and her relationship to others and to society at large. It is not just a medical decision; it is a profound social and ethical one as well."[212] In her study, Eileen Fegan describes the "complex and contradictory feelings of indecision and determination, trauma and grief, regret and relief" that has characterized Canadian women's decision making about abortion.[213] Rather than freedom, isolation and the hardship of responsibility define their experience.[214] Women justify decisions to terminate a pregnancy according to social norms, for example, deeming themselves unworthy of motherhood.[215] Fegan notes that "at an ideological (and experiential) level, the construction of women needing permission for abortion effectively outlasted decriminalization in Canada."[216] Rather than freedom, social judgment and shame guide their decision making.

An equality rights analysis derived from a liberty-based conception of dignity—respect for freedom, autonomy, and self-determination through isolation from the influence of others—is thus terribly lacking. It diverts attention away from the social context in which individuals necessarily act. It obscures the ways in which social context can both negatively and positively affect individuals by ascribing meaning to their conduct and the character of those who engage in it. To the extent that laws regulating abortion services express disapproval or condemnation, women who terminate their pregnancies may internalize this view, believing their actions bespeak their low character and thus their unworthiness of motherhood. Laws that integrate abortion services into the public health system, regulating abortion as a health service distinctive to women's needs, support women who terminate their pregnancies by fostering a belief in the importance of their health, their capacity as autonomous decision makers, and most importantly, their dignity and worth. Where the law challenged is one of exclusion rather than intrusion, human dignity is respected not by isolation, but through support and inclusion. In an effort to reorient the equality analysis under section 15(1) in *Jane Doe I*, Part II

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211 *Morgentaler*, [1988] 1 S.C.R. at 164.

212 *Id.* at 171.

213 Eileen V. Fegan, *Subjects' of Regulation/Resistance? Postmodern Feminism and Agency in Abortion-Decision-Making*, 7 FEMINIST LEGAL STUD. 241, 246 (1999).

214 *Id.* at 266.

215 Eileen V. Fegan, *Recovering Women: Intimate Images and Legal Strategy*, 11 SOC. & LEGAL STUD. 155, 177 (2002).

216 *Id.* at 167.

of this Article elaborates a social conception of human dignity rooted in the self-respect and self-worth attained by relationships with others and the recognition of others.

II. THE DIGNITY OF EQUAL COMMUNITY MEMBERSHIP

Under the *Charter*, human dignity encompasses values of personal autonomy, self-determination, psychological integrity, and empowerment, but as confirmed by a unanimous Supreme Court in *Law v. Canada*, human dignity is not confined to these principles.[217] Human dignity also "means that an individual or group feels self-respect and self-worth."[218]

While values of self-respect and self-worth concern how "a person legitimately feels when confronted with a particular law,"[219] they are not purely subjective. Nor do they simply "relate to the status or position of an individual in society *per se*."[220] Rather, the Supreme Court conceives of human dignity as an inherently social or relational quality.[221] It concerns that self-respect and self-worth attained through relationships with others and by the recognition of others. Human dignity is "harmed when individuals and groups are marginalized, ignored, or devalued, and is enhanced when laws recognize the full place of all individuals and groups within Canadian society."[222]

Supreme Court jurisprudence exhibits a clear continuity in understanding equality rights as concerned with the relationship between individuals and groups in Canadian society. In the first *Charter* equality case, *Andrews*, the Supreme Court held that a citizenship restriction on admission to the Law Society of British Columbia violated section 15(1).[223] In defining an approach to equality analysis, Justice McIntyre recommended that section 15(1) be interpreted in light of the history of social inequality wrought by the modernization and diversification of Canadian society.[224] Justice La Forest

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217 Law v. Canada, [1999] 1 S.C.R. 497, 530 (Can.).
218 *Id.*
219 *Id.*
220 *Id.*
221 Donna Greschner similarly notes that equality ought to be described as a "relational concept" rather than a "comparative concept" insofar as it concerns people's relationships with each other. *See* Donna Greschner, *Does Law Advance the Cause of Equality?*, 27 QUEEN'S L.J. 299, 316–17 (2001).
222 *Law v. Canada*, [1999] 1 S.C.R. at 530.
223 Andrews v. Law Soc'y of B.C., [1989] 1 S.C.R. 143, 157 (Can.).
224 *Id.* at 172.

observed that "[o]ur nation has throughout its history drawn strength from the flow of people to our shores."[225] Laws that unfairly exclude persons, he reasoned, are likely to communicate the message

> that Canadian society is not free or democratic as far as they are concerned and . . . such persons are likely not to have faith in social and political institutions which enhance the participation of individuals and groups in society, or to have confidence that they can freely and without obstruction by the state pursue their and their families' hopes and expectations of vocational and personal development.[226]

With the support of the full Supreme Court, Justice McIntyre concluded that the "promotion of equality entails the promotion of a society in which all are secure in the knowledge that they are recognized at law as human beings equally deserving of concern, respect and consideration."[227] A law breaches the equality guarantee when it imposes "burdens, obligations, or disadvantages . . . not imposed upon others, or . . . withholds or limits access to opportunities, benefits, and advantages available to other members of society."[228]

In her dissenting opinion in *Egan v. Canada*,[229] Justice L'Heureux-Dubé characterized the social equality envisioned by the Court in *Andrews* as a recognition of and respect for human dignity. Equality, she concluded, "means that our society cannot tolerate legislative distinctions that treat certain people as second-class citizens, that demean them, that treat as less capable for no good reason, or that otherwise offend fundamental human dignity."[230] A law is discriminatory within the meaning of the equality guarantee to the extent that it promotes or perpetuates the view that an individual "is less capable, or less worthy of recognition or value as . . . a member of Canadian society, equally deserving of concern, respect, and consideration."[231]

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225 *Id.* at 197.

226 *Id.* (citing Kask v. Shimizu, [1986] 4 W.W.R. 154, 161 (Alta. O.B.) (internal quotations omitted)).

227 *Id.* at 171.

228 *Id.* at 174.

229 [1995] 2 S.C.R. 513 (Can.) (A bare majority held that a provision of the Old Age Security Act that confined benefits to opposite sex couples discriminated on the basis of sexual orientation. The legislation was ultimately held constitutional, however, because Justice Sopinka found that the violation under section 15(1) was a reasonable limit under section 1. Justice L'Heureux-Dubé issued an influential dissenting opinion).

230 *Id.* at 543.

231 *Id.* at 552–53.

This formulation was later adopted by a unanimous Supreme Court in *Law v. Canada*. Under section 15(1), human dignity is demeaned when individuals and groups are marginalized, ignored, or devalued as less capable, less deserving, or less worthy of recognition or value in Canadian society. Human dignity is affirmed by the promotion of a society in which individuals and groups are secure in the knowledge of their full and equal membership in Canadian society. In other words, the mark of membership in Canadian society—of belonging—is equal concern, respect, and consideration. Membership in Canadian society thus implies more than the status or position of an individual in society *per se* or the interaction between individuals and groups in a tangle of social relationships. It concerns a "sense of community."

McMillan and Chavis define a "sense of community" as a "feeling that members have of *belonging* . . . and a shared faith that members' needs will be met through their commitment to be together."[232] The term "belonging," as used in a constitutional equality context, is associated with the work of Kenneth Karst and his principle of "equal citizenship" under the U.S. Constitution.[233] Karst's principle of equal citizenship and the Canadian Supreme Court's conception of human dignity share strong similarities. Karst wrote,

> The principle of equal citizenship, as I use the term, means this: Each individual is presumptively entitled to be treated by the organized society as a respected, responsible and participating member. Stated negatively, the principle forbids the organized society to treat an individual as a member of an inferior or dependent caste or as a nonparticipant. The principle thus centers on those aspects of equality that are most closely bound to the sense of self and the sense of inclusion in a community.[234]

He defined the essence of equal citizenship as

> the dignity of full membership in the society . . . the principle not only demands a measure of equality of legal status, but also promotes a greater equality of that other kind of status which is a social fact—namely, one's rank on a scale defined by degrees of deference or

[232] David W. McMillan & David M. Chavis, *Sense of Community: A Definition and Theory*, 14 J. COMM. PSYCH. 6, 9 (1986).

[233] KENNETH KARST, BELONGING TO AMERICA: EQUAL CITIZENSHIP AND THE CONSTITUTION (1989); *see also* Kenneth L. Karst. *The Supreme Court 1976 Term Foreword: Equal Citizenship Under the Fourteenth Amendment*, 91 HARV. L. REV. 1 (1977).

[234] KARST, *supra* note 233, at 3.

> regard. The principle embodies "an ethic of mutual respect and self-esteem."[235]

Karst's articulated principle of "equal citizenship" provides valuable assistance in drawing out the "sense of community" or "belongingness" that anchors the Canadian Supreme Court's conception of human dignity. The principle of equal citizenship akin to the Canadian conception of human dignity concerns values of self-respect and self-worth. Moreover, these values are understood to depend upon the respect and worth afforded by organized society. It is this status—the presumptive entitlement to be treated as a respected, responsible, and participating member—that marks a sense of community. Karst further elaborates that "[t]he indispensable feature of a community is the . . . sense that 'we are all in this together' . . . . Membership in a community implies obligation to other members."[236] The dignity of equal community membership is similarly informed by the Supreme Court's description of the macro-ethical character of Canadian society: the presumptive entitlement to—an obligation of organized society to provide—equal concern, respect and consideration. The equality guarantee is a commitment of equal access to the opportunities, benefits, and advantages of full community membership.[237] This dignity thus embraces not independence, but interdependence. As Karst notes, a sense of community "means not just tolerance of deviance, and not just deference to another's zone of noninterference. It means treatment as 'one of us,' as a member of a national community."[238]

A conception of dignity rooted in equal community membership is valuable precisely because it diverts attention away from an exclusive focus on the individual or group affected by the law. The law itself becomes the focus of attention as a powerful constitutive force of community, defining both membership and exclusion. As described by Donna Greschner, the "language of exclusion signifies something that is being done to a person by outside forces. It is the system or rules that are wrong, not the person. . . . [T]he language of belonging protects individual dignity by stressing the actions of others . . . ."[239] In *Egan*, Justice L'Heureux-Dubé similarly emphasized the

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[235] *See* Karst, *supra* note 233, at 5–6 (internal citations omitted).

[236] KARST, *supra* note 233, at 189, 190.

[237] For this reason, Greschner describes section 15(1) as moving toward a "full membership" model of equality. Donna Greschner, *The Purpose of Canadian Equality Rights*, 6 REV. CONST. STUD. 291, 293 (2002).

[238] KARST, *supra* note 233, at 214.

[239] Donna Greschner, *Does* Law *Advance the Cause of Equality?*, 27 QUEEN'S L.J. 299, 316 (2001).

importance of this perspective by observing that disadvantage "[m]ore often than not . . . arises from the way in which society treats particular individuals, rather than from any characteristic inherent in those individuals."[240] A community membership of equality conceives of the law—the very structure of the community itself—as a "source of the problem . . . rather than as an unproblematic background."[241]

Equality rights thus require courts to scrutinize exclusionary rules of community membership that single out individuals and groups for inferior treatment. Moreover, equality rights require that social institutions be constructed as inclusive, rather than stretched in benevolence, pity, or sympathy to accommodate difference. The *Charter* engages all public actors in the long-term project of interpreting and enforcing equality rights in a commitment to transform Canadian society "in a democratic, participatory, and egalitarian direction."[242] The enormity of this task does not place it outside of the judicial realm. Full equality can be progressively realized. Through a consistent reframing of existing social institutions, including government benefit programs such as public health insurance, a more inclusive standard will emerge.

A conception of dignity framed in community-based terms may seem counter-intuitive in the abortion funding context. Pamela S. Karlan and Daniel R. Ortiz, for example, argue that restrictions on women's access to abortion services are commonly justified precisely by values of community obligation and interdependence.[243] Sidney Callahan, they observe, derives a "woman's moral obligation to carry her pregnancy to term" both from her status as a human being embedded in the interdependent human community and her unique life-giving female reproductive power."[244] Invocations of the term "community" to support both restrictions on abortion and the funding of access to abortion services, however, may signal divergent conceptions of the term.[245] As noted by Jennifer Nedelsky, "[W]omen's experience of relationships as oppressive as well as essential has the virtue of making us less likely to be

[240] Egan v. Canada, [1995] 2 S.C.R. 513, 552 (Can.).
[241] MINOW, *supra* note 188, at 112.
[242] Karl Klare, *Legal Culture and Transformative Constitutionalism*, 14 AFR. J. ON HUM. RTS. 146, 150 (1998).
[243] Pamela S. Karlan & Daniel R. Ortiz, *In a Diffident Voice: Relational Feminism, Abortion Rights, and the Feminist Legal Agenda*, 87 NW. U. L. REV. 858, 881 (1993).
[244] *Id.* at 881–82.
[245] *See* Martha Minow, *Interpreting Rights: An Essay for Robert Cover*, 96 YALE L.J. 1860, 1862 (1987).

romantic about the virtues of community as such,"[246] but this is precisely why "[w]e need concepts that incorporate our experience of embeddedness in relations, both the inherent, underlying reality of such embeddedness and the oppressiveness of its current social forms."[247] Equal community membership is intended to offer one such model by demanding a mutuality of responsibility: Women have obligations to the community, but the community also has obligations to women as full and equal community members. A conception of dignity as *equal* community membership demands that women as community members have a presumptive entitlement to equal respect, concern, and consideration for their physical and psychological integrity, autonomy, and self-determination.

Part III of this Article returns to the equality analysis in *Jane Doe I*, but seeks to evaluate denied funding for clinic services according to the proposed community-membership model of equality. Judge Oliphant based his section 15 analysis on a conception of human dignity rooted in the values of freedom and self-determination. Part III characterizes the Manitoba regulation as violating equality rights on different terms: the law is discriminatory because it perpetuates and promotes the view that women are less worthy of concern, respect, and consideration as full and equal members of Canadian society.

III. THE INDIGNITY OF DENIED FUNDING IN CANADA UNDER A COMMUNITY-MEMBERSHIP MODEL OF EQUALITY

In *Andrews* and *Law v. Canada*, the Supreme Court of Canada affirmed that "[t]o approach the ideal of full equality before and under the law . . . the main consideration must be the *impact* of the law on the individual or the group concerned."[248] Although section 15(1) is an "individual right, asserted by a specific claimant with particular traits and circumstances,"[249] the inquiry into whether a law demeans a claimant's dignity—the absence or presence of a discriminatory impact—is assessed according to a subjective-objective standard.[250] The inquiry is conducted from the perspective of the claimant taking into consideration "the larger context of the legislation in question, and

[246] Nedelsky, *supra* note 210, at 10 n.9.
[247] *Id.*
[248] Andrews v. Law Soc'y of B.C., [1989] 1 S.C.R. 143, 165 (Can.) (emphasis added); Law v. Canada, [1999] 1 S.C.R. 497, 530 (Can.).
[249] *Law v. Canada*, [1999] 1 S.C.R. at 532.
[250] *Id.*

society's past and present treatment of the claimant and of other persons or groups with similar characteristics or circumstances."[251] The discrimination inquiry seeks to contextualize the impugned law to better understand its social meaning. As Denise Réaume observed, "[T]he question of what constitutes a violation of dignity is a normative question, not an empirical one about psychological effects."[252] The application of equality rights requires courts to interpret the message communicated by differential treatment and to assess whether that message is one of exclusion and inferiority. Discrimination under section 15(1) concerns the symbolic or expressive function of law.[253] The discrimination inquiry thus asks whether the law expresses a disapproval of or increases social sanctions against persons or groups. It asks whether the laws conveys the message that such persons and groups are less capable, less worthy, or less deserving of respect, concern, and consideration as members of Canadian society. The harmful impact of a discriminatory law is not limited, however, to its expressive function—the message it communicates about others. If the expressive function of a law is sufficiently powerful, its claims will be internalized and accepted as true by its subjects. A discriminatory law thus does not simply imply the lesser capabilities, worth, or deservedness of others, but also it induces individuals to perceive themselves as such. A discriminatory law affects self-perception—self-worth and self-respect.

A discrimination inquiry according to a subjective-objective standard therefore requires that the larger socio-political-economic context in which a law operates be examined. In *Law v. Canada*, the Supreme Court identified an open list of contextual factors to assist in this inquiry.[254] The following three factors are relevant to an assessment of the law's discriminatory impact in *Jane Doe I*:

(a) Preexisting disadvantage, stereotyping, prejudice, or vulnerability experienced by the individual or group at issue.

(b) The correspondence, or lack thereof, between the ground on which the claim is based and the actual need, capacity, or circumstances of the individual or group at issue.

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[251] *Id*. at 532–33.

[252] Réaume, *supra* note 196, at 684.

[253] *See* Cass R. Sunstein, *On the Expressive Function of Law*, 144 U. PA. L. REV. 2021, 2024 (1996) ("the expressive function of law—the function of law in 'making statements' [in connection with efforts to change norms] as opposed to controlling behavior directly").

[254] *Law v. Canada,* [1999] 1 S.C.R at 501–02.

(c) The nature and scope of the interest affected by the impugned law.

Guided by these contextual factors, the following analysis demonstrates that the denial of public funding for clinic abortion services demeans women's dignity as full and equal members in Canadian society.

A. Preexisting Disadvantage and Prejudice Against Women who Terminate Their Pregnancies

Preexisting disadvantage and prejudice against the affected individual or group favors a conclusion of discrimination.[255] In *Gosselin*, Justice McLachlin explained that

> [h]istoric patterns of discrimination . . . often indicate the presence of stereotypical or prejudicial views that have marginalized [the group's] members . . . . This, in turn, raises the strong possibility that current differential treatment of the group may be motivated by or may perpetuate the same discriminatory views.[256]

A law may have a discriminatory impact even if not expressly motivated by contempt for the affected individuals or groups. Legal distinctions are often mapped reflexively onto social constructions of difference historically used for discriminatory purposes. As Justice Wilson noted in *Andrews*, "[T]he interest of the excluded is always in danger of being overlooked."[257] Preexisting disadvantage and prejudice can indicate a longstanding failure of the legal system to extend equal respect, concern, and consideration which the impugned law by virtue of its same distinction perpetuates.

Preexisting disadvantage and entrenched prejudice are particularly important indicia of discrimination in the health care context. In *Eldridge*, the Supreme Court held that state failure to fund sign language interpretation for deaf persons violated section 15(1). In demonstrating the discriminatory impact of the law, Justice La Forest characterized the history of disabled persons in Canada as "largely one of exclusion and marginalization . . . [and] denied access to opportunities for social interaction and advancement."[258] He concluded that "disabled persons have not generally been afforded the 'equal

[255] *Id.* at 534.
[256] Gosselin v. Quebec (Attorney General), [2002] 4 S.C.R. 429, 467 (Can.).
[257] Andrews v. Law Soc'y of B.C., [1989] 1 S.C.R. 143, 152 (Can.) (Wilson, J.) (citing JOHN STUART MILL, CONSIDERATIONS ON REPRESENTATIVE GOVERNMENT (1861)) (internal quotation marks omitted)).
[258] Eldridge v. British Columbia (Attorney General), [1997] 3 S.C.R. 624, 668 (Can.).

concern, respect and consideration' that [section] 15(1) of the *Charter* demands. Instead, they have been subjected to paternalistic attitudes of pity and charity."[259] In *Cameron,* Justice Chipman held that denied public funding for fertility treatments was discriminatory after acknowledging the "ancient social stigma" of infertility as "an unworthy state, the object of derision, banishment and disgrace."[260] The infertile, he observed, "have been and see[] themselves portrayed as, having undesirable traits or lacking those traits which are regarded as worthy."[261]

Women who terminate their pregnancies, and those who provide abortion services, have long been condemned under religiously guided moral codes. In the nineteenth century, the moral prohibition against abortion became enforceable under Canadian law. First adopted into the common law, abortion was later criminalized under The Offences Against the Person Act[262] and eventually incorporated into the Canadian Criminal Code of 1892.[263] Criminal law is the classic institution of social condemnation, intended to express disapprobation of the restricted conduct and of those who engage in it.

While morally motivated, the nineteenth century Canadian criminalization of abortion also served the ends of a highly racialized natalist policy. Louise Falconer associates the criminal restrictions on abortion with the rhetoric of "populate or perish" then resonating throughout the British Empire.[264] She explains that as Canada's birth rate began to decline at the end of the nineteenth century, female reproduction became a matter of national obsession.[265] Abortion restrictions condemned white married women who terminated their pregnancies not only for lack of morals, but for depriving fathers of their sons and countries of their soldiers. These women were perceived as neglecting their maternal duties to both husband and state. Women's sense of belonging in Canadian society—their respect and worth—was intimately tied to their reproductive capacity.

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[259] *Id.*

[260] Cameron v. Nova Scotia, [1999] 177 D.L.R. (4th) 611, 657 (N.S. C.A.).

[261] *Id.* at 659.

[262] 1869 (Can.) c. 20. The act was modeled on the British statute of the same name, Offences Against the Person Act, 1861 (U.K.) c. 100 s. 58.

[263] 1892, 55–56 Victoria, c. 29, ss. 272–73.

[264] Louise Falconer, *The Mother Country and Her Colonial Progeny*, 7 L. TEXT CULTURE 149, 150 (2003).

[265] *Id.* at 149. Across Canada, birth rates fell by twenty-four percent between 1871 and 1901. A. MCLAREN & A. MCLAREN, THE BEDROOM AND THE STATE: THE CHANGING PRACTICES OF CONTRACEPTION AND ABORTION IN CANADA 1880–1997, at 9, 18 (1997).

In 1969, an amendment to the Criminal Code created the therapeutic abortion committee regime, subsequently held unconstitutional in *Morgentaler*.[266] Prior to this amendment, statutory law did not formally express permissible grounds for the lawful termination of pregnancy. Courts did, however, recognize a common law defense of necessity: An abortion was lawful when performed in good faith to preserve a pregnant woman's life or physical or mental health.[267] Rather than expanding permissible grounds for a legal abortion, the 1969 *Criminal Code* amendment enabled the legality of an abortion to "be established beforehand, by certification of a therapeutic abortion committee."[268] In *Morgentaler*, Justice Beetz explained that the 1969 amendment was intended "to make therapeutic abortions lawful and available *but also to ensure that the excuse of therapy will not be abused*."[269] The committee regime ensured that only women "deserving" of an exemption from criminal law were granted access to abortion services. Women were not afforded equal concern, respect, and consideration. They were subjected to paternalistic attitudes of pity and charity. Undeserved use—so-called abuse of abortion—remained legally and socially condemned.

From the nineteenth century, private clinics were strongly implicated in this feared abuse. Despite criminal prohibitions, clandestine abortions were widely performed but not without significant costs.[270] Many women sought services from outside the trained profession and avoided medical care even when complications ensued. For women with financial resources, private maternity hospitals or "lying-in homes"—"believed to be (not unjustly in some instances) rudimentary abortion clinics"—offered safer alternatives.[271] The activities of these institutions were well known in the late 1890s,[272] and provincial health legislation sought to regulate the activities of maternity

[266] Criminal Code, R.S.C. 1970, ch. C-34, s. 251.

[267] Bernard M. Dickens, *Legal Aspects of Abortion*, *in* ABORTION: READINGS AND RESEARCH 16, 17 (Paul Sachdev ed., 1981).

[268] *Id.* at 18.

[269] R v. Morgentaler, [1988] 1 S.C.R. 30, 88 (Can.) (emphasis added).

[270] MCLAREN & MCLAREN, *supra* note 265, at 32–53.

[271] Falconer, *supra* note 264, at 151.

[272] *Id.* at 169. In *Of Toronto the Good*, C.S. Clark wrote that "[t]he many lying-in hospitals and institutions for the reception of illegitimate children tell but a portion of the story, and it is probable that the immorality that produced such results, widespread though it may be, is remarkably limited in comparison with that which escapes detection." C.S. CLARK, OF TORONTO THE GOOD: A SOCIAL STUDY; THE QUEEN CITY OF CANADA AS IT IS 96 (1898).

homes.[273] Statutes required proprietors to "ascertain and record the 'antecedents of women coming under their care' and to furnish that information as required."[274] As Louise Falconer observed, "The excessive regulation of individual women, rather than just the institutions housing them, is indicative of a broader agenda not inconsistent with either the moral reform or pro-natalist movements."[275] Under the 1969 *Criminal Code* amendment, the performance of abortions in settings other than "accredited" or "approved" hospitals remained prohibited.[276] Moreover, provincial ministers of health were under no obligation to grant approval to any hospital.[277] Private institutions attracted heightened scrutiny throughout the history of criminalized abortion as the location of clandestine services for undeserving and immoral women. The legal exclusion of clinic services from public health insurance continues to treat clinic abortions as a "moral hazard" in this double sense—the danger that funding clinic abortions will encourage abuse and the poor character of those who seek the service.[278]

Case law respecting similar provincial restrictions on clinic abortion services supports this interpretation. In 1993, in *R. v. Morgentaler*,[279] the Supreme Court of Canada struck down a Nova Scotia act and regulation that together prohibited abortions outside of hospitals and denied public funding for abortions performed in violation of the law.[280] The Court held that the prohibition was an indivisible attempt by the province to legislate in the area of criminal law, a federal jurisdiction. The primary objective of the law, the Court explained, was "to prohibit abortions outside hospitals as socially undesirable conduct."[281] The law regulated "the place where an abortion may be obtained, not from the viewpoint of health care policy, but from the

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[273] Ontario was the first province to pass legislation specifically regulating the maternity homes. Maternity Boarding Houses Act 1897 (Ont.). Manitoba followed suit with a similar statute. Maternity Act 1899 (Man.).

[274] Falconer, *supra* note 264, at 172.

[275] *Id.*

[276] Criminal Code, R.S.C. 1970, ch. C-34, § 251(4) [repealed].

[277] R v. Morgentaler, [1988] 1 S.C.R. 30, 66 (Can.).

[278] Hazel Glenn Beh explains that for nineteenth-century insurers, "moral hazard" represented an unwholesome mix of bad character and temptation which the insurers had a responsibility to ferret out from the insurance enterprise. Older policies excluding venereal diseases demonstrate the bad character aspect of the "moral hazard" in health care insurance. Hazel Glenn Beh, *Sex, Sexual Pleasure and Reproduction: Health Insurers Don't Want You to Do Those Nasty Things*, 13 WIS. WOMEN'S L.J. 119, 127 n.42 (1998).

[279] [1993] 3 S.C.R. 463 (Can.).

[280] Section 91 the Constitution Act reserves legislative authority over the criminal law to the federal government.

[281] *Morgentaler*, [1993] 3 S.C.R. at 513.

viewpoint of public wrongs or crimes."[282] In *Lexogest I*, the first case to address the exclusion of clinic abortion services from Manitoba's health insurance plan, the Court of Appeal declared the impugned health regulation *ultra vires*.[283] A majority of the Court held that the Commission which enacted the regulation was not statutorily authorized to impose limitations or conditions on excluded medical services. Justice Huband also addressed the context of the regulation's enactment and its ultimate effect:

> I would be closing my eyes to the reality that exists outside the four corners of the court-room if I failed to note that the challenged regulation was passed immediately following the Supreme Court decision in *R. v. Morgentaler*. The effect of the regulation is to provide insurance coverage only for the patient who chooses to have her therapeutic abortion performed in a hospital, as the situation existed prior to the *Morgentaler* decision.[284]

Given that for many women the denial of public funding is equivalent to a denial of service, Justice Huband recognized that the law in effect restricted women's access to abortions performed in accredited or approved hospitals. Through exclusion from public funding, access to abortion services in the province of Manitoba was effectively returned to a pre-*Morgentaler* state of suspicion, supervision, and restriction.

For almost one hundred and fifty years, Canadian women who terminated their pregnancies were not simply the objects of derision, banishment, and disgrace. They were a criminal class. These women were perceived as a threat to morality, the family, the community, and the nation. Private clinics to which women turned for care and support were viewed as dens of vice and became a preoccupation of law enforcement. This pattern of prejudice and disadvantage raises a strong presumption that the differential treatment of clinic abortion services under the impugned law in *Jane Doe I* is motivated by the same historic contempt for women who terminate their pregnancies. By denying women access to public health insurance, the Manitoba regulation perpetuates, whether by intention or not, a longstanding failure of the legal system to extend equal respect, concern, and consideration to this group of women. While criminal law may have been the mechanism of social disavowal in the past, in the modern welfare state, public disapproval is most

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[282] *Id.*

[283] [1993] 101 D.L.R. (4th) 523, 562 (Man. C.A.).

[284] Lexogest Inc. v. Manitoba (Attorney General) (*Lexogest I*), [1993] 101 D.L.R. (4th) 523, 561 (Man. C.A.).

effectively expressed through institutional exclusion and the denial of resources.

B. The Lack of Correspondence Between the Exclusion of Clinic Abortions as an Insured Service and the Reproductive and Sexual Health Needs of Women

Legal distinctions do not necessarily constitute discrimination under section 15(1).[285] Rather, differential treatment can both exacerbate and mitigate inequality. A discriminatory impact is therefore only ascertainable by reference to the purpose and effect of differential treatment. Human dignity is demeaned, for example, by legal distinctions which impose burdens or withhold benefits in a manner that "reflects the stereotypical application of presumed group or personal characteristics." [286] Stereotypes are defined as "personal traits or circumstances which do not relate to individual needs, capacities, or merits."[287] The opposite is also true. Human dignity is enhanced by distinctions at law that reflect sensitivity "to the needs, capacities, and merits of different individuals, taking into account the context underlying their differences"[288] A law will thus likely be found discriminatory if the distinctions it creates reflect stereotypes or otherwise fail to correspond to the needs, capacities, and merits of affected individuals and groups. It is difficult after all to demonstrate equal respect, concern, and consideration through neglect of individuals' needs, capacities, and merits.

Lack of correspondence between the law and the needs of affected individuals and groups has proven a particularly important factor in the health care context. In *Eldridge*, the Supreme Court reasoned that in hospital settings where deaf persons cannot effectively communicate without an interpreter, the denial of public funding for sign language services neglects the needs of deaf patients, and thus denies them the same level of medical care as hearing persons. The Court held that a failure to ensure deaf persons' equal participation in health care decision making violated section 15(1). In *Cameron*, Justice Chipman drew attention to the fact that the impugned health insurance scheme "denies to the infertile a major component of the array of services available to ameliorate their condition. They are . . . denied a

[285] Andrews v. Law Soc'y of B.C., [1989] 1 S.C.R. 143, 152, 168 (Can.).

[286] Law v. Canada, [1999] 1 S.C.R. 497, 529 (Can.); *see also Andrews*, [1989] 1 S.C.R. at 174–75.

[287] *Law v. Canada*, [1999] 1 S.C.R. at 530.

[288] *Id.*

treatment which 'may be the most significant for them.'"[289] A public health system that selectively denies funding for medical treatment identified by affected individuals as most significant for them—such as infertility treatment for infertile persons—sends a powerful message that their health care needs, and by extension their improved health, is comparatively less important.

The Manitoba government sought to refute a similar understanding of the challenged law in *Jane Doe I* by focusing directly on the question of health care needs. Clinic abortion services, it claimed, were not "medically necessary."[290] The exclusion of a medically unnecessary service from the public health insurance plan was a rational and fiscally responsible decision undertaken to ensure the sustainability of the health system. The characterization of such exclusions as discriminatory and thus unconstitutional, the government argued, "jeopardizes the province's responsibility to determine the most effective and efficient way to deliver health care."[291] Denied public funding for clinic abortion services reflected nothing more than a concern for the effective and efficient delivery of care.

The term "medically necessary," which anchors the government's position, is defined in neither the Canada Health Act,[292] which introduced the phrase as the standard of comprehensive provincial health insurance, or the Manitoba Health Services Insurance Act. In most provinces, decisions to insure services under the public health system are undertaken by closed negotiation between the ministry of health and the provincial medical association without reference to any substantive definition of the term.[293] Medical necessity thus functions

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[289] Cameron v. Nova Scotia, [1999] 177 D.L.R. (4th) 611, 661 (N.S. C.A.).

[290] Press Release, Gov't of Manitoba, Manitoba Defends Right to Set Health Care Priorities (Jan. 27, 2005), http://www.gov.mb.ca/chc/press/top/2005/01/2005-01-27-01.html ("The effect of this decision . . . suggests that everyone is constitutionally entitled to a health care service based upon the time of their choosing without regard to medical necessity").

[291] *Id.*

[292] R.S.C. 1985, ch. C-6 (Can.). The Canada Health Act requires that provincial health insurance plans insure all hospital and physician services in order for provinces to receive federal cash contributions toward their plans (s. 9). The Act defines hospital services as those services "provided . . . at a hospital, if the services are *medically necessary* for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability." (s. 2) (emphasis added). Physician services are defined as "any *medically required* service rendered by medical practitioners." (s. 2) (emphasis added). The Act does not define medical necessity or medical requirement.

[293] Colleen Flood, Marc C. Stabile & Carolyn Tuohy, *What's In and Out of Medicare? Who Decides?*, *in* JUST MEDICARE: WHAT'S IN, WHAT'S OUT, HOW WE DECIDE, *supra* note 31, at 15, 17; *see also* CANADIAN BAR ASS'N TASK FORCE ON HEALTH CARE REFORM, WHAT'S LAW GOT TO DO WITH IT?: HEALTH CARE REFORM IN CANADA 37 (1994) ("A non-exhaustive review of provincial legislation reveals that provinces simply classify services as "medically required" by regulation, without reference to any substantive or policy-

as an ex post label applied to all noninsured services, rather than an ex ante principled rationale for the exclusion of the service. Without definition and resulting from political negotiation, the designation of a service as not medically necessary carries many interpretations about the service, the needs it serves, and the persons who posses such needs.

A service may be deemed medically unnecessary because it is not safe or efficacious. In the case of clinic abortions, however, neither concern applies. In *Morgentaler*, for example, Justice Beetz confirmed that "no medical justification" required all therapeutic abortions to be performed in hospitals.[294] On the contrary, according to expert testimony, "many first trimester abortions may be safely performed in specialized clinics outside of hospitals . . . possible complications can be handled, and in some cases better handled, by the facilities of a specialized clinic."[295] Clinic services are now widely perceived to offer more comprehensive, supportive, and better quality care than hospitals. As in the case of Jane Doe 1 and Jane Doe 2, many Canadian women are referred to clinic services by hospitals and other health providers. Denied funding for clinic abortions services may thus impedes women's access not only to the service of their choice, but also the service to which many women are referred in the course of seeking insured hospital services.[296]

When a service is both safe and effective, its designation as not medically necessary may suggest that it serves neither a legitimate nor important medical need.[297] Clinic abortion services are often construed as serving mere convenience rather than genuine medical need.[298] The funding of mere conveniences, it may be argued, would impose an unreasonable financial burden on a public health system. Both private and public insurers have long resisted coverage for sexual and reproductive health services for fear that coverage will result in abuse of services and excessive claims.[299] According to

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based definition of that term . . . . While this procedure is flexible, it is arguably susceptible to political and economic winds, as it does not seem to be grounded in any principled definition.").

[294] R v. Morgentaler, [1988] 1 S.C.R. 30, 115 (Can.).

[295] *Id.*

[296] *See* Cameron v. Nova Scotia, [1999] 177 D.L.R. (4th) 611, 650–51 (N.S. C.A.) ("If the decision to deny coverage for a service turned solely on safety or lack or effectiveness, the case would be different. Here, however, we are dealing with what was described by the experts as the treatment of choice, a treatment to which the appellants were referred by their physicians in the course of providing them with insured services.").

[297] Giacomini et al., *supra* note 44, at 1493.

[298] Clinic abortions, for example, are excluded under the Manitoba regulation along with tattoo removal, vasectomy reversal, and weight loss programs—services that generate wide public agreement as to their questionable medical necessity.

[299] *See* Beh, *supra* note 278, at 119.

Hazel Glenn Beh, insurers view coverage of sexual health services as a moral hazard to be avoided "[b]ecause sexual activity is viewed as largely voluntary, negative, and controllable conduct."[300] The Manitoba regulation challenged in *Jane Doe I* reflects this longstanding tradition insofar as it is premised on the belief that, with funded access, women will irrationally forgo forms of contraception and excessively use clinic services. Unlike in the pre-*Morgentaler* era, there is no committee to ensure that lawful and available abortions will not be abused.

The feared moral hazard of insuring clinic abortion services derives from stereotypical assumptions about women's capacity to responsibly engage in sexual intercourse and to independently manage their reproductive health needs. Evidence-based research strongly refutes these assumptions: "Women undergoing repeat abortions are more likely than those undergoing a first abortion to report using a method of contraception at the time of conception . . . . There is little evidence to suggest that women seeking repeat abortion are using pregnancy termination as a method of birth control."[301] As Denise Réaume so aptly observed, denied access to benefits on the basis of a false view that certain attributes renders one less worthy of those benefits "can scarcely fail to be experienced as demeaning."[302] Moreover, many health needs may be conceptualized as resulting from voluntary and controllable conduct. Women often choose to become pregnant and carry their pregnancy to term. In his dissenting opinion in *Beal v. Doe*,[303] Justice Brennan of the United States Supreme Court noted that "[a]bortion and childbirth, when stripped of the sensitive moral arguments surrounding the abortion controversy, are simply two alternative medical methods of dealing with pregnancy."[304] Nevertheless, unlike abortion, all provincial public health plans insure prenatal, maternity, and neonatal intensive care without condition as to where care is provided and despite their significantly greater cost as compared to clinic abortions. Childbirth related services are not considered an unreasonable burden on the public health system. To the contrary, pregnancy

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[300] *Id.* at 126.

[301] William A. Fisher et al., *Characteristics of Women Undergoing Repeat Induced Abortion*, 172 CAN. MED. ASS'N J. 637, 637 (2005).

[302] Réaume, *supra* note 196, at 682.

[303] 432 U.S. 438, 448 (1977) (Brennan, J., dissenting). In this case, a majority of the Supreme Court held that Pennsylvania's Medicaid plan, which denied financial assistance for nontherapeutic abortions, did not violate Title XIX of the Social Security Act or the Equal Protection Clause of the Fourteenth Amendment. *Id.* at 438.

[304] *Id.* at 449 (Brennan, J., dissenting) (internal quotation marks omitted).

is regarded by the Supreme Court of Canada as "not only the hope of future generations but also the continuation of the species. It is difficult to imagine a human condition that is more important to society."[305] It is held to bespeak the obvious "[t]hat those who bear children and benefit society as a whole thereby should not be economically or socially disadvantaged . . . . [I]t is unfair to impose all of the costs of pregnancy upon one half of the population."[306]

The inconsistent treatment of childbirth and abortion reflects an unequivocal preference for continued pregnancy over its termination and for women who continue their pregnancy over those who terminate it. This preference derives from the "powerful ideology of motherhood—the belief that motherhood is the natural, desired and ultimate goal of all 'normal' women."[307] Many women do experience pregnancy as a distinctive joy, but for many others, pregnancy is a major health burden.[308] Unfortunately, the regulation of sexual and reproductive health has been historically characterized by the disregard for individual women's interests and a fidelity to stereotype as truth.[309] A public health insurance plan premised on the gendered norm of motherhood significantly disadvantages women who sit outside the norm.

A biased and partial conception of women's health needs also distorts cost-benefit rationing analyses to the disadvantage of women. Fiscally responsible decisions to list a service as an insured benefit arguably depend not only on whether the treated condition is legitimate, but also whether the benefits of the service are sufficiently important to justify public expenditure.[310] To the extent that conceived benefits of a service are premised on a partial understanding of the health needs served, the costs of a service may appear

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305 Dobson (Litigation Guardian of) v. Dobson, [1999] 2 S.C.R. 753, 769 (Can.). In this case, a majority of the Supreme Court refused to impose a legal duty of care upon a pregnant woman toward her fetus when the fetus is later born alive. The Court thus held that a mother cannot be held liable in tort for damages to her child arising from a prenatal negligent act which caused injury to her fetus.

306 Brooks v. Canada Safeway Ltd., [1989] 1 S.C.R. 1243 (Can.).

307 Michelle Stanworth, *The Deconstruction of Motherhood*, *in* REPRODUCTIVE TECHNOLOGIES: GENDER, MOTHERHOOD AND MEDICINE 10, 15 (Michelle Stanworth ed., 1987).

308 REBECCA COOK, BERNARD DICKENS & MAHMOUD FATHALLA, REPRODUCTIVE HEALTH AND HUMAN RIGHTS: INTEGRATING MEDICINE, ETHICS AND LAW 15 (2003).

309 *See* Reva B. Siegel, *Abortion as a Sex Equality Right: Its Basis in Feminist Theory*, *in* MOTHERS IN LAW: FEMINIST THEORY AND THE REGULATION OF MOTHERHOOD 43 (1995).

310 Recall that under the Health Services Insurance Act, even "medically required" services could be excluded as an insured benefit if "excepted by the regulations." *See supra* note 164 and accompanying text. The claimed purpose of the Manitoba regulation, however, is to strengthen the publicly funded health care system through effective and efficient delivery of care. In order for an exclusion of a service to be consistent with the claimed purpose and scheme of the impugned law, it must be justifiable according to some efficiency (cost-benefit) analysis.

unduly high. An assessment of the salient benefits of in vitro fertilization (IVF) provides an example. In their recent study, Mita Giacomini and her co-authors observed that IVF is often only assessed as a treatment to produce pregnancies.[311] This perspective disregards the alternative benefits that IVF can provide as a diagnostic technology even when it fails to produce a pregnancy. IVF may offer "unique insight into the couple's reproductive function . . . . This additional diagnostic information and emotional closure can potentially benefit the woman's physical health by obviating further infertility interventions."[312] A fuller understanding of the benefits of reproductive health services was similarly evidenced in *Cameron*, in which Justice Chipman rejected the argument that medically necessary services require so-called "medical ends."[313] He reasoned that "[t]he goal of medical treatment is surely not so narrowly defined."[314] Rather, a range of ends or outcomes may be appropriately associated with genuine medical need given that "the end of all medical treatment is to improve the quality of life."[315] He thus concluded that a distinction between medical and other immediate ends is a "distinction without much, if any, difference."[316]

A narrow conception of abortion as terminating the unwanted physical state of pregnancy, similar to a narrow conception of IVF and other fertility treatments, undervalues the full benefits of the service.[317] According to an internationally endorsed definition, "[R]eproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes."[318] The burdens of pregnancy, postpartum recovery, nursing, and the care of dependent children can significantly diminish opportunities necessary for women to maintain and promote their physical,

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[311] Giacomini et al., *supra* note 44, at 1492.

[312] *Id.*

[313] Cameron v. Nova Scotia, [1999] 177 D.L.R. (4th) 611, 634 (N.S. C.A.).

[314] *Id.* at 634.

[315] *Id.*

[316] *Id.*

[317] This is not to suggest that the physical consequences of pregnancy alone are not serious. Pregnancy carries physical pain and additional risks during labor, postnatal physical disability, and additional physical disability during pregnancy, when many women find it necessary to sleep as much as fifteen hours a day and/or vomit daily for months on end, and others are confined to bed or hospital for weeks or months because of toxemia (which can be fatal), premature labor, or other complications. Pregnancy also entails discomforts such as varicose veins, hemorrhoids, rectal bleeding, fainting, and excessive swelling. Rebecca J. Cook & Bernard M. Dickens, *The Injustice of Unsafe Motherhood*, 2 DEVELOPING WORLD BIOETHICS 64, 67 (2002).

[318] Fourth World Conference on Women, Beijing, China, Sept. 4–15, 1995, Platform for Action and Beijing Declaration, para. 94.

emotional, economic, and social well-being. The decision to terminate a pregnancy is typically motivated by diverse and interrelated considerations respecting these different forms of well-being.

A woman may be motivated to seek an abortion because of her emotional unpreparedness to assume or resume motherhood responsibilities or her existing obligations to care for dependants. Women who seek repeat abortions are more likely to report physical abuse by a male partner or a history of sexual violence. Fear for her own safety, and that of a newborn child, may lead a woman to terminate her pregnancy.[319] The associated costs of continued pregnancy or childbirth may undermine a woman's attempts to become economically stable and may prevent her from providing adequate nutrition, housing, clothing, and sanitation for herself, existing family members, and a newborn child. While negative outcomes of adolescent childbearing cannot be generalized,[320] evidence indicates that, as compared to women who delay childbearing, adolescent mothers are less likely to complete high school and more likely to experience single parenthood and high levels of poverty.[321] The full physical, psychological, and social benefits of preventing and controlling the timing of pregnancy are recognizable only when assessed from the many perspectives of differently situated women.

Moreover, the denial of public funding for a service distinctive to women's health needs demonstrates a disregard for the poor economic and social conditions under which many Canadian women live. In 2003, more than 1.5 million Canadian women lived in poverty.[322] Women also represent a disproportionate share of the population in Canada with low incomes.[323] This class of poor and low income women is itself disproportionately composed of lone-parent mothers, women with disabilities, and aboriginal/First Nations, visible minority, and immigrant women.[324] Exclusion of clinic abortion services from the Manitoba Health Insurance Plan thus forces not simply women, but women already facing multiple and compounding forms of

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[319] *See* Fisher et al., *supra* note 301, at 638.

[320] Mary Bissell, *Socio-economic Outcomes of Teen Pregnancy and Parenthood: A Review of the Literature*, 9 CAN. J. HUM. SEXUALITY 191, 202 (2000).

[321] *Id.*

[322] MONICA TOWNSON, POVERTY ISSUES FOR CANADIAN WOMEN: BACKGROUND PAPER 3 (2005), http://www.swc-cfc.gc.ca/resources/consultations/ges09-2005/poverty_e.pdf.

[323] In 2003, 1.9 million females, 12% of the total female population, lived in an after-tax low-income situation. STATISTICS CAN., WOMEN IN CANADA: A GENDER-BASED STATISTICAL REPORT 143 (5th ed. 2006), http://www.statcan.ca/english/freepub/89-503-XIE/0010589-503-XIE.pdf.

[324] TOWNSON, *supra* note 322, at 3–4.

discrimination and disadvantage, to return to overburdened hospital providers or delay receiving care until they can obtain required funds.

Exclusion of clinic abortion services under the Manitoba Health Insurance Plan based on gender stereotype and a partial assessment of their benefits reflects a lack of concern for women's distinctive health needs and circumstances. In *Auton*, the Supreme Court held that "[if] a benefit program excludes a particular group in a way that undercuts the overall purpose of the program, then it is likely to be discriminatory."[325] To the extent that the stated purpose of the Manitoba regulation is to strengthen the health care system through effective and efficient public funding, the exclusion of clinic abortion services on the basis of a partial or biased assessment of their benefits, and of the needs and circumstances of women may lead to an inaccurate efficiency assessment, and thereby undermine rather than promote the legislative object. To the extent that the purpose of the Manitoba Health Services Insurance Plan is to protect, promote, and restore the health of provincial residents without financial barriers, the exclusion of clinic services defeats this objective. As Judge Oliphant noted in *Jane Doe I*, "[T]here is no reason or logic behind the impugned legislation which prevents women from having access to therapeutic abortions in a timely way."[326] The selective exclusion of women's reproductive health services, without reason or logic, sends a powerful message that the health of women is less important than the health of others; that women are not equally deserving of public support and expenditure.

C. *The Nature and Scope of the Interest Affected by the Exclusion of Clinic Abortion as an Insured Service Under a* "*Universally Accessible, Publicly Funded Health System*"

The nature and scope of the interest affected by the challenged law is an important consideration in the discrimination inquiry. Differential treatment that "restricts access to a fundamental social institution, or affects 'a basic aspect of full membership in Canadian society'" communicates by definition a message of exclusion and inferiority.[327] As Denise Réaume observed, "[T]here are some benefits or opportunities, some institutions or enterprises, which are

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[325] Auton v. British Columbia (Att'y Gen), [2004] 3 S.C.R. 657, 681 (Can.).

[326] Jane Doe 1 v. Manitoba *(Jane Doe I)*, [2004] 248 D.L.R. (4th) 547, 563 (Man. Q.B.).

[327] Law v. Canada, [1999] 1 S.C.R. 497, 540 (Can.) (citing Justice L'Heureux-Dubé J. in Egan v. Canada, [1995] 2 S.C.R. 513, 556 (Can.)).

so important that denying participation in them implies the lesser worth of those excluded."[328]

The discriminatory caliber of a law that excludes a service from public health insurance is not fully captured in the individual economic or health consequences of denied funding. Attention must be paid to the more intangible and invidious societal level harms that flow from the exclusion.[329] The indignity of the law resides in the broader message conveyed by denied participation in a fundamental social institution, Canada's universally accessible, publicly funded health system—a claimed right of citizenship.

In Canada, Medicare refers to a national health care system composed of provincially administered health insurance plans jointly funded by the provincial and federal governments. The Manitoba Health Services Insurance Plan is one part of this larger institution. Medicare was created to ensure universal, comprehensive, and accessible health care for all Canadians.

In 1947, Saskatchewan adopted Canada's first universal health insurance plan, which "provided for an almost complete range of hospital services as benefits."[330] Other provinces soon followed, and in 1957, the federal government complemented provincial plans with a national insurance program for hospital services.[331] Under the Hospital Insurance and Diagnostic Services Act,[332] the federal government partially financed all provincial insurance plans that provided universal coverage for hospital services.[333] In 1966, under the Medical Care Act,[334] this cost-sharing program was extended to include physician care as recommended by the Royal Commission on Health Services (1964).[335] Medicare was thus born. A desire to extend the benefits of medical technology to the Canadian community as a whole motivated the Commission's recommendation for a comprehensive program:

> The field of health care services illustrates, perhaps better than any other, a paradox of our age, which is, of course, the enormous gap

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328 Réaume, *supra* note 196, at 688.

329 See *Egan*, [1995] 2 S.C.R. at 557 ("To summarize, tangible economic consequences are but one manifestation of the more intangible and invidious harms flowing from discrimination, which the *Charter* seeks to root out.").

330 *Id.* at 102.

331 *See* Stephen J. Kunitz, *Socialism and Social Insurance in the United States and Canada*, *in* CANADIAN HEALTH CARE AND THE STATE: A CENTURY OF EVOLUTION 104, 115 (1992).

332 R.S.C. 1957, ch. 28.

333 § 5(2)(a).

334 S.C. 1966 , c. 64.

335 1 REPORT OF THE ROYAL COMMISSION ON HEALTH SERVICES 83–84 (1964).

> between our scientific knowledge and skills on the one hand, and our organizational and financial arrangements to apply them to the needs of men, on the other . . . . What the Commission recommends is that in Canada this gap be closed. That as a nation we now take the necessary legislative, organizational and financial decisions to make all the fruits of the health sciences available to all our residents without hindrance of any kind.[336]

Medicare was thus premised from its conception on a presumptive entitlement of equal access to the benefits of scientific knowledge and skill—a national commitment to meet the health needs of community members without discrimination.

In the 1970s, extra billing and user charges led to a public outcry and a second Royal Commission on Health Services. In its 1980 report, the Commission concluded that private payment requirements impeded access to comprehensive and universal health care, and thus undermined the intent and purpose of Medicare.[337] In an effort to revive Medicare, the federal government adopted the Canada Health Act.[338] The Act states that the "primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."[339] It establishes criteria and conditions that provincial health insurance plans must satisfy in order for provinces to qualify for the full federal cash contribution.[340] Pursuant to the Act, publicly administered health insurance plans must ensure that all "medically required" services rendered by a medical practitioner are universally accessible to all Canadian citizens without income barriers across the provinces.

The Canada Health Act reaffirmed a commitment to the principles of interdependence, collective responsibility, and shared risk:

> [A] civilized and wealthy nation, such as ours, should not make the sick bear the financial burden of health care . . . . The misfortune of

[336] *Id.*

[337] SPECIAL COMM'R TO REVIEW THE STATE OF HEALTH SERVS. IN CAN., CANADA'S NATIONAL-PROVINCIAL HEALTH REFORM PROGRAM FOR THE 1980'S: A COMMITMENT FOR RENEWAL, 1980, at 27, 42 (1979).

[338] R.S.C 1985, ch. C-6.

[339] Canada Health Act, R.S.C 1985, ch. C-6, § 3.

[340] § 4. The criteria are public administration, comprehensiveness, universality, portability, and accessibility. § 7.

> illness which at some time touches each one of us is burden enough: the costs of care should be borne by society as a whole.[341]

As further articulated by Robert Evans, under the Canadian health care system,

> [i]llness [is treated] as primarily the result of natural or social malevolence rather than personal default . . . in this domain, the individual is not responsible for his own misfortunes . . . . We are all equal when faced with disease or death, and our institutions reflect that sense of equality.[342]

Medicare—founded on principles of equity, fairness and solidarity—is thus a quintessential symbol of community. It reflects a shared faith that the needs of individuals will be met through collective commitment and mutual obligation. It exhibits an equal concern for the health and well-being of all members of Canadian society. In this sense, although Medicare is neither a legal obligation of government nor a legal right of citizens,[343] it is a fundamental social institution. Canadians have come to embrace it as "a national symbol and a defining aspect of their citizenship."[344] For many, Canada's "[u]niversal publicly funded health care is part of what it means to be a Canadian."[345] "Equality before the health-care system" is thus not only as important but equivalent to "equality before the law.[346]

The exclusion of clinic abortion services, and by extension the women who require them, from a fundamental institution of community membership necessarily implies the lesser worth of those excluded. A "movement away from the solidarity principles underlying social insurance"[347] and the imposition of individual responsibility treats unintended pregnancy as the consequence of personal default undeserving of public support. The fact that unintended pregnancy is a reproductive and sexual health need distinctive to women suggests that women themselves are undeserving of equal respect,

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341 HEALTH AND WELFARE CAN., PRESERVING UNIVERSAL MEDICARE 7 (1983).

342 Robert G. Evans, *"We'll Take Care of It for You": Health Care in the Canadian Community*, 117 DAEDALUS 155, 164–65, 169 (1988).

343 The Canada Health Act is a spending statute that does not expressly establish any rights or duties. Provinces are free to disregard national criteria and forego part or all of the federal contribution. *See* SHEILAH L. MARTIN, WOMEN'S REPRODUCTIVE HEALTH, THE CANADIAN CHARTER OF RIGHTS AND FREEDOMS, AND THE CANADA HEALTH ACT 19 (1989).

344 COMM'N ON THE FUTURE OF HEALTH CARE IN CAN., *supra* note 1, at xviii.

345 CONFERENCE BD. OF CAN., CANADIANS' VALUES AND ATTITUDES ON CANADA'S HEALTH CARE SYSTEM: A SYNTHESIS OF SURVEY RESULTS 6 (2000).

346 Evans, *supra* note 342, at 165.

347 Giacomini et al., *supra* note 44, at 1497 (citing Deborah A. Stone, *The Struggle for the Soul of Health Insurance,* 18 J. HEALTH POL. POL'Y & LAW 287, 288 (1993)).

concern, and consideration. A government's selective divestment from the health of women translates into a selective divestment from women themselves.[348]

IV. DEMONSTRABLE JUSTIFICATION UNDER SECTION 1

Under section 1 of the *Charter*, rights and freedoms are guaranteed "subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society."[349] A law that infringes section 15(1) may thus still be constitutional if the government demonstrates that the infringement satisfies the requirements of section 1.

Under the framework developed by the Supreme Court in *R. v. Oakes*,[350] section 1 requires that the objective of the law be "pressing and substantial" and that the means chosen to attain this objective be reasonable and demonstrably justifiable in a free and democratic society.[351] The latter requirement is satisfied where (1) the means are "rationally connected" to the objective; (2) the means minimally impair the guaranteed right; and (3) the effect of the law is proportional to its objective, such that the benefits of the law outweigh its deleterious effects.[352] While this Article primarily concerns the conception of the right violated by denied funding for clinic services, this part briefly examines the advantages of a community-membership model of equality under a section 1 analysis.

In *Jane Doe I*, Judge Oliphant held that the Manitoba regulation "cannot be saved by [section] 1 of the *Charter*."[353] He rejected the government's characterization of the regulation and asserted that its real objective "was to keep . . . persons, out of the business of operating a free-standing clinic that provides therapeutic abortions in the Province of Manitoba."[354] This objective was deemed insufficiently important to override constitutionally protected rights. Judge Oliphant further reasoned that the means chosen to attain the

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[348] *Id.*
[349] Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982, ch. 11 (U.K.).
[350] [1986] 1 S.C.R. 103 (Can.).
[351] *Id.* at 138–39.
[352] *Id.* at 138.
[353] Jane Doe 1 v. Manitoba, [2004] 248 D.L.R. (4th) 547, 564 (Man. Q.B.).
[354] *Id.* at 564–65.

claimed objective were neither "rational nor fair" and were "out of proportion to the objective."[355]

It is exceptionally rare for a Canadian court to hold that an impugned law lacks a "pressing and substantial" objective.[356] This is particularly true in the health care context. Governments have consistently argued, and courts have largely accepted, that exclusions under provincial health insurance plans are intended to protect the financial sustainability of Medicare. The Manitoba government defended its policy in *Jane Doe I* precisely on these grounds. Under section 1, Courts exercise considerable deference regarding government allocations of scarce resources within social programs on the basis of institutional competence and political accountability.[357] As explained by Donna Greschner and Steven Lewis, "government departments are better equipped than courts to manage complex programs . . . [T]hey have far more [available data and expertise] . . . than judges do, and more practice at using it."[358] Governments also have the advantage of perspective. They "must consider the needs of all patients, compare the sometimes incommensurable, and make often tragic trade-offs."[359] In *Cameron*, for example, while the exclusion of infertility treatments was held to infringe section 15(1), the violation was justified as a reasonable limit under section 1. The Court stated that "policy makers require latitude in balancing competing interests in the constrained financial environment. We are simply not equipped to sort out the priorities."[360]

Members of the Supreme Court have nevertheless warned against deference becoming abdication.[361] Although the administration of health care systems resides with provincial governments,

> the resulting legislation, like all laws, is subject to constitutional limits . . . . The fact that the matter is complex, contentious or laden

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[355] *Id.*

[356] PETER HOGG, CONSTITUTIONAL LAW OF CANADA 743 (2001).

[357] Sheilah Martin, *Balancing Individual Rights to Equality and Social Goals*, 80 CAN. BAR REV. 299, 348 (2001).

[358] Donna Greschner & Steven Lewis, Auton *and Evidence-Based Decision Making: Medicare in the Courts*, 82 CAN. BAR REV. 501, 507 (2003).

[359] *Id.*

[360] Cameron v. Nova Scotia, [1999] 177 D.L.R. (4th) 611, 667 (N.S. C.A.).

[361] *See* RJR-MacDonald Inc. v. Canada (Attorney General), [1995] 3 S.C.R. 199, 332 (Can.). "[C]are must be taken not to extend the notion of deference too far. Deference must not be carried to the point of relieving the government of the burden which the *Charter* places upon it of demonstrating that the limits it has imposed on guaranteed rights are reasonable and justifiable . . . . The courts are no more permitted to abdicate their responsibility than is Parliament." *Id.*

> with social values does not mean that the courts can abdicate the responsibility vested in them by our Constitution to review legislation for *Charter* compliance . . . .[362]

Given the lack of evidence of a colourable intention in *Jane Doe I*, a reviewing Court would likely regard the rationing objective as "pressing and substantial." The government faces a greater challenge, however, respecting the means chosen to attain this objective. The average cost of a clinic abortion is significantly less than the average costs of a hospital abortion or maternal care and childbirth. This fact alone challenges the rational connection between the government's fiscal objective and the exclusion of clinic services. In his opinion in *Lexogest I*, Justice Huband of the Manitoba Court of Appeal focused on the perversity of the scheme:

> If an abortion could be provided at less cost at a hospital than a free-standing clinic, it would make eminently good sense and would be entirely within the spirit of the Act to require that they be performed in the hospitals as a prerequisite to coverage. But the opposite appears to be the case . . . . It is perverse that an insurance scheme designed to control costs should willfully increase them.[363]

A section 15(1) analysis premised on the dignity of equal community membership may also prove especially valuable in demonstrating the disproportionate effect of the Manitoba regulation as compared to its objective. This model of equality captures more than tangible economic costs or health risks. It recognizes the full social significance of exclusion in terms of women's self-respect and self-worth as members of Canadian society. A law that relegates persons to a lesser status—less capable, less worthy, less deserving than others—requires exceptionally strong countervailing reasons to justify its reasonableness in a free and democratic society.

CONCLUSION

The guarantee of equality under the *Charter* requires a perspective that extends beyond affected individuals or groups. It requires a perspective that encompasses the actions of others and the broader context of social interaction. It requires a perspective that critically evaluates the construction of social and political institutions that define membership in a community. What are the

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[362] Chaoulli v. Quebec (Attorney General), [2005] 1 S.C.R. 791, 844 (Can.).

[363] Lexogest Inc. v. Manitoba (Attorney General) (*Lexogest I*), [1993] 101 D.L.R. (4th) 523, 552–53 (Man. C.A.).

legal rules of membership? Do they signify or construct individuals or groups as less capable, less worthy, or less deserving of equal respect, concern, and consideration?

For too long, the mere physical fact of pregnancy—the unique capacity to reproduce—justified the discriminatory treatment of women. Justification for differential treatment monopolized the analysis. Too little attention was paid to the effect of differential treatment—the impact of excluding women from social institutions on the basis of the sexual and reproductive health needs. This Article focuses on the burden of unequal treatment rather than its justification.

In *Jane Doe I*, Judge Oliphant characterized the discriminatory effect of the Manitoba regulation in strongly individualist terms. The indignity of denied public funding for clinic abortion services was located in the loss of women's freedom, autonomy, and self-determination. Under a model of equality premised on the dignity of equal community membership, the impact of the Manitoba regulation is differently conceived. The discriminatory effects of the law extend to women as members of the community. Women are excluded from a fundamental social institution, and thereby denied a right of citizenship. Women are treated as less capable, less deserving, and less worthy of equal concern, respect, and consideration. More significantly, if the law is sufficiently powerful, its claims of inferiority may be internalized and accepted as true by women themselves. The law thus not only affects the perception of others. On the contrary, its most powerful discriminatory impact is in women's diminished self-worth and self-respect.

Access to reproductive and sexual health services is therefore inseparable from the larger project of women's political, economic, and social equality. If women are to be equal members of Canadian society, the Charter must be interpreted and applied in fulfillment of a broader commitment to transform social and political institutions—including our health care system—in an egalitarian direction wherein women are not only perceived as full members of Canadian society, but believe themselves to be.