August 22, 2008

Ms. Jean Wright  
Chair, Interprovincial Health Insurance Agreements Coordinating Committee  
Senior Policy Advisor  
Health Canada

Dear Ms. Wright,

Re: Therapeutic Abortion as an Excluded Service under the Interprovincial Reciprocal Billing Agreement

We are writing on behalf of the Health Equity and Law Clinic, Faculty of Law, University of Toronto, an academic clinic specializing in reproductive and sexual health law and policy, and the National Abortion Federation - Canada, a professional association of abortion providers.

This letter concerns the exclusion of therapeutic abortion under inter-provincial/territorial reciprocal billing agreements for insured health services (“Reciprocal Billing Agreements”).1 It follows our previous correspondence on the subject dated October 15, 2007.

We are writing to:

1. Request that the Interprovincial Health Insurance Agreements Coordinating Committee (“the Committee”) review the listing of therapeutic abortion on the Excluded Services List under the Interprovincial Reciprocal Billing Agreement.2

2. Assist the Committee in undertaking this review by providing reasons that:

   • Support therapeutic abortion as within the general scheme of benefits and needs the Reciprocal Billing Agreements are intended to address, and

   • Demonstrate that the exclusion of therapeutic abortion under the agreements runs counter to the spirit and intent of the Canada Health Act.3

We believe these reasons warrant the removal of therapeutic abortion from the Excluded Services List under the Interprovincial Reciprocal Billing Agreement.

3. Request that if, following its review, the Committee decides there are reasons to maintain therapeutic abortion on the Excluded Services List under the Interprovincial Reciprocal Billing Agreement, the Committee publicly account for these reasons to avoid an adverse inference that the exclusion of therapeutic abortion is arbitrary and thus discriminates against women contrary to the Canadian Charter of Rights and Freedoms.4
1. Request to Review the Listing of Therapeutic Abortion as an Excluded Service

The *Canada Health 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.”\(^5\) To achieve this objective, the Act sets out criteria and conditions that provinces/territories must satisfy to qualify for full federal contribution for insured health services.\(^6\)

One criterion of the *Canada Health Act* is portability, which requires that:

> the health care insurance plan of a province … must provide for and be administered and operated so as to provide for the payment of amounts for the cost of insured health services provided to insured persons while temporarily absent from the province … [or] during any minimum period of residence, or any waiting period, imposed by the health care insurance plan of another province … by reason of having become residents of that other province.\(^7\)

The objective of the portability criterion is to ensure Canadian residents’ continuing protection under public health insurance throughout the country, facilitating their access to insured health services without financial or residence-based barriers.\(^8\)

The Reciprocal Billing Agreements are critical and intended to implement the portability criterion within Canada.\(^9\) The agreements ensure that Canadian residents are not subject to out-of-pocket costs for insured health services, and that health providers receive payment for delivered services.

We are writing to the Committee given its mandate to identify and resolve administrative issues respecting the Reciprocal Billing Agreements.\(^10\) This mandate includes the setting of minimum standards respecting the eligibility and portability of health insurance plans, in particular the *Excluded Services List* under the *Interprovincial Reciprocal Billing Agreement*, which is voluntarily applied to the Reciprocal Billing Agreements.\(^11\)

While not required by the portability criterion, the Reciprocal Billing Agreements, once signed by the provinces/territories, are to be administered consistently with the spirit and intent of the *Canada Health Act* and in a non-discriminatory manner.\(^12\)

We request that the Committee review the listing of therapeutic abortion on the *Excluded Services List* for the following reasons.

- Given financial and residence-based barriers to timely care, the exclusion of therapeutic abortion under the Reciprocal Billing Agreements may be inconsistent with the policy objectives of the portability criterion and the *Canada Health Act* generally.

- Given the sex-specific nature of therapeutic abortion and the history of policy-making respecting therapeutic abortion, this inconsistency raises concerns from the perspective of sex equality rights under the *Canadian Charter of Rights and Freedoms*. 
A. Financial and Residence-Based Barriers to Therapeutic Abortion

Given its exclusion under the Reciprocal Billing Agreements, therapeutic abortions performed in Canada but outside of a woman’s home province/territory may not be publicly insured. In order to receive timely abortion care, in general, a woman must privately pay for either the service costs in the host province/territory ($400 to $2000) with potential reimbursement by her home province/territory, or the travel costs to return and receive care in her home province/territory.

Many women who seek therapeutic abortions outside of their home provinces/territories – women temporarily living away from home for education or employment purposes, women moving residences within Canada and women living in border communities – cannot afford these costs. The importance of timely therapeutic abortion care is well-documented, including in the 1988 Supreme Court of Canada judgment, *R v. Morgentaler*. Delayed care increases the risk of physical complications, psychological distress and denied care due to exceeded gestational limits set by hospital and clinic facilities.

Interprovincial/territorial access to services is of particular importance respecting therapeutic abortion given the decreasing availability and accessibility of abortion facilities and providers in Canada. Abortion is one of the most frequently performed of all surgical procedures, but only select hospitals geographically distributed without reference to need deliver the service. In hospitals where services are formally available, access is often limited by quotas, referrals, and excessive delays. Lacking access to timely hospital services, women increasingly seek or are referred to abortion care in clinics. Clinic facilities, however, are located in urban centers in select provinces. Given this geographic disparity, many women must travel interprovincially/territorially to access therapeutic abortion services. Under the *Canada Health Act*, the accessibility criterion requires that all health insurance plans “provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude … reasonable access to those services by insured persons.”

We are concerned that many Canadian women cannot access timely abortion care because of financial barriers. If therapeutic abortion was removed from the *Excluded Service List*, women could receive publicly-insured therapeutic abortions across Canada (Quebec excepted) without point-of-service private costs or with guaranteed reimbursement.

Some provinces/territories have enacted bilateral agreements or contracted with individual health facilities for the reciprocal billing of therapeutic abortion. These arrangements, however, are administratively costly, restrictive and inequitable.

The arrangements are often informal, with provinces/territories reimbursing health facilities for services rendered on a case-by-case basis following a claim submission. Such requirements are administratively burdensome and costly for individual facilities. The Kensington Clinic in Calgary, Alberta, for example, provides services for an estimated 80 women from Saskatchewan alone each year.

The arrangements are often restricted to services provided in designated neighbouring provinces/territories. A Saskatchewan resident, for example, may receive an insured therapeutic abortion in Alberta or Manitoba. If she is visiting or living in any other Canadian province/territory, she must travel to Saskatchewan, Alberta, or Manitoba for insured services.
These restrictions render the arrangements inequitable. Based on residence, Canadian women are treated differently in respect of point-of-service private costs when seeking the same medical care at the same health facility. The fee schedule at the Kensington Clinic in Calgary, Alberta makes plain this disparate treatment.

Kensington Clinic Fee Structure (based on province/territory of residence)²²

- Fully Insured (No Fees Charged): Alberta, Saskatchewan
- Fully Insured with Prior Written Approval (No Fees Charged): Northwest Territories, Nunavut
- Partially Insured: British Columbia, Yukon, Northwest Territories, Nunavut (without prior approval)
- No Insurance Coverage: Manitoba, Ontario, Quebec, Newfoundland, Nova Scotia, New Brunswick, PEI

For these reasons, current interprovincial/territorial billing arrangements for therapeutic abortion do not adequately compensate for its exclusion under the Reciprocal Billing Agreements.

Given the financial and residence-based barriers to timely care, we are concerned that the exclusion of therapeutic abortion under the Reciprocal Billing Agreements is inconsistent with the policy objectives of the portability criterion and the Canada Health Act generally.

B. Sex Equality Rights under the Canadian Charter of Rights and Freedoms

Given both the nature of therapeutic abortion, a service responding to health needs distinctive to women, and the history of policy-making respecting the service, this inconsistency raises concerns from the perspective of sex equality rights under the Canadian Charter of Rights and Freedoms.²³

Only women require therapeutic abortion. Its exclusion under the Reciprocal Billing Agreements thus uniquely affects women. Women are denied the benefits of reciprocal billing for a health service, and may thus be subject to different treatment on the basis of sex.²⁴ The history and larger context of policy-making respecting therapeutic abortion raises the specter of unequal rather than different treatment. A difference in treatment, in other words, that violates sex equality rights under the Canadian Charter of Rights and Freedoms.

As explained by the Supreme Court of Canada in Gosselin v. Quebec, historic patterns of disadvantage or prejudice “raise[] the strong possibility that current differential treatment of the group may be motivated by or may perpetuate the same discriminatory views.”²⁵
Canadian law and policy have long been used to deny access to therapeutic abortion, and to express contempt for the practice and those who engage in it. While the criminal law was traditionally used, health care regulation has been employed to similar effect. Immediately following the judicial decriminalization of abortion in *R v. Morgentaler (1988)*, provinces/territories enacted laws and regulations in an effort to impede women’s access to abortion services. Many of these attempts did not survive judicial scrutiny.

In *Lexogest Inc. v. Manitoba (Attorney General)*, a majority of the Manitoba Court of Appeal declared a regulation restricting insurance coverage for abortion services invalid. The majority judgment 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.

Given that for many women denied insurance is equivalent to denied service, access to therapeutic abortion in the province of Manitoba was in effect returned to a pre-*Morgentaler* state with services restricted to hospitals without medical, cost or other justification for the restriction.

In *R. v. Morgentaler (1993)*, the Supreme Court of Canada struck down a Nova Scotia act and regulation that together prohibited abortions outside of hospitals and insurance coverage for abortions performed in violation of the provincial law. The Court held that the province had attempted to legislate in the area of criminal law, a federal jurisdiction. The primary objective of the provincial law, the Court explained, was “to prohibit abortions outside hospitals as socially undesirable conduct.” The law regulated “the place where an abortion may be obtained, not from the viewpoint of health care policy, but from the viewpoint of public wrongs or crimes.”

Denied insurance coverage for therapeutic abortion has been the subject of recent legal challenges across Canada. New Brunswick, Québec, and Manitoba have all been called to account for the treatment of therapeutic abortion under their health insurance plans.

Following the reasoning of the Supreme Court of Canada in *Auton (Guardian ad litem of) v. British Columbia (Attorney General)*, we acknowledge that no Canadian resident receives the benefits of reciprocal billing for all health services delivered outside of his or her home province. Nevertheless, given the sex-specific nature of therapeutic abortion, and the history of policy-making respecting the service, we are concerned that its exclusion under the Reciprocal Billing Agreements discriminates against women contrary to the *Canadian Charter of Rights and Freedoms*.

We are concerned that the exclusion constitutes inferior treatment of women in purpose or effect rather than a legitimate exercise of discretion. This distinction, as explained by the Supreme Court in *Auton*, depends on the purpose of the benefit program, in this case the Reciprocal Billing Agreements, and the needs it seeks to address:
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 … 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 … scheme is intended to address.33

Given concerns respecting financial and residence-based barriers to timely care, coupled with the sex-specific nature of therapeutic abortion and the history of policy-making respecting the service, we request that the Committee review the listing of therapeutic abortion on the Excluded Services List under the Interprovincial Reciprocal Billing Agreement. We request that the Committee consider whether therapeutic abortion falls within the general scheme of benefits and needs the Reciprocal Billing Agreements are intended to address, and thus whether its exclusion under the agreements is arbitrary, undercutting their overall purpose.

2. Reasons Warranting the Removal of Therapeutic Abortion from the Excluded Services List

To assist the Committee in undertaking this review, we have provided reasons that:

- Support therapeutic abortion as within the general scheme of benefits and needs the Reciprocal Billing Agreements are intended to address, and
- Demonstrate that the exclusion of therapeutic abortion under the agreements runs counter to the spirit and intent of the Canada Health Act.

We believe these reasons warrant the removal of therapeutic abortion from the Excluded Services List under the Interprovincial Reciprocal Billing Agreement.

A. General Scheme of Benefits under the Reciprocal Billing Agreements: Insured Health Services

We acknowledge that the Reciprocal Billing Agreements are not intended to ensure payment for the cost of all health services delivered outside a Canadian resident’s home province/territory. To insist on such would be to amend the agreements. The exclusion of services is an anticipated feature of the agreements. In setting minimum standards of eligibility, however, we assume that exclusions are based on whether services fall outside the general scheme of benefits and needs which the Reciprocal Billing Agreements are intended to address. We submit that on this standard, therapeutic abortion does not warrant exclusion.

The Reciprocal Billing Agreements are intended to implement the portability criterion of the Canada Health Act within Canada. This criterion requires that health insurance plans “provide for the payment of amounts for the cost of insured health services provided to insured persons” while temporarily absent from their home province/territory or relocating to a new province/territory.34
Under the *Canada Health Act*, the term “insured health services” is a defined term.

“insured health services” means *hospital services*, *physician services* and surgical-dental services provided to insured persons … \(^{35}\)

The terms “hospital services” and “physician services” are further defined as follows.

“hospital services” means any of the following services provided to in-patients or out-patients 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 … \(^{36}\)

“physician services” means any *medically required* services rendered by medical practitioners. \(^{37}\)

The objective of the portability criterion is thus to facilitate Canadian residents’ access to insured health services, *medically necessary health services*, without financial or residence-based barriers. \(^{38}\)

Given that the Reciprocal Billing Agreements are intended to implement the portability criterion, the general scheme of benefits and needs the agreements are intended to address can be interpreted as limited to insured health services, in other words, medically necessary health services. \(^{39}\)

**B. Therapeutic Abortion as an Insured Health Service**

The status of therapeutic abortion as a medically necessary, and therefore an insured health service, has been the subject of much contention.

Under the *Canada Health Act*, the comprehensiveness criterion requires that all health insurance plans “insure all *insured health services* [medically necessary health services] provided by hospitals, medical practitioners …” \(^{40}\) In 1988, following the judicial decriminalization of abortion, all provinces/territories, with the exception of Ontario and Quebec, restricted or withdrew coverage under their health insurance plans for therapeutic abortion. \(^{41}\) British Columbia and Prince Edward Island restricted health insurance to medically necessary hospital abortions. \(^{42}\) 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.” \(^{43}\) Insurance restrictions based on facility type, hospital rather than clinic, have often been used as a proxy for medical necessity. This distinction is difficult to sustain, however, for clinic services do not differ from hospital services in the treated condition, patient risk, or practitioner skill. Most health insurance plans moreover do not require certification that hospital abortions are medically necessary, nor do they provide exceptions for medically necessary clinic abortions. \(^{44}\)

Driven in part by legal challenge, coverage of therapeutic abortion under health insurance plans has been significantly reformed. Québec and Manitoba most recently amended their health insurance plans to fully insure therapeutic abortions provided in clinic facilities. There is now substantial uniformity across the country respecting therapeutic abortion, whether provided in hospital and clinic, as covered by health insurance plans.
There are, however, exceptions. New Brunswick, for example, insures therapeutic abortions only when “performed by a specialist in the field of obstetrics and gynaecology in a hospital facility approved by the jurisdiction in which the hospital facility is located and two medical practitioners certify in writing that the abortion was medically required.”\textsuperscript{45} This restriction is currently being challenged as inconsistent with the \textit{Canada Health Act} and the \textit{Canadian Charter of Rights and Freedoms}.\textsuperscript{46}

It may be claimed that because therapeutic abortion is subject to different terms and conditions under the health insurance plans of one or more province/territory, it should be treated as a non-insured health service for the purposes of the portability criterion. In addition to medically necessary insured health services under the \textit{Canada Health Act}, provinces/territories may insure services under their health insurance plans that fall outside the scope of the Act.\textsuperscript{47} These non-insured health services “are provided at provincial and territorial discretion, on their own terms and conditions, and vary from one province or territory to another.”\textsuperscript{48} It may be claimed that therapeutic abortion is such a service. Therapeutic abortion is insured under health insurance plans not as a medically necessary and thus insured health service, but at provincial/territorial discretion. As a non-insured health service, therapeutic abortion is not within the general scheme of benefits and needs the Reciprocal Billing Agreements are intended to address. Its listing on the Excluded Service List under the \textit{Interprovincial Reciprocal Billing Agreement} is justified on this basis. This claim cannot be sustained.

C. The Spirit and Intent of the \textit{Canada Health Act}

The treatment of therapeutic abortion as a non-insured health service runs counter to the spirit and intent of the \textit{Canada Health Act}. Therapeutic abortion should be treated as a medically necessary and thus insured health service. It should be regarded as within the general scheme of benefits and needs the Reciprocal Billing Agreements, the portability criterion and the \textit{Canada Health Act} generally are intended to address.

The contention respecting the status of therapeutic abortion as medically necessary results from neither the \textit{Canada Health Act} nor provincial/territorial law defining the term. The designation of services as medically necessary is largely undertaken in closed negotiation between ministries of health and medical associations without reference to any substantive definition of the term.\textsuperscript{49} The designation of a health service as a medically necessary and thus insured health service is largely within provincial/territorial discretion.

The intention of the \textit{Canada Health Act}, and the instruments of its implementation including the Reciprocal Billing Agreements, is not to interfere with the rights and prerogatives of provinces/territories to determine and provide insurance coverage for health services rendered in their own or another jurisdiction.\textsuperscript{50} Nevertheless, provincial/territorial discretion respecting the designation of services as medically necessary and thus insured health services cannot be absolute. This would lead to the troubling conclusion that the provincial/territorial designation of any service as within or outside the scope of the \textit{Canada Health Act} is beyond review. A conclusion of absolute discretion undercuts the primary objective and overarching scheme of the Act. Its criteria, including portability, become meaningless from the perspective of facilitating Canadian residents’ access to health services without financial or other barriers if provinces/territories can in effect designate any or all health services as non-insured health services and therefore outside the scope of the Act. Such an outcome runs counter to the spirit and intent of the \textit{Canada Health Act}.  

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For this reason, the fact that therapeutic abortion is subject to different terms and conditions under the health insurance plans of one or more province/territory should not be determinative of its status as a non-insured health service under the Canada Health Act. Rather, if therapeutic abortion is a medically necessary and thus insured health service, these restrictive terms and conditions may themselves be inconsistent with the comprehensiveness criterion of the Canada Health Act. These restrictions may moreover be an illegitimate exercise of discretion, discriminating against women contrary to the Canadian Charter of Rights and Freedoms. These are precisely the claims against the province of New Brunswick in the ongoing legal action. It would therefore be perverse if these same terms and conditions served as justification for the exclusion of therapeutic abortion under the Reciprocal Billing Agreements, intended to implement the portability criterion.

There are moreover valid reasons to treat therapeutic abortion as a medically necessary and thus insured health service under the Canada Health Act, and therefore within the general scheme of benefits and needs the Reciprocal Billing Agreements are intended to address.

A health service may not be designated as medically necessary for many legitimate reasons, including because it is unsafe, it does not serve a legitimate health need or while it serves a legitimate health need, its benefits may not be sufficiently important to justify public expenditure.

A service may not be designated as medically necessary because it is unsafe or experimental. Widespread evidence indicates that abortion, when performed by a skilled provider in a facility that meets medical standards, is a safe, low-risk procedure, safer than pregnancy and childbirth.\(^{51}\) This is true of clinic and hospital abortions. In \textit{R v. Morgentaler (1988)}, the Supreme Court confirmed that no medical justification confines abortions to hospitals. Rather, “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.”\(^{52}\)

A service may not be designated as medically necessary because it does not serve a legitimate health need.\(^{53}\) The need for therapeutic abortion, it is often argued, derives from largely voluntary and controllable conduct, and for this reason the service is construed as serving mere convenience rather than genuine need. Many health needs, however, may be conceptualized as resulting from voluntary and controllable conduct. Many women voluntarily choose to become pregnant and to carry their pregnancy to term. In this sense, abortion and childbirth are simply alternatives for dealing with pregnancy. Unlike abortion, however, prenatal, maternity, and neonatal intensive care, are insured services in all provinces.\(^{54}\)

A service may not be designated as medically necessary because while it serves a legitimate health need, its benefits may not be sufficiently important to justify public expenditure. Cost-benefit assessments of therapeutic abortion are often premised on a partial understanding of its benefits, such that its costs are therefore assessed as unduly high. The benefits of abortion are often construed as simply terminating the unwanted physical state of pregnancy, and avoiding the physical and mental health risks of gestation, delivery, and postpartum recovery. These are significant benefits, but therapeutic abortion also serves important non-medical ends that contribute to a woman’s broader social well-being. The failure to adopt a comprehensive understanding of these benefits leads to inaccurate efficiency assessments.\(^{55}\)
The treatment of therapeutic abortion as an insured health service under the Canada Health Act is not unprecedented. The federal government has penalized the provinces of Alberta, Newfoundland and Labrador, and Nova Scotia under the Canada Health Act for permitting user charges for therapeutic abortion services, a medically necessary health service, in clinic facilities.  

3. Request for Public Accountability

Following its review, the Committee may decide there are legitimate reasons not addressed in this letter to maintain therapeutic abortion on the Excluded Services List under the Interprovincial Reciprocal Billing Agreement. In this circumstance, we request that the Committee publicly account for these reasons to avoid an adverse inference that the exclusion of therapeutic abortion is arbitrary and thus discriminates against women contrary to the Canadian Charter of Rights and Freedoms.

We appreciate your continued commitment to protecting and promoting the health and well-being of all Canadians. We thank you for your time and consideration.

Sincerely,

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Research for this letter was provided by Thomas Rowe, a student in the Health Equity and Law Clinic, Faculty of Law, University of Toronto.

References

1 The term Reciprocal Billing Agreements refers to the bilateral agreements between two provinces, a province and territory, or two territories that allow for the reciprocal processing of out-of-province/territory claims for insured health services to residents of the other province/territory. We understand that all provinces/territories participate in reciprocal hospital agreements and that all, with the exception of Quebec, participate in reciprocal medical agreements. Health Canada. *Canada Health Act: Administration and Compliance.* Available online: http://www.hc-sc.gc.ca/hcs-sss/medi-assur/cha-les/administration-eng.php (date accessed: 18 August 2008).


5 *Canada Health Act,* supra note 3 at s. 3.


7 *Ibid.* at s. 11(1)(b) and (c).

8 Letter from the Honourable Jake Epp, Federal Minister of Health and Welfare, to the Provincial and Territorial Ministers of Health (18 June 1985) (“Epp Letter”) Available online: http://www.hc-sc.gc.ca/. “The intent of the portability provisions of the *Canada Health Act* is to provide insured persons continuing protection under their provincial health care insurance plan when they are temporarily absent from their province of residence or when moving from province to province … [i]n order that Canadians may maintain their health insurance coverage and obtain benefits or services without undue impediment …” *Ibid.*


10 According to Health Canada, the mandate of the Interprovincial Health Insurance Agreements Coordinating Committee is “to identify and resolve administrative issues related to interprovincial/territorial billing arrangements for medical (physician) and hospital services … the Committee's scope also extends to eligibility for health insurance coverage as well as interprovincial-territorial billing issues.” Health Canada. *Canada Health Act: Glossary of Terms.* Available online: http://www.hc-sc.gc.ca/hcs-sss/medi-assur/res/gloss-eng.php (date accessed: 18 August 2008).

11 We understand that the Interprovincial Reciprocal Billing Agreement is equivalent to or serves the same function as the Interprovincial/Territorial Agreement on Eligibility and Portability. According to Health Canada, “[t]he Agreement sets minimum standards with respect to interprovincial and territorial eligibility and portability of health insurance programs. Provinces and territories voluntarily apply the provisions of this agreement, thereby facilitating the mobility of Canadians and their access to health services throughout Canada. Officials meet periodically to review and revise the Agreement.” Health Canada. *Canada Health Act: Glossary of Terms.* Available online: http://www.hc-sc.gc.ca/hcs-sss/medi-assur/res/gloss-eng.php (date accessed: 18 August 2008).

12 *Eldridge v. British Columbia,* [1997] 3 S.C.R. 624. “This Court has repeatedly held that once the state does provide a benefit, it is obliged to do so in a non-discriminatory manner.” *Ibid.* at 678.

13 The term “home province/territory” refers to the province/territory of residence. The term “host province/territory” refers to the province/territory in which care is delivered.


18 Between 1993 and 2005, the percentage of therapeutic abortions performed in clinic facilities in Canada more than doubled from 23% to 48%. Statistics Canada. Induced Abortion Statistics 2005. (Ottawa: Minister of Industry, 2008).


20 Canada Health Act, supra note 3 at s. 12(a).

21 Interview with Celia Posyniak, Executive Director, Kensington Clinic, Calgary, Alberta (April 2008).


26 Rodgers, supra note 15 at 110-114.


29 Ibid. at 513.

30 Ibid.


33 Ibid. at 676.

34 Canada Health Act, supra note 3 at s. 11(1)(b) and (c).

35 Ibid. at s. 2.

36 Ibid.

37 Ibid.

38 There is no evidence that the terms “medically necessary” and “medically required” are different in meaning. The term “medically necessary” is therefore substituted for “medically required.”

39 See Epp Letter, supra note 8. “While temporarily in another province of Canada, bona-fide residents should not be subject to out-of-pocket costs or charges for necessary hospital and physician services … to meet the objective of ensuring no direct charges to patients for necessary hospital and physician services provided in other provinces.”

40 Canada Health Act, supra note 3 at s. 9.


43 Excluded Services Regulation, Reg. 46/93, schedule H, s. 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).

44 Erdman, supra note 23 at 1119.

45 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.


48 Ibid.

50 Epp Letter, supra note 8.
52 R v. Morgentaler, supra note 14 at 115.
54 Erdman, supra note 23 at 1143-1145.
55 Ibid. at 1145-1147.
56 Letter from the Honourable Diane Marleau, Federal Minister of Health, to the Provincial and Territorial Ministers of Health (6 January 1995) Available online: http://www.hc-sc.gc.ca/ (“The Federal Policy on Private Clinics”). “From November 1995 to June 1996, total deductions of $3.585 million were made to Alberta's cash contribution in respect of facility fees charged at clinics providing surgical, ophthalmological and abortion services … Similarly, due to facility fees allowed at an abortion clinic, a total of $284,430 was deducted from Newfoundland and Labrador's cash contribution before these fees were eliminated, effective January 1, 1998 … With the closure of its abortion clinic in Halifax effective November 27, 2003, Nova Scotia was deemed to be in compliance with the Federal Policy on Private Clinics. Before it closed, a total deduction of $372,135 was made from Nova Scotia's CHST cash contribution for its failure to cover facility charges to patients while paying the physician fee.” Health Canada. Canada Health Act Annual Report 2006-2007 (Ottawa: Minister of Health Canada, 2007) at 12.