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Hester Lessard
University at Victoria

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The Construction of Health Care and the Ideology of the Private in Canadian Constitutional Law*

*Hester Lessard***

The purpose of this article is to examine the way health care has been understood within Canadian constitutional discourse and in particular, to explore whether the reconceptualization of Canadian political and social relationships in terms of rights has significantly altered the way women have experienced health care and access to health care. The article is divided into three parts, each of which represents a significant shift in the constitutional and legal frameworks for understanding social issues in Canada. The first part looks at health care within the framework of federalism and focuses on the allocation of jurisdiction over health care between two levels of government. The second part looks at the framework of civil and political rights signalled by the entrenchment of the Canadian Charter of Rights and Freedoms¹ in 1982. The third part focuses on the framework of the social welfare state represented in the area of health care by the establishment of a national healthcare program in the 1970s.

The thesis of this article is that each of these frameworks is founded on and reflects the assumption of a split between public and private spheres of life. This split operates ideologically in ways that have been particularly detrimental to women. Thus, although there appear to have been radical changes in the way Canadians understand the constitutional ordering of relationships, in fact, so-

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** Hester Lessard is an Assistant Professor of the University at Victoria Faculty of Law in Victoria, British Columbia. She received her Master of Laws from Columbia University Law School and her Bachelor of Law from Dalhousie University Law School.

1. CONSTITUTION ACT, 1982 pt. I (Canadian Charter of Rights and Freedoms) (U.K.), c. 11 [hereinafter the Charter].

cial relationships of inequality have persisted and in some respects have become more deeply entrenched.

The example of women's struggle for reproductive self-determination will be used to illustrate the intractability of social inequality. Reproductive self-determination has usually surfaced within legal discourse as a struggle for access to abortion. However, the lessons that can be drawn from the shifting regulatory responses to abortion have broader implications for the way in which healthcare provision is understood and experienced by Canadians. The first part of the article will discuss how, within the framework of federalism, social welfare issues, including health care, were constructed as primarily local matters to be addressed by the private institutions of the family, the church, charity, and the market, or by municipal or community level institutions. The public/private distinction thus acted as the ideological lens through which jurisdiction over health care was allocated between federal and provincial levels of government, ensuring that healthcare provision, including the provision of abortion and other reproductive services, reflected the way in which social power was exercised within familial and commercial networks.

The second part of the essay will examine the way in which the construction of health care as private becomes a matter of constitutional theory and doctrine within the framework of entrenched civil and political rights. The Supreme Court of Canada's recognition that a woman has a right of reasonable access to abortion services as part of her right to security of the person ultimately succeeds in protecting the rights of already powerful private actors, in this context, hospital boards and medical practitioners, to withhold abortion services.

In the final section, this article will discuss the extent to which the expansion of the Canadian welfare state to include universal access to publicly funded healthcare services that are medically necessary addresses the negative impacts that rights discourse has had on the experiences of women seeking access to abortion. I suggest that within this final framework, the ideology of the private re-emerges in the central importance given to technical, scientific, and bureaucratic expertise. In this manner, issues relating to the structural disempowerment of socially marginalized groups become invisible, irrelevant, and once more privatized, while the task of efficient and effective needs satisfaction assumes priority.

I. THE CONSTRUCTION OF HEALTH CARE WITHIN THE FRAMEWORK OF FEDERALISM

In 1867, representatives of the European settlers of the three colonial regimes of Canada, New Brunswick, and Nova Scotia came together to form the federal state of the Dominion of Canada. The arrangements entered into at that time were set out in the Constitution Act 1867,² beginning the process of decolonization and the move to self-government for the European occupants of the colonies of British North America.³ In addition to prescribing the executive and legislative institutions for both the federal government and the governments of the four newly constituted provinces, the Constitution Act 1867 also divided legislative authority between the two levels of government.⁴ Constitutional scholars suggest that there were two rationales built into the Constitution Act 1867 that provide guidance in determining the respective responsibilities of the provincial and federal legislatures: national versus local interests and economic versus sociocultural interests.⁵ These rationales have long since lost their coherence as a way of describing the current division of responsibilities. However, they coincide with another more tenacious distinction that still explains the way Canadians understand their political arrangements, namely, the public/private distinction. While the division of powers is theoretically exhaustive,⁶ and, thus, potentially any issue can be brought within the public sphere once it becomes the object of legislative action, the local, sociocultural, and provincial side of the equation

2. CONSTITUTION ACT, 1867 (U.K.), 30 & 31 Vict., c. 3 (formerly British North America Act, 1867) [hereinafter CONSTITUTION ACT 1867].

3. At the same time aboriginal members of First Nations within British North America became subject to the federal level of the new Canadian state under section 91(24). Thus, while 1867 marked the beginning of the formal process of decolonization for the European settlers, it also marked the deepening of the structures of colonialism for Canada's First Nations. See George Stanley, *As Long as the Sun Shines and Water Flows: An Historical Comment*, in *AS LONG AS THE SUN SHINES AND WATER FLOWS* (Ian A. L. Getty & Antoine S. Lussier eds., Vancouver: U. Brit. Colum. Press 1983). In addition, the terms of Confederation were experienced differently by the descendants of French settlers both within and outside Quebec. Issues concerning the political autonomy of Quebec and the distinctiveness of French culture and society continue to be a major focus of Canadian constitutional discussions. Some would argue that Quebec has never fully achieved self-government within the existing arrangements. See Pierre Fournier, *The Future of Quebec Nationalism*, in *AND NO ONE CHEERED* (Keith Banting & Richard Simeon eds., 1983).

4. §§ 91-95.

5. KENNETH NORRIE ET AL., *FEDERALISM AND THE ECONOMIC UNION* 49-59 (Toronto: U. Toronto Press 1986).

6. *Attorney Gen. of Ont. v. Attorney Gen. of Can.*, 1912 App. Cas. 71, 81 (Reference App.).

is very much concerned about issues that have traditionally been associated with the private sphere. To a large extent, the Constitution Act 1867 assigns jurisdiction over the networks of interpersonal relationships that constitute families, commerce, and community to the provincial level of government.⁷

There are no direct references to health care as such in Canada's foundational document, the Constitution Act 1867. Section 91(11) assigns to the federal government jurisdiction over "Quarantine and the Establishment and Maintenance of Marine Hospitals," and section 92(7) assigns to the provincial governments jurisdiction over "Hospitals, Asylums, Charities, and Eleemosynary Institutions . . . other than Marine Hospitals." This allocation of authority might lead one to speculate that health care as a distinctive matter simply did not exist in the political imagination of the times other than as an aspect of poor relief—hence the lumping together of hospitals and eleemosynary institutions—or as a concern about foreign pestilence—hence the mention of quarantine and marine hospitals. However, it would be more accurate to ascribe the invisibility of health care in the Constitution to its private nature. Health care was not perceived to be an issue that should engage either the attention or the resources of the state. Rather it was understood as an area of human need that was best addressed through the private arrangements of the family and the market. As one commentator has put it, "at that time health was considered a family, or at most, a community affair."⁸ Another has written:

At the time of Confederation, Canada was largely rural and what would today be described as "social problems" were then viewed as the natural concern of the family, local community, or church, rather than of the state. Consequently when the framers of the British North America Act distributed powers between the Dominion and the provinces, with the intention of conferring on the former jurisdiction over "all the great subjects of legislation," the exiguous responsibilities for health and welfare then thought ap-

7. The key provisions in this respect are section 92(12) Solemnization of Marriage, section 92(13) Property and Civil Rights, which gives provinces jurisdiction over commercial relationships within the province, and section 92(16) Local and Private Matters, which gives provinces jurisdiction over family and other social relationships. It is the combination of these latter two provisions plus section 92(7) Hospitals that are most often referred to as the basis of provincial jurisdiction over health care. See generally PETER HOGG, *CONSTITUTIONAL LAW OF CANADA* chs. 18, 21, & 26 (Toronto: Carswell 1992).

8. Janice P. Dickin McGinnis, *Whose Responsibility? Public Health in Canada, 1919-1945*, in *DOCTORS, PATIENTS, AND SOCIETY* 205, 208 (Martin Staum & Donald Larsen eds., Waterloo: Wilfrid Laurier U. Press 1981).

propriate to governments were considered local and private, and thus properly to come within the provincial sphere.⁹

The Rowell-Sirois Commission on Dominion-Provincial relations, reporting in 1940, also attributed the absence of any direct references to health care in the Constitution to its private nature:

In 1867 the administration of public health was still in a very primitive stage, the assumption being that health was a private matter and state assistance to protect or improve the health of the citizen was highly exceptional and tolerable only in emergencies such as epidemics, or for purposes of ensuring elementary sanitation in urban communities. Such public health activities as the state did undertake were almost wholly a function of local and municipal governments.¹⁰

Thus, health care was not invisible so much as it was left to the other-directed altruism of families and a variety of volunteer and charitable organizations, or to the self-directed individualism of a growing market in healthcare goods and services. When healthcare issues surfaced within constitutional litigation, it was usually because of jurisdictional disputes over what level of government had authority to deal with the spread of disease. The two cases most often cited for the proposition that health is within the jurisdiction of provincial governments concerned municipal boards established under authority delegated by the province to municipalities to prevent the spread of small pox from city to city.¹¹ In one of the cases, the city board was to be appointed by the chief officers of city councils upon the request of ten heads of families within the city.¹² Although the court alluded to the possibility that an epidemic might be addressed by the federal government under its residual power, the prevailing understanding was that health care should be managed by family members or, at most, community level institutions, as need arose.

As health care became an increasingly public issue with a large budget attached to it, it became necessary to specify where jurisdiction over health care inhered, at the federal level or at the provincial level. The Rowell-Sirois Commission stated that health care

9. Elisabeth Wallace, *The Origin of the Social Welfare State*, in PERSPECTIVES ON CANADIAN HEALTH AND SOCIAL SERVICES POLICY: HISTORY AND EMERGING TRENDS 25, 26-27 (Carl Meilecke & Janet Storch eds., 1980).

10. 2 REPORT OF THE ROYAL COMMISSION ON DOMINION PROVINCIAL RELATIONS 32-33 (1940) [hereinafter ROWELL-SIROIS COMMISSION REPORT].

11. In re George Bowak, 2 B.C.L.R. 216 (1892); Rinfret v. Pope, 12 Q.L.R. 303 (Que. C.A. 1886).

12. Rinfret v. Pope, 12 Q.L.R. at 312.

should be treated as a basic residual provincial responsibility,¹³ and the Supreme Court of Canada later affirmed this general understanding.¹⁴ However, even at this point of formal constitutional visibility, health care was described as coming within provincial jurisdiction under section 92(16) of the Constitution Act 1867, “generally all Matters of a merely local or private Nature in the Province.”

The understanding of health care as a primarily private matter fits within the prevailing theory of social welfare at the time of Confederation, a theory that is rooted in classical liberal political economy. At the core is the notion that an unimpeded market will generate the greatest degree of social well-being because it honours the natural truths that individuals are the best judges of their own preferences and that competition between producers yields the most efficient results. Thus, social well-being is the accidental outcome of markets and cannot be produced by a state-sponsored rational plan.¹⁵ Canadian social and political life in the mid-nineteenth century reflected this anti-statist vision of social welfare. As Elisabeth Wallace points out in her discussion of the origin of social welfare in Canada, Confederation occurred at the height of the belief in individual self-reliance and the inappropriateness of government intervention.¹⁶ An understanding of health care as local and private is consistent with this vision of social prosperity.

Allen Moscovitch and Glenn Drover¹⁷ identify three basic approaches to welfare in the period before Confederation. First, in French Canada, welfare was undertaken primarily by the Church. Charitable religious institutions often operated under state charter but without any regularized system of state subsidy. Second, Nova Scotia and New Brunswick adopted the approach of the Elizabethan Poor Law whereby the most local form of government, the parish or the township, had the responsibility for funding and maintaining asylums and similar institutions. Lacking the population base of seventeenth-century England, small impoverished communities in the Maritimes sometimes contracted out the care

13. ROWELL-SIROIS COMMISSION REPORT, *supra* note 10, at 34.

14. *Schneider v. The Queen*, 2 S.C.R. 112 (1982).

15. NORMAN P. BARRY, WELFARE 15-21 (1990).

16. Wallace, *supra* note 9, at 26.

17. Allen Moscovitch & Glenn Drover, *Social Expenditures and the Welfare State*, in THE BENEVOLENT STATE (Allen Moscovitch & Jim Albert eds., Toronto: Garamond Press 1987).

of the poor to the lowest bidder.¹⁸ Finally, in Upper Canada, the first legislative act of the colonial legislature rejected even the minimal commitment to the needy represented by the Elisabethan Poor Law. On Moscovitch and Drover's account, "this was done on the grounds that Upper Canada had so many opportunities that anyone who wanted could find their living."¹⁹ In the absence of state assistance, gaols were used to house the poor, the sick and insane, as well as "girls in trouble" and criminals.²⁰ Hospitals were places where the poor were housed during epidemics or where the poor died. In general, this meager network of institutions merely supplemented the market economy model of health care embedded in the ideology of self-reliance and frontier individualism.

The reinforcement of class divisions by the laissez-faire approach to social welfare has been well documented.²¹ In addition, there are at least three ways in which the Canadian experience of health care and healthcare delivery under this model was both gendered and racialized.

First, the market operated on terms that tended to consolidate power in the hands of an elite. Constance Backhouse links the professionalization of medicine during this period to the exclusion of women and socially marginalized groups from the market for medical services.²² Soon after Confederation, licencing statutes placed control of the Ontario medical market in the hands of boards with a voting majority of regular practitioners.²³ Among the numerous sects of practitioners that blossomed in early nineteenth-century Canada, "the regulars" had the most social credibility and economic power. They were predominantly middle-class white males who had apprenticed with a licenced physician and passed a licencing examination or, in some instances, had gone to medical school.²⁴ There were numerous competing sects, including

18. DENNIS GUEST, *THE EMERGENCE OF SOCIAL SECURITY IN CANADA* 11 (2d ed. Vancouver: U. Brit. Colum. Press 1985).

19. Moscovitch & Drover, *supra* note 17.

20. GUEST, *supra* note 18, at 13.

21. See generally *THE CANADIAN STATE: POLITICAL ECONOMY AND POLITICAL POWER* (Leo Panitch ed., Toronto & Buffalo: U. Toronto Press 1977).

22. CONSTANCE BACKHOUSE, *PETTICOATS AND PREJUDICE: WOMEN AND LAW IN NINETEENTH CENTURY CANADA* 141-44 (Canada: The Osgoode Society by Women's Press 1991).

23. *Id.* at 144.

24. Barbara Ehrenreich and Deidre English explain the social homogeneity of the "regulars" in the United States during the same period as follows: "The Regulars were, then, a kind of club. Women could not join because no physician would take a woman as an apprentice and no school would admit one as a student." BARBARA EHRENREICH & DEIDRE ENGLISH, *FOR HER OWN GOOD* 42 (1978).

midwives, homeopaths, and eclectics, which were generally known as the “irregulars.” As Constance Backhouse notes, these latter groups were “more open to women and people of colour.”²⁵ Increasingly, licencing boards required certification from a recognized institution as a condition of practice. This, in turn, made it difficult for members of socially marginalized groups to enter into the healthcare market because of overt and systemic barriers to medical school admission.²⁶ The requirement of professional training also paved the way for the replacement of “regulars,” as well as “irregulars,” with practitioners who regarded the scientific model of medicine as the exclusive model.²⁷

The second way in which the market economy model of health care reinforced social inequalities inheres in the relationship between family and market institutions. The unstated assumption underlying the vision of social welfare that flows from liberal economics is that market actors can count on unpaid or underpaid workers within the family to satisfy an array of basic needs. At various times throughout the colonial and early post-Confederation period, the work of caring for family members was provided by wives, African and First Nations slaves, and female domestic servants.²⁸ The latter were often children who were in-

25. BACKHOUSE, *supra* note 22. Again, the same point is made with respect to medical practice during the colonial and early post-revolutionary periods in the United States by Barbara Ehrenreich and Deidre English, who write: “In general, medical practice was open to anyone who could demonstrate healing skills, regardless of formal training, race, or sex Medical care in rural areas was dominated by lay healers: ‘root or herb’ doctors who relied on Indian remedies, ‘bonesetters,’ and midwives.” EHRENRICH & ENGLISH, *supra* note 24, at 39-40.

26. Veronica Strong-Boag, *Canada’s Women Doctors: Feminism Constrained*, in A NOT UNREASONABLE CLAIM: WOMEN AND REFORM IN CANADA 1880-1920’s 207-35 (Linda Kealey ed., Toronto: Women’s Press 1979). See also BACKHOUSE, *supra* note 22; Wendy Mitchinson, *The Medical Treatment of Women*, in CHANGING PATTERNS: WOMEN IN CANADA 237-263 (Sandra Burt ed., Toronto: McClelland & Stewart 1988).

27. EHRENRICH & ENGLISH, *supra* note 24, at 69-98. In the United States, the turning point in this regard was the publication of the Flexner Report in 1909, which recommended that medical schools be required to provide a scientific education. Ehrenreich and English write that within a few years, “droves” of “irregular” schools, the majority of exclusively female medical colleges and the majority of exclusively black medical colleges were closed. The class impacts of the reforms were similarly striking. The requirement of a minimum of two years of college education for entrance to medical school, which came out of the Flexner Report, “closed the medical schools to all but the upper and upper middle class.” *Id.* at 88.

28. Martha Bailey, *Servant Girls and Masters: The Tort of Seduction and the Support of Bastards*, 10 CAN. J. FAM. L. 137 (1991). Although domestic servant labour was purchased in the market of domestic services, the fact that the work consisted of what is traditionally associated with family work has been linked to the pattern of economic, sexual, and racial exploitation, which persists today. See Sedef Arat-Koc, *In the Privacy of Our Own Home: Foreign Domestic Workers as Solution to the Crisis in the Domestic*

dentured for several years with little or no pay and who were often confined within their employers' households.²⁹ Thus, the assumption that health care is the primary and natural responsibility of families and local communities has often meant that the actual costs of providing health care were borne by slaves, by women as unpaid workers within the family, or by underpaid workers within the market who in turn were often women and/or members of racialized groups.³⁰

The market economy model of health care perpetuated social inequality in a third way. Increased professionalization not only translated into monopoly market power for an elite social group but also into a reconfiguration of the social control of women through the medicalization of women's bodies. Abortion provides an instructive example. Abortion was medicalized in the mid-nineteenth century in Canada with the medical community's rejection of quickening as a "significant biological signpost of a foetus's viability."³¹ This was part of a more general diseasing of reproduction whereby contraception, childbirth, and mothering were increasingly viewed as medical problems rather than as natural processes under the control of individual women or midwives.³² As Alexandra Dundas Todd writes: "During the nineteenth century the foundations of women's reproductive networks were shaken, and a process which undermined women's control of women's health was set in motion."³³ Up until this time, the popular consensus was that "there was nothing morally reprehensible with abortion, at least before quickening, the first perceptible movement of the foetus at about the sixteenth to eighteenth week of pregnancy."³⁴ To a large extent, the pregnant woman herself determined the moment of quickening. However, as medical knowledge about conception increased, doctors became more resistant to and dismissive of women's information about their own

Sphere in Canada, 28 *STUD. POL. ECON.* 33 (1989); Jenifer Aitken, *A Stranger in the Family: The Legal Status of Domestic Workers in Ontario*, 45 *U. TORONTO FAC. L. REV.* 1 (1987).

29. Bailey, *supra* note 28, at 142-145.

30. For an analysis of how the current market economy approach to the general work of caring continues to reproduce and deepen social inequalities along gender and race lines, see *WOMEN'S CARING: FEMINIST PERSPECTIVES ON SOCIAL WELFARE* (Carol Baines et al., eds., Toronto: McClelland & Stewart 1991).

31. Mitchinson, *supra* note 26, at 253.

32. The term "diseasing of reproduction" is used in Alexandra Dundas Todd, *Women's Bodies as Diseased and Deviant: Historical and Contemporary Issues*, 5 *RES. L., DEVIANCE & SOC. CONTROL* 83 (1983).

33. *Id.* at 84.

34. Mitchinson, *supra* note 26, at 252.

pregnancies,³⁵ thus laying the scientific foundation for the moral debate about the sanctity of life and for the anti-abortion reforms of this period.

As several writers have pointed out, the alliance between science and morality was at least as much concerned with the declining birth rate among Canada's Anglo-Saxon population when compared to French Canadian and non-Anglo-Saxon immigrant populations.³⁶ In addition, early statutes criminalized attempts by nonpregnant women to induce miscarriages and characterized as obscene the sale or advertizing of contraceptives and abortifacients.³⁷ Shelley Gavigan points out that the net effect of these sanctions was "to cover all aspects of fertility control—even the efforts of individual women who were unaided and non-pregnant."³⁸ Finally, the fact that abortionists, often midwives or "irregulars," were prosecuted under the new abortion laws, suggests that competition from abortionists underlay physician hostility.³⁹

In summary, within the politics of the late nineteenth and early twentieth centuries, it was the voice of a largely male medical establishment driven by concerns about the threat to conventional morality of women's sexuality and about racial and professional privilege that determined abortion policy. This establishment increasingly acquired control over access. However, women continued to insist on their right to manage their own fertility. Angus McLaren and Arlene Tigar McLaren write that the "fact that significant numbers of women (including working-class women) sought abortions is moreover strong evidence that they were not, as was frequently assumed, passive in relation to their own fertility: they wanted to control it and were willing to go to considerable lengths to do so."⁴⁰ As the twentieth century matured, access to abortion became a central issue for the Canadian women's movement. The domination of the movement by liberal feminism, the

35. ANGUS McLAREN & ARLENE TIGAR McLAREN, *THE BEDROOM AND THE STATE: THE CHANGING PRACTICES AND POLITICS OF CONTRACEPTION AND ABORTION IN CANADA, 1880-1980* 38-39 (Toronto: McClelland & Stewart 1986).

36. *Id.* at 15-17, 99. See also Constance Backhouse, *Involuntary Motherhood: Abortion, Birth Control and the Law in Nineteenth Century Canada*, 3 WINDSOR Y. ACCESS JUST. 61, 76 (1983).

37. Shelley Gavigan, *On "Bringing on the Menses": The Criminal Liability of Women and the Therapeutic Exception in Canadian Abortion Law*, 1 CAN. J. WOMEN & L. 279, 295-96 (1985/86).

38. *Id.* at 296.

39. Mitchinson, *supra* note 26, at 253; Backhouse, *supra* note 36, at 71, 76.

40. McLAREN & McLAREN, *supra* note 35, at 32.

demand for foetal rights by the anti-abortion movement, and the constitutional entrenchment of individual rights meant that, as one writer has put it, "[a]bortion as health care was swamped by the language of 'rights.'"⁴¹

II. RIGHTS LANGUAGE AND THE STRUGGLE FOR ABORTION ACCESS UNDER THE CHARTER

The Charter of Rights and Freedoms was constitutionally entrenched in 1982. By that time, healthcare provision in the form of a national health insurance program had become a central commitment of the Canadian state. Part III of this article will discuss how, in spite of that commitment, the link between healthcare provision and social inequality to a large extent remains private. First, however, this section will examine the vision of state/citizen relationships that underpins the discourse of rights and that, as part III will discuss, is only partially transformed by the recognition of health care as a public responsibility.

The entrenchment of the Charter of Rights and Freedoms has meant that a broad range of social issues, including healthcare issues, are increasingly discussed in terms of rights. For the most part, it has been doctors who have invoked the Charter of Rights and Freedoms in challenging the restraints placed on their freedom to practice by the federal-provincial healthcare regime and by regulatory restrictions on abortion.⁴² However, although brought by doctors, the abortion cases have been argued and generally understood in terms of women's reproductive rights. While some of the abortion cases have resulted in greater freedom for doctors, they may have decreased access to healthcare services for patients generally, and particularly for women patients seeking abortions. The key to understanding the contradictory results of rights litigation lies in the way in which the presumed split between public and private spheres of life manifests itself both at the level of theory and of legal doctrine. The previous section sought to demonstrate

41. Jane Jenson, *Getting to Morgentaler: From One Representation to Another*, in *THE POLITICS OF ABORTION* 15, 54-55 (Janine Brodie et al. eds., Toronto: Oxford U. Press 1992). On Jenson's account, although abortion reform was an important focus for a number of women's groups that formed in the 1960s, it was not until the late 1970s in Quebec and the early 1980s in English Canada that widespread mobilization occurred around the issue of access. *Id.* at 43-52.

42. With respect to freedom to practice generally, see *In Re Mia & Medical Serv's Comm'n of B.C.*, 17 D.L.R.4th 385 (1985); *Wilson v. British Columbia*, 53 D.L.R.4th 171 (1988), *cert. denied*, 2 S.C.R. viii (B.C.C.A. 1988). With respect to abortion, see *R. v. Morgentaler*, 44 D.L.R.4th 385 (1988); *Lexogest, Inc. v. Manitoba*, M.J. No. 54 (C.A. 1993).

how the public/private split operates as the ideological lens through which the federal division of governmental powers is viewed. Within the framework of federalism, health care historically has been understood as a concern that is appropriately addressed through the “local and private” interactions of families and markets rather than as a concern that warrants public attention and resources. Within the framework of rights, public/private ideology takes on definitional importance.

As Allan Hutchinson and Andrew Petter have written, “the major function of a liberal charter is to police the boundary that separates the political and the collective from the pre-political and the individual—to contain the state so as to prevent it from intruding, in its utilitarian zeal, upon the ‘natural’ realm of individual liberty.”⁴³ Within classical liberal theory, the public sphere is comprised of the formal apparatus of the state, which, in turn, is limited to the narrow role of mediating conflict in the private sphere. The private sphere consists of not only the family, the market, the personal, and the social, it is also the sphere of activity that facilitates individual and social well-being. It is the sphere of responsibility, affiliation, and morality. It is also the sphere of nature in the sense that the relationships that are formed between persons and social groups as they freely pursue their interests are viewed as the product of natural talents and individual choices. Nature and individual choice thus provide the litmus test of legitimacy for state incursions into the private sphere. As long as state intervention conforms to the natural arrangements and hierarchies of the private sphere, it preserves its legitimacy and its neutrality.⁴⁴ In Canada, the clearest doctrinal manifestation of this first premise of rights theory, namely the opposition between public and private, is the government action doctrine. Like its American counterpart, the state action doctrine, it defines rights in terms of protection from state-imposed restrictions on the individual pursuit of privately defined goals and preferences.

This section of the essay will explore the ways in which attempts to address healthcare issues in terms of rights have been undermined by the centrality of the public/private split to liberal theory.

43. Allan Hutchinson & Andrew Petter, *Private Rights/Public Wrongs: The Liberal Lie of the Charter*, 38 U. TORONTO L.J. 278, 284 (1988). See also, Hester Lessard, *The Idea of the “Private”: A Discussion of State Action Doctrine and Separate Sphere Ideology*, 28 DALAHOUSE L.J. 107 (1986).

44. Hutchinson & Petter, *supra* note 43. See also Stanley I. Benn & Gerald F. Gaus, *The Liberal Conception of the Public and the Private*, in STANLEY I. BENN & GERALD F. GAUS, *PUBLIC AND PRIVATE IN SOCIAL LIFE* 31-67 (1983).

The first subsection will describe the restrictions on abortion access in the period preceding *R. v. Morgentaler*, a case in which doctors successfully argued that criminalization of abortion was an unconstitutional limit on women's rights to security of the person under section 7 of the Charter of Rights and Freedoms. The next subsection will briefly discuss the way in which the majority judgments in *R. v. Morgentaler* characterized the infringement of rights. Finally, the last subsection will examine the government action doctrine and the implications of *Stoffman v. Vancouver General Hospital*⁴⁵ by looking at both the *Vancouver General Hospital* case and at a struggle between pro-choice and anti-choice forces at Dauphin General Hospital in Manitoba. In *Vancouver General Hospital*, the Court determined that, under the Charter of Rights and Freedoms, hospitals are private rather than governmental actors. The story of Dauphin General Hospital illustrates the social impact of this interpretation of the government action doctrine on the provision of abortion services.

A. Abortion Access before *R. v. Morgentaler*

The focus of the litigation in *R. v. Morgentaler* was section 251 of the Criminal Code.⁴⁶ Section 251 was part of a larger package of liberalizing reforms that were introduced by the federal government in the late 1960s. The changes were lauded for removing archaic and Victorian notions of propriety from divorce and criminal regulation. However, the changes to the abortion provisions in the Criminal Code were directed not so much at the need to liberalize federal laws in light of changing social mores, but rather at the ambiguous legal position of doctors whose only defence against criminal liability was a judicially created exception.

Before the reforms were introduced, it was a criminal offence for a doctor to unlawfully procure an abortion. However, many medical practitioners took this to mean that if a pregnancy endangered the life of a woman, an abortion would be lawful.⁴⁷ The courts eventually placed this interpretation on firmer legal footing. As early as 1901, there was judicial *obiter* recognizing a therapeutic exception to unlawful procurement.⁴⁸ In 1938, an English court in *R. v. Bourne*⁴⁹ found that the procurement of an abortion where a

45. 76 D.L.R.4th 700 (1990).

46. R.S.C. 1970, c. C-34.

47. Gavigan, *supra* note 37, at 306.

48. *R. v. McCready*, 2 Sask. L.R. 46 (Sask. Q.B. 1901) (discussed by Gavigan, *supra* note 37, at 307).

49. 3 All E.R. 615 (K.B. 1938).

pregnancy would endanger a woman's mental health was lawful.

The growing recognition of a therapeutic exception did not necessarily translate into an expansion of women's control of their own fertility. Rather, consistent with the earlier history of the medicalization of reproduction, it simply consolidated control in the hands of medical practitioners. The medical determination that pregnancy would endanger a woman's health was often made on the basis of conventional patriarchal notions of female worthiness.⁵⁰ In addition, as Shelley Gavigan points out, only "women who could afford 'reputable' doctors who were prepared to make the appropriate referrals were able to have the abortions they sought; those who did not have the requisite financial means to do so sought the assistance of what are often described as 'backstreet abortionists.'"⁵¹

Jane Jenson describes the lobby that coalesced in the 1960s around criminal restrictions on the medical practice of abortion as follows:

Doctors who did admit doing abortions but feared the legal ambiguity of their situation led the reform campaign which began in the mid-1960s. By 1963 professional associations of doctors, the Canadian Medical Association (CMA)—and of lawyers—the Canadian Bar Association (CBA)—began at their annual meetings to question the Criminal Code's regulation of abortion. The intra- and inter-professional discussion continued until 1969, paying little attention to the needs of anyone but doctors or lawyers. As a result of this process, the voices of women who were the recipients of the most common type of abortion—the "backstreet" ones—were marginalized in the debate. Indeed, the silence extended to all women, despite the fact that they were the objects of the practice, if not the perceived subject of the law.⁵²

The resulting reforms were set out in section 251 of the Criminal Code. Section 251 legitimized previous medical practice in a more bureaucratically elaborate form than the judicially fashioned defence. Abortions could only be obtained after approval by a hospital therapeutic abortion committee, and only in hospitals that met provincially determined criteria for accreditation and approval as abortion facilities. Qualifying hospitals could decide not to form a committee, in which case abortions would not be available.

While the 1969 reforms clarified the legal position of doctors, they did very little to enhance or clarify for women the conditions

50. McLAREN & McLAREN, *supra* note 35, at 42.

51. Gavigan, *supra* note 37, at 310.

52. Jenson, *supra* note 41, at 15, 25.

under which they could obtain abortions. The combination of section 251's cumbersome administrative structure and the complex and diverse institutional structures for the delivery of hospital services meant that abortion access in Canada was extremely uneven. Several provinces had little or no abortion services.⁵³

In Jenson's view, the formal concentration of abortion decision making in the hands of doctors and hospital committees was a way of privatizing women's continued lack of fertility control by representing state regulation of abortion through the discourse of medicalization.⁵⁴ Procurement of an abortion, although still criminal behaviour, now had a broad, publicly recognised exception to its criminality. This reform seemed consistent with the overall shift to minimal state intervention in the area of moral decision making. However, what was publicly recognized was not the autonomy of female patients seeking fertility control but rather the appropriateness of medical control of abortion decisions. Thus, a volatile political issue about women's fertility and social equality was officially transformed into a scientific question about medical need to be decided by doctors.

In 1975, the federal government established a committee chaired by Robin Badgley to investigate the operation of the abortion law. Two years later the Committee reported on what it characterized as an inequitable law. The report states:

In almost every aspect dealing with induced abortion which was reviewed by the committee, there was considerable confusion, unclear standards or social inequity involved with this procedure. In addition to the terms of the law, a variety of provincial regulations govern the establishment of hospital therapeutic abortion committees and there is a diverse interpretation of the indications for this procedure by hospital boards and the medical profession. These factors have led to: sharp disparities in the distribution and the accessibility of therapeutic abortion services; a continuous exodus of Canadian women to the United States to obtain this operation; and delays in women obtaining induced abortions in Canada.⁵⁵

In addition, many of the hospital committee decisions continued

53. Wendy Mitchinson writes: "By the end of 1986, no abortions could be performed in Prince Edward Island or Newfoundland as no hospitals had therapeutic abortion committees. This forced women to travel either to the United States or Quebec, to self-induce abortion, or to have an illegal abortion. The minimum estimate in 1984 was that 3,484 Canadian women obtained abortions in the States." Mitchinson, *supra* note 26, at 253.

54. Jenson, *supra* note 41, at 36-43.

55. REPORT OF THE COMMITTEE ON THE OPERATION OF THE ABORTION LAW 17 (Ottawa: Ministry of Supply & Services 1977) [hereinafter BADGLEY REPORT].

to reflect considerations of conventional morality. They were often founded on a familial ideology that maternalizes women and punishes them for deviating from the "natural" hierarchy of sex-differentiated roles within the traditional model of the family. The *Badgley Report* found that

more than two thirds of the hospitals surveyed by the Committee (68.4 percent) required the consent of the husband. A few hospitals required the consent of a husband from whom the woman was separated or divorced (18.4 percent) and the consent of the father where the women had never been married.⁵⁶

The administrative inefficiencies generated by section 251 and the consequent emotional, physical, and material costs to women seeking abortions fueled the final step in "liberalization" in the 1980s, the *Morgentaler* case. Again, one has to question who was getting liberated.

B. *R. v. Morgentaler and Abortion Access*

In *R. v. Morgentaler*,⁵⁷ the Supreme Court of Canada struck down section 251 in response to doctors' arguments that the provision was an unconstitutional limit on women's rights under section 7 of the Charter of Rights and Freedoms not to be deprived of life, liberty, and security of the person in a manner that violates the principles of fundamental justice.⁵⁸ In spite of the rights framework, the Court for the most part based its decision on considerations of bureaucratic efficiency and deference to medical expertise rather than individual autonomy or social equality. A majority of the Court, five out of seven judges, found that section 251 was constitutionally problematic. However, the five person majority split into three sets. A group of two, Chief Justice Dickson and Justice Lamer, in reasons written by the Chief Justice, found that the procedural unwieldiness of the administrative structure was a fundamentally unjust deprivation of a woman's right to security of the person.⁵⁹ Chief Justice Dickson described women's security rights in broad and generous terms, extending them to include the emotional and psychological security that comes with being able to de-

56. *Id.* at 245. With regard to the maternalization of women within medical discourse, see also Jane Jenson, *supra* note 41, at 29.

57. 44 D.L.R.4th 385 (1988).

58. Section 7 of the Charter states: "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."

59. 44 D.L.R.4th at 392-420.

termine one's own "priorities and aspirations."⁶⁰ However, Chief Justice Dickson's analysis

comfortably accord[s] with cultural constructions of women as passively enmeshed in the biological and emotional imperatives of their bodies. The reference . . . to "priorities and aspirations" is there not because women should be allowed to control and develop their priorities, for instance to struggle for adequate health care and economic security as an aspect of reproductive self-determination, but because to interfere with women's priorities is to interfere with their bodies.⁶¹

Furthermore, this qualified notion of security was not given substantive protection. Rather, Chief Justice Dickson relied on the procedural aspect of fundamental justice. Thus, "the message about women is not that their reproductive lives should not be managed and controlled by others, but that the management should be more efficient, more attentive to the bodily stresses that flow from legislative inefficiencies."⁶²

A second group of two concurring justices, in reasons written by Justice Beetz with whom Justice Estey agreed, also relied on the due process aspect of the section 7 protection. Justice Beetz's notion of women's security interests is elaborated in even "narrower and more physically grounded"⁶³ terms. He viewed the issue in terms of efficient satisfaction of a medical need: pregnancy is a medical problem for which women need reasonable access to medical services, including abortion services. Again, it is the procedural inefficiencies and delay caused by the administrative structure of section 251 that are constitutionally offensive.⁶⁴

Of the five member majority, only Justice Wilson would give women's reproductive decisions some measure of substantive protection. She based her decision on the liberty component of a woman's section 7 right, and on the protection from deprivations of liberty that are fundamentally unjust in the substantive sense.⁶⁵ Justices McIntyre and La Forest dissented. In reasons written by Justice McIntyre, the dissent found that the Charter of Rights and Freedoms does not include a right to abortion.⁶⁶

The focus on medical need and bureaucratic propriety and effi-

60. *Id.* at 402.

61. Hester Lessard, *Relationship, Particularity, and Change: Reflections on R. v. Morgentaler and Feminist Approaches to Liberty*, 36 MCGILL L.J. 263, 268 (1991).

62. *Id.*

63. *Id.*

64. *R. v. Morgentaler*, 44 D.L.R.4th at 420-461.

65. *Id.* at 482-500.

66. *Id.* at 461-482.

ciency in the reasons by Chief Justice Dickson and Justice Beetz foreshadowed the actual consequences of the ostensible victory for women's rights. *Morgentaler* simply removed the most visible manifestation of state coercion in abortion decision making, namely the Criminal Code prohibition. Indeed, privatization through medicalization became complete in a way that would have been impossible in the era prior to the section 251 reform. It became constitutionally entrenched. Along with women, doctors and hospitals became private actors entitled to rights of autonomy and liberty and shielded from scrutiny under the Charter of Rights and Freedoms. However, the full implications of the decision in *R. v. Morgentaler* became apparent only after the Court, in developing the government action doctrine, clarified the question of which actors and activities are subject to the constraints in the Charter of Rights and Freedoms.

C. *Abortion Access and Government Action Doctrine*

In Canada, the centrality of the public/private split in determining the scope of rights protection was unanimously embraced by the Supreme Court in *Retail, Wholesale & Department Store Union, Local 580 v. Dolphin Delivery Ltd.*,⁶⁷ a case in which a court injunction against picketing was challenged on the grounds that it violated freedom of expression rights. A preliminary issue in the case was whether the Charter of Rights and Freedoms, by virtue of section 32(1), applied to the injunction and to the common law principles on which the injunction was based.⁶⁸ The injunction had been issued in the context of secondary picketing⁶⁹ of a private corporation by members of a private sector union. In a decision by Justice McIntyre, the Court found that section 32 limited the applicability of the Charter to the executive and legislative branches of the federal and provincial governments, thereby excluding its application to the judicial branch or to the common law, except where the common law provides a basis for government action.

Ambiguity about what comprises government action was, for the

67. 2 S.C.R. 573 (1986).

68. Section 32(1) states that the Charter of Rights and Freedoms applies to "the Parliament and government of Canada" and to "the legislatures and government of each province."

69. Secondary picketing is "the exertion of economic pressure, either through picketing or some other medium, on an employer or other person, to induce him in turn to use his influence, usually of an economic kind (for instance, the maintenance or severance of trade relationships, contractual or otherwise), on an employer with whom the union is engaged in a labour dispute." A. W. R. Carrothers, *Secondary Picketing*, 40 CAN. BAR REV. 57, 57 (1962).

most part, resolved by the Court's next extensive consideration of the issue in a trilogy of cases on the scope of section 32.⁷⁰ These three cases reaffirmed *Dolphin Delivery's* interpretation of section 32 and articulated a narrow understanding of state power as coercive authority exercised directly over the subject citizen. Thus, a number of notions became entrenched: the notion of a limited state; the notion of power as coercion; and the notion of state power as juridical and concentrated within a circle of identifiable officials, rather than ideological and diffused throughout a system of actors, structures, and relationships. All three cases addressed the character of entities that, because of extensive funding links, the nature of the services they provide, or formal and actual links with state authority and supervision, are difficult to categorize as either public or private actors.

The *McKinney* case, which involved an equality challenge to mandatory retirement policies at several universities in Ontario, set out the main outlines of the Court's approach. As in *Dolphin Delivery*, the preliminary issue was whether universities are government actors as contemplated by section 32(1) of the Charter of Rights and Freedoms. Justice La Forest, who secured a bare majority on the government action issue, formulated a test of Charter application based on the degree of actual control exercised by government officials over the activities of the institutions. Extensive evidence was presented on the substantial amount of public funding for universities, the statutory requirements with respect to governing structures for each institution, and government's indirect control of university educational policies and standards through the requirement of government approval for degree-granting power as well as for the expansion of programs. In spite of the range of these government-university interconnections and the potential for both direct and indirect governmental control of universities, the majority found that the link between universities and government was not sufficient to warrant application of the Charter of Rights and Freedoms to university decisions.

A more contextualized reading of *McKinney* might permit one to speculate that the case was really about universities, and that the narrow notion of the state as a set of officials exercising direct coercive authority was strategic rather than normative. Justice La Forest referred to the long tradition of autonomy enjoyed by

70. *McKinney v. University of Guelph*, 76 D.L.R.4th 545 (1990); *Douglas/Kwantlen Faculty Ass'n. v. Douglas College*, 77 D.L.R.4th 94 (1990); *Vancouver General Hospital*, 76 D.L.R.4th 700 (1990).

communities of scholars, the importance of a clear separation from government influence in preserving academic freedom, and the actual independence of university decision making on such key matters as hiring, tenure, curricula, and budgetary priorities.⁷¹ However, Justice La Forest's decision, again for the majority, in *Vancouver General Hospital* dispels that notion.

Hospitals do not have a tradition of autonomy rooted in the values of academic freedom and independence in the same way as universities. In addition, the direct absorption of hospitals into the apparatus of the Canadian welfare state in 1957 placed many healthcare policy decisions directly in the hands of government officials. At that point, government became heavily involved in the delivery of health services in hospitals. Federal and provincial governments together launched a national hospital insurance program that provided extensive funding for hospital construction, expansion, and operating costs, as well as universal coverage for users of hospital services. The program extended to privately incorporated hospitals and hospitals set up by provincial governments under special incorporating statutes as municipal or regional hospitals.⁷²

Vancouver General Hospital, originally incorporated in 1902 and continued as a corporation under the Vancouver General Hospital Act,⁷³ is perhaps one of the more clearly public institutions that became deliverers of publicly subsidized hospital care under the 1957 regime and, later, under the national medicare program. The close nexus of control between state officials and Vancouver General Hospital, which was the focus of the Court's discussion in *Vancouver General Hospital*, resulted from the extensive public funding of hospitals in general and was reinforced by the governing structure set in place by the Vancouver General Hospital Act and the Hospitals Act.⁷⁴ For example, in accordance with hospital by-laws, the Cabinet appoints fourteen members of the sixteen-member Board of Trustees that manages the hospital,⁷⁵ and the

71. McKinney, 76 D.L.R.4th at 642-43.

72. For an account of the development of the Canadian Hospital Insurance Program, see MALCOLM G. TAYLOR, *HEALTH INSURANCE AND CANADIAN PUBLIC POLICY* chs. 2, 3, & 4 (Montreal: McGill-Queens U. Press 1978).

73. S.B.C. 1970, c. 55 [title amend. 1979, c. 22, § 51], §§ 2(1), 5 [amend. 1971, c. 25, § 15; 1979, c. 22, § 55], 6 [rep. & sub. 1971, c. 25, § 16; amend. 1979, c. 22, § 53], 11 [amend. 1979, c. 22, § 53], & 32.

74. R.S.B.C. 1979, c. 176, §§ 1 (definition of "board of management"), 2(1), 2(3) [amend. 1983, c. 10, § 21], 3, 4, 18 [amend. 1983, c. 20, § 19], 30, 32 [amend. 1983, c. 10, § 21], 36 [amend. 1983, c. 20, § 19], 37 [amend. 1983, c. 20, § 20], 40, 41(1), 44 [amend. 1983, c. 10, § 21], & 45.

75. McKinney, 76 D.L.R.4th at 726 (per La Forest, J.).

Minister can require the passage of certain bylaws or the revision of any bylaw.⁷⁶

With respect to funding, evidence in *Vancouver General Hospital* disclosed that “the operating costs of the hospital are borne almost entirely by the province.”⁷⁷ In addition, the Cabinet “may withhold amounts payable to the hospital where the board of management refuses or neglects to comply with the Act or the regulations or fails to administer the hospital in a manner satisfactory to the Minister.”⁷⁸ Finally, conditions are attached to government grants for “the planning, constructing, reconstructing, purchasing and equipping of the hospital,” and the “province also subsidizes the hospital’s clientele, the patients.”⁷⁹ Nevertheless, Justice La Forest found that the *McKinney* criterion of control requires “routine or regular control” rather than “ultimate or extraordinary control,” and that government involvement in the affairs of Vancouver General Hospital constituted the latter.⁸⁰ Thus, a negative, “command” model of power is firmly inscribed as the exclusive model of state power underlying section 32 of the Charter of Rights and Freedoms.

The trilogy of government action cases had immediate and direct consequences for abortion access, providing a disheartening illustration of the contradictory promises of rights. As private actors, hospitals not only became potential rights holders, but they also became immune from scrutiny under the Charter. The unevenness in abortion access under section 251 of the Criminal Code, which the *Badgley Report* described as a serious inequity and which the *R. v. Morgentaler* Court found to be a fundamentally unjust violation of women’s rights to security of the person, became part of the free pursuit of individual preferences in the private sphere of social life. Indeed, after *R. v. Morgentaler*, the situation reported on by the Badgley Committee worsened in many provinces, in part because of the pressure put on hospital boards by the anti-abortion constituency.

Vancouver General Hospital raises questions about the coherence of a public/private distinction that consigns to the private side of the split an institution that is central to the Canadian state’s commitment to provide for the health of all of its citizens. The follow-

76. *Id.* at 727.

77. *Id.* at 710 (per Wilson, J., dissenting).

78. *Id.*

79. *Id.*

80. *Id.* at 739.

ing story of the struggle at Dauphin General Hospital in Manitoba provides a stark illustration of the inappropriateness of characterizing hospitals as private. In addition, it represents many struggles that occurred across Canada in the aftermath of *R. v. Morgentaler*.

In Manitoba, under the Health Services Insurance Act,⁸¹ every resident is entitled to receive benefits for medically required services performed by a physician unless the services are excluded by the regulations under the Act. Section 26 of Schedule H of the regulations⁸² excludes coverage for therapeutic abortions unless they are performed in a hospital. Thus, as in several other provinces, although clinic abortions are legal, they are not publicly insured.⁸³ At the time of this writing, Ontario and British Columbia were the only Canadian provinces where clinic abortions are fully insured under the national healthcare program.

In Manitoba, the difficulty is compounded by the lack of easily accessible hospital abortion services for many Manitoba women. At the time the Dauphin issue arose, ninety-five percent of all hospital abortions in Manitoba were performed at a hospital in Winnipeg.⁸⁴ Only three hospitals provided abortions outside Winnipeg: Dauphin General, Brandon General, and Portage La Prairie District.⁸⁵ Although there is an abortion clinic in Winnipeg, because of the Schedule H exclusion, it is accessible only to those who can afford to pay. Rural women wishing to use Winnipeg's abortion clinic face the added cost and difficulty of travel and time away from home.

Thus, although there is a national commitment in Canada to universal and publicly administered health care, in reality there is a two-tiered system that operates to limit access to reproductive services for some women. Outside of the four hospital districts, only privileged women who possess both wealth and mobility have unrestricted access to abortion services in Manitoba. The social

81. R.S.M. 1987, c. H.35.

82. Man. Reg. 5061/88 R.

83. The Schedule H exclusion of clinic abortions from coverage was successfully challenged in *Lexogest, Inc. v. Manitoba*, M.J. No. 54 (C.A. 1993). The majority found that excluding a service from coverage on the basis of the location at which it is performed was beyond the statutory jurisdiction of the Health Services Commission and the Cabinet to make regulations as set out in the Health Services Insurance Act, R.S.M. 1987, c. H35. However, since that decision, the Manitoba government has drafted an amendment to the Act that explicitly gives the government power to exclude services from coverage on the basis of the location at which they are performed. *Morgentaler Vows to Fight Manitoba on Abortion Payments*, *GLOBE & MAIL*, May 13, 1993, at A5.

84. George Nikides, *Hospital Moves to Ban Abortions*, *WINNIPEG FREE PRESS*, Mar. 4, 1991, at 2.

85. *Id.*

divisions perpetuated by the Schedule H exclusion resemble those that characterized the nineteenth-century experience of abortion access discussed earlier, suggesting that little besides the formal structures within which abortion services are delivered has changed.

The controversy at Dauphin General erupted on February 27, 1991, when the Board of Directors at Dauphin voted to ban all abortions except those where continuation of the pregnancy poses an "obvious threat of death" and where two surgeons as well as the patient's physician approve.⁸⁶ These requirements constituted a more onerous restriction on access than those struck down in *R. v. Morgentaler*. Legal experts were called upon to verify that the hospital, as a private actor, was indeed acting legally in spite of *Morgentaler*.⁸⁷ The ban set off a battle both within the hospital and within the Dauphin community. The medical staff at the hospital threatened to withdraw from all hospital committees. The Chief of Staff, invoking a competing and presumably more private sphere of freedom, viewed the ban as an intrusion into professional autonomy.⁸⁸ The mayor of the town was vilified as a feminist because, as a member of the Board, she had voted against the ban. The community, in yet another example of the ideological power of public and private, expressed surprise that the mayor, a public actor, relied on her "personal opinion" and that she took a "position" on the issue.⁸⁹ Frustrated at the Board's refusal to meet, the pro-choice chair of the Board, David Yerama, resigned.⁹⁰

The struggle culminated in a shareholders meeting on August 14, 1991, at which both pro-choice and anti-choice interests sought to gain a majority on the Board. Ordinarily, annual shareholders' meetings are held in a hospital boardroom. The 1991 meeting was held in a hockey arena in order to accommodate the more than one thousand people who attended. According to hospital bylaws, anyone can become a voting shareholder by paying three dollars a year or twenty-five dollars for a lifetime membership.⁹¹ The vote was

86. *Town Erupts Over Abortion Ban*, CALGARY HERALD, Apr. 10, 1991, at B5. See also Alexander Paul, *Abortion Ban in Dauphin Deemed Legal*, WINNIPEG FREE PRESS, Mar. 5, 1991, at 2.

87. Paul, *supra* note 86.

88. *Town Erupts Over Abortion Ban*, *supra* note 86.

89. Randy Turner, *Feminist Mayor Has Dauphin Astir*, WINNIPEG FREE PRESS, Mar. 14, 1991, at 1.

90. Alexander Paul, *Board Chairman Quits to Fight Abortion Foes*, WINNIPEG FREE PRESS, July 31, 1991, at 2.

91. David Kuxhaus, *Abortion Foes Face Off in Dauphin Hockey Arena*, WINNIPEG FREE PRESS, Aug. 16, 1991, at 1.

472 to 446 in favour of an anti-choice Board. Dr. Warrian, Chief of Staff, resigned the next day, accusing anti-choice groups of bringing in outsiders to stack the vote. However, nothing in the hospital bylaws required shareholders to be residents.⁹²

The juxtaposition of *Morgentaler* and *Vancouver General Hospital* with the story of the struggle at Dauphin General Hospital exposes some of the paradoxes underlying the classical liberal vision of rights. In *R. v. Morgentaler*, state intervention in a woman's personal decision to terminate a pregnancy was found to violate the natural boundaries of an individual's bodily security in a manner that was fundamentally unjust. Consequently, the law was struck down, restoring women to their "natural" state of autonomy and security. However, according to *Vancouver General Hospital*, a woman's "state of nature" turns out to include her subjection to the decisions of hospitals, doctors, and medical associations to limit severely or refuse to provide abortion services.

The negative impact of rights litigation extends far beyond the problem of access to abortion. The focus on the restoration of the individual's natural security and autonomy fails to recognize the material and ideological constraints on reproductive decision making that often make it impossible or very difficult for poor women and racial and cultural minority women to refuse abortion and other contraceptive services. Kathleen McDonnell has written about the high percentage of Canadian women who seek abortions because they cannot afford to raise a child and the high incidence of sterilization in conjunction with abortion among women who have little education.⁹³ In addition, the recent controversies over sex-selection clinics and pre-natal diagnosis reveal the powerful constraints that the social and cultural privileging of males and of the abled places on women who may give birth to female or disabled children.⁹⁴

92. David Kuxhaus, *Dauphin's Top M.D. Quits, Lashes Abortion Vote*, WINNIPEG FREE PRESS, Aug. 16, 1991, at 1.

93. NOT AN EASY CHOICE: A FEMINIST RE-EXAMINES ABORTION 70 (Toronto: The Women's Press 1984). With respect to the prevalence of sterilization abuse of racial and cultural minority women in the United States, see ANGELA YVONNE DAVIS, WOMEN, RACE & CLASS 202-22 (1983). The link between racism and sterilization abuse has recently re-emerged with regard to the use of contraceptive implants in sentencing women for child abuse, and with regard to the sterilization of women who are HIV positive or have a high risk of becoming HIV positive. See Margot Young, *Reproductive Technologies and the Law: Norplant and the Bad Mother* (publication forthcoming) (on file with the author); Beverly Smith, *Choosing Ourselves: Black Women and Abortion*, in FROM ABORTION TO REPRODUCTIVE FREEDOM: TRANSFORMING A MOVEMENT 83-86 (Marlene Gerber Fried ed., 1990).

94. See Christine Overall, *Sex Preselection*, in ETHICS AND HUMAN REPRODUCTION:

III. SOCIAL RIGHTS AND THE PUBLIC/PRIVATE SPLIT

The preceding account of the contradictory nature of rights discourse has become a familiar part of the critique of rights. The movement to entrench social rights is in part a response to that critique, a way of retaining the rhetorical power of an assertion of civil and political rights while at the same time addressing their emptiness and their failure to overcome the material constraints on freedom and equality within the private sphere.⁹⁵ Although rights to health care have not been constitutionally entrenched in Canada, the implementation of a national program of health insurance in the 1970s created an entitlement that is viewed by many Canadians as a fundamental aspect of membership in the Canadian community. The fact that the program provides universal access as well as comprehensive coverage of healthcare needs means that it has many of the functional characteristics of a formally entrenched social right.

In Canada, as well as in the United States, there is general acceptance of the notion that the state should not be limited to the coercive, social-ordering role of the classical liberal vision but rather should assume responsibility for a minimum level of welfare. To this end, the limited juridical state of classical theory becomes the juridical-administrative state of modern liberal democracies. Bureaucracies are put in place to facilitate the meeting of needs once thought of as private. This is an important achievement in the struggle for social justice, and the following critique does not mean to dismiss as inconsequential the benefits provided by the modern welfare state. In particular, the provision of basic healthcare services to all Canadians through a publicly funded national health insurance scheme is central to the exercise of meaningful citizenship rights in Canada. However, the ideological framework within which relations between the state and the citizen are understood remains unchanged by the development of the welfare state. This section will explore how that ideological framework, in particular the assumption of a split between public and private spheres,

A FEMINIST ANALYSIS 17-35 (1987); Adrienne Asch & Michelle Fine, *Shared Dreams: A Left Perspective on Disability Rights and Reproductive Rights*, in FROM ABORTION TO REPRODUCTIVE FREEDOM, *supra* note 93, at 233-40.

95. In Canada, the movement to entrench social rights resulted in the inclusion of a section entitled "Canada's Social and Economic Union" in the latest set of proposed amendments to the Constitution. See GOVERNMENT OF CANADA, CONSENSUS REPORT ON THE CONSTITUTION, "THE CHARLOTTETOWN AGREEMENT" (Ottawa: Queen's Printer, Aug. 28, 1992). The proposals were rejected in a national referendum in October, 1992.

reasserts itself in the context of healthcare delivery under the Canadian health insurance program. A brief description of the historical and constitutional background of the Canadian healthcare scheme is first necessary.

A. Canadian Health Insurance Program: The Historical and Legal Framework

Reliance on the market economy model of health care and the hidden network of unpaid and unlicensed caregivers described in the first section of this essay became strained during the depressions of the late nineteenth century and the depression of the 1930s. During the last third of the nineteenth century, the primarily rural agricultural economy of pre-Confederation British North America was transformed into an industrialized and urbanized economy. The expansion of waged work provided the basis for a labour movement, and the visible deterioration of the quality of life in urban centers gave rise to a middle- and upper-class social reform movement that pressed for state welfare programs.⁹⁶ This was followed, in the period from 1891 to 1940, by what Moscovitch and Drover have described as reluctant welfarism.⁹⁷ Pressure from the expanding social reform movement, farmers' and producers' cooperative organizations, immigrant groups, trade unions, and philanthropic groups led to increased state expenditures at both the federal and provincial levels and to a series of ad hoc reforms.⁹⁸

A more comprehensive public response to healthcare issues began with the development of municipal and, later, provincial health boards that for the first time attempted to move beyond an ad hoc, reactive approach to health crises and instead develop long-range health policies. By 1919, most provinces had some sort of health board or commission in place.⁹⁹ In 1917, New Brunswick set up a Ministry of Health and, two years later, a federal Department of Health was established. However, because of the understanding that health care was under provincial jurisdiction, the main policy vehicle for the federal government was the Dominion Council of Health, which was established at the same time as the federal ministry to bring together provincial health officials and experts to discuss health issues. The Dominion Council had no

96. Moscovitch & Drover, *supra* note 17, at 16-18. See also Wallace, *supra* note 9.

97. Moscovitch & Drover, *supra* note 17, at 16-18.

98. *Id.*

99. Dickin McGinnis, *supra* note 8, at 210.

power, however, and produced little other than “hours of talk.”¹⁰⁰ Thus, the private market economy model of health care, supplemented by a network of charity and volunteer organizations, community and family structures, and municipal institutions, remained responsible for dealing with and paying for Canadians’ health care until the second half of this century.

The main impetus for changes to the private market approach involved a combination of social and political factors.¹⁰¹ First, Canada experienced a severe breakdown in healthcare provision during the depression of the 1930s. Secondly, during World War II, fiscal and political power was consolidated and strengthened at the federal level in the form of tax rental agreements. Under these agreements, provincial governments abandoned the tax fields of personal income tax, corporate income tax, and inheritance tax in return for unconditional grants. Finally, the traditional political elites were threatened by the success in Saskatchewan of the Cooperative Commonwealth Federation, a social democratic party formed in 1933 that won the provincial election in 1944 under the leadership of T.C. Douglas. The Douglas government successfully implemented a system of public hospital insurance in 1947 that was followed by similar plans in British Columbia, Alberta, and Ontario. In 1959, the Douglas government again led the way by introducing publicly insured medical care.¹⁰² Even so, it was not until 1961 that a joint federal-provincial arrangement to set up a national scheme of publicly insured hospital care was finally put into place in all the provinces, and not until 1971 that this scheme was expanded into a national medicare system in which all the provinces and territories participated.¹⁰³

The contemporary understanding in Canada of health care as a fundamental aspect of public welfare accessible to every citizen as of right has had to fit itself into a constitutional division of powers that still leaves the delivery of health care to the provinces. In recent years, courts have deferred to a larger federal presence in public health issues by describing health as an “amorphous topic” that can be constitutionally treated as an aspect of either federal or provincial jurisdiction, depending on the nature of the scheme or provision.¹⁰⁴ Thus, the federal government has been able to regulate the manufacture of food and drugs that are dangerous to

100. *Id.*

101. TAYLOR, *supra* note 72, at chs. 1, 4, & 6.

102. *Id.* at chs. 2 & 5.

103. *Id.* at ch. 6.

104. *Schneider v. The Queen*, 2 S.C.R. 112, 142 (1982) (Estey, J.).

health under its "Criminal Law" power¹⁰⁵ and, in general, to criminalize behaviours that are dangerous to health.¹⁰⁶ There is a vaguely defined jurisdiction to deal with health emergencies or problems of a national dimension under the federal "Peace, Order and Good Government" power.¹⁰⁷ However, neither the "Criminal Law" nor the "Peace, Order and Good Government" power has been found sufficient to support a publicly insured and publicly administered social program such as health care.

During the depression of the 1930s, the federal government, under Prime Minister Bennett, referred a number of pieces of social legislation to the Supreme Court for a determination of their constitutional validity. One of those referred to the Court was the Employment and Social Insurance Act.¹⁰⁸ W.H. McConnell has described the constitutional issue before the Court as follows:

The constitutional problem presented by the statute was whether unemployment insurance was like any other type of insurance and thus a matter of contract falling under section 92(13), or whether as "social insurance," it was an insurance *sui generis* not subject to classification with commercial insurance contracts. In the latter case, it might be argued that (despite the precedents conferring jurisdiction over commercial insurance on the provinces) nation wide social need would enable the government to enact a *new* species of social insurance under the residuary clause.¹⁰⁹

Justice Rinfret, writing for the majority, ruled that the legislation was *ultra vires*, stating that "insurance of all sorts, including insurance against unemployment and health insurance, have always been recognized as being exclusively provincial matters . . ."¹¹⁰ The decision was upheld by the Privy Council.¹¹¹

A national scheme of unemployment insurance was made possible by a constitutional amendment in 1941.¹¹² The implementation of national health insurance took another route around the consti-

105. *Labatt Breweries v. Attorney Gen. of Can.*, 1 S.C.R. 914 (1990). Although the majority found that the federal regulation stipulating the alcoholic content of light beer was unconstitutional because it was unrelated to health, the implication was that compositional standards that are related to health come within federal jurisdiction under the criminal law power. See also *R. v. Wetmore*, 2 S.C.R. 284 (1983).

106. *Labatt Breweries*, 1 S.C.R. 914.

107. *The Queen v. Hauser*, 1 S.C.R. 984 (1979).

108. 25-26 Geo. V, c. 38.

109. W.H. McConnell, *The Judicial Review of Prime Minister Bennett's New Deal*, 6 OSGOODE HALL L. REV. 39, 43-44 (1968).

110. Reference re *The Employment & Social Ins. Act*, 1936 S.C.R. 427, 451.

111. *Attorney Gen. of Can. v. Attorney Gen. of Ont.*, 1937 App. Cas. 355.

112. CONSTITUTION ACT, 1867, § 91(2A).

tutional obstacle, namely federal-provincial financial arrangements, which continue to be a source of constitutional and political controversy. Under its spending power, the federal government has asserted jurisdiction to use its tax revenues, which greatly exceed those of the provinces, to establish shared-cost programs.¹¹³ Federal control of the design and uniformity of the programs is accomplished through grants to the provinces that have conditions attached.

The imposition of conditions represents a more intrusive federal presence than simply the consolidation of taxing power at the federal level combined with unconditional grants to the provinces that occurred during the Second World War. Although the conditions are negotiated beforehand with the provinces and participation is voluntary, dissenting provinces are effectively coerced into the regime by the prospect of losing the federal grant. In addition, residents of dissenting provinces must still pay taxes to support the program whether or not they benefit from it.¹¹⁴ Thus, in spite of judicial approval of the arrangement, there is considerable sentiment that the use of the federal taxing and spending power in this manner is an illegitimate invasion of provincial jurisdiction.¹¹⁵

The conditions and terms of the national medicare program are set forth in the Canada Health Act.¹¹⁶ Section 7 of the Canada Health Act sets out five criteria, which must be satisfied in order for a province to receive a federal cash contribution for its health-care insurance plan. The criteria are public administration, comprehensiveness, universality, portability, and accessibility. The criteria are explained in more detail in sections 8 through 12. In short, provinces must publicly insure all hospital services and physician services that are medically necessary. The insurance plan must be operated on a nonprofit basis by a public authority. Healthcare services must be reasonably accessible to all residents of a province on uniform terms and conditions. Sections 15, 16, and 17 set out the enforcement mechanism. A failure by a provincial government to conform to the statutory criteria is penalized by a

113. The Constitution Act 1867 makes no explicit reference to a federal spending power. It is generally thought to be implicit in the power to levy taxes in § 91(3), the power over public property in § 91(1A), and the power to appropriate federal funds in § 106. See HOGG, *supra* note 7, at ch. 6.

114. *Id.* at ¶ 6.8(a).

115. For cases supporting the federal spending power, see *In re Canada Assistance Plan*, 2 S.C.R. 525 (1991) and *Winterhaven Stables Ltd. v. Attorney Gen. of Can.*, 53 D.L.R.4th 413 (Alta. C.A. 1988). For critical commentary, see Andrew Petter, *Federalism and the Myth of the Federal Spending Power*, 68 CAN. B. REV. 448 (1989).

116. R.S.C. 1985, c. C-6.

reduction in or withdrawal of the federal cash contribution. In other words, a violation of the principles of the program, while not illegal, is made financially difficult. In addition, sections 18 and 19 provide that provinces will be financially penalized if they permit medical practitioners to extra-bill for insured services or if they permit hospitals to impose user charges for insured services.

The national medicare program introduced in 1969 and finally put in place in the 1970s rejects the market economy model of health care. However, it is not a shift to a scheme of socialized medicine but to a scheme that socializes the costs of medical care. It is what G.R. Weller calls the "subsidized entrepreneurial model" of healthcare provision.¹¹⁷ Weller elaborates as follows:

Health insurance schemes essentially subsidized the already existing health delivery system, and although health resources were still viewed as primarily a consumption good, they were seen to be so inequitably distributed that some public policy was needed to bring about greater equity.¹¹⁸

Public intervention in the form of public insurance requires direct controls on the market for medical services, especially in the setting of fees and in the allocation of funds for capital expenditures. Nevertheless, many facilities remain under private ownership, and doctors are self-employed entrepreneurs who make a living on a fee-for-service basis rather than on a salaried basis. Doctors remain in a strong negotiating position with provincial governments with regard to fee schedules and the design of healthcare delivery. As a result, doctors as a group have retained a considerable amount of control over the definition of health and over the general design of the process of producing health through curative rather than preventative measures.¹¹⁹

As discussed earlier, the monopoly that medical professionals have historically had on both the practice of medicine and the generation of medical knowledge has had important consequences for women and other groups who have not fully participated in the

117. G.R. Weller, *From "Pressure Group Politics" to "Medical-Industrial Complex": The Development of Approaches to the Politics of Health Care*, in PERSPECTIVES ON CANADIAN HEALTH AND SOCIAL SERVICES POLICY: HISTORY AND EMERGING TRENDS, *supra* note 9.

118. *Id.*

119. Donald Swartz, *The Limits of Health Insurance*, in THE BENEVOLENT STATE, *supra* note 17, at 255, 262. See also Weller, *supra* note 117. Although Weller identifies doctors as a group that has had a significant impact on healthcare policy, he points out that studies in health politics have tended to neglect the influence of other healthcare professionals and of governments in their roles as financiers and deliverers of health care. *Id.* at 319-20.

development of medical institutions and technologies. Although the reconfiguration of healthcare delivery within the Canadian social welfare state has improved access to healthcare services, it has only partially altered the structural disempowerment of marginalized social groups within healthcare practice. Patterns of consumption of medical services continue to reflect class and other social inequalities.¹²⁰ Thus, state-subsidized healthcare provision simply provides another locus for the depoliticization and privatization of those inequalities.

B. Canadian Health Care and the Reincorporation of the Private

Within the classical liberal vision, the institutions and practices of the family and the market, as well as personal and social interactions, are presented as natural. Thus, nature provides an external and objective guide to the boundary between public and private spheres. As discussed earlier, this conceptualization of social and political relationships still provides the underlying rationale for decisions such as *R. v. Morgentaler* and *Stoffman v. Vancouver General Hospital*.

However, the modern state does not conform to the classical liberal vision. To a certain extent, the development of social welfare rights to supplement the negative rights and freedoms of classical liberalism is a way of updating the private/public split. The abstract, unencumbered self of classical liberal theory acquires a body with concrete bodily needs. While it remains a self-interested and atomistic self, this reconstruction of the individual political actor now includes recognized dependencies and needs that must be addressed for the meaningful pursuit of happiness and enjoyment of the abstract freedoms of the classical liberal vision. It is no longer acceptable to dismiss those dependencies and needs as natural or as the result of happenstance or bad individual choices. Consequently, the boundary between public and private shifts by identifying the minimal provision of certain goods as a public responsibility.

The modern welfare state has both an expanded and, arguably, different role. The state is no longer limited to controlling social relations in the interest of order; it also acts positively and quite extensively to facilitate relations and to satisfy basic needs.¹²¹ In

120. Weller, *supra* note 117, at 260.

121. There is, however, a well-established view that the institutions of the welfare state are, in fact, directly aimed at controlling the lives of the poor and at averting outbreaks of social disorder that might disrupt existing economic and social hierarchies,

addition, the reconstruction of the political actor as embodied and encumbered with needs gives political impetus to the development of knowledge and expertise with respect to the measurement, credibility, and content of those needs. Thus, the transformation of the public within the welfare state is matched by a transformation, rather than eradication, of the private, which occurs in the replacement of nature with scientific, technological, and bureaucratic expertise as the objective external benchmark against which to measure public responsibility.

Scientific and administrative experts have become the key actors within the bureaucratic welfare state. Both the transformation of the state into the administrative state and the reliance on expert knowledge require a more complex and subtle understanding of how power is exercised and experienced than that presumed by classical liberalism and by the "direct control" criterion of government action doctrine. Michel Foucault has provided the notion of bio-power to describe the development of modes of control that are not exercised negatively through legal or customary prohibitions but positively through disciplines and technologies that focus on the life processes of the human body and on the characteristics and processes of populations or the species body.¹²² Law continues to play a role within this new regime of power. However, it is not the negative, coercive "law of transgression and punishment,"¹²³ but rather law as regulation and as norm. As Foucault writes:

Such a power has to qualify, measure, appraise, and hierarchize, rather than display itself in its murderous splendor; it does not have to draw the line that separates the enemies of the sovereign from his obedient subjects; it effects distributions around the norm. I do not mean to say that the law fades into the background or that the institutions of justice tend to disappear, but rather that the judicial institution is increasingly incorporated into a continuum of apparatuses (medical, administrative, and so on) whose functions are for the most part regulatory.¹²⁴

rather than at satisfying basic needs. See, e.g., FRANCES F. PIVEN & RICHARD A. CLOWARD, *REGULATING THE POOR: THE FUNCTIONS OF PUBLIC WELFARE* (1971). This article seeks to explore the less direct and more subtle ways in which welfare institutions entrench rather than transform relations of subordination.

122. MICHEL FOUCAULT, *THE HISTORY OF SEXUALITY* 139-145 (1990).

123. *Id.* at 85.

124. *Id.* at 144. Carol Smart questions the diminishing significance of the classic, juridical form of power. She suggests that, at least in some areas of social life, law is extending its influence through the "growing legalization of everyday life from the moment of conception (i.e. increasing foetal rights) through to the legal definition of death (i.e. brain death or 'body' death)." CAROL SMART, *FEMINISM AND THE POWER OF LAW* 8 (London: Routledge 1990). While this is consistent with Foucault's view of the

In particular, Foucault has written about the role of doctors and medical knowledge in extending the “politico-medical hold on a population hedged in by a whole series of prescriptions relating not only to disease but to general forms of existence and behaviour.”¹²⁵ The way in which the therapeutic exception in both the common law and statutory regulation of abortion defers to the authority of physicians, who in turn discipline women who do not conform to ideological notions of good mothers and wives, is an example of such a politico-medical hold. However, the overlay of the coercive apparatus of the criminal law in the most recent formulation of the therapeutic exception in Canada, ultimately brings the power of physicians sitting on hospital therapeutic abortion committees within the classical liberal vision of individual rights and state power. Doctors sitting on such committees are clearly government actors so long as the committees are constituted under the Criminal Code. The power they exercise has been passed to them like a hammer, a thing, by the state. This “thingification” of power obscures the way in which it is exercised more subtly through the medical determination of what constitutes an endangerment to health.¹²⁶

With the historical development of the administrative state and the professionalization of social welfare, the disciplines became integral to the expansion of state power in a very different manner than simply as additions to the state’s coercive apparatus. As H. Dreyfus and P. Rabinow write:

The administrative apparatus of the state posed welfare in terms of peoples’ needs and their happiness. Both of these were, of course, goals to which previous governments had dedicated

shift from law as coercion to law as norm, Smart tends to view the shift in terms of law extending its power into new areas by incorporating the discourses of the human sciences and thus maintaining its primacy in the hierarchy of knowledges, rather than in terms of law being superseded by other nonlegal discourses and modes of control. *Id.* at 8-14.

125. Michel Foucault, *The Politics of Health in the Eighteenth Century*, in THE FOUCAULT READER 273, 283 (Paul Rabinow ed., 1984).

126. Again, the “thingification” of power coincides with what Foucault would characterize as the older, juridico-discursive representation of power, which is most clearly realized in the imposition of legal rules and which has been, in the modern era, penetrated by the new mechanisms of bio-power. FOUCAULT, *supra* note 122, at 12, 82-83, 89. See also IRIS MARION YOUNG, *JUSTICE AND THE POLITICS OF DIFFERENCE* ch. 1 (1990), for a discussion of the inappropriateness of talking about power as if it is a commodity that can be distributed, or as if it is a “dyadic relation, on the model of ruler and subject.” Such an approach misses what Young calls the “structural phenomena of domination.” *Id.* at 31. Young also draws on a Foucauldian notion of power “as something that circulates” and that is “employed and exercised through a net-like organization.” MICHEL FOUCAULT, *POWER/KNOWLEDGE: SELECTED INTERVIEWS AND OTHER WRITINGS, 1927-1977* 98 (Colin Gordon ed., 1980) (quoted in YOUNG, *supra*, at 32).

themselves. But the relations have been reversed. Human needs were no longer conceived of as ends in themselves or as subjects of philosophic discourse which sought to discover their essential nature. They were now seen instrumentally and empirically, as the means for the increase of the state's power.¹²⁷

Other writers have similarly written of the way in which the instrumental rationalism of technological knowledge subsumes the human to the design requirements of the technological function. David Noble states:

Our culture objectifies technology and sets it apart and above human affairs. Here technology has come to be viewed as an autonomous process, having a life of its own which proceeds automatically, and almost naturally, along a singular path. Supposedly self-defining and independent of social power and purpose, technology appears to be an external force impinging upon society, as it were, from outside, determining events to which people must forever adjust.¹²⁸

In the same vein, Justice Beetz in *R. v. Morgentaler*, when addressing the power of doctors in making determinations as to whether a pregnancy endangers health, characterized the section 251 endangerment to health standard as "manageable because it is addressed to a panel of doctors exercising medical judgment on a medical question."¹²⁹ Medical expertise in this passage is invoked as something external to "social power and purpose" in the sense that Noble describes.

In the same passage, Justice Beetz expressed confidence that egregious abuses of the role that medical expertise qualifies doctors to play, such as withholding abortions from married women, will be policed and overruled as clear excesses of legal authority—that is, as exercises of power as a hammer that are not endorsed by the state.¹³⁰ This is perhaps an overly optimistic view of the feasibility of pregnant women successfully litigating such jurisdictional transgressions. In addition, the disciplinary power that is manifested in the way medical expertise shapes and defines "endangerment to health" is not captured by the notion of jurisdictional transgression and, thus, remains completely invisible or, at most, is deferred to as "medical judgment." In this sense, medical expertise provides the

127. HUBERT L. DREYFUS & PAUL RABINOW, MICHEL FOUCAULT: BEYOND STRUCTURALISM AND HERMENEUTICS 139-40 (2d ed. 1983).

128. DAVID F. NOBLE, THE FORCES OF PRODUCTION (1984).

129. 44 D.L.R.4th 385, 441 (1988).

130. *Id.*

external benchmark in accordance with which judges and other officials can determine the boundary between public and private.

Feminist writers have applied the notion of disciplinary power to analyze the way in which reproductive technologies have reinforced cultural images of conception, pregnancy, and birth that emphasize the separability of pregnant women and fetuses and the discontinuity of the female reproductive process.¹³¹ These cultural images subjugate the discourses of pregnant women who describe pregnancy in terms of unity, continuity, and body alteration rather than body inhabitation.¹³² Law, in turn, has been infused with what Marie Ashe calls the medical metaphors of female reproduction both by validating the medical definitions of conception, pregnancy, and birth, and by expanding the regulation or control of pregnancy by medical experts.¹³³

Deference to the scientific expertise of medical professionals, which conceals the expansion of power through a net of social relationships, is reinforced by and often intertwined with a similar deference to the technical expertise generated by bureaucratic practice. In both instances, the effect is to depoliticize issues of disempowerment and marginalization. Kathy Ferguson, drawing on Foucault, makes this point by applying the notion of disciplinary power to the study of bureaucratic modes of thought and action. Writing about the Progressive Era in United States history, she asserts:

Various fields of administrative practice—for example, administrative law, policy “science,” social work, public administration, and rational planning—brought together a focus on instrumental questions of technique and procedure with a substantive concern for reshaping the lives of clients, especially the poor. Together these fields redefined the relation of citizens to the polity in light of “the administrative approach to political membership,” substituting individual therapy and the consumption of services for political action.¹³⁴

Iris Marion Young develops much the same thesis. In her view, need becomes depoliticized within the welfare state so that, with

131. See Rosalind Petchetsky, *Fetal Images: The Power of Visual Culture in the Politics of Reproduction*, 13 FEMINIST STUDIES 263 (1987); IRIS MARION YOUNG, *THROWING LIKE A GIRL AND OTHER ESSAYS IN FEMINIST PHILOSOPHY AND SOCIAL THEORY* ch. 9 (1990); Marie Ashe, *Law-Language of Maternity: Discourse Holding Nature in Contempt*, 22 NEW ENG. L. REV. 521 (1988).

132. Petchetsky, *supra* note 131.

133. Ashe, *supra* note 131, at 537-553.

134. KATHY E. FERGUSON, *THE FEMINIST CASE AGAINST BUREAUCRACY* 33 (1984).

respect to healthcare services, the citizen is constructed as a health-care consumer, and the development of healthcare policy is seen in terms of distributing resources to satisfy needs in the most effective manner, rather than in terms of remedying disempowerment. This, in turn,

discourages public deliberation about collective decisions, especially about the goals of government, or the organization of institutions and relations of power. The depoliticized process of policy formation in welfare capitalist society thus makes it difficult to see the institutional rules, practices, and social relations that support domination and oppression, much less to challenge them.¹³⁵

These two concepts—the first of power exercised as disciplinary control rather than coercion and the second of the depoliticization of need within the welfare state by focusing on technique, procedure, and efficiency as the goals of administration—provide insight into the continued subordination of socially marginalized groups despite their rights to important social goods such as health care. The focus on a technical, “expert” assessment of need and on bureaucratic propriety creates a new realm of the private where claims of disempowerment once more disappear. The following story of the provision of abortion services at Stanton Hospital in the Northwest Territories provides a particularly disturbing illustration of how two technical discourses, one of medical science and the other of distributive efficiency, intertwine in ways that deepen the social divisions of gender and race.

C. *The Stanton Hospital Example*

The Northwest Territories cover a vast area that is roughly one-third the land mass of Canada. The majority aboriginal population is made up of the Inuit, Dene, and Metis Nations.¹³⁶ While there is some decentralization of political and administrative affairs to accommodate a diverse and geographically scattered population, most communities have limited or no road access and a single access point for medical services, either a nurse, a nurse practitioner, or, in larger communities, a physician.¹³⁷ Stanton Hospital, in the territorial capital, Yellowknife, is the only facility in the Northwest

135. YOUNG, *supra* note 126, at 75.

136. KENNETH COATES & JUDITH POWELL, *THE MODERN NORTH: PEOPLE, POLITICS AND THE REJECTION OF COLONIALISM* 2-3 (Toronto: James Lorimer and Company 1989).

137. NORTHWEST TERRITORIES MINISTRY OF HEALTH, *REPORT OF THE ABORTION SERVICES REVIEW COMMITTEE* 9 (Yellowknife June 1992) [hereinafter *REPORT OF THE*

Territories where therapeutic abortions are regularly performed.¹³⁸

Since 1985, doctors at the Stanton Hospital have been performing abortions with little or no pain control provided before, during, or after the procedure. The situation was publicized after a rape victim talked about her experience in obtaining an abortion at Stanton Hospital on a radio program in March of 1992. The program set off a flood of similar complaints.¹³⁹ Shortly afterward, the Minister of Health announced that an inquiry would be conducted. The ensuing report of the Abortion Services Review Committee found the following with respect to pain control:

Prior to the actual abortion procedure, some patients received pre-medication, either Ativan, which is a sedative and used to relieve anxiety; Exdol or Tylenol #3, which are pain relievers; Gravol to relieve nausea; Valium, a sedative; or Fentanyl, a pain reliever. Many women did not receive any pre-medication. During the actual abortion procedure, many patients did not receive any anesthesia. Following the procedure, most patients did not receive any prescriptions but were recommended to use over the counter pain medication if necessary.¹⁴⁰

The lack of pain control provided should be placed within the context of the attitudes of the staff toward abortion patients in general. One woman who complained was told that she did not receive pain control because "the man in charge of [the hospital] didn't approve of abortion."¹⁴¹ Another woman was told by the doctor after the abortion procedure, "Well this really hurt, didn't it? But let that be a lesson before you get yourself in this situation again."¹⁴²

Over half of the women seeking abortions at the hospital were aboriginal women and the treatment they received reveals the intertwining of racism and misogyny. An aboriginal woman who asked whether she would be put under was told "the only under you're going to get is the 40 below [temperature] outside."¹⁴³ A Metis woman undergoing her first abortion was greeted by the attending physician's comment, "so this is number five?"¹⁴⁴

ABORTION SERVICES REVIEW COMMITTEE]. See also COATES & POWELL, *supra* note 136, at 8.

138. REPORT OF THE ABORTION SERVICES REVIEW COMMITTEE, *supra* note 137.

139. Miro Cernetig, *NWT Orders Abortion Inquiry*, GLOBE & MAIL, Apr. 2, 1992, at A1.

140. REPORT OF THE ABORTION SERVICES REVIEW COMMITTEE, *supra* note 137, at 5.

141. Cernetig, *supra* note 139.

142. *Id.* at A5.

143. *Id.*

144. *Id.*

The *Report of the Abortion Services Review Committee* found that some women who begged for pain control during the procedure were refused,¹⁴⁵ while others were never informed of pain control options.¹⁴⁶ One patient was effectively blamed for any pain she was experiencing by the comment that "it was her hyper attitude that would cause pain."¹⁴⁷ Patients reported being frightened by the practice of being strapped onto the operating table with a belt over their stomachs without any explanation.¹⁴⁸ No counselling was offered to most patients throughout the process.¹⁴⁹ Instead, patients were questioned about their birth control practices, and one woman told the Committee that "she was 'lectured' by a nurse on birth control and hygiene, and felt that 'this treatment added insult to injury.'"¹⁵⁰ The enforcement of social hierarchies of race and gender in this manner remained unaffected by the legal and constitutional shifts in healthcare regulation throughout this period: specifically, the provision of the therapeutic exception in the Criminal Code in the name of liberalization, the striking down of the entire regulatory scheme in *Morgentaler* in the name of rights protection, and the ongoing provision of health care under a publicly administered, universal social program in the name of welfare state liberalism.

Although the *Report of the Abortion Services Review Committee* documented the procedures at Stanton Hospital and recommended changes to the pain control practices, it said very little about the attitudes of the staff other than that there was "a lack of communication between patients and caregivers."¹⁵¹ The issue was ultimately treated as one of faulty medical practices. The review committee made detailed recommendations regarding the provision of pain control, including recommendations about physician-patient eye contact and draping of equipment so as not to distress patients.¹⁵² In addition, the committee recommended that the hospital establish a formal process for patient complaints.¹⁵³

The committee's report recognised cultural difference as a factor, but only as something that needed to be accommodated by the

145. REPORT OF THE ABORTION SERVICES REVIEW COMMITTEE, *supra* note 137, at 20.

146. *Id.*

147. *Id.* at 19-20.

148. *Id.* at 20, 23.

149. *Id.* at 52-53.

150. *Id.* at 21.

151. *Id.* at 5.

152. *Id.* at 48.

153. *Id.* at 68-71.

existing arrangements through more sensitivity to different cultural practices, access to interpreters, and better communication. Although these measures are sensible and urgently needed to remedy the situation at the Stanton Hospital, they do very little to address the structural disempowerment of these patients in relation to doctors and administrators. In this sense, new and more detailed medical and bureaucratic procedures simply further obscure the larger issues of race, gender, poverty, and colonialism that shaped healthcare practices at Stanton Hospital. Those issues remain effectively privatized by the discourse of scientific and bureaucratic efficiency. In sum, while welfare state liberalism has conceded the embodiedness of the citizen, it has often turned out to be a body that is male, white, and professional, rather than the multiple bodies of social experience.

IV. CONCLUSION

This article has endeavoured to trace the manner in which healthcare issues have been understood in different historical periods and within different constitutional frameworks. The construction of health care as private in Canadian constitutional discourse has operated ideologically to obscure the way in which the social experience of health care reinforces already deeply rooted social divisions. The characterization of health care as a local and private matter for purposes of the division of powers between federal and provincial levels of government is premised on a denial of public responsibility for ill health and for the provision of healthcare goods. In addition, the discourse of individual rights with respect to access to health care has consolidated rather than transformed existing patterns of privilege and power. Within this latter framework, the social configuration of health and ill health is a result of natural and biological processes and thus beyond the purview of rights protection. The provision of universal healthcare benefits by the Canadian welfare state partially addresses the emptiness of rights discourse. However, the depoliticization of social inequality that occurs within the frameworks of federalism and of rights through the deployment of the notion of a private sphere re-emerges within this last framework in the form of deference to scientific and bureaucratic knowledge and practices. Technical knowledge replaces nature, and a new boundary line is drawn that once more removes the differentiated stories of oppression from the discourse of public responsibility.