



**Laidlaw Scholars Undergraduate Leadership and Research Programme**  
**Research Proposal**

# **Closing Canada's Abortion Access Gap: Legal, But Not Accessible**

**Christina Mai**

**Research Advisor: Christopher Cochrane**

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## **Abstract**

This research project investigates how Canada's decentralized federalist structure has allowed provincial governments to obstruct abortion access, despite national legalization. The study aims to identify regional restrictions that render abortion inaccessible, examine the influence of parliamentary sentiment on provincial policy decisions, and explore precedent for provincial jurisdictional authority restricting access to other politically contentious medical services. The methodology includes creating an updated geospatial map visualizing abortion clinic accessibility across Canada, conducting quantitative sentiment analysis of abortion-related words in parliamentary debates, and reviewing provincial and federal legislative financial penalty trends. By employing policy analysis and quantitative methodologies, the project seeks to contribute evidence-based policy recommendations to initiate overdue reform for equitable abortion access and other politically sensitive healthcare services. The findings will be shared through publication in a Canadian policy journal and presentations to policymakers and reproductive rights groups outside of Canada and the USA via the Leadership In Action project, with the goal of advancing healthcare justice and addressing systemic barriers affecting access to essential medical care.

## **Introduction**

This research project emerged from my firsthand experience of unequal access seeking medical care as an Alberta student in Ontario. Clinics rejecting my out-of-province coverage illuminated systemic jurisdictional barriers affecting access to politically divisive services under Canada's decentralized healthcare framework. This catalyzed an investigation into the policy determinants perpetuating interprovincial abortion access disparities.

By reviewing federal and provincial health legislation, I uncovered how Canada's fragmented jurisdictional landscape enables provincial contravention of national equity standards. Ambiguous statutes and inadequate enforcement within legislation like the Canada Health Act have permitted geographic provincial-level restrictions.

Employing policy analysis and quantitative methodologies, this project empirically examines how Canada's decentralized federalist structure has allowed provincial governments to obstruct abortion access despite national legalization. It proposes that strategic federal policy amendments and improved intergovernmental coordination could incrementally remedy gaps.

This project aligns with my core values of healthcare justice. Contributing evidence-based policy recommendations, I hope to initiate overdue reform for abortion access and other politically contentious healthcare services. Ensuring equitable access is vital, and as a young woman impacted by these barriers, I am committed to being part of the solution.

## **Research Objectives & Questions**

Research Questions:

1. Which regional restrictions in Canada's intergovernmental governance system render abortion inaccessible, despite legalization in Canada?

2. Does sentiment and deliberation in Parliament influence provincial decision-making around policy expansions/restrictions to abortion access?
3. Given project findings, is there precedent for the claim that provincial jurisdictional authority restricts access for other politically contentious medical services, like gender-affirming surgery?

#### Objectives:

1. An updated geospatial map visualizing abortion clinic accessibility across Canada, identifying regions with limited access. This will build on prior research by Sethna and Doull (2013) and reveal whether or not some women still have to travel >100km to access abortion clinics, as of the 2021 census.
2. A quantitative analysis of sentiment in Parliament towards abortion-related words.
3. Comprehensive review of provincial and federal legislative financial penalty trends via historical Canada Health Transfer legislation to assess the effectiveness of federal spending levers for policy enforcement. This analysis will be conducted on deduction reporting legislation during the years of 2013 (or the Census reporting year closest to the one Sethna and Doull (2013) utilized for their maps), 2021 (the most recent Census reporting year to which my map is based on), and 2023 (the latest CHA deduction report released).

## Background

In 1998, *R. v. Morgentaler* decriminalized abortion, affirming it as a life-essential medical service and a right for all Canadians (SCC). However, abortion access disparities persist today. Moreover, stigma and lack of political prioritization undermine women's voices calling for overdue reform (Stettner, 2016). I argue that through the omission of abortion from the Canada Health Act (CHA) and inadequate bilateral intergovernmental coordination, the federal government perpetuated abortion access inequities.

Canada's "Medicare" system divides authority over health insurance throughout the 13 provinces and territories. The system adheres to the principles of the Canada Health Act. The federal government enforces the CHA and funds provinces through the Canada Health Transfer. Provinces must deliver healthcare per CHA standards to receive full CHT funding. This is because provinces that violate CHA standards are subject to federal reductions or withdrawals of their CHT allotment.

Given Canada's decentralized federalist system and Medicare's jurisdictional divide, there is limited federal oversight on provincial healthcare governance legislation (Government of Canada; Palley; Tiedemann). As Palley argues, Canada's bottom-up federalism enables provinces to obstruct national health policies like the CHA without jeopardizing CHT payments. Consequently, provinces are able to limit abortion funding through their own governing legislation (Tiedemann). Another consequence is a lack of interprovincial portability, where out-of-province patients are prevented from using their coverage for services. Despite bilateral agreements stating provincial/territorial health cards should be accepted "in lieu of payment" for out-of-province services (Government of Canada), abortion clinics exploit the CHA's allowance of reimbursement by requiring upfront payment. This effectively denies services to patients unable to pay upfront, disregarding abortion's urgent nature.

Moreover, unregulated payment methods allow exorbitant upfront cash fees that disproportionately burden low-income students. Clinics can charge over \$900 in cash, with out-of-pocket expenses ranging from \$500-\$3200 (UPR). However, some provinces such as British Columbia and Ontario, recently took action against these practices. In 2023, British Columbia strengthened its Medicare Protection Act to increase penalties, protect reimbursements, and recover almost \$16 million of fines incurred from illegal facility fees (Medicare Protection Act). Yet, progress in other provinces is lacking, namely because inter-provincial political ideological difference hinders coordination. Historically, left-leaning parties expanded access after decriminalization while conservative regimes restricted it (Bashevkin).

Moreover, the continued lack of federal accommodations for provincial political ideology asymmetries facilitates these regional access disparities (McIntosh). For instance, the majority of rural Atlantic Canada is completely devoid of clinics (Norman et al.). As well, geographic gaps in access forces extensive travel, with over 18% of women travelling greater than 100km to access clinics (Sethna & Doull). Thus, provincial political inertia disincentivizes national efforts to increase clinic quantity. However, through federal leadership, the government can standardize payment regulation and improve interprovincial portability. Crucially, this requires an abortion-specific CHA provision to justify federal interventions such as national standards or disciplinary measures combating existing access inequities.

Note: I will consider my draft written here as a part of the background section for my paper.

## Methodology

- A quantitative analysis of sentiment in Parliament towards a seed word list for abortion-related words such as “contraceptive”, “abortion rights”, “pregnancy”, etc., using diachronic word embeddings (Rodman, 2019; Cochrane, 2019) with Python’s NLTK package on Professor Cochrane’s Lipad corpus. Then, I will use the words’ vector cosine similarities to calculate the syntactic and semantic relation between a Parliamentarian’s speech with abortion.
- To create the geospatial map, I will access [Statistics Canada’s population density data](#) for 2021, which can be found in the Census information that is available online. Then, I will utilize ArcGIS to create a density map (ESRI, n.d.) of Canada to highlight population distribution with colour gradients. Afterwards, I will use [Action Canada’s Abortion Access Tracker](#) and [Universal Periodic Review](#) data, which lists the number of abortion clinics per province and the cities which they are present in. Then, I will map out distances via lines between cities and towns for each province in relation to the approximate location of abortion clinics, ensuring not to disclose exact locations of clinics.
- For the literature review, I will look at which [provinces are receiving federal deductions](#) to their [Canada Health Transfer allocations due to out-of-pocket expenses](#) through the most recent [Canada Health Act Report](#). I will analyze the provincial deductions in 2021, the most recent Census reporting year to which my map is based on, and 2013, or the Census reporting year closest to the one Sethna and Doull (2013) utilized for their maps. This information will be compared with [provincial policy to expand or restrict abortion](#)

[access in the respective years](#) (2013, 2021, 2023). I will begin my search into the provincial policy with Action Canada's at-a-glance reports on provincial abortion policy.

### **Training/ Certifications Needed**

- [CS50's Introduction to Python](#). This course requires 30 days, which I will complete in May prior to my research process.
- [Interactive Word Embeddings with Word2vec and Plotly](#), takes 2 hours, which I will complete while I learn CS50. In addition, I will read and watch tutorials on using word2vec and diachronic word embeddings, such as [this one](#).

### **Research Location**

I will be studying at Stanford University this summer, so my research will be conducted remotely on-campus. My affiliation remains with the University of Toronto, as I will receive supervision and data from UofT.

### **Research Ethics Board**

My research will not require REB approval, as this my analysis will not be conducted on humans.

### **Timeline**

- May 1st – 30th: Training for certifications for Python prior to research.
- Week 1-2 (June 17<sup>th</sup> - June 30<sup>th</sup>): Geospatial mapping to update Sethna & Doull's 2013 Canadian abortion access map.
- Week 2-4 (July 1st – July 15<sup>th</sup>): Quantitative sentiment analysis.
- Week 4-6 (July 15<sup>th</sup> – 28<sup>th</sup>): Qualitative analysis (literature review), paper write-up and poster creation.

### **Resources & Support Needed**

I might need access to a computer with greater computing power than my current Macbook Air, but I anticipate I can utilize Stanford University's [computer lab resources](#). If there are issues with accessing the computers, I will connect with the Laidlaw Scholars program coordinators to discuss reallocating my budget to potentially getting a computer for the analysis, which I will return to the coordinators after the research duration.

I will also connect with my supervising professor on a weekly or bi-weekly basis to discuss my project, and raise any concerns regarding my progress with computational analysis.

### **Potential Impact**

- I want to emphasize that medical service access is not limited to abortion, by highlighting that provincial jurisdictional authority can restrict access for other politically contentious medical services like gender-affirming surgery. I believe this research potentially advances not only abortion access, but also highlight barriers to politically contentious healthcare services in Canada's healthcare system.

- Sharing these findings spotlight abortion access issues in Canada and opens policy windows, per the Punctuated Equilibrium Model (Baumgartner & Jones, 1993). I aim to publish in a Canadian policy journal and present to policymakers and reproductive rights groups, in addition to my Leadership In Action project outside of Canada and the United States.
- In relation to my Leadership In Action project, I hope to utilize the findings from this research to inform the political and policy process of increasing access in countries struggling with the legislative and intergovernmental factors to negotiating abortion access, such as creating a recommendations policy brief for a European Union nations.

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