

**Policy Brief:**  
**Safe Access to Free Contraceptive Care including Abortion**  
**for**  
**All Ontario Residents**  
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## Summary Statement

The purpose of this policy brief is to demonstrate the necessity for Ontario to implement a healthcare policy, similar to that in British Columbia, ensuring free and accessible contraceptives for all cisgender women, non binary, trans, and gender expansive folks (WNBTGE) capable of pregnancy residing in Ontario regardless of un/documented status. The inclusion of uninsured and undocumented folks under this policy further emphasizes the immediate right for uninsured and undocumented WNBTGE to free and accessible abortion care when contraceptives fail.

Implementing this policy is urgent because half of pregnancies are unintended, and almost 90% of fertile WNBTGE sexually active with male-bodied partners are currently trying to avoid pregnancy (Norman, 2023; SOGC, 2024). Dr Wendy Norman, CIHR-PHAC Family Planning Research Chair, reminds us that *“the most effective way to reduce the number of people with inequitable access to abortion, is to provide universal subsidy for prescription contraception”* (2023). Restriction of sexual and reproductive health (SRH) rights has negative consequences on mental health, and disproportionately impacts marginalized WNBTGE (Chabot, 2021; Stotland, 2019).



(SOGC, n.d.)



(SOGC, n.d.)

The World Health Organization (WHO) determined that access to full spectrum SRH care is a universal human right (Stotland, 2019). The Canadian Medical Association (CMA), Society of Obstetricians and Gynecologists of Canada (SOGC), and the Canadian Pediatric Society (CPS) each recommend that all contraceptives be covered for all WNBTGE federally and provincially/territorially (Albanese, 2024). The lack of access to SRH care creates a **gap in service delivery** and poses a human rights violation (Norman, 2023). From a cost perspective, access to free contraceptives could save close to \$27 million per year in healthcare costs (Chow, 2023).

I conclude with a discussion of evidence-based recommendations for immediate implementation of this proposed policy. Comprehensive SRH services demonstrate a social justice approach to healthcare (Goodman, 2014). Recommendations include collection of race-based and disaggregated data to determine how systematic racism impacts

BIPOC access to SRH care, and the steps necessary towards SRH health equity (Ashcroft & Adamson, 2022; Coen-Sanchez et al., 2022). Next, I recommend creating a model of universal access to contraceptives modelled from BC. Finally, I explore funding mechanisms that will allow SRH access without fear for marginalized and uninsured groups.

### Contraceptive Care in Ontario

Most individuals lack private insurance coverage for prescription medication, and reliable effective contraceptives are prohibitively expensive (Canadian Pediatric Society, 2019). Health Canada's 2023 news release acknowledges that marginalized populations face intersecting barriers to accessing abortion care due to overall minimal access to SRH care (Health Canada, 2023). This matters because Canada's population in 2011 was 20.6% newcomers, and estimated to be half of Canada's population by 2036 (Machado et al., 2022).

### Relevant History

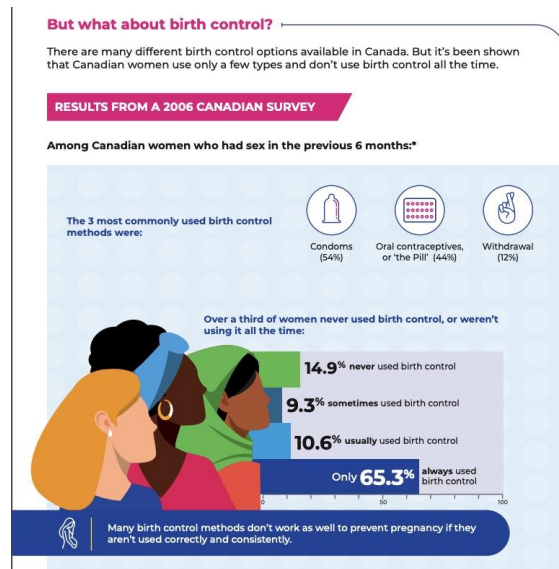
The Canada Health Act (CHA) in 1984 promised public administration, universality, comprehensiveness, accessibility, and portability across provinces (Hutchison et al., 2011). However, government funded provincial health programs are only available to citizens and permanent residents who have cleared the 90 day waiting period to receive OHIP in Ontario, and access to provincially funded insurance determines access to SRH care (Machado et al., 2022; Tolentino et al., 2024). Individuals needing contraceptives, or abortion after barriers to obtaining contraceptives, are unable to access SRH services for fear of deportation upon entering the healthcare system (Chabot, 2021). Unwanted pregnancies can increase WNBTGE social precarity and dependence on unsafe relationships (CART-GRAC, 2018; Chabot, 2021). The CHA determines abortion an essential healthcare service, yet there remain service gaps that disproportionately affect newcomer WNBTGE (Chabot, 2021).

### Past policy

The Physician and Hospital Services for Uninsured Persons (PHSUP) was implemented March 2020 until March 31 2023 to ensure accessible healthcare for all Ontario residents during the COVID-19 pandemic (Tolentino et al., 2024). PHSUP showed potential for true universal healthcare for all, reduced delays in accessing care, better access to emergency care, and less financial and psychological stress (Tolentino et al., 2024). While the argument for true universal healthcare is beyond the scope of this paper, the evidence supporting universal healthcare demonstrates the necessity of universal SRH care.

### Current policies

The 2021 federal budget allocated \$45 million over three years for SRH resources targeting marginalized populations with limited access to healthcare (Health Canada, 2023). The 2023 budget increased this amount by \$36 million over another three years starting 2024-2025



(SOGC, n.d.)

(Health Canada, 2023). Bill C-64 or the Pharmacare Act was passed in the House of Commons on June 3 2024, and approved by the Senate October 10 2024 (Morgan & Herder, 2024). While this ostensibly ensures immediate coverage of contraceptives, it perpetuates the fragmentation of care seen in our current national healthcare system (Morgan & Herder, 2024). The Pharmacare Act (2024) provides guidance for a national strategy for universal pharmacare (Morgan & Herder, 2024). However, this offers only the potential of universal pharmacare without concrete timelines or immediate strategies to impact population health (Morgan & Herder, 2024).

## Recommendations and Policy Options

I will conclude with three research-based recommendations and discuss the feasibility of and barriers to immediate implementation of each recommendation.

- ***Recommendation 1: Collection of race-based and disaggregated data***

The lack of race-based data in Canadian health scholarship has contributed to indiscernible statistical inequities in our healthcare system, and no specific indicators of how to remedy current policy failing marginalized populations (Coen-Sanchez et al., 2022; Goodman, 2014). Systemic racism impacts BIPOC SRH as a functional reinforcement of ongoing colonization, assimilation, and the institution of patriarchal healthcare paradigms (CART-GRAC, 2018; Coen-Sanchez et al., 2022). There is a dearth of BIPOC leadership at policy, institutional, and service provider levels. Power and social capital together provide access, therefore undocumented BIPOC have the least access and autonomy in SRH care (Coen-Sanchez et al., 2022). Ontario Health (2024) provides detailed resources on guidelines for the collection and analysis of race-based data. From an economic standpoint, implementing this recommendation has low financial barriers. A trend of heightened xenophobia and a growing pushback against antiracism in our current political climate present potential barriers to carrying out this recommendation (Lee et al., 2021; Machado et al., 2022).



(Ontario Health, 2024)

- ***Recommendation 2: Model a policy for universal access to contraceptives similar to BC***

Starting April 1 2023, BC residents enrolled in Medical Services Plan are eligible to receive most hormonal contraceptives, emergency contraceptive pills (ECP), and medication abortion paid for by PharmaCare (“Free Contraceptives”, 2023). The resident must present their BC health card and a prescription from an eligible prescriber such as a physician (MD), registered midwife (RM), nurse practitioner (NP), street health nurse, or pharmacist (“Free Contraceptives”, 2023). The CART research team investigated the economic and health impacts of subsidized contraceptives in BC and found that free contraceptive care is estimated to reduce unintended pregnancies and contribute to an annual \$27 million savings from year four of

implementation (CART-GRAC, 2018). Norman (2023) describes a steady state prediction of Ontario experiencing an overall annual savings of almost \$80 million by implementing a similar policy. The first year outcomes of this policy in BC models the financial feasibility of a similar healthcare policy change in Ontario (Chow, 2023). Potential challenges may lie in introducing this model of SRH care to Ontario’s provincial government amidst a trend of increasingly conservative public health policy (Tolentino et al., 2024). Requiring a health card to receive funded contraceptives prohibits access for uninsured folks (Tolentino et al., 2024).

Table 3. Cost of contraception in Canada\*

Method	Typical use failure rate <sup>1</sup>	Cost per unit	Units per year	Cost per year
Oral contraceptive	9%	\$11	13	\$143
Vaginal ring	9%	\$15	13	\$195
Transdermal patch	9%	\$15	13	\$195
Intramuscular injection (depomedroxyprogesterone acetate – DMPA)	6%	\$27	4	\$108
Intrauterine system (IUS) (levonorgestrel 20 mcg/day – effective for 5 years)	0.2%	\$319	1	\$63
Intrauterine device (IUD) (Copper – effective for 5 years)	0.8%	\$60	1	\$12
Male condom	18%	\$1	83	\$83
Female condom	21%	\$4	83	\$332
Diaphragm	12%	\$30	1	\$30

\*Dispensing fees are not included.  
<sup>1</sup>Based on typical couples who start using any method (though not necessarily for the first time) and experience an unintended pregnancy within the first year (if they do not stop use for any other reason).  
 Adapted from references (6,8).

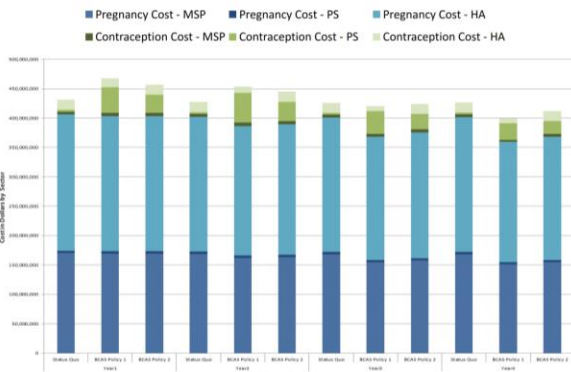
(Canadian Pediatric Society, 2019)

o **Recommendation 3: Funding mechanisms for SRH access for uninsured populations**

The current crisis of primary care providers arose from an unstable, nonexistent primary healthcare infrastructure (Hutchison et al., 2011). Hutchison et al. (2011) describe an expansion of the “primary health care provider pool” since 2000 due to dwindling provider numbers and consumer demands for quality care (p. 271). Research suggests that interprofessional health teams thrive, fostering work satisfaction and improving patient care (Hutchison et al., 2011). Interprofessional collaboration is a remedy for territoriality caused by overlapping scope of practice between MD, RM, and NP (Hutchison et al., 2011). In August 2023 the Ontario government announced a total of \$8.27 million to expand existing midwifery services and support expanded scope proposals (“Ontario Newsroom”, 2023). This is an opportunity to explore creative funding mechanisms to compensate SRH providers for providing care to

uninsured folks seeking out contraceptives. Currently, midwifery care is funded provincially such that all Ontario residents regardless of status are eligible to receive care free of charge, in contrast to physicians’ fee for service billing to OHIP (Association of Ontario Midwives, 2019). Midwifery scope of prescribing and regulated acts is rapidly increasing, meaning that Ontario RMs are now able to prescribe contraceptives, insert IUDs, and perform medication abortion in some circumstances (“E-laws | Ontario.ca,” 2023). Retrospective data on PHSUP corroborates that the period of universally accessible healthcare did not put a significant financial strain on the province’s healthcare expenditures; rather, appropriate access to care intercepted medical conditions before they became

medically complicated and more costly (Tolentino et al., 2024). Although we have documented examples of the feasibility of universally funded healthcare for all, once again growing anti-migration sentiments and political unrest across North America will be obstacles to carrying out this recommendation (Machado et al., 2022; Tolentino et al., 2024).



(CART-GRAC, 2018)

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