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Chapter 20

***R (on the application of A and B) v Secretary of State for Health* [2017] UKSC 41 (UK): What is the Cost of Reproductive Rights?**

Lynsey Mitchell

1. Introduction

R (on the application of A and B) v Secretary of State for Health (hereinafter *A and B*) was heard at the UK Supreme Court amid growing media attention paid to the prohibition on abortion in Northern Ireland (NI) and against the backdrop of the Campaign to Repeal the Eighth Amendment in Ireland.¹

The Abortion Act 1967 was not extended to NI, which meant that abortion provision has always existed in something of a legal vacuum there. Rather than the framework adopted in England, Scotland and Wales that allows doctors to provide abortions if certain criteria are met, abortions could only be legally carried out in NI when there was a threat to the woman's physical or mental health or life.² This meant that there was some provision of legal abortion in NI but the vast majority of people needing an abortion were forced to travel to Great Britain to seek abortion care.³ The lack of guidance on when an abortion was legal meant that there was a series of cases seeking judicial clarity on the matter.⁴

¹ For an overview of the Repeal the Eighth Campaign and its wider significance, see Ruth Fletcher, '#RepealedThe8th: Translating Travesty, Global Conversation, and the Irish Abortion Referendum,' *Feminist Legal Studies* 26 (2018), 233; Máiréad Enright et al, 'Abortion Law Reform in Ireland: A Model for Change,' *Feminists@Law* 5(1) (June 29, 2015).

² Abortion is criminalised in England and Wales by s.58 and s.59 of the Offences Against the Persons Act 1861, which also applied to Northern Ireland until 2020. The blanket prohibition on abortion was challenged in 1939 by an English doctor who instigated his own prosecution after performing an abortion on a thirteen-year-old rape victim. The Court interpreted s.58 and s.59 as allowing for some abortions and determined that these included where there was a threat to the woman's physical or mental health or life. See *R v Bourne* [1939] 1 KB 687.

³ Between 2020 and 2021, 63 abortions were carried out; in 2019-2020 there were 22; in 2018-19 there were 8; and in 2017-18 there were 12: Department of Health, 'Northern Ireland Termination of Pregnancy Statistics' (Hospital Information Branch), accessed 11 August 2023, <https://www.health-ni.gov.uk/articles/termination-pregnancy>.

⁴ *Northern Health and Social Services Board v F and G* [1993] NILR 268; *Northern Health and Social Services Board v A and others* [1994] NIJB 1; *Western Health and Social Services Board v CMB* (Unreported), High Court (Family Division), 29 September 1995; *Down Lisburn Health and Social Services Board v CH and LAH* (Unreported), High Court (Family Division), 18 October 1995.

2. Background

The case was brought by A and B, a daughter and a mother respectively. A was a fifteen-year-old girl who was pregnant and wished to have an abortion and B supported this. However, the fact that A and B resided in NI meant that A could not access an abortion there and her best alternative option was to travel to England. As well as the inconvenience and stress of travel, B had to raise money to pay for the termination as people from NI could not access National Health Service (NHS) funded abortions in England. Had A resided in England, the abortion would have been provided for free.

A and B was the first Northern Irish abortion case to reach the Supreme Court, and activists were hopeful that the court would determine that discrimination against Northern Irish people⁵ when it came to accessing funded abortions in England was unlawful and a violation of human rights. This case was not about the lack of abortion provision in NI; it was solely focussed on the discriminatory treatment afforded to those who travelled to England to have an abortion. Around the same time, the Northern Irish Human Rights Commission instituted judicial review proceedings, asking the Northern Irish High Court to rule that the lack of provision of abortion in cases of rape, incest, fatal foetal abnormality and serious malformation of the foetus was a contravention of human rights.⁶ Horner LJ declared the law incompatible with article 8 of the European Convention on Human Rights (ECHR) and issued a declaration of incompatibility under section 4 of the Human Rights Act 1998 (HRA), which was overturned on appeal.⁷

⁵ This commentary and judgment use the term ‘pregnant people’ recognising that trans men and non-binary people also experience pregnancy and may require access to abortion care. Recognising that trans and non-binary people need abortion care is important and adopting more inclusive language around pregnancy and abortion may help to improve access. Adopting inclusive language that challenges the assumption that only women can experience pregnancy and abortion also helps to dismantle the patriarchal narratives and norms applied to abortion and pregnancy. However, abortion law generally uses the term ‘woman’ to refer to those seeking abortion. The original judgment refers to ‘women’ (both the applicants specifically, and others seeking abortion more generally). Where possible, this commentary and rewritten judgment use the term ‘pregnant people’ but for clarity it uses the term ‘woman’ when referring to the original judgment or to legislation.

⁶ *In the Matter of an Application for Judicial Review by the Northern Ireland Human Rights Commission in the Matter of the Law on Termination of Pregnancy in Northern Ireland* [2015] NIQB 96.

⁷ *Attorney General for Northern Ireland v Northern Ireland Human Rights Commission* [2017] NICA 42 and *In the matter of an application by the Northern Ireland Human Rights Commission for Judicial Review (Northern Ireland)* [2018] UKSC 27.

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There was also growing recognition internationally that lack of access to abortion could constitute a violation of human rights,⁸ and UN treaty bodies called on States to reform abortion laws and remove criminal sanctions.⁹ The UK has been repeatedly criticised by UN treaty bodies for failing to redress the situation.¹⁰ Northern Irish activists and lawyers referred the UK Government to the UN Committee on the Elimination of Discrimination Against Women (CEDAW) over the lack of abortion provision in NI.¹¹

The Secretary of State for Health acknowledged that A and B had been treated differently when accessing abortion care in England.¹² His argument, which was accepted by the majority of the judges, was that treating people differently based on residence was justified and that it did not amount to discrimination under the ECHR. He argued that it was acceptable to force people from NI to endure serious financial and mental hardship because their needs were secondary to the devolved health settlement and because of the need to demonstrate respect for the wishes of the Northern Irish Assembly.¹³ However, neither the Secretary of State nor the majority of the judges explained why allowing people from NI to access the same funded abortions

⁸ Human Rights Committee (HRC), *Amanda Mellet v Ireland* (9 June 2016, CCPR/C/116/D/2324/2013); HRC, *KL v Peru* (22 November 2005, CCPR/C/85/D/1153/2003); CEDAW, *LC v Peru* (4 November 2011, CEDAW/C/50/D/22/2009); HRC, *LMR v Argentina* (28 April 2011, CCPR/C/101/D/1608/2007).

⁹ The Committee on Economic, Social and Cultural Rights (CESCR) has called on states parties to the International Convention on Economic, Social and Cultural Rights to ‘liberalize restrictive abortion laws; to guarantee women and girls access to safe abortion services and quality post-abortion care’: CESCR, *General Comment No. 22: The Right to Sexual and Reproductive Health*, (2016) UN Doc. E/C.12/GC/22 (2016), para. 10.

¹⁰ In 2016, CESCR recommended that the UK should ‘amend the legislation on termination of pregnancy in Northern Ireland to make it compatible with other fundamental rights, such as women’s rights to health, life and dignity’: CESCR, *Concluding Observations on the Sixth Periodic Report of the United Kingdom of Great Britain and Northern Ireland*, UN Doc. E/C.12/GBR/CO/6 (2016), para. 62. The Committee on the Rights of the Child (CRC) has also advocated that abortion be decriminalised and called on the UK to ‘review its legislation’: CRC, *Concluding Observations on the Fifth Periodic Report of the United Kingdom of Great Britain and Northern Ireland*, UN Doc. CRC/C/GBR/CO/5 (2016), para. 65(c). CEDAW has repeatedly challenged the NI regime in its UK reports: for example, CEDAW, *Concluding observations on the seventh periodic report of the United Kingdom of Great Britain and Northern Ireland*, UN Doc. CEDAW/C/GBR/CO/7, para. 51, and *Concluding observations on the sixth periodic report of the United Kingdom of Great Britain and Northern Ireland*, UN Doc. C/UK/CO/6, para. 289.

¹¹ FPANI, Northern Ireland Women’s European Platform and Alliance for Choice, *Submission of Evidence to the CEDAW Committee Optional Protocol: Inquiry Procedure*, Transitional Justice Institute Research paper (No 15-01), 60-61. For commentary on the utility of leveraging international human rights law, see Catherine O’Rourke, ‘Bridging the Enforcement Gap - Evaluating the Inquiry Procedure of the CEDAW Optional Protocol,’ 27 *American University Journal of Gender Social Policy & the Law* (2018), 1.

¹² *R (on the application of A and B) v Secretary of State for Health* [20].

¹³ The UK devolves certain areas of law (known as competencies) to the devolved nations—Scotland, Wales and Northern Ireland—which each have their own parliament or law making assembly. In Northern Ireland, health is a devolved competency under the Northern Ireland Act 1998. The devolution settlement sets out that the UK Parliament should not legislate in areas that are devolved.

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available to everyone else in the UK would threaten the devolution or democratic settlement in NI.

I find the framing of this case by the Government as a devolution issue rather than a reproductive rights issue particularly troubling given the conceptualisation of reproductive rights within the international legal regime's right to health. Framing abortion as an elective treatment which depends on the devolved political settlement elevates abortion to a position of great consequence in politics, while simultaneously de-prioritising it as a gendered health issue worthy of time or debate.¹⁴ This sends the message that reproductive rights can be bartered away,¹⁵ and positions abortion not as a right but as a privilege that is only granted when the political or social conditions allow.¹⁶

3. Queering Abortion Law?

The Court did not consider forced pregnancy to be a gross violation of bodily autonomy and human rights. I suggest this is because pregnancy and motherhood are still positioned as a gendered norm and ideal, rendering abortion a last resort, necessary in only the most extreme circumstances, rather than routine reproductive healthcare. Those who need abortions are constructed as tragic victims needing the legal and medical establishment's pity and paternalistic permission to access abortion.¹⁷ Human rights law has been of limited utility, securing access to abortion only where those who need abortions can demonstrate suitable justifications such as a threat to life.¹⁸ Since A did not fall within this category, the majority of the judges appeared content to view her quest to obtain an abortion as nothing more than the

¹⁴ The appellants cited a variety of international human rights law documents and decisions on abortion access, but their weight was considered 'slight' by the Court: *R (on the application of A and B) v Secretary of State for Health* [35].

¹⁵ Nicholas Hellen and Caroline Wheeler, 'Abortion Reform "Blocked to Protect DUP Deal,"' *The Times*, 27 January 2019, accessed 11 August 2023, <https://www.thetimes.co.uk/article/abortion-reform-blocked-to-protect-dup-deal-kpbw8vltt>.

¹⁶ Lynsey Mitchell, 'Reading Narratives of Privilege and Paternalism: The Limited Utility of Human Rights Law on the Journey to Reform Northern Irish Abortion Law,' 7/1 *NILQ* (2021), 89.

¹⁷ Rosamund Scott, 'Risks, Reasons, and Rights: The European Convention on Human Rights and English Abortion Law,' 24 *Medical Law Review* (2015), 1, 2.

¹⁸ Brid Ní Ghráinne and Aisling McMahon, 'Abortion in Northern Ireland and the European Convention on Human Rights: Reflections from the UK Supreme Court,' *International and Comparative Law Quarterly* (2019), 490.

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pursuit of elective treatment that would logically incur costs. That these costs were the main barrier to her not accessing an abortion is not understood as a problem, or certainly not one serious enough to merit legal redress.

There was no claim or consideration that the failure to provide funded abortions on the NHS to people from NI was a violation not only of article 14 (the right to enjoy the convention rights without discrimination) in conjunction with article 8 ECHR (the right to private and family life), but also of article 3 ECHR (The prohibition on torture and inhuman or degrading treatment). The failure to engage with the reality of A's circumstances appears to be another instance of pregnant people's suffering meriting sympathy, but not being considered serious enough to be a violation of human rights.¹⁹ Implicit within this is the idea that simply being forced to remain pregnant cannot be construed as a violation of human rights and that enduring hardship or suffering to procure an abortion is acceptable. A and B told the Court how the failure to fund abortions caused them severe trauma and suffering, yet this was not enough to engage article 3. However, a queer lens allows us to start from the position that actual trauma and suffering caused by the State's lack of protection for bodily autonomy is a violation of article 3, on the basis that the physical and mental hardships this causes reach the threshold for inhuman or degrading treatment.²⁰

Ludlow has highlighted this hierarchy within discourse about abortion, whereby narratives of 'traumatized' abortion stories resplendent with suffering eclipse those stories that reinforce the ordinary and routine nature of abortion.²¹ The implicit demand that 'abortion be the exception, and not a normal part of women's lives' reinforces the association between abortion and trauma, shame, violence, and abuse:

Because they are presented so frequently, these circumstances [rape and abuse, medically dangerous pregnancies] have become reinscribed as the

¹⁹ For a discussion of the failure of abortion trauma to engage article 3, see Ní Ghráinne and McMahon, 'Abortion in Northern Ireland and the European Convention on Human Rights.'

²⁰ Alyson Zureick, '(En)Gendering Suffering: Denial of Abortion as a Form of Cruel, Inhuman, or Degrading Treatment,' 38 *Fordham International Law Journal* (2015), 99.

²¹ Jeannie Ludlow, 'The Things We Cannot Say: Witnessing the Traumatization of Abortion in the United States,' 36/1-2 *Women's Studies Quarterly* (2008), 28, 41.

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‘appropriate reasons’ to have an abortion, and they render all other reasons for aborting questionable at best, and frivolous at worst.²²

This case positions pregnancy and childbirth as *normal* and abortion as *exceptional* and *elective*, rather than routine healthcare that is fundamental to respecting bodily autonomy and so, the law’s ability to offer redress to those needing to end a pregnancy is limited. This is because of the powerful heteronormative framing in which pregnancy is positioned as normal and desirable. This results in State regulation in the way of abortion restrictions being understood as justified.

4. Reproductive Justice

While abortion regulation may seem a firmly established feminist domain of legal critique, this case offers an important opportunity to demonstrate how a queer perspective allows for an alternative decision that would situate bodily autonomy, choice, physical and mental health at its centre, but also engage with wider social factors that are central to the reproductive justice movement. Reproductive justice is a term coined by Black and ethnic minority women that seeks to go beyond the narrow binaries of pro-choice and anti-choice which had become the focus of the reproductive rights campaign.²³

In attempting to conceptualise what queer reproductive justice would look like, many acknowledge a clash of ideologies.²⁴ Thomas and Morrison concede that a queer reproductive politic may appear ‘paradoxical,’ as feminist and reproductive rights movements have long sought refuge in political and legal protectionism while queer theory has produced ‘some of the most incisive critiques of identity politics and appeals to State protection.’²⁵ However, they

²² Ludlow, ‘The Things We Cannot Say.’

²³ See Justin Murray et al, ‘Introduction’ in *In Search of Common Ground on Abortion: From Culture War to Reproductive Justice*, ed. Robin West, Justin Murray and Meredith Esser (Farnham: Taylor and Francis, 2014), 4; Loretta J. Ross and Rickie Solinger, *Reproductive Justice: An Introduction* (Oakley: University of California Press, 2017); Laura Nixon, ‘The Right to (Trans) Parent: A Reproductive Justice Approach to Reproductive Rights, Fertility, and Family-Building Issues Facing Transgender People,’ 20/1 *William & Mary Journal of Law, Race, Gender and Social Justice* (2013), 73, 79-80.

²⁴ Mimi Marinucci, *Feminism is Queer* (London: Zed Books, 2016).

²⁵ Carly Thomsen and Grace Tacherra Morrison, ‘Abortion as Gender Transgression: Reproductive Justice, Queer Theory, and Anti-Crisis Pregnancy Center Activism,’ 45/3 *Signs: Journal of Women in Culture and Society* (2020), 705.

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demonstrate that insightful and powerful activism and alternative conceptualizations can emerge when feminist and queer theory approaches are united to champion reproductive justice:²⁶

We argue for reading abortion as gender transgression and suggest that approaching something as wildly ordinary as abortion—nearly one-quarter of US women obtain an abortion in their lifetime, after all—as transgressive encourages broadening queer conceptualizations of normativity and transgression, allowing us to recognize deeper connections between queer and reproductive issues and, further, to complicate this very distinction.²⁷

The case of *A and B* demonstrates society's and the judiciary's inherent patriarchal construction of those who need abortions as deserving sympathy, while mandating that they justify their need to have an abortion. Anyone who does not fit this narrow stereotype of having a tragic circumstance necessitating an abortion is therefore viewed as deviant. In rewriting this judgment, I wanted to subvert the law's continued adherence to stereotypical gendered attitudes and assumptions about pregnant people that deny agency and bodily autonomy when it comes to sex and reproductive decision making. The majority judgment in *A and B* refused to grapple with the wider reality for people like A, i.e., they cannot afford the cost of an abortion in England, so the real barrier is socio-economic. I wanted to centre this perspective and offer an alternative interpretation of abortion rights that was rooted in reproductive justice.

By adopting a queer perspective, I acknowledge that we can conceptualize access to abortion as constituting more than just a negative duty. Such a conceptualization as a negative duty does not engage with the reality of people's lives and is overly deferential to a heteronormative system in which abortion is positioned as deviant and destructive. As Cohen argues, queer politics will be most powerful when it engages with those who have not benefited from

²⁶ Thomsen and Morrison note that in 2013 there was almost no mention of the term queer reproductive justice, but that in the past decade, this has changed. In 2014, Unite for Reproductive and Gender Equity (URGE, formerly Choice-USA) added a 'Queering Reproductive Justice' page to its website. In 2015, the University of Michigan organized an event called 'Queering Reproductive Justice: Opportunities and Challenges.' In 2017, SisterSong held a 'Queering Reproductive Justice 101' workshop, and the National LGBTQ Task Force created 'Queering Reproductive Justice: A Toolkit.' See also Barbara Sutton & Elizabeth Borland, 'Queering Abortion Rights: Notes from Argentina,' *20/12 Culture, Health & Sexuality* (2018), 1378.

²⁷ Thomsen and Morrison, 'Abortion as Gender Transgression', 703.

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heteronormativity (e.g. Black single mothers) rather than being limited to LGBTQ-identified people.²⁸ For reproductive justice scholars and activists, a wider conceptualization of pro-choice advocacy borne of a queer lens is necessary because the right to legal abortion will ‘not resolve the barriers to having children that many women of color and low-income women face.’²⁹

Therefore, to truly have reproductive choice, critiques of barriers to abortion must include social and economic barriers, otherwise decisions around whether to become a parent cannot be made freely by everyone. It cannot be the case that reproductive freedom is only available to those with economic means. Not only do barriers to abortion perpetuate discrimination, but they reinforce the dominance of certain lifestyles. This is especially true around pregnancy and child rearing, where heteronormativity seeks to capture those with reproductive capacity:

[W]e cannot challenge dominant ideas about gender without taking reproductive norms seriously ... Because requirements for being considered a ‘good’ woman are sutured to what it means to be a ‘good’ mother, any work to upend gender norms requires critical engagement with ideas about reproduction—even for those of us who plan to avoid parenthood or do not have heterosexual sex.³⁰

In this judgment, I aim to similarly acknowledge the emancipatory potential of queer reproductive justice as a means to move beyond heteronormative narratives that position abortion as a tragedy or procedure of last resort or an elective procedure only for those with money. Instead, a queer lens offers the potential to disrupt the positioning of pregnancy as *normal* and *natural* with abortion juxtaposed as *exceptional* and *deviant*. It acknowledges that a society that values true reproductive freedom should determine that lack of access to funded abortion constitutes a human rights violation because a lack of funded abortion is, for many, a barrier to abortion.

²⁸ Cathy J. Cohen, ‘Punks, Bulldaggers, and Welfare Queens: The Radical Potential of Queer Politics,’ 3/4 *GLQ* (1997), 437.

²⁹ Zakiya Luna and Kristin Luker, ‘Reproductive Justice,’ 9 *Annual Review of Law and Science* (2013), 327, 328.

³⁰ Thomsen and Morrison, ‘Abortion as Gender Transgression’ 719.

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In this judgment, I also draw a parallel with other teenagers like A who seek healthcare but are forced to gain parental help to validate those decisions. Despite well settled case law on teenagers being able to consent to healthcare decisions privately,³¹ there are still situations, mainly around contraception, abortion, and gender affirming healthcare³² where teenagers are not considered to have agency, and this is reflected in State regulation of such care. True reproductive justice can empower teenagers and young adults to seek the care they need without overly burdensome State regulation making this impossible.

³¹ See, e.g. *Gillick v West Norfolk & Wisbeck Area Health Authority* [1986] AC 112, *Re R (A Minor) (Wardship: Consent to Treatment)* [1991] 3 WLR 592, and *Re E (A Minor) (Wardship: Medical Treatment)* [1993] 1 FLR 386.

³² *R (Bell) v Tavistock and Portman NHS Foundation Trust* [2021] EWCA Civ 1363.

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THE SUPREME COURT OF THE UNITED KINGDOM

Easter Term

[2023] UKSC 7

On appeal from: [2015] EWCA Civ 771

R (on the application of A and B) v Secretary of State for Health

before
Lady Mitchell

JUDGMENT GIVEN ON
10 August 2023

Heard on 15 and 16 March 2023

Introduction

1. This case concerns the provision of NHS-funded abortions to pregnant people from Northern Ireland (NI). The question for the court is whether it is lawful for the Secretary of State for Health (the respondent) to exclude A (a woman from NI who travelled to England to receive abortion care) from the provision of NHS-funded abortions.

The Abortion Act 1967

2. The Abortion Act 1967 (the 1967 Act) regulates the provision of abortion care in England, Wales and Scotland. It created a set of exceptions to the general criminalisation of abortion. S.1 lists four grounds on which an abortion can lawfully be provided. These are:
 - (a) that the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family; or
 - (b) that the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman; or
 - (c) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated; or

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- (d) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.
3. The Act did not decriminalise abortion. It provides permissible exceptions to criminalisation. S.5 states that any abortion that is performed outwith the grounds stated in s.1 remains a criminal act (*Greater Glasgow Health Board v Doogan and another (Scotland)* [2014] UKSC 68).
4. While the 1967 Act was considered a radical piece of legislation allowing doctors to provide abortions free from criminal sanction, it was not extended to NI as set out in s.7(3). Abortion remained criminalised there under the Offences Against the Persons Act 1861 and the Criminal Justice (Northern Ireland) Act 1945. Abortion in NI is allowed only when continuing the pregnancy would threaten the life of the woman, or her physical or mental health (*Family Planning Association of Northern Ireland v Minister of health and Social Services and Public Safety* [2004] NICA 37). The grounds on which a person can seek an abortion in NI are therefore much narrower than the grounds in the rest of the UK.
5. Consequently, most people who need an abortion in NI are forced to travel to Great Britain or elsewhere to obtain an abortion. This incurs significant costs.

Facts

6. The appellants (A and B) are both Northern Irish women. A was fifteen years old when she found out she was pregnant. B is A's mother. A wished to have an abortion. B helped to organise this and accompanied A to Manchester, where the procedure was carried out. The procedure and travel costs amounted to £900. Neither A nor B could readily afford this. B was able to raise £500 by borrowing money from friends. The other £400 was contributed by the charity Abortion Support Network, who intervened in this case. The stress of having to raise money urgently was a particular strain on A and B and caused particular difficulties.

Due in part to the virtual prohibition on abortion in NI, many medical practitioners are reluctant to even provide information on abortion due to fear of prosecution, a situation that

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the UN Committee on the Elimination of Discrimination Against Women called ‘chilling’ (CEDAW Committee, Inquiry Concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women, Report of the Committee, 6th March 2018, UN Doc. CEDAW/C/OP.8/GBR/1.)

7. Despite the European Court of Human Rights (ECtHR) making it clear that even in states where abortion is prohibited, the provision of information on abortion services comes within the ambit of article 10 of the European Convention on Human Rights (ECHR) (*Open Door and Dublin Well Woman v. Ireland*, Application no. 14234/88, 1992), the fear of prosecution meant that A had little advice and no opportunity to discuss abortion with medical professionals. This lack of information contributes to the stigma and fear of discussing abortion, which creates further obstacles for those trying to plan travel and secure funds to do so. It may also significantly delay the organisation of travel and abortion care.
8. Statistics show that approximately 1,000 pregnant people travel from NI to England for abortion care each year.³³ However, the true figure is much higher because many do not disclose they are from NI, and some travel to Scotland or Wales or further afield to undergo abortions. Changes to the law in the Republic of Ireland to allow for lawful abortion care means that some are now likely to travel there for abortion care.³⁴
9. If a pregnant person is not able to raise the funds to travel for an abortion, they are either forced to continue with a pregnancy they do not want and ultimately raise a child in circumstances that they would not have chosen, or they choose to undertake illegal self-administered abortions. ‘Back-street’ or self-administered abortions are the leading cause of death during pregnancy: 10,000 women and pregnant people die annually worldwide from

³³ 1,014 women travelled from Northern Ireland in 2019. In 2020 and 2021 the numbers were lower (371 and 161) but this is attributed to the travel restrictions in place due to the COVID-19 pandemic: ‘Abortion Statistics for England and Wales,’ accessed 11 August 2023, <https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2020/abortion-statistics-england-and-wales-2020>.

³⁴ In 2021, five people from Northern Ireland officially had abortions in the Republic of Ireland. The numbers are thought to be higher. See ‘Department of Health Ireland Annual Report,’ accessed 11 August 2023, <https://www.gov.ie/pdf/?file=https://assets.gov.ie/229909/2e7c74df-8c05-4263-be47-5ffe1b435250.pdf#page=null>.

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unsafe abortions and the UN cites lack of access to safe abortion as a risk to health and life.³⁵ While modern medical abortion is safe and poses less risk than pregnancy, criminal crackdowns and seizures of abortion medication means people may be forced to resort to unsafe non-medical self-administered abortions. Those who undertake self-administered abortions in NI are liable to criminal prosecution and several people have been prosecuted.³⁶ However, the availability and reliability of abortion pills means that many in NI attempt to obtain these from abroad, so the true number of abortions carried out in NI is unclear.

Abortion in Great Britain

10. The vast majority of abortions carried out in Great Britain are medical abortions.³⁷ Those seeking treatment are prescribed mifepristone and misoprostol. These drugs are considered safe and effective by the World Health Organisation (WHO).³⁸ At the time A sought an abortion, pregnant people in England were required to attend in person to obtain treatment. Subsequent amendments have allowed pregnant people's homes to be classed as a suitable place of treatment, thus allowing abortions to effectively take place at home following a consultation and prescription of medication.

Grounds of Challenge

³⁵ World Health Organisation (WHO), 'Abortion factsheet,' accessed 11 August 2023, <https://www.who.int/news-room/fact-sheets/detail/abortion>.

³⁶ In 2016, a student who miscarried after taking pills purchased online was found guilty and sentenced to three months of imprisonment (suspended): Henry McDonald, 'Northern Irish Woman Given Suspended Sentence Over Self Induced Abortion,' *The Guardian*, 4 April 2016, accessed 11 August 2023, <https://www.theguardian.com/uk-news/2016/apr/04/northern-irish-woman-suspended-sentence-self-induced-abortion> The facts are narrated in *In the matter of an application by the Northern Ireland Human Rights Commission for Judicial Review* (Northern Ireland) [2018] UKSC 27 [89]. In 2017, a mother was charged with procuring pills for her 15-year-old daughter. The judge ordered the jury to acquit her following amendments to the law on 22 October 2019. The case is unreported but the decision to prosecute was the subject of a judicial review: *In the Matter of an application for judicial review by JR76 and in the matter of a continuing decision by the Director of Public Prosecutions to prosecute the first applicant* [2019] NIQB 103.

³⁷ In 2021, 87% of abortions in England and Wales were medical abortions: 'Abortion Statistics England and Wales,' accessed 11 August 2023, <https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2021/abortion-statistics-england-and-wales-2021>. In Scotland, 98.8% of abortions were medical: 'Abortion Statistics Scotland,' accessed 11 August 2023, <https://publichealthscotland.scot/media/19737/2023-05-30-terminations-2022-report.pdf>.

³⁸ World Health Organisation (WHO), 'Clinical practice handbook for safe abortion' (WHO: Geneva, 2014).

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11. The appellants argue that the respondent's failure to provide an NHS-funded abortion for A (a UK citizen ordinarily resident in NI) was unlawful in public law and a breach of A's human rights.

The NHS in England

12. Section 1(1) of the National Health Service Act 2006 (the 2006 Act) places a duty on the respondent to promote a comprehensive health service in England, designed to secure improvement in '(a) the physical and mental health of the people of England, and (b) in the prevention, diagnosis and treatment of physical and mental illness.' The Act states that the respondent must provide services in accordance with the Act and exercise their functions so as to secure that such services are provided.

13. The respondent's argument is that, since the 2006 Act refers to the 'people of England,' they were obligated to only provide abortion services for those ordinarily resident in England, which would exclude any duty to people from NI, since they are not ordinarily resident in England. The respondent also claims that, since the system of devolved healthcare places a similar duty on the Northern Irish Health Secretary to provide healthcare for the people of NI, it would be incorrect for the respondent to include people from NI within the confines of the services provided to the 'people of England.' Regulation 3(2) of the National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Admissions Arrangements) (England) Regulations (SI 2002/2375) delegates the operation of the respondent's functions to primary care trusts. Regulation 3(7) sets out the categories of persons for whom the trust should exercise these functions:

- (a) Persons registered, other than temporarily, with a GP in the area of the trust;
- (b) Persons 'usually resident in the area';
- (c) Persons resident outside the UK who were present in its area (albeit that other regulations required a trust to charge such persons for services);
- (d) Persons suffering serious mental illness who were resident in other parts of the UK and who were present in its area; and

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(e) All persons present in its area but only for the provision to them of emergency and analogous services, treatment for certain infectious diseases and ‘any other services which the [respondent] may direct’.

14. The appellants argue that it was within the powers of the respondent under regulation 3(7)(e) and s.7(1) of the 2006 Act to dictate to trusts that the provision of abortion services should include those who were UK citizens resident in another part of the UK. Had the respondent done this, A would have been entitled to an NHS-funded abortion in England. The appellants argue that the failure of the respondent to exercise this power was irrational and a violation of their human rights.

Public Law

15. The respondent acknowledges that it was within his power to choose to include people from NI in his direction to trusts when commissioning services. However, he argues that his decision not to exercise this power is justified, as he did so to respect the devolved system of healthcare throughout the UK and the democratic mandate in NI that chose not to provide abortions and continues to criminalise them. It was argued that allowing people from NI to access NHS services in England would contribute to wider ‘health tourism’ that would undermine the devolved system of healthcare.

16. The issue to be decided here is whether the respondent should have directed trusts to allow people from NI who needed abortions access to the funded regime in England. Since Northern Irish people can already receive NHS-funded care if they happen to need it when in England, it is strange and absurd to suggest that allowing access to NHS-funded abortions would create a precedent for health tourism. Despite the respondent’s duty being to the people of England, those from the rest of the UK and abroad can receive treatment via the NHS in England. Someone ordinarily resident in NI who develops acute appendicitis while visiting England would receive an appendectomy free on the NHS. That same person has to pay if they require an abortion. The respondent justifies this discrepancy by claiming he is respecting the system of devolved healthcare in the UK. The case in question relates to abortion care, which is unique as it is healthcare that cannot be accessed in NI. People from NI are not travelling to

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England for better abortion treatment, they are forced to travel to obtain abortion care because they cannot have this treatment legally at home. It is not the funding that is enticing them to England, but the fact that there is no option to have the treatment in NI.

17. In respect of the argument that the respondent's decision to deny funding stems from a desire to respect the will of the Northern Irish Assembly (which continues to criminalise abortion), I am unconvinced. Permitting Northern Irish people to travel to Great Britain to access abortion is understood to respect the will of the Northern Irish Assembly, therefore I am unconvinced that extending funded care to those same people somehow tips the balance into disrespect.

18. I therefore find that the respondent was remiss in not exercising his powers to direct trusts to fund abortions for those from NI. I do not find his reasoning compelling and do not agree that excluding people from NI from any possibility of funded abortion care in the UK is a legitimate aim.

Human Rights

19. The appellants argue that the failure of the respondent to exercise his power to make provision for people from NI to have funded abortions violates article 14 (right to enjoy Convention rights without discrimination on any ground) of the ECHR in conjunction with article 8 (the right to respect for family and private life).

Article 8 ECHR

20. It is established that decisions over abortion engage article 8 (*A, B & C v Ireland*, Application no. 25579/05, 2011). While the ECtHR makes clear that article 8 does not confer a right to abortion, state decisions to prohibit or limit abortion come within the parameters of article 8. This was accepted by the respondent.

Article 14 ECHR

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21. Article 14 provides that persons will not be discriminated against in the application of the Convention. The applicants' argument is that they are being discriminated against because they are from NI, and had they been from another region of the UK, then they would have been able to access an NHS-funded abortion in England. The respondent does not dispute this but claims that it amounts to different treatment and not discrimination within the ambit of article 14, because his decision struck a fair balance and was not manifestly without reasonable foundation.

Residency

22. While residency is not specified as a ground in article 14, it does fall under 'other status' (*Carson v United Kingdom* 51 EHRR 13 [70]). The respondent relied heavily on *Magee v UK* ((2000) 31 EHRR 35). Here the applicant was a man ordinarily resident in England, who was arrested while visiting NI. He complained that he was treated differently based on residency, because had he been in England, he would have received better treatment after his arrest. However, the situation here is not analogous. It is not a case of a person from England arguing that they are being discriminated against because they have less access to abortion in NI than they would in England. It is a case of a person from NI arguing that they are in England, and the only reason for denying them access to funded NHS care is their residency in NI and the fact that the care they need is abortion care. The appellants are being treated differently because they normally reside in NI.

Is the Difference in Treatment Justified?

23. Someone present in England would be treated free of charge by the NHS in England if they were from NI and required immediate medical care in any other situation. This appears uncontroversial. However, in excepting abortion care from this understanding, those who travel to England for an abortion are being singled out solely on the basis that they are seeking abortion care, and they are from NI. If Northern Irish people who are not pregnant are entitled to free NHS treatment in England should they require it, and this is considered uncontroversial, then it is difficult to understand why providing free abortion care to pregnant people from NI

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is controversial. Abortion care, which is healthcare, is being singled out as different from *routine* healthcare.

Did the Difference in Treatment Pursue a Legitimate Aim?

24. The respondent does not clarify why he believes he should defer to the fact that abortion is criminalised in NI when making decisions about funding abortion care in England. Were the respondent's explicit aim to prevent pregnant people from NI from seeking abortions in England,³⁹ this could at least be said to be respecting the democratic will of the Northern Irish Assembly, as this position would be logically coherent, although unlawful. However, the fact that over 1,000 people travel to England annually for abortion care demonstrates that the respondent's decision not to provide funded abortions for people from NI does not prevent abortions, it simply makes them harder, more costly, and more traumatic to obtain. Preventing abortion cannot be his aim. The logic behind his decision seems less about being respectful of democratic will and devolution and more about being punitive to those seeking abortions. It is not clear how this respects the devolution settlement. The UK Government maintains overall responsibility for meeting the UK's human rights obligations and reproductive healthcare is one such obligation.

25. Attempting to reproduce the criminality of abortion and the restricted access to all but the most extreme cases would mean denying the majority of Northern Irish pregnant people seeking abortion any effective access to abortion in Great Britain, ultimately forcing them to carry pregnancies to term against their will, forcing them to resort to unsafe or illegal abortions, or forcing to travel abroad to access abortion services. While people are not explicitly prohibited from travelling outside NI to have an abortion, the very real effect of the respondent's decision is that at best it frustrates and encumbers those seeking to travel for abortion care, and at worst prevents it entirely. I am not convinced that the cost of abortions being prohibitive to many can be considered anything other than a direct consequence of the respondent's decision. Nor is this an unintended consequence. By claiming to respect the democratic and devolution settlement in NI, the respondent can only intend to frustrate access

³⁹ Preventing people from accessing abortion is a violation of the ECHR. In *P & S v Poland*, application no 57375/08 (ECHR, 30 October 2012), the ECtHR held that Poland had violated the applicant's article 8 rights.

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to abortion for people from NI. I do not find his justifications for treating those from NI differently compelling, nor do I find that they constituted a legitimate aim or struck a fair balance.

Young people and body autonomy

26. At the time she found out she was pregnant, A was 15. Courts have previously been asked to determine the limits of young persons' ability to consent to medical treatment (*Gillick v West Norfolk & Wisbeck Area Health Authority* [1986] AC 112 House of Lords; *R (Bell) v Tavistock and Portman NHS Foundation Trust* [2021] EWCA Civ 1363). However, in this case, both mother and daughter agreed about the best treatment for A. The lack of abortion provision in NI meant that the only way to achieve this was by travelling to Great Britain. The initial barrier to A receiving abortion care was the lack of provision, and criminal sanctions for abortion, in NI. A further barrier was the respondent's decision to exclude pregnant people from NI from funded abortion services that he commissioned.

27. Article 12 of the United Nations Convention on the Rights of the Child (UNCRC) provides that 'States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.' In domestic law, as *Gillick* and subsequent cases have set out, in almost all other medical situations, young people's views are respected, and parents should not be informed against their children's wishes. This case involved an abortion about which both mother and daughter agreed. It would be almost impossible for a young person who did not have parental support, or did not wish to inform their parents, to navigate such a system. These consequences would have been known by the respondent and considered acceptable.

Intersectional barriers due to age and socio-economic background

28. The respondent's position is that pregnant people were not prevented from leaving NI to obtain abortion care. Here the respondent frames his obligations to NI people needing abortion care only in a negative context. While at no point did the State detain or actively seek

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to prevent A from travelling to Great Britain to obtain an abortion, the reality is that the respondent's decision to exclude her and others like her from funded abortion care services creates a real barrier to access. In many cases, this will prevent people from accessing an abortion. This is surely much more so when the persons involved are under 18 and unlikely to be able to access the necessary funds. They will be unprepared for navigating the complexities of booking an abortion and travel to Great Britain, especially if they are trying to do this without informing a parent or guardian and without any professional guidance or support.

29. The appellants' case was that A had been discriminated against on the basis of residency. However, it was open to them to argue that A was also discriminated against on grounds of age, sex, and the fact that she was pregnant. Had A wished to obtain an abortion and not inform her mother, she would have found the barriers almost unsurmountable. The practical effect of the respondent's decision is that young people like A face an almost virtual prohibition on leaving NI to obtain an abortion. This amounts to discrimination against people from NI, particularly young pregnant people. This creates trauma and embeds stereotypes around pregnancy and abortion.

Conclusion

30. The question for the court was whether the respondent's decision to exclude people from NI from accessing NHS abortion care was a dereliction of his duty under public law and whether this decision violated A's human rights. The fact that A was ultimately supported by her mother to have an abortion, does not detract from the harsh realities that the respondent's decision created for people like A.

31. He argued that his decision to exclude pregnant people from NI from funded abortions was motivated by desire to afford respect to the devolved healthcare system and democratic decision making in NI. He did not explain why he should be motivated by this in respect of provision of abortion care in England. Regardless, I am not convinced by his argument that his decision was justified.

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32. It is my view that the respondent deferred too much to the fact that abortion is criminalised in NI. The fact is that abortion is still effectively criminalised throughout the UK. The Abortion Act 1967 did not repeal the underlying criminal law, but instead merely created legal exceptions that escape criminalisation. The difference in NI is not that abortion is criminalised; the difference is that the regime for commissioning legal abortion care services under the 1967 Act was never extended to NI. While it is true that NI has therefore retained the pre-1967 position and allows for abortion only in situations where the pregnant person's life or physical or mental health is at risk (*R v Bourne* [1939] 1 KB 687), it is the case that some abortions are legally carried out there. A did not meet the criteria for a legal abortion in NI, but the respondent appears to have sought to replicate many of the barriers to abortion care for Northern Irish people in England. It is not clear why.

33. In excluding Northern Irish pregnant people from funded abortion care, the respondent has effectively sought to allow abortion for those from NI in only the narrowest circumstances. Rather than criminalisation, the barriers these people face in England are costs and ability to travel. While not explicitly preventing them from obtaining an abortion in England, for many, his decision has that practical effect. In my mind, this is exactly what the respondent means when he says that he is respecting the system of devolved health care and respecting the democratic mandate in NI. He is doing so by deliberately making it difficult for people from NI to obtain abortion care. However, his duty is not to Northern Irish law makers, but to facilitate healthcare for the people of England (which can include people from NI).

34. The respondent agreed that because of his decision, people from NI were treated differently, but claimed this did not meet the threshold for violating article 14 as his decision to treat NI people differently pursued a legitimate aim and was proportionate. It is not clear what the respondent's aim was, and his claim that he was respecting the devolved system of healthcare and the democratic mandate of the Northern Irish Assembly is unconvincing and illogical. I therefore find that his decision to treat people from NI differently amounts to discrimination under article 14. A was a child who was pregnant and from NI. For all of these reasons she was discriminated against.

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35. I find that the respondent's decision not to exercise his duties and not to fund A's abortion, amounted to a violation of the appellants' article 14 rights in conjunction with article 8. She was excluded from necessary healthcare and treated less favourably because she was from NI. While it was not open to me to consider whether this treatment amounts to a violation of article 3, it is clear to me that the effect of the respondent's decision was real suffering, trauma, and hardship.

For these reasons I would allow the appeal.