ABORTION ACCESS AND THE BENEFITS AND LIMITATIONS OF ABORTION-*PERMISSIVE* LEGAL FRAMEWORKS: LESSONS FROM THE UNITED KINGDOM

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Abstract

This paper argues that abortion access is an important subject for bioethics scholarship and reflects on the relationship between legal frameworks and access to care. The author uses the example of the United Kingdom to examine the benefits and limitations of abortion-permissive legal frameworks in terms of access. These are legal frameworks that enable the provision of abortion but subject to restrictions. An abortion permissive regime – first in Great Britain and then in Northern Ireland, has gone some way to improving access to care over time. However, aspects of the regime (that lead to its description as permissive rather than supportive of abortion) have the potential to endanger abortion access in the future and so legal reform is necessary.

Keywords

Abortion, Abortion Law, Abortion Rights, Access to Abortion, United Kingdom

Conflicts of interest

The author declares no conflict of interest.

INTRODUCTION

In 1967, the passing of the Abortion Act 1967 (AA 1967) meant abortion became *legally* accessible in a wider range of circumstances in Great Britain (England, Wales, and Scotland).[1] The AA 1967 remains the basis of abortion provision in Great Britain today, and there have been few attempts to modernise it. Amendments have only been made twice in 1990[2] and 2022[3] (and only one of these can be described as a progressive change). Interpretation of the AA 1967, however, has liberalised increasingly since its inception meaning that abortion has become increasingly accessible to British people.[4] In Northern Ireland, in contrast, abortion was only lawful where necessary to save a pregnant person's life/to avoid very serious harm[5] until 2019 when abortion was partially decriminalised.[6] Even since decriminalisation, and the instigation of new abortion regulations,[7] abortion has remained inaccessible for many abortion-seekers in Northern Ireland, many of whom are still having to travel to England for care.[8] There are no rights to abortion in the United Kingdom (UK). While abortion remains a criminal offence across Great Britain, and in limited circumstances in Northern Ireland, conditions of abortion access have continued to improve over the last decade.

In this paper, I explore the relationship between abortion rights and abortion access using the United Kingdom as a case study. First, I set out the importance of access to abortion. I suggest that bioethics has a role to play in advocating for abortion access. Abortion is clearly necessary and important, and bioethics should be working through how people can have the best abortion possible – with minimal legal risk. Second, I outline the law in the constituent parts of the United Kingdom to illustrate the differences. Third, I make some observations about how access has been facilitated (or not) across the UK. I argue that, while legal rights to abortion are important, access without legal risk is *more* important. I do not mean to

suggest that legal rights are unimportant, but that rights without access achieves less good than access without rights. Finally, I reflect on some of the problems with legal frameworks for abortion without legal rights to abortion, using the United Kingdom as an example. I argue that the UK can only be described as an 'abortion-*permissive*' legal framework, as opposed to 'abortion-*supportive*'. Legal reform is necessary to secure access for the future. Access matters and good legal frameworks can better guarantee access for the long-term.

ABORTION IS ESSENTIAL

Abortion is the most common gynaecological procedure, and one of the most common procedures in all of healthcare, performed worldwide.[9] Approximately 73 million pregnancies end in abortion every year.[10] In England and Wales, 214, 869 abortions were performed (18.6 per 1,000 women)[11] in 2021.[12] It is widely reported that 1 in 3 women in the UK will have an abortion within their lifetime.[13] People have abortions for a variety of reasons, but fundamentally it is because they want their pregnancy to end.[14] All reasons for wanting an abortion are important to the person experiencing an unwanted pregnancy. For some, it is a matter of preserving their life and health. For others, the reasons relate to not becoming a biological parent. Abortion-seekers often explain that their abortion, for whatever reason – including those that are sometimes described as 'social reasons' – was not a choice for them, but a necessity.[15] The reasons for abortion will always be there. People have abortions regardless of its legal status.[16] However, abortion is much safer in jurisdictions where it is lawful because people are much more likely to have access to quality care.[17] While abortion medications have significantly improved the safety of self-managed abortion,[18] the associated legal risks can make it much more unsafe because people feel unable to access emergency medical care in the rare event that there are complications.[19] Restrictions on abortion kill

people in a variety of ways; whether because they were unable to access medical support, or because healthcare professions are precluded from performing (or feel too scared to perform) abortions when they are necessary to save people's lives.[20]

Against this context, the World Health Organization (WHO) has consistently reiterated the importance of safe access to abortion and, in 2022, recommended against the use of legal and procedural barriers– including the use of the criminal law – to regulate abortion.[21] The United Nations has also come close to recognising abortion as a human right. While there is no reference to a right to abortion in any of its treaties, there are provisions that can be interpreted as such. As Zoe Tongue has observed, international bodies continuously develop human rights standards to recognise the importance of access to abortion in a growing number of circumstances.[22] The UN Convention on the Elimination of All Forms of Discrimination Against Women (CDEAW) is explicit that people have the right to control their reproduction ("the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights").[23] This could be, and has been, interpreted to be inclusive of abortion.

Despite growing recognition from the international community and the WHO of the need for abortion access, the bioethics literature has remained focused on debating the 'wrongs' and 'rights' of abortion: "about the idea of abortion more than the experience of abortion".[24] These debates are completely acontextual and inherently of little use: particularly for those people who experience unwanted pregnancy. The reality is that abortion happens, and it happens often; abortion is both necessary and common. There would be much more utility in a bioethics literature that is more attentive to the issues surrounding abortion redirects its

focus to the ethical, social, and legal issues that surround a pressing problem: access to abortion. Even in countries where legal frameworks are abortion-permissive, there are often considerable barriers to access. These can be legal barriers, for example, procedural requirements that can literally delay care, or extra-legal barriers that can equally delay care or make it impossible to access through formal channels at all, for example, the cost of care (pertinent in countries without free-at-the-point-of-access healthcare) or associated with care (such as travel, time off work, or childcare).[25] These access barriers often have the greatest impact on people who are marginalised within society, for example, people who are socio-economically disadvantaged or people with disabilities.[26] Nathan Emmerich notes that thinking about abortion as basic healthcare, and thus I argue issues of access,

> [does] not deny that abortion is seen as having a moral dimension. Rather, it is to make clear that any moral concerns should be seen as secondary to ensuring the proper provision of services… Almost all medical interventions raise ethical concerns in at least some cases. Nevertheless, no one supposes that these call provision itself into question. Termination of pregnancy should be treated in the same way.[27]

Katie Watson has explicitly made the case for bioethics interrogating the barriers abortion-seekers face in accessing abortion. She argues that "framing the need for abortion care as an issue of health disparities shifts us from the ethics of the act of abortion to the ethics of access to abortion care".[28] A bioethics literature that is attentive to the healthcare needs of individuals would pay greater attention to context, and the problems of access and disparate access to abortion, rather than conceptualising abortion itself as a problem.

While feminist bioethical literature that chooses to take this approach is sometimes criticised as political, it is also a political stance to frame abortion as a problem and ignore

contemporary issues in provision and access. As I have argued elsewhere with Horn, it is a considerable problem in the bioethics literature that

> [A]uthors who take the position that abortion is in need of some greater justification beyond that of respecting the importance of a private choice of termination are less frequently subject to challenge for their starting position than those who approach ethico-legal issues from the starting point of abortion as healthcare.[29]

For this reason, it can be very difficult to publish bioethics scholarship that looks at ethical issues in the provision of care (as Emmerich suggested should be a primary focus) and disparities of care (as Watson suggests is a priority). The conventions of bioethics as a field of scholarship, in promoting conversation that moralises abortion as a choice rather than those that seek to examine ethical issues in barriers to care and disparities in access, must shift. In this paper, I will continue to examine the relationship between the ethical problem of disparity in access to abortion and the relationship between legal rights and abortion access.

ABORTION LAW IN THE UNITED KINGDOM

Abortion remains a criminal offence in Great Britain. In England and Wales, this is by virtue of the Offences Against the Person Act 1861,[30] which criminalises the procurement of miscarriage (this also applied in Northern Ireland until 2019), and the Infant Life (Preservation) Act 1929, which criminalises child destruction.[31] In Scotland, abortion remains a crime under the common law.[32] Across Great Britain, the AA 1967 is in effect and renders abortion lawful when abortion is performed in compliance with conditions set out in section one of the AA 1967[33] relating to the why, when, where, and how of abortion.[34] Conversely, any ending of pregnancy done with the intent to procure miscarriage outside the conditions of the AA 1967 is unlawful and the pregnant person, and any health professional/other person

who assists risks life imprisonment. Per the Offences Against the Person Act 1861, a person who was seeking abortion will only have committed the actus reus of criminal miscarriage if they were actually pregnant at the time of the attempted abortion. A doctor or other assisting person commits the actus reus if they act with intent to procure miscarriage even if the person is not pregnant at the time of the attempt. Abortion is lawful where *two* doctors, forming their opinion in good faith, determine that the abortion-seeker meets one of the following conditions:

- s.1(1)(a) pregnancy has not exceeded 24 weeks and continuing the pregnancy would present greater risk than if the pregnancy were terminated to the pregnant person's physical or mental health or any existing children of their family. (The Act specifies that in determining whether pregnancy poses a risk to a person's health 'account must be taken of the pregnant woman's actual or reasonably foreseeable environment'.)[35]

- s.1(1)(b) abortion is necessary to prevent grave, permanent injury to the physical or mental health of the pregnant person

- s.1(1)(c) continuing the pregnancy would be a greater risk to the life of the pregnant person than termination

- s.1(1)(d) there is a substantial risk that the fetus suffers from a physical or mental abnormality that means that, if it were born alive, it would be 'seriously handicapped'

In addition to meeting one of the above conditions, abortions must be prescribed by a *doctor* (rather than any other health professional who is qualified to prescribe other medications) and performed in a hospital, clinic, or other approved place.[36] Since changes to the law made temporarily in 2020 during the COVID pandemic[37] that have since become permanent, before 10 weeks' gestation a person can be provided with both abortion medications, mifepristone and misoprostol, to be administered at their "usual place of residence" in England and

Wales.[38] In Scotland, approval orders issued during the pandemic to enable abortion medications to be administered at home remain in effect on a rolling basis. Abortion medications can be provided to a person for use in their home in Scotland until 11 weeks 6 days' gestation.[39]

The framing of the AA 1967, and the conditions it places on the reason for abortion and under what circumstances, is highly medicalised. Essentially, who can have an abortion is entirely subject to medical control,[40] and this is by design. While the campaign for legal change had been led by the Abortion Law Reform Association since the late 1930s, the medical profession had considerable influence in shaping the AA 1967.[41] The Abortion Act 1967 was introduced as a public health measure:[42] to address the high incidence of mortality and morbidity resulting from clandestine abortion. However, there were also other relevant motivations that shaped the framing of abortion provision. Sally Sheldon argues that the AA 1967 was also intended to curb the ongoing "de facto female resistance to the law" evident in the routine seeking and performance of clandestine abortion.[43] Politicians wanted to control who was having abortions and under what circumstances and this was much easier to do with regulation permitting abortion in situations they see as justifiable, monitored by the medical profession, than in completely prohibiting the practice (except where necessary to save a pregnant person's life)[44] as had been the status quo. The AA 1967 was written for medical professionals, not only to assist them by reducing the number of people needing treatment following clandestine abortion or in controlling who had abortions, but also in offering them some certainty about the legality of the abortions they were already readily performing for (usually) wealthier people.[45] The Royal Medico-Psychological Association was explicitly in favour of the AA 1967 because "many medical men were inhibited from advising or performing abortion through fear of the law".[46] While the AA 1967 might be described by

some as some sort of compromise – allowing access to abortion while affording some respect to the fetus –it does no such thing; it only protects doctors.[47] The medicalisation of abortion was a mechanism that enabled the practice to be somewhat depoliticised and more palatable to politicians: making room for legislation that enabled access.

While the AA 1967 was passed in Great Britain, and with it access to legal abortion for more people, no such changes were not introduced in Northern Ireland where the political climate was even more complex. Consequently, the criminal provisions in the Offences Against the Person Act 1861 remained in force. People in Northern Ireland had no access to terminations unless they were able to travel to England and shoulder the costs themselves (even though their taxes would contribute to NHS-funded access for women in Great Britain).[48] Since 2017, abortions in Great Britain have also been NHS-funded for people who travelled from Northern Ireland.[49] This did not eliminate other associated costs, however, such as taking time off work, travel, and potentially childcare. Abortion was partially decriminalised in 2019 with the relevant criminal offences in the Offences Against the Person Act 1861 ceasing to apply in Northern Ireland. New regulations were introduced to govern abortion provision. These regulations can be described as somewhat more progressive than the AA 1967;[50] the criminal offence they establish of providing abortion care outside of the terms of the regulations cannot be used to prosecute pregnant persons themselves,[51] the regulations enable abortion on demand until 12 weeks,[52] and they permit nurse prescription of abortion medications.[53] Despite these improvements, the regulations "continue to embody an approach [to care] that enables non-medically indicated interference" in people's abortion decisions.[54] For example, the regulations do not enable home use of the first abortion medication, mifepristone. Mifepristone must still be administered in a clinic and then misoprostol can be provided for home use.[55] People in Northern Ireland, therefore, must (unlike people in Great

Britain) attend a clinic in-person to have an early medical abortion. The framing of abortion in these regulations remains steeped in medicalisation and exceptionalism.

Abortion-seekers from Northern Ireland have been travelling to England since the enactment of the AA 1967.[56] It was hoped that partial decriminalisation and the new regulations would enable care closer to home. While the number of people travelling to England has declined since the regulations have passed (371 in 2020; 161 in 2021),[57] this has not been wholly attributable to the availability of care locally. The Department of Health and Social Care in England noted that '[t]he large decrease in the number of abortions for residents outside of England and Wales may be explained by travel restrictions in place throughout 2021 due to the COVID-19 pandemic' as well as changes to the law.[58] While abortion is more available in Northern Ireland than it was pre-2019, Northern Ireland's Department of Health did not immediately commission a service roll-out of funded abortion care. This meant people carried on travelling or turning to local activist groups that help individuals obtain abortion medications for home use.[59] In December 2022, the Westminster Northern Ireland Secretary commissioned local services[60] and some information is available on how to access care locally.[61]

ACCESS TO ABORTION

In Great Britain, the wording of the AA 1967 provisions leave considerable discretion for healthcare professionals.[62] The first ground for abortion (before 24 weeks and on the basis that risk of pregnancy is greater than termination) is often called the 'social ground' for abortion.[63] Parliament was clear, during the debates surrounding the AA 1967, that none of its provisions were intended to enable "abortion on demand".[64] However, healthcare

professionals' interpretation of the 'social ground' for abortion became gradually more liberal in the few decades after 1968,[65] especially with the advent of medication abortion.[66] The ground is interpreted, in practice and in legal scholarship alike, as meaning that abortion is *always* legal early in a pregnancy because abortion is very safe and, especially early in a pregnancy, safer than birthing.[67] The British Medical Association endorses this interpretation.[68] Consequently, the consensus is that every pregnancy can be legally terminated under 24 weeks.[69] Where people are able to make contact with abortion provider early in a pregnancy, abortion can thus be easily provided under the AA 1967 conditions.

One notable point about the operation of the AA 1967 and abortion provision in the UK is the "dominant role" that is played by abortion charities (Sheldon and others describe this as "highly distinctive and significant aspect of the Abortion Act's biography").[70] The leading providers of abortion care are the British Pregnancy Advisory Service (BPAS) and MSI (formerly Marie Stopes International – now just MSI). 77% of abortions in England and Wales are performed by these clinics that have contracts with the NHS.[71] These services were established to ensure access in areas of the country where abortion provision was made difficult by medical gatekeeping[72] (BPAS started life as the 'Birmingham Pregnancy Advisory Service'[73]) and have become an embedded feature of provision over time.[74] Abortions provided by these independent clinics are free at the point of access for people entitled to NHS treatment. In 2021, 99% of abortions performed in England and Wales were funded by the NHS.[75]

Emmerich criticises the fact abortions are outsourced to independent providers as a feature of abortion exceptionalism. He argues that service provision by "third parties contributes to the

idea that such services are unusual, different, or in some way out of the norm… such services should simple be brought 'in house'".[76] There is more nuance to the story than this, however. It is the case that abortion to third-party providers makes for a "structural weakness" in regulation (these independent providers can be more easily targeted with hostile measures[77] – at present these providers are facing considerably more scrutiny that other healthcare providers surrounding their safeguarding obligations to patients, for example).[78] But, it is important to acknowledge there are ways in which the independent providers have been integral to improving access. Sheldon and others note that the role abortion charities have occupied, enabled by the AA 1967, has entrenched "the long-term sustainability of a permissive model of service provision" and equally it has enabled dedicated providers to become "a powerful voice for further liberalising reform".[79]

At the level of the experience of the service-user, people accessing abortion can directly contact an independent provider that specialises in providing this care (there is no need for a referral). This means that abortion-seekers need only interact with healthcare providers and support staff that have chosen to work in abortion services, which likely improves their experience. There is considerable stigma in the law e.g., in the labelling of abortion as a 'crime'[80] (this will be reflected on later in more detail); however, this is not a stigma that many abortion-seekers experience since many are not aware that it is a crime.[81] I think it reasonable to suggest that this is because dedicated providers work to ensure that abortion-seekers are shielded from the stigmatising elements of the regulation.

Independent providers have also been pivotal in campaigns for law reform. For example, they have successfully campaigned for several changes over the last five years that have made a

considerable difference in improving the accessibility of abortion in Great Britain. First, independent providers were instrumental in the campaign for home use of misoprostol (the second abortion medication in the drug regimen recommended by he WHO), which eventually culminated in legal changes in 2017/2018.[82] Home use of misoprostol greatly improved the accessibility of abortion because it meant that people did not have to travel to a clinic twice for services, as well as enhancing the comfort and experience of abortion-seekers because they could miscarry in their own homes.[83] Second, the providers were also instrumental in the shift to and delivery of telemedical abortion – which became temporarily lawful in 2020 in Great Britain during the COVID-19 pandemic.[84] This greatly improved the accessibility of abortion because it meant people did not have to leave their homes during a public emergency, risking their safety, to access care.[85] There were people who (even before the pandemic) would have struggled to access care in a clinic for a variety of reasons: living in a rural area, no access to public transport, limited financial resources, disability, inability to find suitable childcare, or fear of a domestic abuser.[86] Abortion providers, with the data they had collected during the pandemic period showing the clear benefits,[87] led the campaign to make telemedicine permanent. Amendments were made to the AA 1967 by the Health and Social Care Act 2022, which became law in April 2022. Finally, BPAS's 'Back Off' campaign – which sought to introduce 'buffer zones' around abortion clinics to prevent abortion-seekers from being harassed by anti-choice protestors[88] - culminated in a legal victory in October 2022. MPs passed an amendment to the Public Order Bill (expected to become law in early 2023) that creates buffer zones and criminalises the violation of the zones in England and Wales.[89] This is also important for abortion access because it can ensure that in-person care, for people who want to attend a clinic, remains a possibility where people may otherwise have felt too intimidated to attend.

These examples all illustrate that abortion access in Great Britain is improving, but not without considerable effort by campaigning groups, including abortion providers, for legal reform.

ABORTION ACCESS VS. ABORTION RIGHTS

'Framing matters, but access matters more'.[90]

Given the time sensitive nature of abortion care,[91] ensuring adequate and timely access to services is the most important aspect of service provision. The health and legal risks of later term abortions outside of formal healthcare channels mean that ensuring people have the abortions they need as soon as possible is the best way to guarantee quality and safe care. I have argued elsewhere that "[it] seems less important to have a formally declared constitutional right to services than it does to have access to them".[92] This comment was made about the United States in its *Roe* era – at the time, precedent that understood the right to privacy as encompassing a right to abortion before viability[93] was still standing. Despite this, however, the foundations of the right to abortion had been so eroded that there were vast expanses of the country where people had practically no access to abortion at all.[94] Michele Goodwin termed the abortion right a 'mish-mash' because what it meant in practice was still governed by laws at the State level.[95] The legal framework established by *Roe* and subsequent case law (notably, *Planned Parenthood v Casey*[96]) enabled State regulation of abortion that was able to target both abortion providers and abortion-seekers to make abortion more difficult. Further, federal law prohibiting the use of federal funds for abortion prohibited support for the poorest people.[97] Access to abortion in the US was never 'reflective of its widely acclaimed status as a constitutional right'.[98] This illustrates that declarations about abortion rights are meaningless if they are not made *in terms that also ensure access* (I will come back to this in the last section of this paper). The reproductive

justice movement in the US, led by Black and women of colour feminists in organisations such as SisterSong,[99] has long criticised the emphasis placed on rights and choice in reproduction as a fundamental problem. Roberts emphasises how "[t]he language of choice has proved useless for claiming public resources that most women need in order to maintain control over their bodies and their lives".[100] *Roe v Wade* was an empty promise for people living in anti-abortion States (who could *choose* termination but would struggle to get one). That is not to say that things are not likely worse now post-*Roe*, but just that having a right to abortion did not mean a person in Louisiana, or Texas, or Mississippi could get one.

In contrast, people in the UK have no right to abortion at all. However, access to abortion has consistently improved over time. While there is no law in the UK that is actively abortion-supportive (like declaring a right to abortion – or more meaningfully, to access abortion), people in Great Britain will have had a better experience of abortion than many of their counterparts in much of the US. In many ways, the reason access continued to improve in Great Britain was a direct result of the medicalisation of abortion that depoliticised provision[101] that enabled charitable providers, and the committed healthcare providers that work for them, to make changes within the existing framework. This is why looking at how legal provisions come to operate in practice matters so much – on paper, one might have been forgiven for thinking that a *Roe v Wade* United States was more abortion-supportive than the UK, however that was far from the reality. The story from the UK is a much less tragic one than that of the US, however it is far from ideal. The story of improving access in the UK is not perfect and there are important lessons to be learned. First, while medicalisation may have had benefits in improving access, it also means that there is some fragility to abortion access. Section, abortion exceptionalism means that even within a system that enables access

to abortion limits are still placed on the quality of care.[102] These two themes are explored in the next section.

PROBLEMS WITH ABORTION- 'PERMISSIVE' REGULATION

While ensuring access is imperative, the fact that access is improving across the UK – due to the work of dedicated providers and activists against a hostile legal and regulatory environment – does not mean that there is not the need for fundamental legal reform. In fact, the current conditions exemplify the need for sweeping reform. The legal regime across the UK can be described as 'abortion-*permissive*' – in that has enabled access to abortion and even enabled some evolution in access over time (though many of the biggest changes required legal change). But permissive regulation is not the same as *supportive* regulation, which we might consider to be a framework that solidifies the importance of access over time. The framing of the AA 1967 provisions, procedural requirements in the AA 1967 and the Northern Irish regulations, prevent more radical service evolution. They also embody the fundamental fragility of abortion access; given that it is rooted in medicalisation. These two factors thus make it impossible to describe the UK framework as *abortion-supportive*. This potentially has implications for abortion access over time.

The current legal framework has come under considerable scrutiny from legal scholars. First, in that the use of the criminal law, which still underpins provision in Great Britain, perpetuates abortion stigma[103] and abortion exceptionalism.[104] While there are few prosecutions of healthcare professionals for procuring miscarriage where they have not complied with the terms of the AA 1967, there have been prosecutions against abortion-seekers, usually when they have used abortion medications later in pregnancy.[105] In these

cases, the people who have done so are often in very vulnerable circumstances and the use of the criminal law to respond has been strongly criticised.[106] In 2021, a new mother was charged with procuring miscarriage when doctors found what they believed to be misoprostol in her body while she was in hospital for delivery. She explained that she had been previously prescribed them and had accidentally taken them believing them to be anti-thrush medications. While the case was dismissed in 2022, with the judge noting that he was 'flabbergasted' that the charges were pursued,[107] it illustrates both the expansiveness of the criminal provisions, and the willingness of prosecution services to pursue people for use of abortion medications. The criminal law thus remains a very real threat to abortion-seekers. This is especially true since the introduction of telemedical abortion. There is concern that in all the benefits that telemedicine has, it also increases the likelihood of abortion-seekers, even acting in careful, safe, and responsible ways, may inadvertently fall foul of the provisions that make the abortion lawful (strict about the when, where, how etc. of abortion).

While the AA 1967 does provide circumstances for lawful abortion, it is heavily medicalised. Between the criminalisation and medicalised exceptions, Maxine Lattimer explains that legally '[a]bortion is constructed as an unusual or abnormal act, undertaken for primarily medical reasons',[108] which does not reflect abortion-seekers' reality and reinforces stigma. As we have explored, the medicalisation of abortion through law has had substantial benefits in securing and improving people's access to abortion services, however, as Sheldon has warned, it also poses substantial problems for that access, and these have been inadequately addressed'.[109] Fundamentally, the law provides no guarantee of abortion to abortion-seekers: within the law 'there is no basis for recognising a woman's right to choose at any stage in pregnancy'[110]. Abortions are contingent on *doctors* determining that they are appropriate.[111] While dependent on healthcare professionals' opinions, rather than individuals own rights

and decisions about their reproduction, access to abortion is innately fragile. It is highly unlikely, given the existence of dedicated providers, that there would be change within the profession that means that health providers are no longer willing to provide care. However, the willing providers being vulnerable to hostile regulation, and people having no recourse if they are unable to access abortion, are significant weaknesses in the regime that leave abortion-seekers without any guarantee of care.

As has been evidenced, access has improved considerably in the UK. We have seen the introduction of measures that have enabled local care in Northern Ireland, and home use of abortion medications in Great Britain. On both counts, the privacy, autonomy, and comfort of abortion-seekers has been enhanced by reducing the need for travel in having an abortion. However, these success stories still exemplify issues. The legal framework across the UK remains deeply flawed, perpetuates stigma, and changes are difficult to make. Legal changes are necessary for structural changes in provision and have only occurred in the system usually after some involvement of external forces. In Northern Ireland, change resulted from internal pressure from activists but also strong criticism from the UN Committee on the Elimination of Discrimination against Women.[112] In Great Britain, telemedicine and home use of both abortion medications resulted from the pressures of a pandemic – despite the evidence about the benefits and safety of telemedicine having existed long before.[113] Thus, reform is needed. Many scholars have argued that decriminalisation is a necessary reform in the UK.[114] This would go some way towards the construction of an abortion-supportive legal framework. Decriminalisation can begin the demystification and normalisation of, and dismantling the stigma around, abortion.[115] Further, if there were no criminal regulation of abortion it would be much easier for providers to evolve their service provision in line with evidence about best practice[116] from organisations like the WHO, without having to campaign for legal change first.

This leaves us with the question of what a better abortion-supportive legal framework looks like? Decriminalisation is a start, but it also does not go far enough. For example, in Canada, which has had a complete decriminalisation of abortion since the law was 'struck down' by the Supreme Court in 1988,[117] there remain multiple structural barriers to accessing care.[118] Though arguably, decriminalisation would better secure structural changes that enable access, and better access, for abortion-seekers in the UK since there are established independent providers.[119] What exactly a comprehensive abortion-supportive regime might look like in the UK is a question that requires and deserves further reflection from bioethicists on addition to the work being done by legal scholars, activists, and dedicated politicians.

CONCLUSION

Abortion access matters. Bioethics needs to redirect its focus from problematising abortion to thinking about the experience of abortion and how this can be improved for abortion-seekers. Since abortion is common, how abortion is talked about should begin to reflect its normalcy. Abortion access remains a challenge because of the intersection of complex barriers that ought to be recognised as "structural violence".[120] These barriers manifest for all abortion-seekers, but their effect is much greater amongst marginalised people. The story from the UK is one of increasing liberalisation of abortion regulation and improving access. Though, the experience of abortion-seekers is made better, against what is a fundamentally a hostile legal environment to abortion in hyper-regulation, by the work of charitable providers and their committed staff. Moreover, improvements to care at the individual level are often despite the legal framework, rather than because of it. Moreover, changes to service provision have always required legal change that takes time and resources and means that abortion-seekers

do not get the best possible care while that process takes place. While I have argued that access to abortion is the most important matter at hand, the UK example illustrates that legal frameworks must be better than abortion-permissive (they must be abortion-supportive) to secure abortion access in the long-term.

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