Human rights: transforming services?

social care institute for excellence

Access to health care and human rights

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"It is my aspiration that health will finally
be seen not as a blessing to be wished for,
but as a human right to be fought for."

United Nations Secretary General, Kofi Annan

Introduction

The NHS is in crisis again.[1] By the end of the year it will be at least £800m over budget. It could end up being as much as £1.2bn in the red. This is a level of indebtedness unprecedented in the history of the health service. Its Chief Executive Sir Nigel Crisp has, sensibly, taken early retirement.

Those of an earlier generation who took seriously the old Labour sound-bite of free health care *'from cradle to grave'* have been replaced by cynics who might, with some force, observe that the modern under-resourced NHS is more likely to hasten one's approach to the grave and, indeed, judging by the recent baby cases barely allow one to arrive at the cradle. The main sufferers will, of course, be the most vulnerable in society. The frail, the elderly, the disabled.

Increased costs forced by private finance initiatives, massive pay increases for consultants and GPs and a swelling range of entirely unnecessary and proliferating structures such as Primary Care Trusts account for much of the problem.[2] But the sad (essentially political) story of why this has been allowed to happen[3] is, alas, not the subject of this Paper.

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[1] And not just a funding crisis. Professor Taylor-Gooby (Professor of social policy) at the University of Kent has demonstrated a breakdown of trust in the NHS as opposed to private sector medical provision: see *'The Efficiency/Trust Dilemma'* in *'Health, Risk and Society'* Vol 8 No 2.

[2] The BBC website on Friday 24th March 2006 had the catchy headline *'up to 20,000 facing axe in NHS'.* This turned out to be a Conservative (i.e. large 'C') estimate rather than any statistical information from the Government. Indeed, Health Secretary Patricia Hewitt reassuringly announced that the best care would be maintained. However, somewhat unpromisingly, within

The subject of this Paper is *'Access to Health Care and Human Rights.'* But the political story reflects the everyday stories that I do address. With NHS budgets going into reverse, Eastbourne Downs PCT, to take but one example, has just told the town's hospital not to operate on any patient who hasn't been waiting a full six months. London hospitals have been warned against *'unexpected overachievement'* in reducing waiting times.

What, if anything, can law (in general) and human rights (in particular) do to help those for whom access delayed is justice denied or those, in a worse position, for whom access is denied altogether?

I want to approach these issues from the viewpoint first of domestic law, then from a human rights and EC perspective before attempting to scale the dizzy heights of international law and finally descending to reality as I summon up courage to contemplate the likely legal future for the NHS. I see my remit, essentially, as being to provoke discussion and to suggest a few potential legal approaches that might usefully be tested in the cases that will undoubtedly be brought in the Courts.

Domestic law

Conventionally, it has been thought that our domestic law is not a gateway to getting better (or any) health services. This is because of the axiom drummed into our heads in successive pre Human Rights Act cases that the NHS is not infinite. Far from not being infinite, any duty to provide services under the National Health Service Act 1977 was held to be – in that wonderful creation of Lord Woolf – merely a *'target'* duty; that is, not a duty at all but only an aspiration.

In a recent case, still not finally resolved, a triptych of arguments designed to save Mrs. Watts from having to wait forever for a double hip replacement, got nowhere with purely domestic law arguments. Indeed, they were abandoned before judgment. Mr. Justice Munby said that they were unarguable. In the end, as I shall show later, Mrs. Watts was assisted to get her new hips not by domestic law, nor by any fundamental rights of hers but, rather, by the economic coal-and-steel rights of French doctors of freedom to provide services under EU law because they could treat her a lot faster than any hospital in this country and should be allowed to do so.

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hours of this statement it was announced that 480 jobs were to be axed at North London's Royal Free Hospital and East Kent Hospitals NHS Trust said it would have to cut jobs to claw back a predicted £35m deficit for next year.

[3] It has even been suggested that deteriorating services in the NHS is a function of the decline in the number of service-oriented women in society: see *'A Public Realm'* by Nicholas Timmins and Barry Cox, Prospect July 2001.

Despite this gloomy start, though, I suggest that domestic law is stronger than it seems. Wisely, our politicians have always refrained from writing a constitution. Traditionally, administrators have not stated any reasons for their decisions in writing for (as Lord Shaftesbury once wrote to his son) his judgment would usually be right but his reasons would always be wrong.

But this traditional Anglo Saxon wisdom has not been followed in the NHS. Written Government guidance, some mandatory, some permissive, all of it impossible to understand (and most of it wrong) spews from the pen of civil servants as if designed to compensate for our constitutional deficit. In its wake, come mission statements, protocols and, most important for present purposes, written health eligibility criteria.

Criteria for continuing NHS health care (itself a phrase not easy to understand but meaning free NHS funded health care outside hospital) have been drawn up by SHAs throughout the country. They have to be agreed between SHAs, PCTs (who usually apply them to individual patients) and social services departments of local authorities who are responsible for community care rather than health provision.

The difference between health and community care is that health is free whereas community care may be charged for. So, the written criteria are very important. If the SHAs are over generous in saying what is health care their NHS budgets will be depleted. In *R v. North & East Devon Health Authority, ex p. Coughlan* (decided by the Court of Appeal in 1999) Pam Coughlan became the first disabled patient to strike a blow for free provision of health services.

Coughlan did not, at the start, have the feel of a landmark case. It felt like (because it was) a home closure case. But there was more to it than met the eye. Ms Coughlan, a chronically ill patient, had been persuaded to move from a traditional NHS hospital into (at least then) a flagship modern hospital (Mardon House) that seemed much more like a residential care home than a hospital. She was promised that if she moved into Mardon House it would be her home for life. The home for life promise, as it came to be known, was broken. The health authority wanted to move Ms Coughlan into a residential care home because, it said, she was the legal responsibility not of the NHS but of social services. In a word, Ms Coughlan failed the North and East Devon health eligibility criteria.

The rest, as they say, is history. *Coughlan* is a landmark case for two reasons. First, it was the case that created the concept of a substantive legitimate expectation; that is, if a public body makes a promise it must keep it. But secondly, *Coughan* decided that there were limits to what social services were empowered to provide. When the Court of Appeal heard what N&E Devon regarded as community care it simply could not accept it. To the judges, some of whom still rather touchingly believed that the NHS continued (in 1999) to provide convalescent homes, it was impossible to think that the scale of nursing care that

Ms Coughlan needed could be regarded as anything other than the sole funding responsibility of the NHS. So, the Court held that the authority's written eligibility criteria were unlawful. This was because they failed to set out the respective contributions of health and social services and, in particular, to indicate that where there was a primary need for healthcare outside hospital, that care was the entire funding responsibility of the NHS.

Now I believe that if Ms Coughlan had asserted a right to be provided with NHS services she would have been met with Lord Woolf's notion of a target duty. But what she did was to attack the written criteria. The effect of the Court's judgment was to drive a coach and horses through the idea that a patient cannot compel provision of medical treatment under domestic law. However, the Court was simply doing what judges do every day; that is, interpreting written documents and deciding whether those documents comply with the law.

This idea that if you repackage a legal concept and present it as a quite different concept you can win cases that no one previously thought could be won, is an idea to which I will return.

The year after *Coughlan* was decided, the Human Rights Act 1998 was passed. Many believed that this would be the vehicle through which patients would be able to increase access to NHS services especially given the right to life under Article 2 and the right to be protected from inhuman and degrading treatment under Article 3. As will be seen, the HRA, thus far at least, has not proved the catalyst so far as NHS access is concerned.

The next case in which a patient succeeded in improving the right to access to NHS continuing care was the very recent decision of the Administrative Court in *R (Grogan) v. Bexley NHS Care Trust*[4] *('Grogan').* Judgment was handed down by Charles J on January 25th 2006.

Mrs Grogan, now aged 65. is, on any view, chronically sick. She has 'deteriorating' multiple sclerosis, dependant odema with the risk of ulcers breaking out and double incontinence. She also has 'nil' mobility and is a wheelchair user requiring two people to transfer her, together with some cognitive impairment.

Is she, in law, the funding responsibility of health, social services or both? The High Court judgment is full of criticism for the present system for deciding who should pay for nursing home care for the chronically sick. The judgment may, indeed, lead to major changes in the way decisions are made as to whether a person qualifies for free NHS nursing care.

[4] [2006] EWHC 44 (Admin)

In 2004 and 2005 Mrs Grogan was assessed as not requiring fully funded NHS care by the Bexley NHS Care Trust ('the Trust'). The Trust applied criteria drawn up by the South East London Strategic Health Authority ('SHA'). As a result, Greenwich council placed her in a BUPA run nursing home purportedly pursuant to its functions under s21 National Assistance Act 1948. But Mrs Grogan was forced to sell her home to pay the fees – so far almost £100,000 – as the local authority is under a duty to charge for services . However, she was assessed as having substantial nursing needs for which the NHS made a small contribution each week as part of the RNCC scheme. Those needs had, in the past, been registered as 'high band' RNCC although Mrs. Grogan was, at the time of the proceedings, registered in the 'medium band' RNCC category.[5]

Mrs Grogan challenged the decision of the Trust not to fund all her care and accommodation. Her case was based on the principles thought to have been set out in *Coughlan* that if a person's primary need is for health care (rather than social care), then the NHS should pick up the whole bill. She claimed that the Trust assessment was not founded on criteria that applied the *Coughlan* test.

The Court found that the criteria drawn up by the SHA and adopted by the Trust were *'fatally flawed'* as they did not reflect the fact that those with a primary health need should be NHS funded. The judge quashed the decision not to fund Mrs Grogan's care and ordered the Trust to reconsider her case again in line with *Coughlan*. The Trust claimed its decision was in line with Department of Health guidance and therefore lawful, but the Court rejected that claim.

Further, in a long judgment Charles J added his voice to the criticism of Department of Health guidance already made by the health service ombudsman and the Health Select Committee and called on the Department to revisit it *'not least to promote a consistency of approach to the relevant issues which concern important and widespread issues of public importance and …which can have a profound effect on the individuals concerned'.*

According to the judge, the lack of clarity in the guidance by the Department meant that local NHS bodies had difficulty in turn in developing criteria which lawfully described the all important divide between health and social care. The Department's attempt in the registered nursing care contribution ('RNCC') to introduce a nursing care contribution for those in local authority care led to a two tier system described by the Select Committee (in a passage set out by the judge) as

[5] These bands are discussed, briefly, below .

a *'nonsense'*, and by the ombudsman as leading to confusion and injustices for old and vulnerable persons.

To date, *Coughlan* and *Grogan* have proved to be the most effective legal entry point to obtaining wider access to NHS services. The interesting thing, though, is that each of these cases succeeded as a purely domestic law challenge to written documents thus challenging the conventional wisdom that old fashioned judicial review is the poor relation of its fast-track ECHR and EU neighbours.

I turn, now, to the HRA and ECHR.

NHS Access from the human rights perspective

There is a tendency for human rights enthusiasts, with the ECHR, to start at full throttle with Articles 2 and 3. This is, presumably, because it is thought that if one cannot push through the NHS gate with the strongest Convention provisions there is little hope of succeeding with anything else.

This is, as with domestic law, a conventional wisdom that I believe to be wrong. Let us start, nonetheless, with Articles 2 and 3.

As is well known, Article 2 protects the rights to life and requires that the state take positive action in order to safeguard life; "everyone's right to life shall be protected by law." The qualifications found in article 2(2) have no application in cases concerning the provision of health care. The obligation is not however absolute, in that not every risk to life places an obligation on the authorities to take measures to prevent the risk materialising, but it is sufficient for an applicant to show that "the authorities did not do all that could **reasonably be expected of them** to avoid a real and immediate risk to life of which they have or ought to have knowledge" (see *Osman v. United Kingdom*, emphasis added). . The Court has also recognised that there may be a duty on the authorities to protect a person from "life threatening illnesses" (see *L.C.B. v. the United Kingdom*, judgment of 9 June 1998, *Reports* 1998-III, pp. 1403-04, paras 36-41)

The threshold for engaging article 2 has been considered on a number of occasions by the domestic courts, most recently in the cases o*f (1) Irwin Van Colle (administrator of the estate of Giles Van Colle, deceased) (2) Corinne Van Colle v Chief Constable of Hertfordshire [2006] EWHC 360 (QB),* which followed the analysis of Auld LJ in *R(Bloggs)-v-Secretary of State for the Home Department [2003] 1 WLR 2724* who said at [60] that *'real and immediate risk'* to life is inappropriate, rather all that was required was *'a risk to life'.*

The key question is whether that obligation can be qualified by, for example resource considerations. In particular (a currently topical question) can access to

healthcare or essential drugs be limited on the ground of resources where a person's life is (at least potentially) at risk?

This is a question which has yet to be directly addressed by the ECtHR,[6] but in Danevich-v-Ukraine *[2004] 38 EHRR 25* the ECtHR it was said that *'lack of resources cannot in principle justify prison conditions which are so poor as to reach the threshold of treatment contrary to Art.3 of the Convention.'* (paragraph 144).

By analogy (always a dangerous mode of legal argument) failure to protect a person's life might be said not be justified under Article 2 purely on the grounds of lack of resources.

Such an argument might be bolstered by reliance on those cases in which the Strasbourg Court has held that systemic defects cannot be justified by resort to resource constraints.

Where issues of resource allocation, policy and the organisation of public services are concerned the State will obviously be given a wide margin of appreciation, but the ECtHR has consistently emphasised that that the margin of appreciation goes "hand in hand" with the supervision of the Court and it can never override the Court's primary duty to assess the proportionality of an impugned measure. Therefore, even at it's widest, the margin of appreciation:

> *'…does not mean that the Court's supervision is limited to ascertaining whether the Respondent state has exercised its discretion reasonably, carefully and in good faith; what the court has to do is to look at the interference complained of in the light of the case as a whole and determine whether it was "proportionate" to the legitimate aim pursued and whether the reasons adduced by the national authorities to justify it are "relevant and sufficient'*[7].

There is a right to a trial within a reasonable time contained in Article 6(1), and the authorities cannot merely seek to justify delays because of the workload of the court or shortages of resources. There is an obligation on the State to organise their legal systems so that the courts can comply with Article 6(1). The

[6] The closest is probably the Commission decision in Scialacqua v. Italy, application no: 34151/96, where the applicant argued that refusal of the authorities to provide financial covering for the medical treatment he was taking constituted a breach of his right to life. The Commission found the case inadmissible, but on the basis that "even assuming that Article 2 of the Convention can be interpreted as imposing on States the obligation to cover the costs of certain medical treatments or medicines that are essential in order to save lives, the Commission considers that this provision cannot be interpreted as requiring States to provide financial covering for medicines which are not listed as officially." The medicine he was receiving was an alternative herbal remedy (fitofarmaci) from a doctor in the UK.

[7] Vogt v. Germany (1996) 21 E.H.R.R 205 para.52 (iii), see also Sunday Times v. United Kingdom (1979) 2 E.H.R.R 245 para 59

ECtHR has dealt with many cases concerning alleged violations of the reasonable time requirement and the Court has distinguished between temporary backlogs and “organisationally in-built” backlogs. In cases of endemic backlog, it is clear in several of the decisions that the State is under the duty to reorganize structurally its delivery of judicial services.

An early example is Zimmermann and Steiner v. Switzerland, application No. 8737/79, A66, 13 July 1983, where the ECtHT pointed out that:

> ‘in the first place that the Convention places a duty on the Contracting States to organise their legal systems so as to allow the courts to comply with the requirements of Article 6 § 1 (art. 6-1) including that of trial within a "reasonable time". Nonetheless, a temporary backlog of business does not involve liability on the part of the Contracting States provided that they take, with the requisite promptness, remedial action to deal with an exceptional situation of this kind (see the above-mentioned Buchholz judgment, Series A no. 42, p. 16, § 51, and the Foti and others judgment of 10 December 1982, Series A no. 56, p. 21, § 61).
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> Methods which may fall to be considered, as a provisional expedient, admittedly include choosing to deal with cases in a particular order, based not just on the date when they were brought but on their degree of urgency and importance and, in particular, on what is at stake for the persons concerned. However, if a state of affairs of this kind is prolonged and becomes a matter of structural organisation, such methods are no longer sufficient and the State will not be able to postpone further the adoption of effective measures.
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> The statistics supplied by the Government show that since 1969 there has been a progressive increase in the volume of litigation before the Federal Court, above all in the area of administrative law.
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> Initially, the Swiss authorities may have thought that it was a matter of a temporary excess of work, but as early as 1973 the situation - which, moreover, finds an equivalent in many other Contracting States - was seen by the Federal Court to be one that depended on questions of structural organisation (see paragraph 12 above).
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> However, although the steps taken during the period ending on 15 October 1980, the date of the Federal Court’s judgment, reflected a genuine willingness to tackle the problem, they did not give sufficient weight to the structural aspect and therefore only produced results that were not very satisfactory. The Federal Court

did recommend in 1973 certain urgent measures, but it asked for them to be deferred pending a full-scale revision of the Constitution of the Courts Act (see paragraph 12 above). It renewed its request therefore in December 1977, when the position became more critical; they were adopted by the Federal Assembly in 1978, entered into force on 1 February 1979 and consisted, inter alia, of an increase in the number of judges from 28 to 30 and in the number of registrars and secretaries from 24 to 28. In addition, the Federal Court effected a general revision of its Rules of Procedure (see paragraph 13 above). Nevertheless, these measures could not be regarded as sufficient, even at that time; in fact, the backlog of cases grew progressively worse, the reason being that the volume of litigation continued to increase. The more drastic measures voted on 20 March 1981 - that is, after the appeal by Mr. Zimmermann and Mr. Steiner had been dismissed - will probably prove to be more effective (see paragraphs 11, 14 and 15 above); however, the Court does not have to make any assessment thereof.

The proceedings in question lasted for nearly three and a half years, and during most of that period the applicants' case remained stationary. Having regard to all the circumstances of the case, the Court finds this lapse of time excessive; the difficulties undeniably encountered by the Federal Court could by then no longer be considered to be temporary, nor could they deprive the applicants of their right to a hearing within a "reasonable time" (see the above-mentioned Foti and others judgment, Series A no. 56, p. 23, § 75).

There has therefore been a violation of Article 6 § 1 (art. 6-1). The Court does not have to specify to which national authority this violation is attributable: the sole issue is the international responsibility of the State (see the above-mentioned Foti and others judgment, ibid., p. 21, § 63).*'*

In Sussmann v. Germany (1996) 25 E.H.R.R 64 at para 55 it was said "The Court recalls that, as it has repeatedly held, Article 6 (1) imposes on the Contracting States the duty to organise their judicial systems in such a way that their courts can meet each of its requirements, including the obligation to hear cases within a reasonable time", and in Klein v. Germany 33379/96 20 July 2000 where the court said that "according to the Court's established case-law, a chronic overload, like the one the Federal Constitutional Court has laboured under since the end of the 1970s, cannot justify an excessive length of proceedings".

The ECtHR has shown a willingness under Article 6(1) to assess the organisation of State's judicial systems in order to reach decisions concerning the reasonable time requirement in Article 6(1). Similarly in cases involving access to courts and

the provision of legal aid the court has been willing to consider whether decisions concerning the allocation of resources when deciding whether the right to access to a court has been violated. The case-law has laid down that:

(a) The right of access to the courts secured by Article 6 para. 1 (art. 6-1) is not absolute but may be subject to limitations; these are permitted by implication since the right of access "by its very nature calls for regulation by the State, regulation which may vary in time and in place according to the needs and resources of the community and of individuals

(b) In laying down such regulation, the Contracting States enjoy a certain margin of appreciation, but the final decision as to observance of the Convention's requirements rests with the Court. It must be satisfied that the limitations applied do not restrict or reduce the access left to the individual in such a way or to such an extent that the very essence of the right is impaired.[8]

In cases involving Article 5 the court has also found that delay is releasing patients from detention cannot always be justified on the basis of lack of resources (lack of after-care facilities) (see Johnson v. UK (1999) 27 E.H.R.R)).

Under Article 8 when considering what is "necessary in a democratic society" in cases involving taking children into care the court had said that:

> 'In determining whether the impugned measures were "necessary in a democratic society", the Court will consider whether, in the light of the case as a whole, the reasons adduced to justify these measures were relevant and sufficient for the purpose of paragraph 2 of Article 8 of the Convention (see, inter alia, the Olsson v. Sweden (no. 1) judgment of 24 March 1988, Series A no 130, § 68).
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> In so doing, the Court will have regard to the fact that perceptions as to the appropriateness of intervention by public authorities in the care of children vary from one Contracting State to another, depending on such factors as traditions relating to the role of the family and to State intervention in family affairs **and the availability of resources for public measures in this particular area.** However, consideration of what is in the best interest of the child is in every case of crucial importance. Moreover, it must be borne in mind that the national authorities have the benefit of direct contact with all the persons concerned (see the Olsson v. Sweden (no. 2) judgment of 27 November 1992, Series A no. 250, § 90), often at the very stage when care measures are being envisaged or immediately after their implementation. It follows from these

[8] See for example Ashingdane v. United Kingdom 28 May 1985, Application No. 8225/78, para 57

considerations that the Court's task is not to substitute itself to the domestic authorities in the exercise of their responsibilities for the regulation of the public care of children and the rights of parents whose children have been taken into care, but rather to review under the Convention the decisions taken by those authorities in the exercise of their power of appreciation (see, for instance, the Hokkanen v. Finland judgment of 23 September 1994, Series A no. 299-A, § 55; the above-mentioned Johansen judgment, § 64; and the decision of 8 February 2000 as to the admissibility of application No. 34745/97 in the case of Scott v. the United Kingdom, Third Section, unpublished).

The margin of appreciation to be accorded to the competent national authorities will vary in the light of the nature of the issues and the seriousness of the interests at stake*…'* [emphasis added][9]

Under Article 2 in a case concerning the failure of the state authorities to deal with a risk to life – rubbish dump – the Court rejected resource and policy arguments raised by the government:

'The Court acknowledges that it is not its task to substitute for the views of the local authorities its own view of the best policy to adopt in dealing with the social, economic and urban problems in this part of Istanbul. It therefore accepts the Government's argument that in this respect, an impossible or disproportionate burden must not be imposed on the authorities without consideration being given, in particular, to the operational choices which they must make in terms of priorities and resources (see Osman, cited above, pp. 3159-60, § 116); this results from the wide margin of appreciation which States enjoy, as the Court has previously held, in difficult social and technical spheres such as the one in issue in the instant case (see Hatton and Others v. the United Kingdom [GC], no. 36022/97, §§ 100-101, ECHR 2003-VIII).

However, even when seen from this perspective, the Court does not find the Government's arguments convincing. The preventive measures required by the positive obligation in question fall precisely within the powers conferred on the authorities and may reasonably be regarded as a suitable means of averting the risk brought to their attention. The Court considers that the timely installation of a gas-extraction system at the Ümraniye tip before the situation became fatal could have been an effective measure without diverting the State's resources to an excessive degree in breach of Article 65 of the Turkish Constitution (see paragraph 52 above) or giving rise to policy problems to the extent alleged by the

[9] K. and T. v. Finland (Application no. 25702/94) 27 April 2000

> Government. Such a measure would not only have complied with Turkish regulations and general practice in the area (see paragraphs 56, 58 and 101 above), but would also have been a much better reflection of the humanitarian considerations which the Government relied on before the Court'[10]

It seems to me, though, that there are difficulties with an argument put in that way. In law, as Lord Steyn famously remarked, *'context is everything.'* The European Commission, at least, has rejected an attempt to rely upon Article 2 to challenge *'wider issues'* as to the organisation and funding of the NHS; it concluded that such issues lay outside the scope of the Convention (see *Taylor v. United Kingdom (1994) 79-A DR 127).*

Although – moving to Article 3 - a refusal to provide access to essential healthcare may, exceptionally, lead to 'treatment' which is so severe that it may violate Article 3, the test is a high one. The level of 'severity' required for Art. 3 to be engaged, in this context, was outlined in *Pretty v United Kingdom [2002] 35 EHRR 1*, where the Strasbourg Court said this::

> 'As regards the types of "treatment" which fall within the scope of article 3 of the Convention, the Court's case law refers to "ill-treatment" that attains a minimum level of severity and involves actual bodily injury or intense physical or mental suffering. Where treatment humiliates or debases an individual showing lack of respect for, or diminishing, his or her human dignity or arouses feelings or fear, anguish or inferiority capable of breaking an individual's moral and physical resistance, it may be characterised as degrading and also fall within the prohibition of article 3. The suffering which flows from naturally occurring illness, physical or mental, may be covered by article 3, where it is, or risks being exacerbated by treatment, whether flowing from conditions of detention, expulsion or other measures, for which the authorities can be held responsible.'

The type of case where Article 3 is particularly relevant is where a person is receiving NHS treatment but is in risk of losing it through deportation. Even then the circumstances must be exceptional. This occurred in *D v. United Kingdom.* There, the ECtHR found a violation of Article 3 where the UK Government proposed to deport the applicant to St Kitts following his criminal conviction for importing drugs. The Applicant had been diagnosed as suffering from AIDS while in prison in the UK and was receiving treatment. D argued that his removal to St Kitts would condemn him to spend his remaining days in pain and suffering in conditions of isolation, squalor and destitution. He had no close relatives or friends in St Kitts to attend to him as he approached death and had no accommodation, financial resources or any access to any means of social support. It was an established fact that the withdrawal of his current medical

[10] Oneryildiz v. Turkey (application No. 48969/99) Judgment of November 2004. para 107

treatment would hasten his death. He argued that the hospital facilities in St. Kitts were extremely limited and that his death would not only be further accelerated, but would also come about in conditions which would be inhuman and degrading. His life expectancy was stated to be in the region of eight to twelve months even if he continued to receive treatment in the United Kingdom.

The ECtHR, in finding a violation of Article 3, noted that the applicant was in the advanced stages of a terminal and incurable illness, that his removal would hasten his death, and that there was a serious danger that the conditions in St Kitts would further reduce his already limited life expectancy and subject him to acute mental and physical suffering.

In stark contrast to this is the distressing House of Lords ruling in *N v. HS.* The facts and the dilemma were simply set out by Lord Nicholls. He said this:

> 1.This appeal raises a question of profound importance about the human rights obligations of the United Kingdom in respect of the expulsion of people with HIV/AIDS. The appellant, a woman 30 years of age, comes from Uganda. She was born there in December 1974. She came to London on a flight from Entebbe in March 1998. She was refused leave to enter this country. Her claim for asylum was rejected. The Secretary of State proposes to expel her. But there is a tragic complication: she suffers from advanced HIV/AIDS ('full blown AIDS', in the old terminology).
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> 2.When the appellant arrived here she was very poorly. Within hours she was admitted to Guy's Hospital. She was diagnosed as HIV positive, with an AIDS defining illness. In August 1998 she developed a second AIDS defining illness, Kaposi's sarcoma. The CD4 cell count of a normal healthy person is over 500. Hers was down to 10.
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> 3.As a result of modern drugs and skilled medical treatment over a lengthy period, including a prolonged course of systematic chemotherapy, the appellant is now much better. Her CD4 count has risen to 414. Her condition is stable. Her doctors say that if she continues to have access to the drugs and medical facilities available in the United Kingdom she should remain well for 'decades'. But without these drugs and facilities her prognosis is 'appalling': she will suffer ill-health, discomfort, pain and death within a year or two. This is because the highly active antiretroviral medication she is currently receiving does not cure her disease. It does not restore her to her pre-disease state. The medication replicates the functions of her compromised immune system and protects her from the consequences of her immune deficiency while, and only while, she continues to receive it.
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> 4.The cruel reality is that if the appellant returns to Uganda her ability to obtain the necessary medication is problematic. So if she returns to

> Uganda and cannot obtain the medical assistance she needs to keep her illness under control, her position will be similar to having a life-support machine switched off.'

That last sentence says it all. To switch off a life support machine against a competent refusal to die would, as the Court of Appeal recognised in the recent *Burke* case amount to murder. If it would amount to murder, then it may seem obvious that sending a person to be murdered is an affront to Article 3. That, indeed, had been the reasoning of the European Court of Human Rights in *D*

But in *N* the House of Lords held that Miss N had no rights under Article 3. This was because, so the reasoning went, the analysis of Strasbourg in *D* had been that Article 3 could only apply to such a case in very exceptional circumstances and that in *D* the Applicant was close to death.

It is by no means obvious in reading *D* whether it would, in fact, have made a difference to the Court's ruling had the Applicant, like Miss N, enjoyed currently good health because of continuing treatment. The idea that there is something less humane in deporting someone who may be comatose to a country where they will, inevitably die, as opposed to removing someone in full possession of their faculties who may be terrified at the prospect of certain death is not entirely clear.

Nor, indeed, was it clear to the House of Lords in *N.* Lord Nicholls observed that the Strasbourg case law in this area lacked its customary clarity (paragraph 14), He accepted that the humanitarian considerations were of a very high order (paragraph 14). But his analysis was to the effect that the Strasbourg cases on Article 3 suggested that this provision did not require the State to provide medical treatment for would be immigrants for the rest of their lives. So, the distinction made sense because a person near death would not be a burden on the State for very long.

Illuminatingly, Lord Hope (at paragraph 23) said it was not the words of Article 3 that the House was being asked to interpret but, rather, the Strasbourg jurisprudence. In his view, the case was not sufficiently exceptional to fall within the ambit of Article 3. This was because there was a difference between D's being near death and N's currently good state of health.

But as Lord Hope then observed at paragraph 49:

> '49. It may be said that the court has not really faced up to the consequences of the developments in medical techniques since the cases of D v United Kingdom and BB v France were decided. The position today is that HIV infections can be controlled effectively and indefinitely by the administration of antiretroviral drugs. In almost all the cases where this treatment is being delivered successfully it will be found that at present the

> patient is in good health. But in almost all these cases stopping the treatment will lead in a very short time to a revival of all the symptoms from which the patient was originally suffering and to an early death. The antiretroviral treatment can be likened to a life support machine. Although the effects of terminating the treatment are not so immediate, in the longer term they are just as fatal. It appears to be somewhat disingenuous for the court to concentrate on the applicant's state of health which, on a true analysis of the facts, is due entirely to the treatment whose continuation is so much at risk.'

The speeches on this issue were unanimous. Lord Walker who simply delivered a concurring speech was plainly troubled by the House of Lords' ruling several months later when he spoke about the dilemma at a seminar.

The concern that one has with the ruling is first the extreme deference that the House paid to Strasbourg rulings which were, as the Court recognised, neither clear nor unambiguous. Under HRA s. 2 Strasbourg rulings must be taken into account by the domestic Court but where that Court has (to use Lord Hope's word) been somewhat 'disingenuous' it is surely questionable whether it has to be followed. Secondly, it is by no means obvious (though the House of Lords has already discussed this in another case) that Lord Woolf was wrong in the decision in *S&M v HS* in the Court of Appeal when he said that the national Courts could develop higher Convention standards than the bare minimum required by Strasbourg. At first sight this seems entirely consistent with the idea of the principle of subsidiary whereby Strasbourg defers to national judgments. Finally, and fundamentally, adopting the opening words of Lord Nicholls and - mentally holding on to the judgment of the CA in *Burke* – it is entirely contrary to the absolute protection afforded by Article 3 to in effect sentence a living human being to death.

It seems clear that *N* represents something of a policy or utilitarian judgment on the part of the House of Lords. That element was disregarded by the House in another Article 3 case – that of *Limbuela*. I can deal with *Limbuela* briefly. That was a case about destitute asylum seekers. In summary, in an earlier case *(Q)* the CA had effectively ruled that the State could, for the purposes of the Immigration Nationality and Asylum Act 2002, require a person who was ostensibly destitute to seek help from a charity before the State owed any Article 3 obligation.

In *Limbuela,* the House of Lord's ruling was well expressed by Lord Bingham. He said this:

> '8. When does the Secretary of State's duty under section 55(5)(a) arise? The answer must in my opinion be: when it appears on a fair and objective assessment of all relevant facts and circumstances that an individual applicant faces an imminent prospect of serious suffering caused or

> materially aggravated by denial of shelter, food or the most basic necessities of life. Many factors may affect that judgment, including age, gender, mental and physical health and condition, any facilities or sources of support available to the applicant, the weather and time of year and the period for which the applicant has already suffered or is likely to continue to suffer privation.
>
> 9. It is not in my opinion possible to formulate any simple test applicable in all cases. But if there were persuasive evidence that a late applicant was obliged to sleep in the street, save perhaps for a short and foreseeably finite period, or was seriously hungry, or unable to satisfy the most basic requirements of hygiene, the threshold would, in the ordinary way, be crossed. I do not regard O'Rourke v United Kingdom (Application No 39022/97) (unreported) 26 June 2001 as authority to the contrary: had his predicament been the result of state action rather than his own volition, and had he been ineligible for public support (which he was not), the Court's conclusion that his suffering did not attain the requisite level of severity to engage article 3 would be very hard to accept*.'*

This restores commonsense to Article 3. The issue of whether a person denied by the State and sleeping rough falls within Article 3 had divided earlier Courts of Appeal. As with torture – where as we have seen the Court of Appeal was divided – the House of Lords in *Limbuela* again came to the rescue of Article 3.

But what a pity that it fell back into the black hole of *N.* Legal values need constant reassertion to become embedded in judicial and national consciousness. I suspect that we have not heard the last of judicial debate over the parameters of Article 3.

Where the threshold in Article 3 is not reached, it is (nonetheless) likely that Article 8 will be engaged.

It is well established that Article 8(1) is capable of being engaged where an interference may adversely affect a person's *'physical or psychological integrity',* his right to personal development and his right to establish and develop relationships with other human beings and the outside world: see (for reference only) *Pretty v United Kingdom, (2002) 35 EHRR 1,* paragraph 61

In *Pretty* the European Court of Human Rights observed (at paragraph 65) that:

> *'The very essence of the Convention is respect for human dignity and human freedom'.*

The Court also explained (at paragraph 61) that:

> '… the concept of "private life" is a broad term not susceptible to exhaustive definition. It covers the physical and psychological integrity of a person. It can sometimes embrace aspects of an individual's physical and social identity … Article 8 also protects a right to personal development, and the right to establish and develop relationships with other human beings and the outside world. Though no previous case has established as such any right to self-determination as being contained in Article 8 of the Convention, the Court considers that the notion of personal autonomy is an important principle underlying the interpretation of its guarantees.'
>
> (Emphasis added).

Here, therefore, the Court is making it as clear as it can that: (i) the term *'private life'* is not susceptible to exhaustive definition but that (ii) it embraces autonomy (freedom to choose).

This newly emerging concept of autonomy is very important. As the Strasbourg Court made clear at #61 of *Pretty,* no previously decided case has established the right to self determination *'as such.'* But the notion of *autonomy* and the concomitant right to ensure personal development and relationships with other people without interference by the State is, and has for some time been, central to Article 8 protection.

We can, in fact, trace through the Court's express emphasis on autonomy in *Pretty* to its most recent ruling in *Evans v. UK* (the recent frozen embryos ruling). The Court there observed thus:

> 'It is not disputed between the parties that Article 8 is applicable and that the case concerns the applicant's right to respect for her private life. The Court agrees, since "private life," which is a broad term, encompassing, inter alia, aspects of an individual's physical and social identity <u>including the right to personal autonomy, personal development and to establish and develop relationships with other human beings and the outside world</u> (Pretty #61), incorporates the right to respect for both the decisions to become and not to become a parent*.'*

I believe that it is the less dramatic area of autonomy as developed in some of the Article 8 cases that improved access to NHS services may be argued for. Take, for example, the recent case of Mrs. Rogers, the cancer patient who is currently in remission but who has been refused access to a potentially life saving drug Herceptin. It seems clear to me that arguments fashioned on Articles 2 and 3 ECHR are unlikely to succeed. This is because, in order to use those Convention provisions, the Court would have to modify the high threshold that it has set for cases under Articles 2 and 3. However, using Article 8 may be more productive. It seems at least possible that Mrs. Rogers' physical and

psychological integrity may well be detrimentally affected by the refusal to continue to provide her with Herceptin. The fact that she has been allowed to use the drug thus far and the effect of its sudden removal on the quality of her life is a less threatening argument that the bold proposition that any cancer patient is entitled to Herceptin as of right in every case. The resource implications of a successful Article 2/3 challenge would be enormous. But a softer-edged Article 8 submission might work wonders with a sympathetic Court.[11]

Having made these points, I have some reservations about the indiscriminate use of an autonomy concept. That is the problem with many legal rules and many legal pigeon holes. They are constructed for one purpose but often have to fit others. Once the words have appeared on the pages of a law report it is supposed that they apply to all situations.

A good example of this is the autonomy principle. It seems axiomatic, does it not, that a person with legal capacity may make and implement decisions – however irrational – that he or she is competent to make? But if that is right, autonomy provides a compelling moral (and hence legal) justification not merely for suicide but also for assisted suicide. Why should a person be able to commit suicide but not be able to invite a third party to assist him or her to do so?

There is, indeed, an extreme position that some may take which is that assisting a competent person to commit suicide should always be lawful because it reflects the legal principle of autonomy. But, at least in its extreme form, I suggest that it is unlikely to be right. I suggest that whilst autonomy is an important moral principle it is not (and certainly should not be) an *absolute* principle.

Take the extreme example. Suppose that I, otherwise perfectly physically healthy and with full legal capacity, whilst in a fit of momentary depression want to give myself a lethal injection but that I am too much of a coward to perform the act. I ask a third party. Is he or she entitled to give me the lethal injection? If not, why not?

The intuitive answer to this question is that my life is obviously not – at least in that scenario – worthless and that if a third party gave me the injection he would be morally culpable. In the present state of the law it would be murder. If the conclusion is right my autonomous request to be killed is not, or should not, in any way be persuasive.

Take, then, a case at the opposite end of the spectrum. Suppose that I – a competent person - am suffering from a terminal illness but that I am simply too weak to commit suicide. I ask my spouse to help me to kill myself at the point that I find life unbearable. We can, of course, readily empathise with Diane

[11] Unfortunately, a pre autonomy domestic case – the CA ruling in *R v. NW Lancashire Health Authority ex p, A* has held that Article 8 imposes no positive obligation to provide medical treatment.

Pretty's predicament. In that scenario the Netherlands, Belgium and (now as I understand it) France would allow a so-called mercy killing though the UK – as yet – does not. Is there not a compelling moral case for allowing – albeit under strictly controlled procedures – a legal route that would have enabled Mrs. Pretty to die with dignity?

I suggest that a plausible answer could be 'yes' but that it is not necessarily to be found through the autonomy principle. If there is a case in which death is likely only to produce a positive benefit (however these words are interpreted) then two conclusions seem to follow. First, a non-competent patient should not be denied that benefit merely because he or she does not possess autonomy. Secondly, in the case of a competent patient, whilst autonomy may be a necessary condition for allowing a patient wishing to die to be killed, it is hardly (as explained earlier) a sufficient condition. In the examples I have come up with, the trigger for euthanasia would not be the autonomous will of the patient but, rather, what Dworkin would call the *detached* argument that life no longer has any intrinsic benefit.[12] In the case of the competent patient, I suggest, the patient's consent would also be needed.

If answers to these questions cannot always be supplied via the ECHR (and we know from *Pretty* that this is so) why is it, nonetheless, at least intuitively clear to a great many people that Mrs. Pretty should have been allowed to choose the manner and time of her death? What is the moral framework for answering a question like that?

Before seeking to answer that question, let me put another (related) one. Suppose the question is not whether there is a right to die but, rather, whether there is a right to *live.*

This was the position in *R (Burke) v. GMC (2005) 2 WLR 431.* There, Mr. Burke (who possessed full legal capacity) asked the Court to determine the legality of GMC guidelines that could have had the potential effect of preventing him from being able to receive artificial nutrition and hydration at the end of his life against his will. Munby J at first instance held, essentially, that in a number of important respects the guidelines were unlawful because they violated, amongst other things, Article 8 ECHR. This was because Mr. Burke, as a competent person, had the right to decide determinatively what was in his best interests even if the clinicians thought otherwise.

According to the judgment, the provision of artificial nutrition and hydration did not involve questions of financial resources. That being so, Mr. Burke – as an autonomous person – had the right to have his autonomy respected and his wishes followed save, perhaps, where death was imminent and where life would

[12] There are, though, difficulties with so-called 'detached' arguments. No life is worthless and, as Jane Campbell's moving experiences show, the life of a disabled person is every bit as valuable as that of a non disabled person.

be truly intolerable for him. However, the CA overruled Mr. Justice Munby observing merely that to deprive Mr. Burke of artificial nutrition and hydration would violate Article 2 ECHR and that nothing in the GMC Guidelines was unlawful.

One can see how in the *Pretty* and *Burke* cases it is easy to confuse the decisions as reflecting an unqualified autonomy principle. But they do not. What if, in *Pretty,* Mrs. Pretty had not been suffering from motor neurone disease but from depression and asked her husband to kill her in her sleep when she did not know about it? What if, in *Burke,* it was an established fact that two million people wanted to be kept alive on artificial nutrition and hydration (with all the resources in terms of nursing care that this would involve)? In each or either case would there be (respectively) a right to die or a right to live?

Somehow, I doubt it. But the reason that I doubt it is because autonomy is not (I suggest) always the sole or determinative consideration in deciding whether a person should live or die. Nor can it, sensibly, be said that the guiding principle is either the sanctity of life (that is, the inviolability of life) or, something subtly different, vitalism (the preservation of life no matter what the cost).

The moral answer, I believe, is that underlying each human being's destiny (whether they possess capacity or not) is an essential dignity. This is what Munby J recognised in *Burke.* Citing a recent lecture by Baroness Hale, he said this:

'Very recently in her 2004 Paul Sieghart Memorial Lecture Baroness Hale of Richmond made much the same point:

> " … human dignity is all the more important for people whose freedom of action and choice is curtailed, whether by law or by circumstances such as disability. The Convention is a living instrument … We need to be able to use it to promote respect for the inherent dignity of all human beings but especially those who are most vulnerable to having that dignity ignored. In reality, the niceties and technicalities with which we have to be involved in the courts should be less important than the core values which underpin the whole Convention."

I respectfully agree.'

The relevant moral framework is, I believe, strongly connected with the basic idea of human dignity. In the case of a person with legal capacity, their autonomy is a reflection of their basic dignity. In the case of an incapacitated person, their dignity derives from the simple fact of their humanity. That is why even a corpse may – as Munby J observed in *Burke* – be subject to legal protection under Article 3 ECHR.

Reliance on dignity reconciles what are sometimes viewed as ostensible contradictions in the law in this difficult area. It explains why an autonomous patient has an absolute right to refuse medical treatment even if his or her refusal is intentionally suicidal. It would allow Mrs. Pretty to choose her moment of death even though it would not allow autonomy to validate all intentional killing by a third party.

Importantly, though, dignity is not the same thing as the sanctity of life at least as that doctrine is espoused by religious ethicists such as Keown. Keown makes a distinction between the preservation of life at all costs (what he terms 'vitalism') with the sanctity or inviolability of life. According to this thesis, suicide is always wrong – even if not criminal. And the assistance of suicide is always wrong. However, there may be cases where life would be so intolerable as to make it justifiable for it to end provided that intentional killing is not the objective.

This is too tortuous an analysis for me. The sanctity of life cannot, at least since the ECHR, be seen as a religious notion. It is – by the law that this country has incorporated – essentially secular. It gives pride of place to autonomy though not, as I have sought to demonstrate, absolute pride of place. My suggestion is that the only moral (and hence legal) framework that is permissible following the coming into force of the Human Rights Act 1998 is one that recognises the essential dignity of all human beings and that seeks to reflect that by according the strongest emphasis to autonomy and, in any event, to the fundamental dignity of the humanity of all of us whilst, at the same time, recognising the demands of society and the relationship that we have towards each other as human beings.

The last Convention provision I want to consider is Article 14. With the ever-increasing burden on NHS resources and the rising cost of treatment some are suggesting that resources and treatments should be limited to those who are, for want of a better term, most "deserving". The first group of the "less deserving" would include those who are said in some way to have contributed to, or even caused, their need for treatment, such as those who smoke, or are obese or who are heavy drinkers. A second category of the "less deserving" would include the elderly, the premature and the disabled, where the issue is one of cost benefit, is the benefit that treatment would bring to the quality or length of life justified by the cost? Framing these questions in terms of discrimination law may provide the necessary framework within which to consider the legality of these emerging policies.

Article 14 does not guarantee a freestanding right to protection from discrimination but does guarantee a right not to be discriminated against in respect of the other rights, so if access to healthcare can be brought within the "ambit" of Article 2, 3 or 8, then Article 14 can be relied upon to protect from discrimination.

Would the facts here fall within the ambit of one of the Convention rights? When looking at Article 14 in conjunction with other Convention rights there is no need to find a violation of the other right, but merely for the facts to fall within its ambit, the limitations in Article 8(2) are therefore not relevant, however the "minimum threshold" of treatment must be crossed when considering Article 3, and life must be "at risk" when considering Article 2. As noted above Article 8 covers the right to moral and physical integrity, which includes health, and so the right to access to healthcare would come within the "ambit" of Article 8. If the consequences are severe enough then the restriction on access to healthcare could also fall within the ambit of Article 2 and/or 3.

Having come within the ambit of another Convention you next have to show you are being treated differently and less favourably than others who are in a similar or analogous situation, the Strasbourg jurisprudence says you have to compare like with like. So, for example, if the state denied treatment to smokers then the complainant would be a smoker and the comparator may be non-smokers who were entitled to the treatment. But is a smoker in this situation in an analogous position to a non-smoker? It could be argued that to compare "like with like" then the comparison should be between a smoker and another smoker, but to do that is to take away the very ground on which the difference in treatment is based. It puts the cart before the horse. This is a difficulty the House of Lords identified in R (Carson) v Work and Pensions Secretary with this approach to Article 14 discrimination. Their Lordships found the use of a comparator in some cases as being an unhelpful way in determining whether a measure was discriminatory. A better approach it was suggested may be simply to reach an overall conclusion as to whether in the enjoyment of Convention rights there had been unfair and unjustifiable discrimination on the grounds of some personal characteristic. The real questions then are whether the difference in treatment was based on a personal characteristic (or "status") and if so was it justified?

Article 14 lists the grounds upon which there should be no difference of treatment, however, this is a non-exhaustive list. The catch-all group of 'other status' means that categories of people or individuals not covered by the specified list of grounds still have the protection of Article 14, the notable examples being sexual orientation and disability. The ECtHR takes a broad view of "other status" and has found it to include marital status, trade union status, military status, conscientious objection, professional status, and imprisonment (see for example Monnell and Morris v. UK where a difference in treatment was found between convicted prisoners in custody and convicted persons at liberty, although the different treatment was then found to be justified).

As already mentioned disability, would clearly come within the definition of "other status", as would probably age in certain circumstances (see age of consent cases), but what about lifestyle choices, do they create the necessary "status". Arguably if smoking, drinking and obesity could be classed as an "illness", so for

example someone has an eating disorder or are an alcoholic, then a difference in treatment based on their status as a person suffering from that illness might fall within “other status”.

The final, and most important question is whether the less favourable treatment is objectively justified. In Convention terms did the impugned measure seek to achieve a legitimate aim, and is there a reasonable relationship of proportionality between the difference in treatment and the aim sought? Here the basis for the difference in treatment is relevant. Where the difference in treatment is on the grounds of one of the express categories, so for example race or sex, then it will be rarely if ever possible to justify different treatments. But for other categories such as on the grounds of being a smoker or obese then whether the difference is justified will more likely depend upon considerations of the general public interest (see Lord Hoffman in *R (Carson) v Work and Pensions Secretary*). So we are back to the dreaded question of resources.

Whether a policy refusing access to healthcare on the basis of a person’s lifestyle choices could or could not be objectively justified will in the end probably depend on the consequences of refusing or delaying treatment. The more life threatening, or the more life debilitating the refusal to provide the treatment the more likely the refusal would be found to be disproportionate and so discriminatory. Justifying a difference in treatment on the basis of lifestyle choices is likely to be easier than on the basis of a characteristic outside the control of the individual, so on the basis of disability or age, which is much more akin to the express prohibited grounds. The advantage of arguments under Article 14 though would be that you are directly challenging whether the reason for denying the treatment is reasonable and proportionate (not “Wednesbury” unreasonable), and unlike when analysing it in terms of Article 8 there is no need to first find that you have a “right” to the treatment, as soon as someone else is given the treatment not to afford to you, you could (if you can bring yourself within “other status”) require the state to justify why the denial is objectively jusitifiable, which may be more difficult for the state than justifying a denial of treatment under Article 8(2).

There is also domestic discrimination law that could be relied upon, particularly the Disability Discrimination Act 1995 which protects disabled persons in relation to the supply of goods, facilities and services.

EC Law

Watts is a curious case. Who would have thought that a patient needing improved NHS access for a double hip replacement would end up (so far at least) winning her case not on any human right of hers but on the basis that

foreign doctors wanting to treat her in a different EC country had commercial rights in EU law?[13]

We all know that waiting lists – unknown in Europe – are commonplace here and entirely lawful. If they were unlawful someone, somewhere would surely have won a case before now. However, in the context of EU law, important questions have arisen as to the legality of waiting lists. No case before *Watts* had centred on a free NHS because the cases in which the issue arose were in the context of foreign insurance schemes with (as you would expect) unpronounceable names and unappealing (heavily consonanted) acronyms such as ZWF.

The issues arise, mainly, because of the EU right under Article 49 [59] EC of freedom to provide services within the Community which has been broadly interpreted by the ECJ. As the Court of Appeal observed in *Watts*[14] (at paragraph 31 of the Court's judgment):

> 'It is evident that Article 49 was directed to prohibiting restrictions on those who provide services within the community. In the present context, that would mean doctors, nurses and hospitals, not patients. Its purpose was evidently to prohibit inter-state discrimination so as to prohibit, for instance, restrictions on a French doctor practising in England. The Court of Justice has, however, put in place on the foundation of Article 49 a substantial edifice not immediately apparent from its literal terms. One consequence of this, in our view, is that submissions based on the literal meaning of Article 49 and related articles may not be regarded as persuasive. There has been much judicial policy-making, and the policy goes well beyond the words of the Article*.'*

Mrs. Watts, required replacements of both her hips. Her daughter made enquiry of the Bedford Primary Care Trust about her mother having surgery abroad under the Government's E112 scheme which gives effect to Article 22 of Council Regulation 1408/71. There is no mechanism for giving effect to Article 49 because the UK Government does not believe that it applies to the NHS at all.

Mrs. Watts was seen by a consultant in October 2002. In late October of that year the consultant wrote to the PCT saying that she was as deserving as any of the other patients on his list with severe arthritis, that her mobility was severely hampered and that she was in constant pain but that she would have to wait approximately one year to have the operation at her local hospital. He classified her case as *'routine.'*

On November 21 2002 the PCT wrote to the Claimant's daughter refusing to support the E112 application because the conditions set out in Article 22 were

[13] The ECJ judgment is due on 16th May 2006.
[14] *R (Watts) v. Secretary of State for Health [2004] EWCA Civ 166.*

not met. Mrs. Watts issued judicial review proceedings the following month. The PCT replied that treatment could be provided locally within the time *normally necessary for obtaining the treatment in question* taking into account the Claimant's current state of health, and thus without *'undue delay'* (the relevant triggering criterion for application of Article 22). In doing so, the PCT interpreted *'undue delay'* as meaning *'within the Government's NHS Plan targets.'*

An application for permission to apply for judicial review was held in January 2003. By that time, Mrs. Watts had seen a consultant in France who warned her that her need for surgery was becoming more urgent in view of her continuing weight loss. She saw her English consultant at the end of January. He wrote to the PCT stating that he would now categorise her as someone who required surgery *'soon.'* The PCT wrote to the Claimant's daughter on February 4 2003 continuing to refuse support for the Claimant's E112 application on the grounds that she would now only have to wait between three and four months for treatment locally. In that letter, the PCT repeated its reliance on NHS Plan targets as determinative of the question of whether there was *'undue delay.'*

Mrs. Watts did not wait to have treatment locally. She had a hip replacement operation on March 7 2003 in France. In the substantive application for judicial review, which was heard in April 2003 before Munby J, she sought both declaratory relief as to the law and reimbursement from the NHS of the cost of her treatment abroad. She commenced proceedings against both the PCT and the Secretary of State. Her case was founded on EU law, asserted Convention rights (most notably under Article 8 ECHR) and on traditional principles of administrative law.

In summary, the Defendants denied that there was any proper basis for HRA or domestic administrative law arguments. In fact it was considered by all parties that the real battleground was, as it proved to be, EU law. The Claimant abandoned her administrative law arguments and did not further pursue her arguments under the HRA.

In respect of EU law, the Defendants argued that Article 49 did not apply to a health care system such as the NHS which was free at the point of delivery. The only relevant provision of EU law that covered Mrs. Watt's case was, so it was argued, Article 22 of Council Regulation 1408/71 and it was contended that Mrs. Watts fell outside the protection afforded by that provision.

At the time of this talk, the Advocate General (A-G Geelhoed) produced (on December 15th 2005) an Opinion in support of the Claimant's case. The main elements of the opinion are these:

(i) Article 49 should be interpreted as meaning that, in principle, persons ordinarily resident in a Member State operating a national health service in the United Kingdom are entitled to receive hospital

treatment in another Member State at the expense of the NHS. There may be a requirement for prior authorisation provided that such authorisation is based on objective, non-discriminatory and transparent criteria. Refusal of authorization must be capable of being challenged in judicial or quasi judicial proceedings.

(ii) Considerations relating to the management of waiting lists can only justify a refusal to receive hospital treatment in another Member State if the waiting lists are managed in such a way that they take the individual medical needs of patients sufficiently into account and do not prevent treatment being provided in another Member State in a case of urgency.

(iii) Where conditions on granting authorisation to receive hospital treatment in another Member State are designed to guarantee the financial stability of the national health system, considerations of a purely budgetary or economic character cannot justify a refusal to grant such authorisation.

(iv) In determining whether treatment is available without undue delay for the purposes of Article 49 EC, it is permissible to have regard to waiting times and the clinical priority accorded to the treatment by the relevant NHS body, on condition that these are based on concrete indications relating to the patient's condition at the time of assessment, as well as to his medical history and the probable course of the disease in respect of which that patient seeks treatment.

(v) On the proper interpretation of Article 22, the applicable criteria are identical to those in determining questions of *'undue delay'* for the purposes of Article 49 EC.

In summary, the Advocate General, at least, has not differentiated between a health service funded under insurance schemes such as the ZFW and an NHS health service. He has accepted that Article 49 applies to both and requires patients to be able, in principle, to choose medical treatment abroad. There is no material difference, in this context, between the requirements of Article 49 and Article 22 of Council Regulation 1408/71. Whilst there may be derogation, it must be objectively justified on traditional administrative law basis. Waiting lists may only be taken into account in terms of an individual patient's case by reference to the medical circumstances of that patient's case.

Watts exemplifies a number of important aspects relating to domestic judicial review challenges founded on EU law grounds. First, although the case was largely fought on an EU basis the Claimant also raised issues of domestic and HRA public law. These grounds were easily defeated. The purely domestic

challenge was abandoned because of the difficulty in challenging health care decisions in circumstances where duties under the National Health Service Act 1977 (the over-arching statute regulating the NHS) are target duties and, therefore, not easily enforceable by individuals.

The HRA challenge was stronger but failed on the domestic and Strasbourg case-law. There is no obvious basis in any of the cases for compelling the State to provide medical treatment. Even the case-law on potentially life saving treatment under Article 2 (the right to life) is by no means clear.[15] So, *Watts* is a graphic example of a case where EU arguments were by far the strongest that could be deployed.

The second feature of *Watts* is the counter-intuitive nature of the EU argument. At first sight, any legal flaw in delay in treating a UK patient would appear to depend upon a fundamental right of the *patient.* However, as the EU case-law has developed under Article 49, it is the right of freedom of services vested in the *doctor* that provides the key to whether or not a patient has the right to be treated abroad. The Court of Appeal was clearly troubled about this ostensible paradox. Not only does it (as the Court observed) go beyond the literal wording of Article 49, it produces a situation in which the State can be compelled to pay for treatment that it could not have been required to provide under domestic law to a patient in the United Kingdom. Thus, EU law has the potential to produce very different consequences that can bypass an entire national infrastructure such as the NHS and, in so doing, to avoid traditional constraints familiar to administrative lawyers such as allocation of resources.

Thirdly, *Watts* shows that even where the ECJ has pronounced on the applicable law on several occasions, the national Courts are – in a case affecting national public interest - likely to seek a preliminary ruling for the purposes of clarification to a specific concrete situation. This appears to be so even where – as here – exactly the same arguments have already been advanced before the ECJ. As has been seen in *Watts*, the domestic Court will use every opportunity to raise issues or lay emphasis on practical matters that it queries were fully considered by the ECJ in previous decisions.

Finally, it is important for the domestic practitioner to have a practical appreciation of the policy imperatives that may drive the ECJ to different conclusions to that of national Courts. The ECJ jurisprudence on Article 49 shows that its ambit has been extended well beyond its ostensible wording. Having created that momentum in a series of decisions that were directly concerned with insurance schemes, it would not have been easy for the ECJ to draw back from the principles set out in earlier cases so as to make an exception for the NHS. It is, no doubt, for these underlying reasons that the ECJ also

[15] See, eg, the discussion in Clayton and Tomlinson 'The Law of Human Rights' (Oxford, 2000) at paragraphs 7.62-7.66 (pp. 365-367).

considered Article 22 of the Council Regulation to be (for present purposes) a sub-set of Article 49 with the same overall meaning and structure.

Watts demonstrates that the selection of relevant principle for particular cases may be very different (and actually stronger) from those prevailing in HRA or domestic judicial review. This may be of great importance when deciding whether – and how – to run EU arguments in future cases when seeking improved access to NHS services.

International Treaties and the use to which they might be put

This Paper contains an Annex with an outline of international treaties that may, at least potentially, be relevant to seeking improved access to NHS services. The important question, though, is this. No matter how compelling the terms of an international instrument might be, how can international Treaty obligations (even if – by no means usually so - they are sufficiently precise) be enforced on the national level in cases before the Courts?

It seems clear that there are circumstances in which international treaties can be used before national Courts. True it is that domestic courts do not have the power to enforce non-incorporated international obligations *directly.* But in construing any provision in legislation which is ambiguous, in the sense that it is capable of a meaning which either conforms to or conflicts with treaty obligations, the Courts will presume that the legislature intended to legislate in conformity with treaty obligations, rather than in conflict with them. In Garland v British Rail Engineering Ltd [1983] 2 Ac 751, Lord Diplock formulated the presumption thus:

> '… it is a principle of construction of the United Kingdom statutes, now too well established to call for citation of authority, that the words of a statute passed after the Treaty has been signed and dealing with the subject matter of the international obligation of the United Kingdom, are to be construed, if they are reasonably capable of bearing such a meaning, as intended to carry out that obligation, and not to be inconsistent with it.'.

This implicitly suggests that legislation should be treated as ambiguous if it is reasonably capable of bearing a meaning consistent with a treaty obligation as well as a meaning inconsistent with that obligation.

In two cases - Ahmad v ILEA [1978] QB 36 and Williams v Home Office (No.2) [1981] 1 All ER 1211 - this presumption has been applied to non treaty implementing legislation. Further, in Ahmad, the presumption was applied even though the international obligation came after the domestic statute, (there, the ECHR was resorted to in the interpretation of the Education Act 1944).

By the time of R v Secretary of State for the Home Department, ex parte Brind [1991] AC 696, Lord Bridge was able to refer to a *'canon of construction'* whereby the Courts, when confronted with a simple choice between two possible interpretations of a statutory provision, *'prefer that which avoids conflict between our domestic legislation and our international obligations'*.[16] We may have reached the stage, therefore, where the correct question to be asked when construing domestic law in the context of international obligations is not *'is domestic law ambiguous?'* but *'can domestic law be reasonably interpreted in a way which avoids a conflict with international law?'*

There is a further point. Human rights treaties may also be argued to be different from traditional multilateral treaties in that they are (albeit on the international level) intended to confer individual rights, as opposed to being concerned with the more traditional notion of a reciprocal exchange of rights between states. This has been explicitly recognised by the Inter American Court in its Advisory Opinion on The Effect of Reservations on the Entry Into Force of the American Convention on Human Rights (Arts. 74 and 75), (Advisory Opinion OC-2/82, September 24, 1982, Inter-Am. Ct. H.R. (Ser. A) No. 2 (1982). There, the Court stated that:

> " 29. The Court must emphasize, however, that modern human rights treaties in general, and the American Convention in particular, are not multilateral treaties of the traditional type concluded to accomplish the reciprocal exchange of rights for the mutual benefit of the contracting States. Their object and purpose is the protection of the basic rights of individual human beings irrespective of their nationality, both against the State of their nationality and all other contracting States. In concluding these human rights treaties, the States can be deemed to submit themselves to a legal order within which they, for the common good, assume various obligations, not in relation to other States, but towards all individuals within their jurisdiction.

This is potentially very important although no UK Court has gone as far as this.[17]

What can be seen, though, is the next best thing, that is a recognition of the persuasive relevance of international obligations that the State has signed up to. Most recently our domestic courts have made direct reference to international treaties and the European Charter on Fundamental Rights for substantive as opposed to purely interpretative purposes. Thus, in R (Howard League for Penal Reform) v Home Secretary, East Sussex [2003] 1 F.L.R. 484 where the policy guidance issued by the Secretary of State for the Home Department was found to be wrong in law as it stated that the Children Act 1989 did not apply to

[16] p.748

[17] Though in the *Metric Martyrs* case, Laws LJ recognised that the European Communities Acr 1972 was a constitutional statute. Perhaps the same could be said for the HRA so as to give a stronger force to international human rights treaties.

persons under 18 years of age in prison., Munby J was referred to the ECHR as well as the United Nations Convention on the Rights of the Child 1989, and the Charter of Fundamental Rights of the European Union.

He found these to be 'important sources of possible obligations both owed to and enforceable by children in YOIs.'[18], and that while '[n]either the UN Convention nor the European Charter is at present legally binding in our domestic law and they are therefore not sources of law in the strict sense. But both can, in my judgment, properly be consulted insofar as they proclaim, re-affirm or elucidate the content of those human rights that are generally recognised throughout the European family of nations, in particular the nature and scope of those fundamental rights that are guaranteed by the European Convention.' [19]

This approach was said by Munby J to be consistent with the approach taken by The House of Lords in R v Secretary of State for the Home Department ex parte Venables; Same ex parte Thompson [1998] AC 407, where similarly the UN Convention on the Rights of the Child were used to aid interpretation of domestic law. Lord Browne Wilkinson said of the Convention:

> 'The Convention has not been incorporated into English law. But it is legitimate in considering the nature of detention during Her Majesty's pleasure (as to which your Lordships are not in agreement) to assume that Parliament has not maintained on the statute book a power capable of being exercised in a manner inconsistent with the treaty obligations of this country.' [20]

These are exciting developments and suggest that international human rights treaties could prove to be a rich source of material for arguing for improved NHS access. Of the many possible examples set out in the Annex consider, especially, Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), which has been ratified by 151 countries including the UK. It provides as follows:

> 1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
>
> 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
>
> > (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

[18] paragraph 46
[19] paragraph 51
[20] p.499

> (b) The improvement of all aspects of environmental and industrial hygiene;
>
> (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
>
> (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

The future

This short discussion shows, perhaps, that we are moving away from the rather unimaginative approach to NHS access that prevailed even a decade ago in our national Courts. Ten years or so ago, I remember arguing the *Bournewood* case in the House of Lords. Their Lordships were simply not interested in the Strasbourg case-law. In that they were short-sighted, because Strasbourg was in due course to override their approach to what constitutes detention of an incapacitated patient for the purposes of the European Convention.

We are now in a fast-moving area of law which includes ECHR and EC systems with which our judges have rapidly had to make themselves familiar. But the basic question remains. How do lawyers fight cases for the disabled in a way that is likely to enhance NHS access for the disabled?

My suggestion is that this is not going to be achieved by fighting points of extreme principle head-on. The judges both here and in Strasbourg are never going to commit themselves to any proposition that creates a right to treatment.

That does not mean that nothing can be done through the Courts to improve access to the NHS. The case-law proves that achievement is possible at least incrementally. It is possible through the use of diversionary tactics. If the Courts do not like some concepts (an absolute right to treatment) then the concept needs to be re-packaged (a right to treatment in this case flowing from the autonomy guaranteed by Article 8 ECHR). Cases founded on eligibility criteria, best interests and EC law have had a marked success rate. Cases fought on wide issues of principle have generally been less successful whereas those raising human issues (especially high profile human dilemmas) have had a much higher success rate.[21]

A lower-key and incremental approach, though somewhat less dramatic than winning high points of principle, is where I believe the future lies in securing improved NHS access for the disabled and other vulnerable client groups.

[21] Consider, e.g., the cases involving keeping babies alive who doctors have suggested have no or insufficient quality of life.