social care institute for excellence

Access to Social Care

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A critique of the domestic law framework

1. What I mean by 'social care' is those housing and community care services provided primarily by local authorities, but in some cases by health authorities, to adults and children *in the community* who need assistance in order to alleviate the symptoms of any disability, disease, illness or infirmity from which they suffer and to enable them to access opportunities for work, education or recreation in the community that they are restricted or prevented from accessing by virtue of such disability etc. That assistance may take the form of income support, disability or other benefits, housing, nursing or domiciliary care and other community care services.

2. The term 'community care services' has a specific meaning in community care law as those services falling within section 46(3) National Health Service and Community Care Act 1990 (NHSCCA) in respect of which local authorities are under a duty to make an assessment of the needs of adults for those services under section 47. The relevant services are those provided under sections 21 and 29 National Assistance Act 1948 (NAA), section 2 Chronically Sick and Disabled Persons Act 1970 (CSDPA), section 117 Mental Health Act 1983 (MHA) and (to a much lesser extent) under section 45 of the Health Services and Public Health Act 1968 (power to make arrangements for promoting the welfare of old people) and section 21 and Schedule 8 of the National Health Service Act 1977 (power to make arrangements for the care of expectant and nursing mothers, the prevention of illness and for the care of persons suffering from illness and for the after-care of persons who have been so suffering and the provision of home help and laundry services).

3. I will use the term 'community care services' more generally as including all services provided under statutory powers and duties falling within the definition in §1 above. Thus my definition includes not only those services described in §2 above but also accommodation and social welfare services provided to children 'in need' under Children Act 1989, especially section 17; the making of 'disabled facilities grants' by housing

authorities for housing adaptations under the Housing Grants, Construction & Regeneration Act 1996 ('HGCRA 1996'); services provided to asylum seekers under section 95 of the Immigration & Asylum Act 1999 and section 55 Nationality, Immigration & Asylum Act 2002; the various assessment duties owed by local authorities to adults (section 47 NHSCCA), children (Children Act 1989, section 17) and carers (Disabled Persons (Services, Consultation & Representation) Act 1986, Carers (Recognition & Services) Act 1995, Carers & Disabled Children Act 2000); the making of direct payments under Community Care (Direct Payments) Act 1996 (now the Health and Social Care Act 2001); nursing and other care services provided at home, in nursing homes and other residential accommodation by local authorities under section 21(8) NAA and by Primary Care Trusts under the National Health Service Act 1977. I exclude from my definition housing provided under homelessness legislation under the Housing Acts 1985 and 1996.

4. The starting-point of modern community care law is the National Assistance Act 1948, one of the key pieces of legislation introduced by the post-war labour government and which remains in force today. The NAA abolished the Poor Laws (section 1) and introduced a duty on local authorities to provide residential accommodation for those 'who by reason, illness, disability or any other circumstances are in need of care and attention which was not otherwise available to them' (section 21) but a mere power to 'make arrangements for promoting the welfare' of persons who are 'blind, deaf or dumb or who suffer from mental disorder and other persons who are substantially and permanently handicapped by illness, or congenital deformity or such other disabilities as may be prescribed' (section 29). These 'arrangements' include (but are not limited to) the provision of information, instruction, workshops and recreational facilities in their own homes or elsewhere.

5. The major shortcoming of the NAA 1948, as regards community care services, was (and remains) that local authorities are not obliged to provide services to those that have been assessed as needing them: they have a *discretion* rather than a *duty* to provide such services. This was remedied, in part, by the Chronically Sick and Disabled Persons Act 1970 (CSDPA), introduced as a private members' Bill by Alf Morris MP. Section 2 of the CSDPA converted the *power* in section 29 NAA 1948 into a *duty* to provide a range of services that included the provision of practical assistance for that person in his home, the provision of recreational and educational facilities, assistance in arranging adaptations to the home, the taking of holidays and the provision of meals (R v Gloucestershire CC ex p Barry [1997] AC 584).

6. Section 2 has been described as 'the finest community care statute' (Luke Clements, 'Community Care and the Law'), providing disabled people with specific, enforceable rights to those community care services once a need for those services has been identified by the authority, regardless of the availability of resources. Three other community care provisions have a similar effect: section 21 NAA (R v Kensington & Chelsea RLBC

ex p Kujtim (1999) 2 CCLR 340), section 117 of the Mental Health Act 1983 (MHA), which creates specific and enforceable rights to 'aftercare services' for patients released from hospital after being formally detained under the provisions of the MHA (R v Manchester CC ex p Stennett [2002]) and sections 23/24 Housing Grants, Construction & Regeneration Act 1996 ('HGCRA 1996') under which housing authorities are obliged to provide disabled facilities grants for adaptations that they have assessed as being 'necessary and appropriate to meet the needs of the disabled occupant' (R v. Birmingham City Council ex p Taj Mohammed [1999] 1 WLR 33, 38). Of the other relevant statutory provisions, none give rise to a similar specific duty to provide services. On the other hand, section 2 CSDPA and section 21 NAA have the particular shortcoming that local authorities may means-test services so provided and levy a charge for those receiving the service.

7. These provisions relate to powers and duties to provide services. Complementary to these are statutory provisions requiring local authorities to assess individuals' needs for these services. The key such provision is section 47 NHSCCA which obliges local authorities to carry out an assessment of the needs of those who 'appear' to be in need of such services. This is a relatively low threshold. Section 17 Children Act creates a similar legal duty to assess children who may be in need of such services. Various other statutory provisions create powers and duties to carry out assessments of the needs of carers for any services to assist them in their task.

8. The shortcomings of the domestic legal framework for the delivery of community care services are many, but include the following:

   (i) As the list set out at §3 above demonstrates, the statutory framework is confusing and fragmented. This is compounded by the fact that much of the relevant law is contained in a series of ministerial and departmental circulars and guidance, some of which is binding, some of which is not, and none of which is readily available except to those who are skilled in knowing where to look for it.

   (ii) The split between the responsibilities of various public authorities (primarily between health authorities (Primary Care Trusts) and local authorities) creates confusion and perverse incentives for those authorities to contest responsibility for particular individuals leading to time-consuming and expensive disputes. These disputes arise between differing social services authorities when there is an issue as to the 'ordinary residence' of an individual. Where the issue is as to the nature of the service being provided – especially whether it is a healthcare or a community care service, the former being free and the second for which a charge may be levied – disputes arise between local authorities and Primary Care Trusts as to who is responsible (see the recent Grogan judgment and R (T) v Hackney (2006) 9 CCLR 58).

(iii) A further consequence of responsibility for services being placed upon local authorities (and PCTs) by reference to 'ordinary residence' is the so-called 'post-code lottery': services in some areas are more or less extensive than those in other areas. Moreover a person with a care package in one local authority or PCT area has no right to transport his care package to the area of another local authority or PCT (for example, if his partner wishes to move to take up an employment opportunity in another part of the country). If he moves he must start all over again, running the risk of losing vital support he may have fought long and hard to obtain in the first place.

(iv) With the exception of section 21 NAA, section 2 CSDPA and section 17 MHA, the relevant community care provisions create a *power* rather than a *duty* to meet assessed needs. A local authority may therefore refuse to provide such services on the basis of a shortage of resources.

(v) This problem is particularly acute in relation to children, who (other than in the case of those services falling within section 2 CSDPA) have no enforceable right to receive services even where those would fall within the terms of section 21 NAA, to which an adult in a corresponding situation would be entitled: R (G) v Barnet LBC [2004] 2 AC 208.

(vi) Even where a local authority is under a *duty* to provide services to meet assessed needs, a local authority is entitled to take into account its resources in assessing the need in the first place (Barry, ibid). An individual's needs are to be assessed by reference to the needs of others and available resources are to be allocated fairly between all those who are in need (in accordance with the Fair Access to Care Services (FACS) Guidance). Local authorities are entitled – indeed obliged – to develop FACS eligibility criteria by which the individuals' needs for services are to be assessed. A local authority may at any time adjust its eligibility criteria and – providing it reassesses those receiving those services - reduce the services it provides on the ground of a shortage of resources. Provided that it meets the most basic and urgent needs then local authorities are under no duty to provide those other services which add value to lives which are otherwise blighted by illness, disability or infirmity.

(vii) Moreover, even where such a duty exists, in some cases (notably sections 21 and 29 NAA and section 2 CSDPA) local authorities are entitled to means-test and charge for services so provided. The fact that there is a duty to provide such services thus becomes largely academic for some as they have to pay for these services in any event. The result is that many people, in particular elderly people who are assessed as requiring residential care, are compelled to sell their homes to pay for care in a place that neither they nor their family would choose for them to be.

(viii) Although close, live-in family members can be paid to provide community care services that is permitted only in exceptional circumstances, namely where that is the only way of satisfactorily meeting the person's need for that service (Direct Payments Regulations 2003, Reg. 6, see Luke Clements, 'Community Care and the Law', §§9.18-9.22). This can still force carers who – often for a relatively modest amount – will provide care to abandon their role as carer because for financial reasons they cannot afford to do so, to be replaced by expensive professional carers, often agencies, who provide unskilled staff with high turnover of staff of a much lower standard at a much greater cost.

(ix) Individuals receiving community care services still have little control or autonomy over how their care is delivered. Granted, there is now provision for individuals to receive direct payments under the Community Care (Direct Payments) Act 1996 (now the Health and Social Care Act 2001) and – where individuals lack capacity to manage such payments - for so-called 'Independent User Trusts' to be established as 'voluntary agencies' with which local authorities and PCTs may contract to deliver services (A & B v East Sussex CC (2003) CCLR 177 and R (Gunter) v SW Staffordshire PCT (2006) 9 CCLR 121). However, IUTs are rarely used, direct payments have their limitations such as the fact many (including mental health service users) are excluded - and local authorities are not under any duty to encourage and inform service users about this option.

(x) There is no overriding statutory right to receive care of any particular standard. This compounds the problem identified in (ix) above. A right to receive care of a particular standard would enable the individual service user to argue that they should be able to develop their own care package.

(xi) The problem in (x) is compounded by the fact that local authorities are not responsible for the standard of care provided by private residential care homes. While such care homes are subject to the regulatory framework of the Care Standards Act 2000 and the investigatory regime of the Commission for Social Care Inspection (CSCI), local authorities are not responsible for abuse perpetrated by private care homes even though care is being paid for by those authorities under statutory duties.

(xii) There is no statutory right to receive care in an individual's own home or to keep family members together. Stories of husband and wife being separated after decades of marriage hit the headlines every now and again; these are not uncommon.

(xiii) There is no statutory duty to provide services to support carers in their role. While there is a *power* to provide such services, local authorities can refuse to provide services on the basis that their resources are scarce. Coupled with the fact that carers cannot be

paid for providing care, the legislative framework perversely encourages carers to give up their role because of the lack of any financial support and the absence of adequate respite care.

(xiv) There is no statutory duty to provide advocacy or communication support. This issue is particularly acute with children in care, learning disabled adults and other individuals with disabilities that impair their ability to communicate. Although a statutory right to advocacy has been introduced for incapacitated adults under the Mental Capacity Act, a similar proposal made in the Mental Health Bill 2004 appears no longer to be carried forwards since the Bill was abandoned.

(xv) While the various duties of local authorities to carry out assessments of need are relatively strong, they suffer from a number of defects: first, the duty is placed only upon local authorities and where an individual has multiple needs requiring the input of a number of different agencies there is no corresponding duty upon those agencies to carry out assessments, only vague duties of 'co-operation' which are effectively unenforceable by individuals (R (T) v Hackney (2006) 9 CCLR 58); second, there are no standard and enforceable assessment formats or time scales (by contrast, for example, with the procedure for making Statements of Special Educational Needs) and any consistency between local authorities is limited to that required by ministerial guidance (which may, in any event, be departed from).

(xvi) The remedies for breach of any of the statutory powers or duties to assess for and provide services are inadequate. Complaints mechanisms through the local authority or PCT's own internal process are time-consuming and exhausting, with little opportunity for any realistic compensation being made other than an apology. Access to the complaints mechanism of the Ombudsman and/ or CSCI and/ or the Healthcare Commission is generally restricted to those who have first exhausted the local authority complaints procedure. Moreover these bodies have no power to order the provision of suitable services (in particular on an interim basis in emergency situations) and only have a power to *recommend* the payment of compensation where maladministration has been identified.

(xvii) The 'nuclear option' of judicial review can be very effective, in ensuring that decision-making accords with the terms in which powers and duties are conferred upon public authorities by way of statute and with public law principles of fairness and rationality. Judicial review can be particularly effective in ensuring the continuing provision of essential services by way of interim order. It has many shortcomings, however. These include:

(a) Judges of the Administrative Court are not experts in the assessment of individuals with social welfare needs.

(b) Courts will often deny recourse to judicial review because alternative remedies are available. It used to be the case that such remedies need only be pursued if equally effective, just and convenient as judicial review. Since Cowl v Plymouth a presumption has developed that mediation should be sought as an alternative remedy, notwithstanding in practice it is as expensive, if not more so, than JR and does not readily fit a dispute where one party (the authority) holds all the cards and the other has little or nothing to negotiate with in any mediation.

(c) The Administrative Court on judicial review has no jurisdiction to substitute its own decision for that of the primary decision-maker – its role is limited to determining whether the decision-maker has made an error of law. By one particular measure of unlawfulness – the so-called 'Wednesbury unreasonableness' or 'irrationality' test – the Court affords a very wide area of discretion to public authorities so that, if a decision falls within that wide area of discretion, the Court will not intervene *even if* the Court considers the decision to have been particularly harsh or even wrong on the facts. Moreover, even if it finds that the decision was wrong in law its remedies are limited to quashing the decision and requiring that the decision be taken again – often leading to precisely the same result, this time with the public authority ensuring that it avoids the legal pitfalls it fell into on the previous occasion.

(d) Partly as a consequence of this aspect of judicial review, the Courts consider it an inappropriate forum in which to resolve disputed issues of fact or opinion; evidence is almost always produced by way of statement or affidavit and oral evidence and cross-examination is extremely rare; orders for the disclosure of evidence are correspondingly rare.

(e) Damages are (almost never) available for breach of statutory duty. The are almost no circumstances in which a private law action for breach of statutory duty or a common law negligence action may lie in relation to a breach of statutory duty in the social welfare field. This has the consequence that where a claim for judicial review succeeds (whether on final hearing or following settlement) in compelling an authority to take appropriate action, it is rare that anything may be done to compensate the individual for past breaches of duty (which may have been causing suffering to the individual or his carer for months or even years).

(xviii) There is a further domestic law remedy available which can be of some use, namely the jurisdiction of the Family Division of the High Court to make declarations as what is in the 'best interests' of a child or adult who lacks capacity to make treatment or welfare decisions. Where a dispute arises as to, for example, whether an individual should remain at home or be admitted to a residential

care home it may be appropriate to seek the Court's determination of which would be in his 'best interests'. The limitations of the remedy are many, however, including (a) the individual must lack capacity; (b) the Court cannot compel the local authority to provide services to enable the individual to remain at home. A joint best interests/ judicial review claim can be effective but it is an area that requires further case-law to develop.

The European Convention on Human Rights and the Human Rights Act 1998

9. The ECHR contains a number of provisions that have been interpreted as creating or enhancing existing rights of access to social care:

    (i) Article 2: the right to life

    (ii) Article 3: the right not to be subject to inhuman or degrading treatment.

    (iii) Article 6: the right to a fair trial 'in the determination of his civil rights or obligations'

    (iv) Article 8: the right to respect for private and family life

    (v) Article 2 of Protocol 1: the right to education

    (vi) Article 14: non-discrimination in relation to the enjoyment of the Convention rights.

10. These are among the rights (the Convention rights) that have been 'given further effect' in domestic law by the Human Rights Act 1998 in three ways. First, by section 6 it is unlawful for a public authority to act incompatibly with an individual's Convention rights, and by section 7 a claim may be brought for breach of such rights and a remedy awarded under section 8, which may include an award of compensation. Second, by section 3 Courts are obliged to read and give effect to domestic legislation in a manner that is compatible with Convention rights 'so far as it is possible to do so'. Third, where it is not possible to do so the Courts may make a declaration that the legislation in question is incompatible with Convention rights. This triggers a process by which a government minister may table amending legislation (a remedial order) to remedy the identified incompatibility.

11. A few terms require a short explanation:

    (i) Rights may be categorised as either <u>substantive</u> or <u>procedural</u>. A substantive right confers an entitlement to a benefit, which may be either negative (e.g. not to be treated in an inhuman or degrading manner) or positive (e.g. to receive a fair trial) in nature. Procedural rights tend to be parasitic upon substantive rights: they determine the means by which a person may lawfully be deprived of his rights.

(ii) Convention rights fall into one of two categories: qualified rights and absolute rights. Absolute rights such as the right to life and the right not to be tortured or subject to inhuman and degrading treatment. Qualified rights are those that may in some circumstances be overridden in the in the public interest, but only for strictly defined purposes and only to the extent necessary to achieve that purpose.

(iii) A distinction may also be made between express and implied Convention rights. Because the Convention rights are drafted in very broad and general terms, the detail of the rights protected can only be deduced from the jurisprudence of the European Court of Human Rights, which has implied a wide range of specific rights out of the general wording of the Convention. So, for example, the right to life includes an implied right to an effective investigation of a death at the hands of a state agent.

(iv) Convention rights are both negative and positive in nature. Of most relevance for our purposes, the ECtHR has found a number of so-called 'positive obligations' arising by implication from the wording of a number of Convention articles. Such positive obligations may require States to take appropriate measures to protect individuals from the consequences of naturally-occurring illnesses or disabilities: note in particular Botta v Italy and Pretty v United Kingdom.

12. What has been the impact of the Human Rights Act in the area of social care? It must be borne in mind, first, that domestic legislation already creates an extensive network of powers and duties (with correlative rights) that have been discussed already. Thus the effect of the HRA is to be gauged by how it has remedied the defects that I identified above at §*.

13. The benefits of the HRA in improving rights of access to social care may be summarised as follows.

(i) Domestic law provisions are couched in terms of *powers* and *duties* on public authorities rather than in terms of *rights* exercisable by individual citizens. As a matter of law the distinction is, in one sense, academic because duties give rise to correlative rights. However the distinction is seismic in another sense. Prior to the incorporation of the ECHR public authorities (the State) were free to interfere with individual rights unless prohibited by law from doing so. Now such interferences must be justified in law and, while they may prove to be justified, the process renders public authorities *accountable* for their actions in a *transparent manner*. The distinction also has an emotional and, therefore, a political significance. To have rights is empowering and is a mark of a mature society, peopled by citizens with rights that cannot be overridden without justification rather than subjects upon whom benefits may be conferred or to whom duties are owed.

(ii) The Convention rights have been interpreted as creating certain substantive rights to social care *not already guaranteed* by domestic law. Examples include:

A right to a minimum level of support:
R (Limbuela) v. Home Secretary (2006) 9 CCLR 30: Violation of Article 3 to deprive asylum-seekers of all support, leading to destitution and suffering reaching the threshold of 'inhuman and degrading treatment'.

A right to be treated with dignity:
R (A & B) v East Sussex (Manual Handling) (2003) 6 CCLR 194. A blanket ban for 'health and safety' reasons on the manual handling of profoundly disabled individuals could violate Article 8. A balance is to be struck between the health and safety of carers, on the one hand, and the rights of severely disabled people to be treated with dignity.

R v Enfield London Borough Council, ex p Bernard [2002] EWHC 2282 (Admin). Authority violated Article 8 by its failure to provide adequate accommodation or community care package in accordance with its own assessments had 'condemned the claimants to living conditions which made it virtually impossible for them to have any meaningful private or family life for the purposes of Article 8'.

A right to be cared for at home where possible:
R (Gunter) v SW Staffordshire PCT (2006) 9 CCLR 121: A refusal to provide care to severely learning disabled woman *at home* violated Article 8 because insufficient weight had been given to her right to respect for private life.

HL v United Kingdom, 5 October 2004. The removal of an incapacitated adult from his home and his subsequent de facto detention in psychiatric hospital without the consent of his carers violated Article 5(1) and 5(4).

(iii) The Convention also creates a number of *procedural* rights not guaranteed by domestic law: decisions refusing to provide services that do not involve adequate consultation, or assessment may violate Article 8 and (possibly) Article 6. It is not clear, however, whether and if so to what extent these procedural rights exceed those that exist at common law by virtue of the principles of natural justice. This is likely to be an area for future exploration.

(iv) The *non-discrimination* provisions of Article 14 are capable of giving rise to both substantive and procedural rights, but have been of limited effect to date. This also is likely to be an area for future exploration, particularly when taken in tandem with the new duties on public authorities created by the Disability Discrimination Act 2005, which comes into force in December 2006.

(v) The Convention thus makes *justiciable* a range of issues concerning the care of disabled people and others with profound needs. This has the important effect of allowing a body of jurisprudence to build up ensuring greater consistency of decision-making across the board, even if, sometimes, that means decisions being consistently *less* generous. But it is nevertheless an important role that the Convention plays in identifying *gaps* in the law which it cannot fulfil. The issue has then been highlighted allowing for other democratic processes to come into play to seek a specific solution.

(vi) The remedies available are somewhat more effective. Thus:

(a) The measure of unlawfulness of 'Wednesbury' unreasonableness is replaced by the test of 'proportionality'. The Courts submit decision-making to a much more intense scrutiny and the band of 'proportionate' (and therefore lawful) responses is a narrower one than the band of 'reasonable' responses under the 'Wednesbury' test. The degree of scrutiny, and the width of that 'band, still depends upon the context of the decision, but in general public authorities are held more accountable, and their decisions require to be commensurately more transparent, than before the HRA came into force.

(b) Although the Courts still consider judicial review to be an inappropriate forum in which to resolve disputed issues of fact or opinion, in HRA cases the Court is more likely to have to resolve such disputes and oral evidence, cross-examination and orders for disclosure of evidence are correspondingly more likely. That said, they are still extremely rare. Cross-examination is likely to be limited to cases where the Court must decide whether the decision under challenge will violate an absolute right such as Article 3 (as in a series of cases concerning compulsory treatment of detained psychiatric patients, starting with R (Wilkinson) v Broadmoor RMO [2002] 1 WLR 419 and, most recently, R (B) v Dr. SS [2006] EWCA Civ 28).

(c) Damages are available under section 8 for acts made unlawful by section 6 HRA. However they are generally very low, pegged to the levels awarded by the ECtHR rather than to the awards available for analogous domestic law causes of action. This has the consequence that (i) public funding is very rarely available *merely* for a HRA damages claim because the quantum is so low; (ii) other avenues of recompense, in particular the Ombudsman, are generally required to be pursued before bringing proceedings: Anufrijeva v LB Southwark [2004] 2 WLR 603.

14. The main shortcomings of the HRA (and the Convention) in the present context are, in my view, as follows:

(i) The Convention is, in the main, limited to the protection of civil and political rights and does not include the specific social, cultural and economic rights contained in the United Nations the International Covenant on Economic, Social a and Cultural Rights (ICESCR) 1966[1] and the Revised European Social Charter 1961 (ESC)[2], which are not otherwise specifically enforceable in domestic law without enacting legislation. While certain obviously economic rights have been given express effect by the Convention and its protocols (such as the right to education) and others have been implied, their development is unlikely to match that of other advanced democratic nations such as South Africa and India which have specific rights to health and social care included in their constitutions.

(ii) The HRA only applies to 'public authorities' within the meaning of section 6, namely 'any person certain of whose functions are functions of a public nature'. This has been interpreted as excluding private bodies which contract with public authorities and discharge their functions on their behalf. Thus a private care home in which an individual is placed by a local authority under its statutory community care duties is not covered by the HRA and cannot be prevented from closing or moving residents in circumstances that would otherwise violate Article 8: see R (Heather) v Leonard Cheshire Foundation [2002] 2 All ER 936. The Joint Parliamentary Committee on Human Rights (JCHR) has issued a report calling for the HRA to be amended to include such bodies: 7th Report of Session, 2003-4, HL Paper 39 HC 382.

(iii) Convention challenges are, like public law challenges, only ever able to ensure that decision-making is *lawful*: they are rarely, if ever, a means of achieving the ultimate result that is being sought (to prevent closure of a care home, to provide a particular service or whatever). Such challenges are good at ensuring the *process* is properly followed, but bad at achieving *outcomes*. This is a reflection of the tension that lies at the heart of all constitutional law: unelected judges should not substitute their decisions for those of publicly elected decision-makers. The allocation of scarce resources is pre-eminently a task for elected representatives. Domestic legislation may confer that role upon a court or tribunal - for example, SEN Disability Tribunals are given a jurisdiction to adjudicate between LEAs and parents as to the content of Statements of Special Educational Need – but in the absence of such legislation it is a violation of the principle of the separation of

[1] Relevant Articles of the ICESCR include Article 9 (right to social security), 10 (right to protection of the family), 11 (right to an adequate standard of living, including the right to food, clothing and housing), 12 (right to health), 13 (right to education), 15 (right to culture

[2] Relevant Articles of the ESC include Article 11 (right to protection of health), 12 (right to social security), 13 (right to social and medical assistance), 14 (right to benefit from social welfare services), 15 (right of persons with disabilities to independence, social integration and participation in the life of the community.

powers for judges to arrogate that function to themselves. The contrary argument - that the HRA itself confers jurisdiction upon judges to make those kinds of decisions – does not meet the objection entirely. This problem will exist even if the ICESCR and ESC were to be incorporated in domestic law.

(iv) Low quantum for compensation and other shortcomings of the available remedies (evidence, alternative remedy etc.; see above).

15. In my opinion the way forward is as follows:

(i) The UK should incorporate the ICESCR and the ESC, as the JCMH recommends in its 21st Report of Session 2003-4, HC Paper 183 HC 1188.

(ii) Even if it does not, the standards therein set out may *eventually* be recognised under the jurisprudence of the Convention. The Convention is a 'living instrument' and the European Court of Human Rights (ECtHR) will interpret and apply its terms in accordance with any 'changing perceptions of individual right'[3]. Those 'changing perceptions of individual right' may be informed by developments within the Convention state itself, within Convention states generally and by the 'general principles of law recognized by civilized states' (Golder v United Kingdom, (1979-80) 1 EHRR 524, §35, p. 535). Thus, the United Kingdom cannot insulate itself from developments internationally for ever by refusing to incorporate international treaties that it has ratified. Moreover, as standards for the treatment of disabled people and others develop then what is not currently considered to be a Convention violation may in future turn out to be. A classic example of this has been in the ECtHR jurisprudence relating to the rights of transsexuals to be recognised by their gender of choice rather than that of birth: Goodwin v United Kingdom (2002), departing from Sheffield & Horsham v United Kingdom (1998).

(iii) Domestic Disability Discrimination legislation, particularly Part III DDA 1995 *taken together with* the new duty in section 2 DDA 2005 requiring public authorities not to discriminate on the grounds of disability, which includes a duty to change any 'practice, policy or procedure which makes it- (a) impossible or unreasonably difficult for disabled persons to receive any benefit that is or may be conferred, or (b) unreasonably adverse for disabled persons to experience being subjected to any detriment to which a person is or may be subjected, by the carrying-out of a function by the authority'. The DDA has tended to be underused in public law proceedings, perhaps because of the perception that it claims may only be brought in the County Court: however this requirement does not prevent the making of an application for judicial review (Schedule 3,

[3] Dyer v Watson [2004] 1 AC 379, per Lord Bingham at §49; Soering v United Kingdom (1989) 11 EHRR 439, §102, page 473; Goodwin v United Kingdom (2002) 35 EHRR 18, §74

Part II §5(2)). Joined proceedings under the HRA (including an Article 14 claim) and DDA have the added advantage that oral evidence, disclosure and cross-examination are more likely to be ordered.

(iv) There is no substitute, in the final analysis, for good domestic legislation creating specific rights tailored to the problems that have been identified by, among others, the DRC and Lord Ashley in the proposed Independent Living Bill.