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The Right to Health in Prison

A Socio-Economic Right Under the Jurisdiction of
the European Court of Human Rights(?)

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ABSTRACT

Currently, more than 10 million people are held in prisons or other penal institutions throughout the world, often facing an environment, which is particularly harmful to the imprisoned individuals' health. As a socio-economic right, the right to health, however, receives a lower level of protection than that granted to traditional civil and political rights in the Council of Europe human rights protection system. Accordingly, the right to health is absent from the text of the European Convention on Human Rights, raising questions regarding the effective protection of the prisoners' right to health and beyond.

In light of this, the research questions addressed in this thesis are; does the right to health in general and especially in a prison context, fall within the scope of jurisdiction of the European Court of Human Rights, despite it traditionally being a socio-economic right? And if so; to what extent does the European Court of Human Rights engage with the right to health in general and especially in a prison context?

It is argued that by applying progressive means of interpretation, the Court opens its doors for an engagement with the right to health, at least in prisons. While the reluctance of the European Court of Human Right regarding health-related issues in hospitals and other health services outside prisons is far from overcome, prisoners' health is indeed well-covered by the jurisprudence of the Court.

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ABBREVIATIONS

| | |
|--------|---|
| art/s | article/s |
| BBC | British Broadcasting Cooperation |
| BMA | British Medical Association |
| CESCR | United Nations Committee on Economic, Social and Cultural Rights |
| CoE | Council of Europe |
| CoM | Committee of Ministers of the Council of Europe |
| CPT | European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment |
| dec | decision |
| ECHR | European Convention on Human Rights |
| EComHR | European Commission of Human Rights |
| ECSR | European Committee of Social Rights |
| ECtHR | European Court of Human Rights |
| ed/eds | editor/s |
| edn | edition |
| EPR | European Prison Rules |
| ESC | European Social Charters |
| ETS | European Treaty Series |
| EU | European Union |
| f/ff | following page/s |
| GC | Grand Chamber |
| HIV | human immunodeficiency virus |
| HRC | United Nations Human Rights Committee |
| ICCPR | International Covenant on Civil and Political Rights |
| ICESCR | International Covenant on Economic, Social and Cultural Rights |
| LNTS | League of Nations Treaty Series |
| OHCHR | Office of the United Nations High Commissioner for Human Rights |
| UDHR | Universal Declaration of Human Rights |
| UN | United Nations |
| UNGA | United Nations General Assembly |
| UNODC | United Nations Office on Drugs and Crime |
| UNTS | United Nations Treaty Series |

| | |
|------|---------------------------|
| USA | United States of America |
| U.S. | United States |
| WHO | World Health Organization |
| WMA | World Medical Association |

INTRODUCTION

It is without doubt that there are more original ways to open an academic discussion than to refer to statistics. In general, the Scottish novelist and folklorist Andrew Lang – adopting a quote of the English poet and scholar Alfred Edward Housman¹ – is right when he states: ‘I shall try not to use statistics as a drunken man uses lamp-posts, for support rather than for illumination’.² In the context of this thesis, however, statistics indeed aim to shed light on the importance of its overarching topic, namely the right to health in prison. Currently, more than 10 million people are held in prisons or other penal institutions throughout the world. The prison population in Europe has decreased by more than 20% since the year 2000. However, over the same period, the worldwide prison population has grown by almost as much. This rate of prison population growth is slightly above the rate of global population growth.³

In theory, the international community has accepted that apart from restraints on the individuals’ liberty, limitations of prisoners’ human rights are only legitimate if they are necessary for their incarceration.⁴ By extension, this also applies to prisoners’ right to health. In practice, however, the increasing prison population throughout the world regularly faces a prison environment which is particularly harmful to its individuals’ health. In fact, prisons tend to foster a wide range of physical and mental health problems, which generally occur more frequently than in populations outside prison walls.⁵ In addition, the prisoners’ dependence on the state authorities for their healthcare puts them in a very vulnerable position.

As a socio-economic right, the right to health receives a different level of protection than that granted to traditional civil and political rights. This categorisation of human rights is also reflected in the dualism of the Council of Europe (hereafter CoE) human rights protection system. Whilst the right to health is explicitly included in the European Social Charters⁶

¹ Alfred E Housman, *M. Manilii Astronomicon: Liber Primvs Recensvit et Enarravit A. E. Hovsman* (Grant Richards, 1903) liii.

² See the footnote in Francis Yeats-Brown, *Lancer at Large* (The Viking Press, 1937) 9.

³ Roy Walmsley, ‘World Prison Population List’ (Institute for Criminal Policy Research, 2016). This figure considers only the prison population at any given moment in time, while much more individuals, passing through different kind of institutions restraining the liberty, are held on an annual basis, see Joanne Mariner and Rebecca Schleifer, ‘The Right to Health in Prison’ in José M Zuniga, Stephen P Marks and Lawrence O Gostin (eds), *Advancing the Human Right to Health* (Oxford University Press, 2013a) 291.

⁴ For example, see UNGA, Basic Principles for the Treatment of Prisoners (28 March 1991) A/RES/45/111, para 5.

⁵ See below Chapter 1.

⁶ CoE, European Social Charter (adopted 18 October 1961, entered into force 26 February 1965) ETS 35; CoE, European Social Charter (Revised) (adopted 3 May 1996, entered into force 1 July 1999) ETS 163.

(hereafter ESC or the Charters), it is absent from the text of the European Convention on Human Rights⁷ (hereafter ECHR or the Convention). Given that the protection mechanism provided by the ESC is significantly weaker than the one provided by the ECHR, problems regarding the effective protection of the prisoners' right to health arise in the CoE system.⁸

In light of this, the research questions addressed in this thesis are; does the right to health in general and especially in a prison context, fall within the scope of jurisdiction of the European Court of Human Rights, despite it traditionally being a socio-economic right? And if so; to what extent does the European Court of Human Rights engage with the right to health in general and especially in a prison context?

The thesis at hand can be divided in two parts. The first part (Chapters 1 and 2) provides the reader with a compact contextualisation of the overall research topic. Chapter 1 demonstrates the benefits to society of having good health in its prisons and underlines the health-related challenges faced specifically in prisons today. It is necessary to keep in mind the important but challenging issue of health in prison in order to better understand the urgent need for international bodies, such as the European Court of Human Rights (hereafter ECtHR or the Court), to further engage with the right to health. Next, Chapter 2 traces the right to health back to its roots. The findings are surprising and may explain why states accepted the Court's engagement with the right to health in the past more easily than other socio-economic rights.

In the second part of this thesis (Chapters 3, 4 and 5), however, a narrower focus is applied. Thus, the examinations made are more closely related to the CoE system. Accordingly, Chapter 3 not only gives a compact overview on today's international legislative framework governing the right to health, but also presents the United Nations (hereafter UN) and CoE (soft-law) instruments relevant to the right to health in prison. Furthermore, keeping the international legislative framework in mind, Chapter 4 discusses the protection of socio-economic rights in the CoE system. Thereby, the ESC and the work of the European Social Rights Committee are central to the examinations conducted. It becomes apparent that there is a need for the ECtHR to engage with the right to health in order to guarantee more effective human rights protection within the CoE. In the end, Chapter 5 provides the final link to answer the overarching research

⁷ CoE, European Convention for the Protection of Human Rights and Fundamental Freedoms, as amended by Protocols Nos. 11 and 14 (adopted 4 November 1950, entered into force 3 September 1953) ETS 5.

⁸ See below Chapter 4.

questions of this thesis. It is shown that the judges in Strasbourg do indeed regularly engage not only with socio-economic rights in general, but also with the right to health, especially regarding prisoners.

The right to health in prison can be examined from various scientific perspectives. Ethical, philosophical as well as historical or theological aspects are inherent to all topics related to the field of human rights. In addition, considerations regarding the right to health in prison could be made from a medical as well as public health point of view and furthermore, the issue is undoubtedly related to a wide range of political and economic considerations.⁹ This interdisciplinarity is also reflected in the approach chosen in this thesis. For instance, the examinations made in Chapter 1 regarding the importance of health in prison include arguments made in the sphere of public health and medicine. Furthermore, the discussion on the origins of the right to health in Chapter 2 is not only shaped by legal developments but also by historical and political events at the time, as well as philosophical considerations. However, the approach applied to the second part of this thesis is characterised by arguments deriving from the legal dimension of the right to health. The choice is made to put the main focus of the analysis on such a legal approach in the light of the overarching research questions being asked. Accordingly, the findings of the CoE bodies, and especially of the ECtHR, are central to the explorations at hand. Most of the primary sources used in the thesis were distilled by using the HUDOC database of the CoE or the Official Document System Search of the UN. The analysis of these sources was made in accordance to widely accepted methods of legal interpretation. In addition, the thesis is based on intensive research of the international literature and the work of leading scholars, as well as on documents provided by international organisations active in the field of socio-economic right protection. Most of these secondary sources were accessible via the library catalogues of the University of Nottingham, the University of Graz and the University of Vienna as well as via various well-respected academic online search engines. An overwhelming proportion of the sources used are available in English, but sources written in French, Italian and German have been somewhat considered.

⁹ For different approaches to the issue see for example Jonathan M Mann, 'Medicine and Public Health, Ethics and Human Rights' (1997) 27(3) *The Hastings Center Report* 6; Micheline R Ishay (ed), *The History of Human Rights: From Ancient Times to the Globalization Era* (University of California Press, 2008); Paul G Lauren, *The Evolution of International Human Rights* (2nd edn, University of Pennsylvania Press, 2003); Sir Hersch Lauterpacht, *International Law and Human Rights* (first published 1950, Gardland, 1973). All referred to in Marks (2013a) 3f.

Before entering the substantive part of the thesis, some clarifications regarding the terminologies used in this thesis are necessary. Firstly, it is important to note that the term *right to health* might be misleading, since it seems to suggest that it is up to governments, international organisations or individuals to guarantee a person's good health. However, as the human rights professor Virginia Leary appropriately points out, an interpretation which asks states to provide for the perfect health of every individual is 'obviously absurd', and it has never been understood this way in human rights law.¹⁰ Thus, in the context of this thesis, the term is used as shorthand, referring to the far more detailed language contained in multiple international treaties and fundamental principles of human rights.¹¹ In addition, the word *prison* does not limit the discussion of the right to health solely to prison facilities. Rather, for the sake of this thesis, it covers all institutions where states hold people, depriving them of their liberty.

Finally, the aim of this thesis must always be at the forefront of one's mind. The scope is strictly limited to the regional human rights system of the CoE, supplemented only by the most crucial international aspects and considerations to the topic. Therefore, it should not come as a surprise that, for instance, the European Union's (hereafter EU), African, Inter-American human rights systems do not play a significant role in the examinations of the thesis, nor do individual states'. This choice must be made even though in some states, sophisticated legislative frameworks with regard to the right to health in prisons do indeed exist.¹²

¹⁰ Virginia A Leary, 'The Right to Health in International Law' (1994) 1(1) Health and Human Rights 24, 2

¹¹ *ibid* 28.

¹² For example, see Finnish Imprisonment Act 767/2005, chapter 10.

1 HEALTH IN PRISON: ABOUT THE NEED TO CARE

Prisoners belong to a group of people which are ‘usually forgotten and sometimes demonized by the public’.¹³ The prevailing view that the longer the sentence and the harsher the prison regime, the better, is undoubtedly present in parts of society and governments throughout the world.¹⁴ Against this background, to foster improvements of health in prison, at first glance, might not seem logical for some. Therefore, the starting point of this thesis asks is it even plausible to discuss the inevitable question of; why is health in prison relevant for the society as a whole and; what are the health-related challenges inherent to the prison environment? Overall, the arguments found in this chapter suppose that a healthier prison population would benefit all prisoners, governments and the general population. At the same time, the challenges arising in the prison context have to be taken into account.

The questions raised above are now reflected in the chapter’s structure. Accordingly, first, a rationale of the relevance of health in prison is provided, followed by an examination of the health-related challenges particularly inherent to the prison context.

1.1 THE RELEVANCE OF HEALTH IN PRISON

The work of the World Health Organization (hereafter WHO) provides an ideal starting point for identifying the relevance of health in prison, since the organisation has profound experience in this very field. Over the years the WHO accumulated a considerable amount of data and information regarding the overall health situation in prisons around the world.¹⁵ In 2007, by publishing its UN Health in Prison guide¹⁶ the organisation set ‘[t]he cornerstone for health in prisons’.¹⁷ The report was a supplement to the efforts made by the WHO starting in the 1990s,

¹³ Mariner and Schleifer (2013) 291.

¹⁴ Mark Leech very recently raises the question of ‘who cares?’, see Mark Leech, ‘Prisoners Are Being Left to Rot – And the Public Doesn’t Seem to Care’ (*The Guardian*, 22 January 2018) <<https://www.theguardian.com/commentisfree/2018/jan/22/prisoners-left-to-rot-public-does-not-care-hmp-liverpool>> accessed 21 June 2018.

¹⁵ ‘Prisons and Health’ (*WHO*) <<http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health>> accessed 15 May 2018.

¹⁶ Lars Møller, Heino Stöver, Ralf Jürgens and others (eds), ‘Health in Prisons: A WHO Guide to the Essentials in Prison Health’ (WHO Europe, 2007).

¹⁷ Michael W Ross and Amy J Harzke, ‘Towards Healthy Prisons: The TECH Model and Its Applications’ (2012) 8(1) *International Journal of Prisoner Health* 16, 23.

when it first launched its Health in Prisons Programme.¹⁸ Over the years different approaches towards health in prison developed.¹⁹ Eventually, in 2014, the organisation published a report specifically dealing with the issue of health in prison context, which provides a convincing rationale for the importance of health in prison.²⁰ This rationale of why to foster health in prison, complemented by further arguments made by other organisations and scholars than the WHO, are now discussed. The reader should keep in mind that due to the limited scope of this thesis the points raised are not exhaustive, but rather reflect the most striking reasons to underline the relevance of prison health.

1.1.1 Prisons as open systems

First of all, in its report the WHO refers to the public dimension of health in prison. It appropriately points out that health issues within prison walls must not be seen as isolated from the health situation of the general public. After all, most prisoners are allowed to leave the prison sooner or later and return to their communities. To neglect the state of health of prisoners might, hence, have a negative impact on the health situation of the whole society.²¹ This is even more true as prison populations often face a high prevalence of individuals with serious communicable diseases.²² Thus, there is real risk that untreated conditions and new diseases spread over to the community in the general public, which may potentially add to the public burden of disease.²³ From this perspective, societies indeed should have a strong interest to improve the health situations in prisons.

¹⁸ ‘WHO Health in Prisons Programme (HIPP)’ (*WHO Europe*) <<http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/who-health-in-prisons-programme-hipp>> accessed 22 June 2018.

¹⁹ For instance, the *whole prison* approach, which took into account the multi-faceted issues linked to health in prison, was transformed completely by the *healthy prison* approach as described by Ross and Harzke. The latter extends the whole prison approach and ‘is understood as the achievement and long-term maintenance of a prison that promotes the health of both inmates and correctional staff while in prison and as they interface with the community’, see Ross and Harzke (2012) 16. For detailed information on the whole prison approach see Møller, Stöver, Jürgens and others (eds) (2007) 17-19.

²⁰ Stefan Enggist, Lars Møller, Gauden Galea and others (eds), ‘Prisons and Health’ (World Health Organization, 2014) 1.

²¹ Enggist, Møller, Galea and others (eds) (2014) 2.

²² See below 1.2.1.

²³ Enggist, Møller, Galea and others (eds) (2014) 2. The idea that ‘[p]rison health is public health’ was recently reaffirmed by a team of scholars in the British Medical Bulletin, see Sunita Stürup-Toft, Éamonn J O’Moore and Emma H Plugge, ‘Looking Behind the Bars: Emerging Health Issues for People in Prison’ (2018) 125 British Medical Bulletin 15, 16.

1.1.2 Social justice

Furthermore, for the WHO, the importance of promoting health in prison derives from the society's commitment to social justice. Accordingly, '[h]ealthy societies have a strong sense of fair play'.²⁴ In this context, it is important to note that most of today's prisoners come from the most underprivileged parts of society, with a lack of financial opportunities, employment experience and education.²⁵

To give an example related to the level of poverty amongst prisoners before their imprisonment, a survey conducted in the United Kingdom shows that 15% of prisoners were homeless before their imprisonment, while, in comparison, only 3.5% of the general population reported having ever been homeless.²⁶ Moreover, Magdalena Carmona, UN Special Rapporteur on Extreme Poverty and Human Rights, holds that disproportionately high numbers of the most excluded and poorest parts of the society are imprisoned. For Carmona this is '[b]ecause law enforcement officials often use "poverty", "homelessness", or "disadvantage" as an indicator of criminality' and hence 'persons living in poverty come into contact with the criminal justice system with a disproportionately high frequency'.²⁷ In addition, the poor level of education of prisoners is reported all over the world.²⁸ For instance, the Scottish Prison Service released that more than 80% of prisoners screened were assessed as lacking functional literacy and more than 70% as lacking in functional numeracy.²⁹

²⁴ Enggist, Møller, Galea and others (eds) (2014) 2. For the link between health and social justice see Roberto Garbero, 'Social Justice and Criminal Justice Go Hand in Hand' (*BioMed Central On Health Blog*, 20 February 2017) <<https://blogs.biomedcentral.com/on-health/2017/02/20/social-justice-and-criminal-justice-go-hand-in-hand/>> accessed 21 June 2018.

²⁵ Enggist, Møller, Galea and others (eds) (2014) 2.

²⁶ Kim Williams, Jennifer Poyser and Kathryn Hopkins, 'Accommodation, Homelessness and Reoffending of Prisoners: Results from the Surveying Prisoner Crime Reduction (SPCR) Survey' (Ministry of Justice, 2012) 1. For an earlier report on the profile of prisoners in the USA, which shows the low income of prisoners previous their imprisonment see Doris J James, 'Profile of Jail Inmates, 2002' (Bureau of Justice Statistics, 2004). For more examples see Andrea Huber, Olivia Rope and Frances Sheahan, 'The Sustainable Development Goal and Criminal Justice' in Penal Reform International and Thailand Institute of Justice (eds), *Global Prison Trends 2017* (2017) pull-out section 2.

²⁷ Magdalena S Carmona, 'Report of the Special Rapporteur on Extreme Poverty and Human Rights' (04 August 2011) A/66/265.

²⁸ To give an example, for a report on women prisoners in Uganda see Foundation for Human Rights Initiative and Penal Reform International, 'Who Are Women Prisoners? Survey Results from Uganda: Towards a Gender-Sensitive Penal Policy' (2015) 11. See also Huber, Rope and Sheahan (2017) pull-out section 4.

²⁹ Official response from the Scottish Prison Service cited in 'Political News Updates: Literacy Crisis in Scotland's Jails' (*The Professional Trades Union for Prisons, Correctional & Secure Psychiatric Workers*, 3 January 2013) <http://www.poauk.org.uk/index.php?current-affairs&newsdetail=20130103-2_literacy-crisis-in-scotlands-jails> accessed 21 June 2018.

Against this background, one could argue that prisons might serve as to curb existing health inequalities. For some people, imprisonment might be the first time to be able to live a settled life with adequate nutrition and education. Hence, as noted by the WHO, the admission to prison potentially helps to reduce vulnerability to social failure and ill health.³⁰

1.1.3 Costs

Apart from the points raised in the WHO report, there are further reasons why it is rational to increase the level of health in prisons. For instance, it is evident that a healthier prison population would reduce the public health expenditure.³¹ The Pew Charitable Trust in its report regarding costs and quality of prison healthcare in the USA, accordingly notes:

With state prisons housing so many individuals with extensive health conditions – some of which threaten to spread to others inside and outside prison gates or contribute to costly and dangerous recidivism – and with nearly all of them destined to return to their communities, the manner in which care is provided in prison and handed off after release carries high stakes.³²

Thus, investments in the prisons preventive healthcare system seem reasonable. As with all public health-related investments, opponents will object to the increase in expenditure. However, while cost increases may be true in the beginning, in the long-term, preventive health related measures may in fact save money. This is supported by a study published by the BioMed Central Health Services Research, which says that ‘prevention can contribute to avoid developing or worsening of chronic illnesses – along with costly complications and comorbidities – and to contain costs’.³³

Yet, there are cases, which evidentiary show that there is an ongoing reluctance to invest in prison health-services. To give a very recent example, the budgets for healthcare in the United Kingdom’s ‘worst prison’, Her Majesty’s (HM) Prison Liverpool, were cut at the beginning of

³⁰ Enggist, Møller, Galea and others (eds) (2014) 2.

³¹ See also ‘Prison and Health: Fact Sheet’ (*WHO Europe*) <http://www.euro.who.int/__data/assets/pdf_file/0020/250283/Fact-Sheet-Prison-and-Health-Eng.pdf?ua=1> accessed 29 May 2018.

³² The Pew Charitable Trust, ‘Prison Health Care: Costs and Quality: How and Why States Strive for High-Performing Systems’ (2017) 56.

³³ Karine Moschetti, Véra Zabrodina, Tenzin Wangmo and others, ‘The Determinants of Individual Health Care Expenditures in Prison: Evidence from Switzerland’ (2018) 18(160) *BioMed Central Health Services Research* 1, 11.

this year.³⁴ In addition, the Director of Law and Policy at Amnesty International Joanne Mariner and the scholar Rebecca Schleifer do not withhold criticism by referring to ‘many cases of “stubborn resistance” to instituting certain preventive health measures’.³⁵

1.1.4 Reintegration

Finally, to give a last example on the relevance in prison, it should come as no surprise that promoting health in prison would further improve the reintegration of prisoners into society and thereby, reduce the risk of reoffending. As a result, this would curb the size of prison populations, saving costs for the prison system as a whole.³⁶

Indeed, studies show the link between health and reentry into society after release. For example, the academics Kamal Mallik-Kane and Christy Visser, examining the situations in the USA, conclude that, amongst others, both physical and mental health as well as substance abuse conditions are related to recidivism and other criminal involvement after prison. In this regard they hold:

Reentry outcomes varied by health status. Individuals with physical health, mental health, and substance abuse conditions followed distinct reentry trajectories, reporting significantly different experiences with regard to housing, employment, family support, substance use, and criminal involvement.³⁷

Thus, these multi-faceted problems related to a lack of healthcare during imprisonment on the reintegration of prisoners must always be considered when discussing the importance of health in prison.

³⁴ Michael Buchanan, ‘HMP Liverpool: Britain’s “Worst Prison” Cuts Healthcare Budget’ (*BBC*, 20 January 2018) <<http://www.bbc.co.uk/news/uk-england-merseyside-42758480>> accessed 24 May 2018. Regarding the health conditions in HM Prison Liverpool see also Peter Clarke, ‘Report on an Unannounced Inspection of HMP Liverpool by HM Chief Inspector of Prisons: 4-15 September 2017’ (HM Inspectorate of Prisons, 2018); House of Commons, Justice Committee, ‘HM Inspectorate of Prisons Report on HMP Liverpool: Fifth Report of Session 2017-19’ (2018) HC 751, 11f.

³⁵ Mariner and Schleifer (2013) 292.

³⁶ ‘Prison and Health: Fact Sheet’ (*WHO Europe*).

³⁷ Kamal Mallik-Kane and Christy A Visser, ‘Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration’ (The Urban Institute, 2008) 2. See also Andrea Huber, Olivia Rope and Frances Sheahan, ‘The Rehabilitation and Reintegration of Offenders in the Era of Sustainable Development’ in Penal Reform International and Thailand Institute of Justice (eds) *Global Prison Trends 2018* (2018).

1.2 HEALTH-RELATED CHALLENGES IN THE CONTEXT OF PRISON

The examinations made underline the relevance of health in prison. This is not to say, however, that potential health-related improvements do not face certain challenges particular to the prison context. Accordingly, these challenges are now discussed to raise further awareness for the complexity of the issue at stake.

1.2.1 The prison and its population

The nature of the prison environment raises a number of particular challenges regarding health-related issues distinct to the problems outside prison walls. While the roots of these problems seem diverse, it is apparent that some issues are inherent to the special circumstances of the prison setting, such as lack of exercise, drugs, confinement and violence.³⁸ In addition, overcrowding, a frequent problem in prisons around the world,³⁹ has negative impacts on the health of imprisoned individuals, especially regarding infectious and psychiatric diseases.⁴⁰ Thus, one can assume that the prison setting fosters a variety of mental, physical and social harms caused to the prisoners.⁴¹

The fact that the prison environment is often harmful for the health of the imprisoned individuals is particularly problematic given that prisoners on admission already disproportionately suffer from severe health problems compared to the rest of the general population.⁴² Amongst others, this results from the fact that a lot of prisoners belong to the low socioeconomic milieu described above, and also regularly are members of marginalised groups, which often lack access to healthcare. Furthermore, the prison population generally includes drug addicts, sex workers and people with intellectual or psychosocial disabilities.⁴³ The closed environment of the prison aggravates the situation, by providing fertile ground for increased

³⁸ Tim Owen and Alison Macdonald (eds), *Livingstone, Owen, and Macdonald on Prison Law* (5th edn, Oxford University Press, 2015) 277. See also British Medical Association, 'Prison Medicine: A Crisis Waiting to Break' (2001); Alan Parrish, 'Prison Health Care: Is It a Crisis Waiting to Break?' (2001) 10(9) *British Journal of Nursing* 558.

³⁹ There are numerous NGO reports highlighting the phenomenon of overcrowding in prisons around the world. For example, see Amnesty International, 'Amnesty International Report 2017/2018: The State of the World's Human Rights (2018); Human Rights Watch, 'World Report 2018: Events of 2017' (2017).

⁴⁰ For a review of the scant literature on overcrowding in prisons from the perspective of health see Julio García-Guerrero and Andrés Marco, 'Overcrowding in Prisons and Its Impact on Health' (2012) 14 *Revista Espanola De Sanidad Penitenciaria* 106.

⁴¹ Dirk Van Zyl Smit and Sonja Snacken, *Principles of European Prison Law and Policy* (Oxford University Press, 2009) 147.

⁴² Van Zyl Smit and Snacken (2009) 147.

⁴³ Mariner and Schleifer (2013) 292. For an overview on characteristics of the prison populations see also Van Zyl Smit and Snacken (2009) 54-59.

rates of communicable diseases, including extremely serious disease like tuberculosis, hepatitis C and HIV, compared to the rest of the general public.⁴⁴ In addition, the increase of non-communicable diseases⁴⁵ as well as the disproportional level of substance abuse⁴⁶ have to be seen as highly challenging.

1.2.2 The medical personnel in prisons

The closed environment of prisons makes it hard for the medical personnel presence to attend to physical or mental needs of their patients. But this does not remain the only problem. As appropriately pointed out by Tim Owen and Alison Macdonald, one must keep in mind that prison medical staff works in a field of tensions in two counts. First, all decisions must seek to strike a balance between the best interest of the individual prisoner and legitimate considerations of security by the prison authorities. Second, the role of medical profession in prison is different to the outside world, given that in prison the medical personnel are part of the criminal justice system. In this role, doctors and nurses are involved in reporting on prisoners for parole purposes or trial. Additionally, they might be involved in the decision regarding the prisoner's ability to work and other crucial aspects of imprisonment.⁴⁷ Another challenge facing the prison system with regard medical personnel is reflected by the fact that globally there is a shortage of suitably qualified healthcare professionals, further exacerbated by a general lack of appropriate medical equipment needed for doctors and nurses.⁴⁸

1.2.3 Prison health versus public health

The issue of separating prison health from their general health system counterparts persists, despite the far acceptance of the principle of equivalence throughout the international community. A prominent example for the implementation of the principle is Rule 24(1) of the

⁴⁴ Mariner and Schleifer (2013) 292. For details on the issue of communicable diseases in prison see, most recently, European Centre for Disease Prevention and Control and European Monitoring Centre for Drugs and Drug Addiction, 'Public Health Guidance on Active Case Finding of Communicable Diseases in Prison Settings: Prevention and Control of Communicable Diseases in Prison Settings' (2018). See also Kate Dolan, Andrea L Wirtz, Babak Moazen and others, 'Global Burden of HIV, Viral Hepatitis, and Tuberculosis in Prisoners and Detainees' (2016) 388(10049) *The Lancet* 1089.

⁴⁵ Katharine Herbert, Emma Plugge, Charles Foster and others, 'Prevalence of Risk Factors for Non-Communicable Diseases in Prison Populations Worldwide: A Systematic Review' (2012) 379(9830) *The Lancet* 1975.

⁴⁶ Seena Fazel, Parveen Bains and Helen Doll, 'Substance Abuse and Dependence in Prisoners: A Systematic Review' (2006) 101(2) *Addiction* 181.

⁴⁷ Owen and Macdonald (eds) (2015) 277f.

⁴⁸ Mariner and Schleifer (2013) 292.

Mandela Rules, which states that '[p]risoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status'.⁴⁹ However, often this is not the case.⁵⁰ This is despite the fact that it can even be argued that under certain circumstance equal healthcare might not suffice to guarantee prisoners' human rights protection with regard to health. As argued by Rick Lines, in fact, 'standards of prison health care only equivalent to that in the community would in some cases fall short of human rights obligations and public health needs'.⁵¹ It is interesting to note that this argument is reflected in a number of judgements issued by Courts in South Africa. Most notably, in the 1997 *Van Biljon* case the Court agreed that 'the State indeed owes a higher duty of care to HIV positive prisoners than to citizens in general who suffer from the same infection'.⁵² However, this view is not without debate.⁵³

1.3 INTERIM CONCLUSION: A BENEFIT FOR ALL

In the 1990s Alison McCallum looked for an answer to the question: 'healthy prisons: oxymoron or opportunity?'⁵⁴ Against the background of this chapter it can be concluded that the answer to McCallum's question is clear. Not only do healthier prisons provide improved opportunities for the imprisoned individuals, but to foster health in prison must be seen as a benefit for all prisoners, the society, and governments. In this regard it is indeed useful to understand prison health as public health as recently suggested by scholars in the British Medical Bulletin. Accordingly, the scholars underline:

⁴⁹ UNGA, United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) (17 December 2015) A/RES/70/175, rule 24(1). See also below 3.2.1.

⁵⁰ Ralf Jürgens, Manfred Nowak and Marcus Day, 'HIV and Incarceration: Prison and Detention' (2011) 14(26) *Journal of the International AIDS Society* 1, 12.

⁵¹ Rick Lines, 'From Equivalence of Standards to Equivalence of Objectives: The Entitlement of Prisoners to Health Care Standards Higher Than Those Outside Prisons' (2006) 2(4) *International Journal of Prisoner Health* 269, 269.

⁵² High Court Cape of Good Hope Provincial Division, *B and others v Minister of Correctional Services and others* (17 April 1997) 1997 (6) BCLR 789 (C), para 51. For a similar example see Durban High Court, *N and others v Government of Republic of South Africa and others (No 1)* (22 June 2006) 2006 (6) SA 543 (D).

⁵³ Critically, see Julian Rademeyer, 'Do Prisoners Have Access to Better Medical Facilities than the Public?' (*Africa Check*, 18 December 2014) <<https://africacheck.org/reports/do-prisoners-have-access-to-better-medical-facilities-than-the-public/>> accessed 22 June 2018. In the context of antiretroviral treatment, see also Nasreen Motala and David J McQuoid-Mason, 'Do Prisoners in South Africa Have a Constitutional Right to a Holistic Approach to Antiretroviral Treatment?' (2013) 6(2) *The South African Journal of Bioethics & Law* 40. For the statements made by the deputy minister see also 'Prisoner Get Better Healthcare Than Public' (*Independent Online*, 01 December 2014) <<https://www.iol.co.za/news/politics/prisoners-get-better-healthcare-than-public-1789079>> accessed 22 June 2018.

⁵⁴ Alison McCallum, 'Healthy Prisons: Oxymoron or Opportunity?' (1995) 6(4) *Critical Public Health* 4.

Prisons (...) offer an important opportunity for tackling health problems in a way that can deliver benefits to the individual but are likely also to have a potential knock-on effect in supporting their reintegration into community life and future health – providing a “community dividend” to health interventions in prisons.⁵⁵

Therefore, it is of utmost interest for all to improve inadequate health conditions, which make many prisons ‘a petri dish for the propagation of bacterial and viral infections’.⁵⁶ The potential to reduce costs should further provide an attractive incentive for fostering investments in the prison health system. This would not only save tax money, but would also pay due regard to the tremendous human and social costs caused by insufficient healthcare in prisons.

In any case, to achieve sustainable improvements, one must not only focus on the situation in prisons itself. Preventive measures beforehand are equally important as to find strategies for the time after a prisoner’s release. As research has shown concrete interventions, like offering better healthcare also after release or attempts to link former prisoners to community-based family psychiatrists and physicians, evidentiary be beneficiary in this regard.⁵⁷

For all these reasons, the ongoing reluctance by states like the United Kingdom towards sophisticated prison reforms seems irrational. Rather, the need to deal with the wide range of particular challenges existing in the prison health is apparent. Innovative models to improve health in prison⁵⁸ and voices optimistic on potential prison reforms⁵⁹ might contribute to the creation an environment fruitful for positive change in the future. In the end, however, enhancements will only be achieved if and only if both the governments and the general public reflect on their attitude towards prisoners and they start to see that better health in prisons would be tantamount to a win-win for all prisoners, governments and the society as a whole.

⁵⁵ Sturup-Toft, O’Moore and Plugge (2018) 16.

⁵⁶ Mariner and Schleifer (2013) 292.

⁵⁷ Fiona G Kouyoumdijan, Kathryn E McIsaac, Jessica Liauw and others, ‘A Systematic Review of Randomized Controlled Trials of Interventions to Improve the Health of Persons During Imprisonment and in the Year After Release’ (2015) 105(4) *American Journal of Public Health* e13.

⁵⁸ A representative example for an innovative approach is the so-called TECH Model, which aims ‘to describe the steps that can be taken to promote health in prisons and lead to healthy prisons’. The name stands for ‘testing for and treating infectious diseases and vaccination; environmental modification to prevent disease transmission; chronic disease identification and treatment; and health maintenance and education’, see Ross and Harzke (2012).

⁵⁹ For a recent example of such a positive view concerning prison reforms in the United Kingdom see Rory Stewart, ‘I Strongly Believe We Can Improve Our Prisons and Make Progress’ (*The Guardian*, 17 February 2018) <<https://www.theguardian.com/commentisfree/2018/feb/17/rory-stewart-reform-prisons-crisis>> accessed 22 June 2018.

2 THE ORIGINS OF THE RIGHT TO HEALTH: ABOUT THE MYTH OF A COMMUNIST IDEOLOGY

Having analysed the general relevance of health in prison, the focus of this chapter shifts towards the right to health from a legal-history point of view. Accordingly, the following examinations aim to trace back the emergence of the right to health, to answer to the questions of; what are the origins of the right to health and; how might these origins have influenced the ECtHR's approach towards the right to health? It is argued that the assumption of the right to health merely derives from a communist ideology is to simplify the right's historical origins. It is rather shown that it is possible to identify a Latin American philosophy and strong efforts made by the international community as the starting points of the right to health as a normative concept in international law. Thereby, the right takes a special position in the discussion on the categorisation of human rights, which was strongly shaped by the ideological battle between East and West in the aftermaths of World War II.

After providing a brief overview of the well-known debate regarding the categorisation of human rights, the chapter unveils the myth that the right to health merely derives from communist ideology. Afterwards, light is shed on the impact of World War I and World War II on the international community's perception on the right to health, which further underlines the non-communist influence on the right. Against this background it is finally assumed that, amongst others, this might have been a justification for the ECtHR to not shy away from engaging with the right to health in its jurisprudence.⁶⁰

2.1 THE CATEGORISATION OF HUMAN RIGHTS

The current international, as well as regional human rights regimes, are strongly influenced by the categorisation of human rights in the two groups of civil and political rights on the one hand and economic, social and cultural rights on the other. The idea of such a distinction is reflected primarily in the separate adoption of two of the main international human rights instruments, the 1966 International Covenant on Civil and Political Rights (hereafter ICCPR)⁶¹ and the 1976 International Covenant on Economic, Social and Cultural Rights (hereafter ICESCR).⁶² For

⁶⁰ See Chapter 5.

⁶¹ UNGA, International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) UNTS 999, 171.

⁶² UNGA, International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) UNTS 993, 3.

Matthew Craven the reason for this categorisation of human rights can be found in ‘the ideological conflict between East and West pursued (...) during the drafting of the Covenants’.⁶³ He further briefly sums up the different state interests at the time:

The Soviet States, on the one hand, championed the cause of economic, social, and cultural rights, which they associated with the aims the socialist society. Western States, on the other hand, asserted the priority of civil and political rights as being the foundation of liberty and democracy in the “free world”.⁶⁴

Consistently, Barbara Stark underlines the scepticism of the West, or more precisely the USA, towards economic, social and cultural rights at the time, noting that ‘[d]uring the Cold War, the U.S. Department of State viewed ICESCR as a socialist manifesto thinly veiled in the language of rights’.⁶⁵ Against the background of an explanation of the USA’s position on the realisation of economic, social and cultural rights made in March 2017 the country’s reluctance towards certain issues regarding these rights, for instance, the right to development, is evidentiary ongoing.⁶⁶

The underlying problem of the, for some ‘outlived’,⁶⁷ categorisation of human rights lays in the imbalanced level of protection of rights inherent to such a separation. It is well-known that Human Rights Courts around the world, which are able to issue binding judgements for states, are merely provided with jurisdiction for civil and political rights, rather than socio-economic rights. In contrast, it is well-known that socio-economic rights are regularly protected by

⁶³ Matthew C R Craven, *The International Covenant on Economic, Social and Cultural Rights: A Perspective on its Development* (Oxford University Press, 1995) 8f.

⁶⁴ Craven (1995) 9.

⁶⁵ Barbara Stark, ‘Economic Rights in the United States and International Human Rights Law: Toward an “Entirely New Strategy”’ (1992) 44 *Hastings Law Journal* 79, 81. Stark further refers to a number of sources supporting this argument. For example, Dobriansky bluntly denying the same status of economic, social and cultural rights and civil and political rights by stating ‘Myths and Realities’ in her overview on the human rights policy of the USA, see Paula Dobriansky, ‘U.S. Human Rights Policy: An Overview’ (1988) United State Department of State, Bureau of Public Affairs, WILS GOVU S 1.71/4:1091, 2f. See also Alex Kirkup and Tony Evans, ‘The Myth of Western Opposition to Economic, Social, and Cultural Rights? A Reply to Whelan and Donnelly’ (2009) 31 *Human Rights Quarterly* 221. Au contraire, in the context of the developments after 1953, Whelan and Donnelly disagree, stating that ‘contrary to the common perception of Western hostility to economic and social rights, Western states were strong, consistent, and essential supporters of international recognition of economic and social human rights. Western states were also leading practitioners of dramatically expanded domestic implementation of those rights’, see Daniel J Whelan and Jack Donnelly, ‘Yes, a Myth: A Reply to Kirkup and Evans’ (2009) 31(1) *Human Rights Quarterly* 239.

⁶⁶ William J Mozdzierz, ‘U.S. Explanation of Position on the Realization of Economic, Social, and Cultural Rights’ (23 March 2017) A/HRC/34/L4/REV.1.

⁶⁷ Stephen P Marks, ‘The Past and Future of the Separation of Human Rights into Categories’ (2013b) 24(1) *Maryland Journal of International Law* 209, 243.

international bodies unable to do so. With regard to the ongoing reluctance to further improve the protection of socio-economic rights it is often argued that it is impossible for states to realise such rights to the full extent. The reasons raised are various, but can often be traced back to a lack of political will rather than the actual existence of insurmountable – financial – hurdles.⁶⁸

2.2 A LATIN AMERICAN PHILOSOPHY

Now, while it is without doubt that the ideological battle between East and West in the aftermaths of World War II has significantly shaped today's understanding of human rights, the question of the origins of the right to health remains more complex.

Admittedly, *prima facie*, the situation might seem clear. Scholars regularly suggest that the right to health, as a traditional socio-economic right, largely derived from a communist ideology.⁶⁹ However, in spite of the fact that this might be true for a number of the rights entailed in the ICESCR, surprisingly, the same cannot be said with regard to the right to health.

This is already emphasised by John Tobin who – in a remarkably clear manner – states that the emergence of the right to health can rather be traced to a philosophy from Latin American, which ‘sought to navigate between the consequences of extreme liberalism and collectivism to produce a form of social liberalism’.⁷⁰ In this regard the Latin American approach was not the product of any socialist or Marxist ideology, but rather ‘relied heavily on Catholic teachings with respect to human dignity and social justice’.⁷¹

As a normative starting point of this philosophy the Mexican constitution of 1917 can be identified, which did not yet entail a specific right to health, but only provisions regarding

⁶⁸ An in-depth examination of the categorisation of human rights would go far beyond the scope of this thesis. For a critical discussion see Marks (2013b). In favour of a separation of human rights, *inter alia*, regarding the right to health see, for example, the brief critique on socio-economic rights of Neier stating that ‘[t]he concern I have with economic and social rights is when there are broad assertions of the sort that appear in the Universal Declaration of Human Rights or that appear in the South African Constitution, which speak broadly of (...) a right to health care. There, I think, we get into territory that is unmanageable through the judicial process and that intrudes fundamentally into an area where the democratic process ought to prevail’, Aryeh Neier, ‘Social and Economic Rights: A Critique’ (2006) 13(2) Human Rights Brief 1, 1. See also from a philosophical perspective Maurice Cranston, ‘Human Rights, Real and Supposed’ in David D Raphael (ed), *Political Theory and the Rights of Man* (Macmillan, 1967).

⁶⁹ Manisuli Ssenyonjo, *Economic, Social and Cultural Rights in International Law* (Bloomsbury, 2016) 15; Craven (1995) 9; Cranston (1967) 45f.

⁷⁰ John Tobin, *The Right to Health in International Law* (Oxford University Press, 2012) 15.

⁷¹ Tobin (2012) 19f.

medical service for women.⁷² Admittedly, the constitution entails classical socialist elements, like the authorisation of state control of certain economic areas and special natural resources and the possibility of expropriation and redistribution of land. However, the assumption that this constitution would be socialist in its original orientation is proven wrong. Accordingly, Paolo Carozza notes that '[n]either the history of the Constitutional Congress nor the resulting text itself support such a view, and in fact it obscures the uniqueness of the Mexican developments'.⁷³

However, as indicated above, to refer solely to the Latin American philosophy is insufficient to explain the eventual adoption of the right to health in international law. Rather, it sadly needed two World Wars for the international community to understand and accept the strategic importance of health in achieving and maintaining global peace.⁷⁴

2.3 TWO WORLD WARS FOR A SHIFT OF PERSPECTIVE

In the aftermaths of the atrocities of World War I, the League of Nation set significant steps to raise awareness of the need of inter-state collaboration in the health context. These activities were, again, anything but driven by a communist ideology. The need for cooperation was rather reflected in the Covenant of the League of Nations, which provided a number of provisions dealing with the issue of health.⁷⁵ Moreover, the League of Nation set relevant steps on an institutional level to further develop to role of the right to health in international law.⁷⁶

However, it would be daring to assume that the discernment of the international community to implement measures concerning health-related issues resulted from the existence of an explicit human right to health. Against the background of the primary purposes of the League of

⁷² Constitution of Mexico (5 February 1917) art 123 B. XI(1) cited in Tobin (2012) 22.

⁷³ Paolo G Carozza, 'From Conquest to Constitutions: Retrieving a Latin American Tradition of the Idea of Human Rights' (2003) 25 Human Rights Quarterly 281, 305.

⁷⁴ Tobin (2012) 22f.

⁷⁵ For example, see League of Nations, Covenant of the League of Nations (28 April 1919) LNTS 37(1924) 493, arts 23(f) and 25.

⁷⁶ In this context, an important step was the establishment of the League of Nations Health Organisation in 1920, a predecessor of the WHO. As stated by the WHO nearly four decades later, no official reason is to be found why the League of Nations felt the need to engage in the field of health, given that in the Office International d'Hygiene Publique there already existed an experienced intergovernmental organisation responsible for health cooperation at the time. However, apart from the fact that at the time the general desire for coordination at international level was beginning to manifest itself, undoubtedly the devastating state of health throughout the world in the end of World War I and in the post-war period, were driving factors for the international community to foster the focus on health-related issues. See WHO, 'The First Ten Years of the World Health Organization' (1958) 22. See also Tobin (2012) 23f.

Nations, namely to achieve peace and security while preserving state sovereignty, the states' commitment to international cooperation. This commitment was driven by various strategic and political interests as well as advances in medical knowledge. Hence, it was only the inconceivable atrocities of World War II that made the international community understand the need for a right to health for all individuals in international law.⁷⁷

Moreover, Franklin Roosevelt's famous Four Freedom Speech provides further evidence that the communist ideology played a subordinated role in the emergence of the right to health. The speech must be understood as being of the utmost importance for the subsequent development of the right to health.⁷⁸ Including the freedom of want, as the third of the four freedoms, Roosevelt specified that 'translated into world terms, [it] means economic understandings which will secure to every nation a healthy peacetime life for its inhabitants – everywhere in the world'⁷⁹ and further underlined the need to 'widen the opportunities for adequate medical care'.⁸⁰

Against the background of the ongoing brutalities of World War II, Roosevelt's view that states had an obligation towards their constituents to attend to their economic and social needs as a matter of human rights, gained more and more support throughout the international community. The right to health, gradually became accepted as precondition for global peace and security.⁸¹

Finally, an important role was again played by Latin American states. Thus, a statement of a committee appointed by the American Law Institute, made in 1945, already entailed provisions concerning health-related issues. It strongly reflected on the national constitutions of Latin American states, including a number of non-communist countries.⁸² In the end, the work of the

⁷⁷ Tobin (2012) 23f.

⁷⁸ Tobin (2012) 24f.

⁷⁹ Franklin D Roosevelt, 'The Annual Message to the Congress: January 6, 1941' in Sameul I Rosenman, *The Public Papers and Addresses of Franklin D. Roosevelt with a Special Introduction and Explanatory Notes by President Roosevelt* (Volume 9, Macmillan, 1941) 672.

⁸⁰ *ibid* 671. For a critical discussion of Roosevelt's Four Freedom Speech see Roger Normand and Sarah Zaidi, *Human Rights at the UN: The Political History of Universal Justice* (Indiana University Press, 2008) 88-90.

⁸¹ Tobin (2012) 25.

⁸² While in its main text the statement explicitly refers to health with regard to social security, in its comment health is also mentioned in the context of reasonable work wages, see ALL Committee of Advisers on Essential Human Rights, 'Statement of Essential Human Rights' (American United for World Organization, 1945) art 13, 23f. The comment on social security even imposes duties upon the states 'to see that resources of society are organized (...) to raise standards of health (...) to prevent sickness and accident (...) [and] to provide medical care wherever needed', see *ibid* art 15, 25f. See also William D Lewis, 'The Statement of Essential Human Rights by Representatives of the Principal Cultures of the World' (1945) 89(3) *Proceedings of the American Philosophical Society* 489.

American Law Institute directly affected the drafting process of the Universal Declaration of Human Rights (hereafter UDHR),⁸³ which in its adopted version implicitly included references regarding adequate health in its adopted version. This can be seen as keystone of the normative evolution of the right to health in international law, albeit not the first one.⁸⁴

2.4 INTERIM CONCLUSION: A BROADER LEEWAY

The impacts of the ideological differences of *the East* and *the West* in the aftermaths of World War II are, without doubt, far reaching and significantly affected and still affect human rights systems around the world, thereby shaping the overall understanding of human rights as a legal concept. To give an example, it is well-known that ECHR provide the ECtHR for jurisdiction merely with regard to civil and political rights, while leaving socio-economic rights unconsidered almost completely. An explicit right to health is absent to the Convention at all. Nevertheless, the ECtHR indeed provides for protection of the right to health, albeit limited to certain cases.⁸⁵

Now, the chapter at hand might have delivered a political explanation why this is the case with regard to the right to health, while other socio-economic rights seem to be mainly neglected. Thus, it can be supposed that the long-lasting engagement of the ECtHR with the right to health in its jurisprudence might have been supported by the fact that the right to health does not derive from a merely communist ideology. It seems plausible to assume that the judges have a broader leeway in interpreting the scope of the Court's jurisdiction when the right at stake has always been part of both the ideology of the East as well as the West. The right to health is such a right. Therefore, states might have had accepted certain interventions by the ECtHR in health matters more easily than in other social matters, which are more clearly associated with the communist ideology. In the end, these assumptions would be in accordance with the view that during the Cold War human rights were wielded 'as a weapon against communism'.⁸⁶ However, to verify this, extensive research of the case-law of the ECtHR is needed, which would go far beyond the scope of this thesis.

⁸³ For John Humphrey, at the time the first Director of the UN Division of Human Rights within the UN Secretariat and famous for its work regarding the first draft of the UDHR, the Statement of Essential Human Rights was '[t]he best of the texts from which I worked (...) and I borrowed freely from it', see John P Humphrey, *Human Rights & the United Nations: A Great Adventure* (Transnational, 1984) 32.

⁸⁴ See UNGA, Universal Declaration of Human Rights (10 December 1948) 217 A (III), art 25(1). See below 3.1.

⁸⁵ See below Chapter 5.

⁸⁶ Marco Duranti, *The Conservative Human Rights Revolution: European Identity, Transnational Politics and the Origins of the European Convention* (Oxford University Press, 2017) 168

Of course, other reasons, like the fact that the right to health is closely related to a number of other human rights, some of which belong indeed to the category of civil and political rights, seem to be convincing.⁸⁷ Furthermore, the reasonable line of argumentation of the Court on its justification to engage with the right to health expressed in its jurisprudence provide a further rationale.⁸⁸

⁸⁷ For details of how the right to health is related to other human rights see Marks (2013) 11-17.

⁸⁸ See below 5.1.1.

3 THE RIGHT TO HEALTH IN PRISON IN INTERNATIONAL LEGISLATION: ABOUT TREATIES AND SOFT-LAW

It is well known that in the aftermath of the Second World War the international community put strong efforts on the codification of human rights. Over the years, the general right to health was implemented in a number of treaties ratified by the majority of states throughout the world. In addition, attention was paid to the right to health in the specific context of imprisonment, albeit by other means. It is now demonstrated that a homogenous definition of both the general right to health as well as the right to health in the context of prison is lacking. This lack of definition should not be seen as a shortcoming but rather reflects the fact that health issues are inherent to various contexts. Besides, the current international legislative protection framework sheds light on the fact that the right to health in a prison context is protected to a lesser extent than the right to health in general.

Logic would dictate that the right to health in a specific prison context depends on a general right to health. Hence, the first part touches upon the normative evolution of the right to health at an international level. The limited scope of this thesis, however, restricts the number and depth of the examinations that can be made. Thus, only the most common international legal instruments that contain provisions for the right to health are mentioned. This aims to provide the reader with a brief overview of the right to health in international treaty law. The main focus of the chapter, however, lies on some of the most important international prison standards existing. Thereby, this chapter answers the question of; how is the right to health in general and especially in a prison context interlaced in the international legal framework?

3.1 THE RIGHT TO HEALTH IN INTERNATIONAL LAW

The aforementioned ideological battle of the Cold War has strongly influenced today's perception of the international human rights system. This is reflected, inter alia, on a legislative level. Accordingly, the implementation of the right to health in international treaty law is strongly shaped by the normative division of human rights embodied in the existence of the ICCPR and ICESCR. In any case, there are also other legal instruments apart from these two main human rights treaties which are of utmost relevance to today's understanding of the right to health.

The right to health was first explicitly articulated in the Preamble of the 1946 Constitution of the WHO.⁸⁹ The preamble not only entails a definition of health, namely as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’,⁹⁰ but most notably states that ‘[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition’.⁹¹ From today’s perspective, the standard set by the Preamble of the WHO Constitution can be seen as a milestone in the normative evolution of the right to health, given that it is reflected in most/some/many of the treaties adopted over the following years.

While the right to health was also implicitly entailed in the UDHR,⁹² for today’s understanding of the right to health, the implementation of it in the UN treaty regime is more important. Accordingly, in 1966, the right to health was prominently embodied in the ICESCR, reflecting on the standard of health established in the Preamble of the WHO Constitution. The right to health according to Article 12 of the ICESCR is divided in two parts. On the one hand, being defined in general terms, paragraph (1) of the Article understands the right to health as ‘the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’.⁹³ On the other hand, paragraph (2) of Article 12 of the ICESCR non-exhaustively lists five ‘steps to be taken (...) to achieve the full realization of this right’, namely:

- (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
- (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.⁹⁴

⁸⁹ International Health Conference, Constitution of the World Health Organization (22 July 1946) Official Records of the WHO 2, 100. For closer examination of the Preamble of the WHO Constitution see Frank P Grad, ‘The Preamble of the Constitution of the World Health Organization’ (2002) 80(12) Bulletin of the WHO 981.

⁹⁰ International Health Conference, Constitution of the World Health Organization, preamble.

⁹¹ *ibid.*

⁹² UNGA, Universal Declaration of Human Rights, art 25(1). See also Navanethem Pillay, ‘Right to Health and the Universal Declaration of Human Rights’ (2008) 372 The Lancet 2005.

⁹³ UNGA, International Covenant on Economic, Social and Cultural Rights, art 12(1).

⁹⁴ *ibid* art 12(2)(a)-(d). See also Marks (2013) 7.

Considering this broad definition, the academic Audrey Chapman appropriately underlines that Article 12 of the ICESCR reflects ‘the fullest and most definitive conception of the right to health’ of all major international human rights instruments.⁹⁵

In addition, the normative commitment to the right to health was maintained in a number of other international UN treaties, like the 1965 International Convention on the Elimination of All Forms of Racial Discrimination,⁹⁶ the 1979 Convention on the Elimination of All Forms of Discrimination against Women,⁹⁷ the 1989 Convention on the Rights of the Child⁹⁸ as well as in the 2006 Convention on the Rights of Persons with Disabilities.⁹⁹ According to the thematic issue underlying these conventions the definition of what is meant by the right to health varies in wording and scope.¹⁰⁰

3.2 INTERNATIONAL PRISON STANDARDS

Analysing the international standards existing for the protection of health in prisons it must be noted that the protection of this specific issue is different to the protection of the right to health in general. While the right to health is embodied in a number of international treaties, this is not the case with regard to the right to health in a prison context. Nevertheless, the latter is dealt with by a number of soft-law instruments seeking to guarantee certain minimum health standards for prisoners. Given that a homogenous definition of the right to health in prison is lacking, such international prison standards give an idea of what is meant by health in prison within the international legislation.

In the following, some of the international prison standard-setting documents are discussed. First, the focus is on the so-called Nelson Mandela Rules¹⁰¹, which represent the most significant standard-setting instrument in the prison context at UN level. Referring to the

⁹⁵ Audrey R Chapman, ‘Conceptualizing the Right to Health: A Violations Approach’ (1998) 65 Tennessee Law Review 389, 397.

⁹⁶ UNGA, International Convention on the Elimination of All Forms of Racial Discrimination (adopted 21 December 1965, entered into force 5 January 1969) UNTS 660, 195, art 5(e)(iv).

⁹⁷ UNGA, Convention on the Elimination of All Forms of Discrimination Against Women (adopted 18 December 1979, entered into force 3 September 1981) UNTS 1249, 13, arts 11.1 (f) and 12.

⁹⁸ UNGA, Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) UNTS 1577, 3, art 24.

⁹⁹ UNGA, Convention on the Rights of Persons with Disabilities (adopted 13 December 2006, entered into force 3 May 2008) A/RES/61/106, Annex I, art 25.

¹⁰⁰ Marks provides for a useful comparative table of the different definitions of the health to right in the conventions, see Marks (2013) 8. See also Tobin (2012) 18.

¹⁰¹ UNGA, United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules).

principle of equivalence as one of the ‘basic principles’¹⁰² in the protection of prison health standards, the interlinkage of the various international prison standards is demonstrated. Hereafter, the European Prison Rules (hereafter EPR)¹⁰³ of CoE are at the centre of the discussion. This set of rules seems particularly relevant in the context of this thesis, since the judges in Strasbourg regularly refer to the EPR in their jurisprudence.¹⁰⁴

The scope of this thesis only allows to touch upon other international standard-setting instruments very briefly. This is necessary to give a glance of how the right to health in prison gained increased acceptance, especially at CoE level. UN documents, like the 1991 UN Basic Principles for the Treatment of Prisoners,¹⁰⁵ or more recently, the 2010 UN Bangkok Rules which deal with the treatment of women prisoners, are not taken into consideration.¹⁰⁶ In addition, neither the legal instruments of the World Medical Association (hereafter WMA)¹⁰⁷ nor the growing role of the EU – or other regional organisations than the CoE – in shaping international prison standards is discussed.¹⁰⁸

3.2.1 The United Nations Nelson Mandela Rules

The relevance of the right to health in prison is underlined by the fact that the issue shows a longstanding tradition of being part of the agenda of the international community. Accordingly, it was in 1955 when the UN first adopted its Standard Minimum Rules for the Treatment of

¹⁰² Van Zyl Smit and Snacken (2009) 153.

¹⁰³ CoM, Recommendation to Member States on the European Prison Rules (11 January 2006) Rec(2006)2, rule 40.5.

¹⁰⁴ The research conducted shows that references to the EPR can be found in more than 250 cases of the ECtHR of the Court, which is significantly more than with regard to the Nelson Mandela Rules or its predecessors. These numbers arise from the HUDOC research conducted. Different version of one or the other set of rules, like “European Prison Rules”, “Standard Minimum Rules for the Treatment of Prisoners” or “United Nations Standard Minimum Rules” have been used. In this regard it is interesting to note that the term “Nelson Mandela Rules” or “Mandela Rules” is all but absent from the jurisprudence of the Court. Admittedly, as already mentioned in the beginning of the section, the official introduction of the abbreviation “Nelson Mandela Rules” took place only in 2015 when the revised version of the UN Standard Minimum Rules for the Treatment of Prisoners got adopted. Hence, the use of this term will certainly increase over time. See ‘Document Collections’ (*HUDOC ECHR*, 26 June 2018) <<https://hudoc.echr.coe.int/eng>> accessed 26 June 2018.

¹⁰⁵ UNGA, Basic Principles for the Treatment of Prisoners.

¹⁰⁶ UNGA, United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders (the Bangkok Rules) (16 March 2011) A/RES/65/229.

¹⁰⁷ See most notably WMA, Declaration of Tokyo – Guidelines for Physicians Concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in relation to Detention and Imprisonment (October 1975, last revised October 2016); WMA, Declaration of Malta on Hunger Strikers (November 1991, last revised October 2017); WMA, Declaration of Edinburgh on Prison Conditions and the Spread of Tuberculosis and other Communicable Diseases (October 2000, revised October 2011).

¹⁰⁸ EU, Charter of Fundamental Rights of the European Union (18 December 2000) 2000/C 364/1, art 25. See also with regard to health and work *ibid* arts 31(1), 32. For a brief examination on the growing role of the European Union in the given context see also Van Zyl Smit and Snacken (2009) 27-30.

Prisoners. These rules already embodied comprehensive provisions regarding ‘medical services’.¹⁰⁹ Additionally, the rules integrated considerations with respect to multiple health-related issues, such as the accommodation¹¹⁰ and personal hygiene¹¹¹ of prisoners, food¹¹² and work¹¹³ in prison, but also regarding education and recreation¹¹⁴.

Only in 2015 the UNGA adopted a revised version of its preceding standard minimum rules, which from that date forward have been officially referred to as the Nelson Mandela Rules.¹¹⁵ The revised Nelson Mandela Rules indeed provide ‘important advances’¹¹⁶ compared to the pre-existing provisions regarding medical services in prison. Thus, in the separate section named ‘Health-care services’ the current rules entail comprehensive provisions dealing with various health-related issues.¹¹⁷

A prominent example of one of the health-related features is embodied in today’s Rule 24(1) of the Nelson Mandela Rules,¹¹⁸ which outlines the principle of equivalence of healthcare. The rule reflects on a number of international provisions preceding the adoption of the Nelson Mandela Rules. Indeed, the principle in its original form is anything but innovative and can similarly be found, for instance, in the Principle 1 of the 1982 UN Principles of Medical Ethics relevant to the Role of Health Personnel in Prison.¹¹⁹ Furthermore, Rule 24(1) of the Nelson Mandela Rules only refines and enhances the view of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (hereafter CPT). The CPT already expressed its view in 1993 by stating that ‘a prison health care service should be able to provide medical treatment (...) in conditions comparable to those enjoyed by patients

¹⁰⁹ UN Congress on the Prevention of Crime and the Treatment of Offenders, Standard Minimum Rules for the Treatment of Prisoners approved by the Economic and Social Council by its RES 663 C (XXIV) 31 July 1957 and RES 2076 (LXII) 13 May 1977 (30 August 1955) rules 22-26.

¹¹⁰ *ibid* rule 10.

¹¹¹ *ibid* rule 15.

¹¹² *ibid* rule 20(1).

¹¹³ *ibid* rule 74(1).

¹¹⁴ *ibid* rule 78.

¹¹⁵ UNGA, United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules).

¹¹⁶ Ivan Šimonović, former Assistant Secretary-General for Human Rights, cited in ‘UN Launches “Nelson Mandela Rules” on Improving Treatment of Prisoners’ (*UN News Centre*, 7 October 2015) <<http://www.ohchr.org/EN/NewsYork/Stories/Pages/UNLaunchesNelsonMandelaRulesOnTreatmentOfPrisoners.aspx>> accessed 21 May 2018.

¹¹⁷ UNGA United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), rules 24-35.

¹¹⁸ UNGA, rule 24(1).

¹¹⁹ UNGA, Principles of Medical Ethics relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (18 December 1982) A/RES/37/194, principle 1.

in the outside community'.¹²⁰ Additionally, the CoE Committee of Ministers (hereafter CoM) also referred to the principle of equivalence long before it became part of the Nelson Mandela Rules.¹²¹ Finally, the principle has already been part of the 2006 EPR¹²², albeit using a different wording and scope.¹²³

Against this background, the importance of the Nelson Mandela Rules in the international legislative framework becomes apparent. The rules reflect on a broad range of international prison standards. Thus, one can say that the rules cumulate the international mainstream views of what is accepted as the minimum health standards in prisons around the world. The unanimous adoption of the rules in the UNGA further strengthen this argument.¹²⁴ Therefore, even though the Nelson Mandela Rules must be seen as soft-law and, hence may not impose legally binding obligations on the states, one cannot underestimate the relevance of these prison standards.

3.2.2 Prison standards made by the Council of Europe setting

In the following sections, the focus shifts away from UN level to the activities set by the CoE in shaping prison standards. By pointing out the work of the CoM and the CPT, it is shown that the work of the CoE is ambitious. Thereby, the European Prisons Rules are at the centre of attention.

3.2.2.1 The European Prison Rules

The EPR consist of a set of three recommendations issued by the CoM. The origin of today's EPR lies in the 1973 Standard Minimum Rules for the Treatment of Prisoners,¹²⁵ which already embodied numerous health-related provisions, even including a section named 'medical services'.¹²⁶ The rules were closely modelled on the 1955 UN Standard Minimum for the

¹²⁰ CPT, 3rd General Report (1993) CPT/Inf(93) 12, para 38.

¹²¹ CoM, Recommendation Concerning the Ethical and Organisational Aspects of Health Care in Prison (8 April 1998) R(98)7 para 10.

¹²² CoM, Rec(2006)2, rule 40.5.

¹²³ For a comprehensive examination of the principle of equivalence see Van Zyl Smit and Snacken (2009) 153-158. See also Owen and Macdonald (eds) (2015) 280.

¹²⁴ UNGA, Official Records of the 70th Session, 80th Plenary Meeting (17 December 2015) A/70/PV.80, 25.

¹²⁵ CoM, Standard Minimum Rules for the Treatment of Prisoners (19 January 1973) RES(73)5.

¹²⁶ For the section 'medical services' see CoM, RES(73)5, rules 21-26. For other health-related provisions see also *ibid* rules 14 (sanitary facilities), 16(1) (clothing), 19 (food and hygiene).

Treatment of Prisoners,¹²⁷ and as appropriately pointed out by the academic Alain Reynaud, ‘the European text did not contain any revolutionary departure from the United Nations text’.¹²⁸

Later, in the 1980s, the CoM adopted new rules, namely the 1987 EPR.¹²⁹ The document entailed significant developments, using a formulation further away from the predecessor of the UN. Even though the 1987 EPR did not fulfil the expectations of its authors,¹³⁰ the document did improve standards regarding health at the normative level. In this context, it was stated as a basic principle in the 1987 EPR that ‘[t]he purposes of the treatment of persons in custody shall be such as to sustain their health’.¹³¹ Besides, a section on ‘medical services’ as well as multiple other health-related provisions remained part of the 1987 EPR.¹³²

Finally, in 2006, the CoM adopted a revision of the 1987 EPR. For the professors Dirk Van Zyl Smit and Sonja Snacken these updated rules paid due regard to new developments regarding the jurisprudence of the ECtHR and the findings of the CPT and thus ‘represent a synthesis of many of the trends that preceded it’.¹³³ By comparing the provisions of the 1987 EPR and its revised version of 2006, it becomes obvious that the latter put a more explicit focus on human rights. In this regard, Rule 1 of the 2006 EPR prominently states that ‘[a]ll persons deprived of their liberty shall be treated with respect for their human rights’.¹³⁴ Amongst other improvements, this enhanced focus on human rights also had impacts on the implementation of increased health standards in the document. This is underlined by the fact that, for the first time, a comprehensive, separate section is dedicated to the issue, which goes far beyond what was covered by the ‘medical services’-sections of its predecessors. Thus, Part III of the 2006 EPR entails numerous additional provisions regarding health in prison, including rules which deal with the responsibility for the safeguarding of health,¹³⁵ the organisation of healthcare,¹³⁶ questions regarding the medical and healthcare personnel¹³⁷, duties of doctors in prison,¹³⁸

¹²⁷ Van Zyl Smit and Snacken (2009) 20f.

¹²⁸ Alain Reynaud, *Human Rights in Prison* (CoE, 1984) 33.

¹²⁹ CoM, Recommendation to the Member States on the European Prison Rules (12 February 1987) R(87)3.

¹³⁰ Van Zyl Smit and Snacken (2009) 23.

¹³¹ CoM, R(87)3, rule 3.

¹³² For the section ‘medical services’ see CoM, R(87)3, rules 26-32. For other health-related provisions see also *ibid* rules 15 (accommodation), 20-21 (personal hygiene), 22(1) (clothing), 25(1) (food).

¹³³ Van Zyl Smit and Snacken (2009) 36.

¹³⁴ CoM, Rec(2006)2. See also CoM, RES(73)5, rule 1.

¹³⁵ CoM, Rec(2006)2. See also CoM, RES(73)5, rule 39.

¹³⁶ *ibid* rules 40.1-40.5.

¹³⁷ *ibid* rules 41.1-41.5.

¹³⁸ *ibid* rules 42.1-45.2.

issues regarding mental health¹³⁹ as well as the conduct of medical experiments.¹⁴⁰ Moreover, additional health-related provisions can be found all over the 2006 EPR.¹⁴¹

Finally, it is important to mention that the EPR undergo continuous development to fill existing gaps and to react to evolving challenges. Accordingly, Rule 108 of the 2006 EPR explicitly provides that EPR shall be updated regularly.¹⁴² In September 2017, a revision exercise started, which initially aimed to revise the commentary to the rules alone. However, most recently the Council of Europe has agreed to extend the revision to the 2006 EPR. This is because ‘there have been major changes brought in by other standards, principles and recommendations at both European and international level’ as pointed out by Dirk Van Zyl Smit and Harvey Slade in an analytical report to the European Committee on Crime Problems, in which they suggest updates to a number of rules.¹⁴³ Despite the fact that the current revision process is not as extensive as the kind undertaken in 2006, some of these updates would also be linked to health-related issues, such as proposed improvements to record and file management or solitary confinement. However, as yet, no major changes are put forward by the scholars with regard to the current health section of the EPR.¹⁴⁴

3.2.2.2 Other recommendations of the Committee of Ministers

The 2006 EPR was not the last recommendation made by the CoM with regard to the prison context. Indeed, the CoM further issued a few recommendations dealing with more special prison-related issues, covering a broad range of topics, from the use of remand in custody¹⁴⁵ and juvenile offenders¹⁴⁶ to probation rules and¹⁴⁷ foreign prisoners¹⁴⁸ or ethical standards for prison staff, which ask to ‘ensure the full protection of the health of persons in their custody’.¹⁴⁹

¹³⁹ *ibid* rules 47.1-47.2.

¹⁴⁰ *ibid* rules 48.1-48.2.

¹⁴¹ For some out of many examples see *ibid* rules 12.1 (detention of mentally ill prisoners), 15.1(f) (medical confidentiality at admission), 22.1 (nutrition), 52.5 (observation of national health and safety laws).

¹⁴² CoM, Rec(2006)2. See also CoM, RES(73)5, rule 118.

¹⁴³ Dirk Van Zyl Smit and Harvey Slade, ‘Updating the European Prison Rules: Analytical Report’ (2 May 2018) PC-CP(2018) 4rev, 2.

¹⁴⁴ *ibid*.

¹⁴⁵ CoM, Recommendation on the Use of Remand in Custody, the Conditions in which it Takes Place and the Provision of Safeguards Against Abuse (27 September 2006) Rec(2006)13.

¹⁴⁶ CoM, Recommendation on the European Rules for Juvenile Offenders Subject to Sanctions or Measures (5 November 2008) CM/Rec(2008)11.

¹⁴⁷ CoM, Recommendation on the Council of Europe Probation Rules (20 January 2010) CM/Rec(2010)1.

¹⁴⁸ CoM, Recommendation Concerning Foreign Prisoners (10 October 2012) CM/Rec(2012)12.

¹⁴⁹ CoM, Recommendation on the European Code of Ethics for Prison Staff (12 April 2012) CM/Rec(2012)5, para 20.

In addition, recent recommendations concern the electronic monitoring of prisoners,¹⁵⁰ establish rules on community sanctions and measures¹⁵¹ or children with imprisoned parents.¹⁵² An earlier recommendation further concerns the control of communicable diseases.¹⁵³ With respect to the areas covered by the work of the CoM, it becomes evident that the Committee constantly strives to tackle issues that arise in a timely manner. In any case, all the recommendations mentioned are closely linked to the 2006 EPR, which is reflected in the fact that reference is made to these rules in the preambles of every recommendation.

3.2.2.3 The work of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment

The work of the CoM is complemented by the activities undertaken by the CPT, which was established by the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment¹⁵⁴. Over the years, the CPT published a number of comments dealing with health-related issues in prison in specific contexts, such as life-sentenced prisoners,¹⁵⁵ juveniles,¹⁵⁶ mentally-ill offenders,¹⁵⁷ illegal aliens,¹⁵⁸ or most recently the issue of healthcare in remand detention.¹⁵⁹ In addition, the previously cited 3rd General Report regarding the general healthcare services in prison must be kept in mind.¹⁶⁰ Thereby, the CPT provides guidance not only for the CoE member states but also influences nations around the world.

Furthermore, the fact that the CPT deals with health-related issues in prison related to the prohibition of torture can be seen as a hint at the way in which the right to health entered into the jurisdiction of the Court. This is because, as is demonstrated in the last chapter of this thesis,

¹⁵⁰ CoM, Recommendation on Electronic Monitoring (19 February 2014) CM/Rec(2014)4.

¹⁵¹ CoM, Recommendation on the European Rules on Community Sanctions and Measures (22 March 2017) Rec(2017)3.

¹⁵² CoM, Recommendation Concerning Children with Imprisoned Parents (4 April 2018) CM/Rec(2018)5.

¹⁵³ CoM, Recommendation Concerning the Control of Transmissible Diseases Including AIDS and Related Health Problems in Prison (18 October 1993) Rec(1993)6.

¹⁵⁴ CoE, European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (adopted 26 November 1987, entered into force 1 February 1989) ETS 126.

¹⁵⁵ CPT, 25th General Report (2016) CPT/Inf(2016) 10, paras 77-79.

¹⁵⁶ CPT, 24th General Report (2015) CPT/Inf(2015) 1, paras 113-118; CPT, 9th General Report (1999) CPT/Inf(99) 12, para 37-41.

¹⁵⁷ CPT, 16th General Report (2006) CPT/Inf(2006) 35, paras 36-54.

¹⁵⁸ CPT, 13th General Report (2003) CPT/Inf(2003) 35, paras 39f.

¹⁵⁹ CPT, 26th General Report (2017) CPT/Inf(2017) 5, paras 71-73.

¹⁶⁰ CPT, CPT/Inf(93) 12.

the Court regularly refers to Article 3 of the ECHR in its examinations of health standards in prisons and takes the findings of the CPT into account.¹⁶¹

3.3 INTERIM CONCLUSION: COMPREHENSIVE GUIDANCE

The chapter shows that the right to health is embedded in a comprehensive international legislative framework. Given that health plays a significant role in various contexts and is therefore addressed from different angles, it is highly plausible that the right to health can encompass multiple meanings. Against this background, when discussing the right to health, the lack of a homogenous, universal definition of the right to health must always be kept in mind.

With regard to the right to health in the prison context, the UN treaties are complemented by a wide-range of soft-law instruments. A separate UN treaty on the issue does not exist. The absence of such a binding instrument underlines the lack of effective protection of the health of prisoners. This is not to say, however, that the current international prison standards do not provide detailed and comprehensive guidance for states regarding the issue, as demonstrated by the Nelson Mandela Rules and the 2006 EPR. The current revision process of the EPR gives hope that the protection of health-related prison standards will further increase in the near future. Sophisticated approaches to the existing standards, as supported by scholars like Van Zyl Smit and Slade are more than welcome. In the end, the results of such approaches will strongly depend on the extent of the political will to foster improvements.

Finally, it must be kept in mind that the provisions of the ECHR ‘cannot be interpreted in a vacuum, but must be interpreted in harmony with other international law and soft law’, as reaffirmed by ECtHR Judge Paulo Pinto de Albuquerque.¹⁶² Indeed, the regular references to the international prison rules made by the ECtHR underlines their impact on the jurisprudence of the Court. Accordingly Judge De Albuquerque further holds that ‘[w]hen establishing these obligations, and in a spirit of coherence with the standards set by other Council of Europe bodies and organs, the Court refers frequently to soft-law materials which enshrine a right to health

¹⁶¹ See below 5.3.

¹⁶² Judge Paulo Pinto De Albuquerque, ‘Is the ECHR Facing an Existential Crisis?’ (*UK Supreme Court*, 28 April 2017) <<https://www.supremecourt.uk/docs/speech-140212.pdf>> 3, accessed 28 June 2018.

care in prison'.¹⁶³ As a result, these references provide a way for the ECtHR to more explicitly include the right to health in a prison context in its jurisprudence.

¹⁶³ Judge Paulo Pinto De Albuquerque, 'Partly Concurring, Partly Dissenting Opinion' in ECtHR (GC), *Lopes De Sousa Fernandes v Portugal* (19 December 2017) 56080/13, para 93.

4 SOCIO-ECONOMIC RIGHTS AND THE COUNCIL OF EUROPE:

ABOUT A PAPER TIGER

As aforementioned, the human rights regime of the CoE is strongly shaped by the categorisation of human rights: on the one hand, civil and political rights and socio-economic rights, on the other. The structure of the legislative human rights framework in the CoE is similar to the original separation of rights at the international level. The ECHR merely – albeit not exclusively¹⁶⁴ – embodies traditional civil and political rights. In contrast, the 1961 European Social Charter (1961 Charter),¹⁶⁵ deals with the protection of socio-economic rights within the CoE. Later, this dichotomy was supplemented by the adoption of the Revised European Social Charter in 1996 (Revised Charter).¹⁶⁶ The right to health, being a traditional socio-economic right is protected by either one or the other of the ESC. In the following these two documents and their protocols are examined. A particular focus lays on Article 11 of the Charters, which outlines the right to protection of health.

Furthermore, the chapter points out the major differences between the protection system provided by the ESC and the protection system of the European Convention for Human Rights. The argument is made that the apparent weaknesses inherent to the Charters cause a potential lack of protection for the right to health within the CoE human rights regime. This calls for the ECtHR to make up for these deficits.

Accordingly, this chapter provides answers to the questions on; how is the right to health in general and especially in the prison context enshrined in the ESC and its protocols? What are the advantages and disadvantages of this system compared to the protection regime established by the ECHR?

The focus on the ESC results from the fact that these Charters originally were seen as a counterpart, or ‘pendant’¹⁶⁷ to the ECHR. In the context of this thesis, it seems plausible to shed light on the relation of these main human rights documents of the CoE. The examination of other CoE documents which influence the way in which member states organise their national

¹⁶⁴ See below 5.1.1.

¹⁶⁵ CoE, European Social Charter.

¹⁶⁶ CoE, European Social Charter (Revised).

¹⁶⁷ For a critical discussion of the 1961 European Social Charter as ‘pendant’ to the European Convention on Human Rights see Jean-Bernard Marie, ‘Consultation Sur les Droits de l’Homme Dans l’Europe de Demain (Strasbourg, 20-21 octobre 1972)’ (1973) 25(1) *Revue Internationale de Droit Comparé* 91, 93.

protection regimes with regard to the right to health, such as the so-called Oviedo Convention, would go beyond the scope of this thesis.¹⁶⁸ The same is again true with any outcome of the work of the EU or other regional organisations than the CoE.

4.1 THE EUROPEAN SOCIAL CHARTERS AND THEIR PROTOCOLS

First drafted in 1961, the Charter was revised in 1996.¹⁶⁹ Today, both documents are in force, aiming to guarantee the protection of socio-economic rights within the CoE human rights regime. The idea is that over time the Revised Charter replaces the substantive guarantees of its predecessor as all member states of the CoE become parties to the former.¹⁷⁰ At present, the total number of states which have ratified the Revised Charter is 34, while there are 11 signatures not followed by ratifications.¹⁷¹ At the same time, the 1961 Charter shows 27 ratifications/accessions and 5 signatures not followed by ratifications.¹⁷² Against this background, it must be mentioned that apart from Switzerland, Liechtenstein, San Marino and Monaco, all CoE member states have ratified one or both of these two Charters.¹⁷³

At the start of the drafting process of the 1996 Revised Charter, the need for a revision of the 1961 Charter was apparent. The standards outlined in the latter were outdated and there had been obvious gaps in the protection of some of the most crucial rights. For example, there was no general right to housing included.¹⁷⁴ The Revised Charter filled some of these gaps and provided a more comprehensive human rights protection framework. Thus, David Harris is right in stating that ‘the Revised European Social Charter contains considerable improvements that make it a much more up-to-date and comprehensive guarantee than its predecessor’.¹⁷⁵

¹⁶⁸ CoE, Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (adopted 4 April 1997, entered into force 1 December 1999) ETS 164, art 3. See also CoE Parliamentary Assembly, Recommendation 1626 (2003) (1 October 2003); WHO, ‘A Declaration on the Promotion of Patients’ Rights in Europe: European Consultation on the Rights of Patients Amsterdam 28 – 30 March 1994’ (28 June 1994) ICP/HLE 121.

¹⁶⁹ CoE, European Social Charter (Revised).

¹⁷⁰ David Harris and John Darcy, *The European Social Charter* (Transnational, 2001) 1.

¹⁷¹ ‘Chart of Signatures and Ratifications of Treaty 163: European Social Charter’ (revised) (*CoE*, 11 June 2018) <https://www.coe.int/en/web/conventions/full-list/-/conventions/treaty/163/signatures?p_auth=gYZFSzSh> accessed 11 June 2018.

¹⁷² ‘Chart of Signatures and Ratifications of Treaty 035: European Social Charter’ (*CoE*, 11 June 2018) <https://www.coe.int/en/web/conventions/full-list/-/conventions/treaty/035/signatures?p_auth=gYZFSzSh> accessed 11 June 2018.

¹⁷³ For a useful comparison of the states’ ratifications see ‘Signatures & Ratifications’ (*CoE*, 12 June 2018) <<https://www.coe.int/en/web/turin-european-social-charter/signatures-ratifications>> accessed 12 June 2018.

¹⁷⁴ The Revised Charter filled that gap, see CoE, European Social Charter (Revised) art 31.

¹⁷⁵ Harris and Darcy (2001) 18. For a useful list of the improvements entailed in the Revised Charter see *ibid* 19f.

Along with the two ESC, three additional protocols to the 1961 Social Charter must be considered.¹⁷⁶ Given their general impact on the human rights protection system of the CoE, these protocols also influence the member states' understanding of the right to health. This is true especially with regard to the 1995 Collective Complaints Protocol, which entered into force in 1998.¹⁷⁷ The protocol is designed to improve the effective enforcement of the social rights guaranteed by the Charters. It entitles non-governmental organisations and social partners to lodge collective complaints, which get examined by the Committee of Independent Experts, also known as European Committee of Social Rights (hereafter ECSR), a treaty body established by the 1961 Charter.¹⁷⁸ After declaring a complaint admissible the Committee takes a decision on the merits of a case and forwards it not only to the parties concerned but also to the CoM in a public report. On the basis of this report resolutions are adopted. In case of states' inaction recommendations to the member state concerned may be issued by the CoM to urge states to take specific measures to comply with the ratified Charters' provisions.¹⁷⁹

4.2 AN À LA CARTE CHOICE OF THE RIGHT TO HEALTH

Against the background of this comprehensive normative framework, it must be noted that the right to health in prison is not expressly entailed in any of the ESC. A provision regarding the protection of health in general, however, was already entailed in Article 11 of the 1961 Charter. Its updated version in the Revised Charter is almost identical, only adding a short reference to 'accidents' in its Article 11(3).

¹⁷⁶ CoE, Additional Protocol to the European Social Charter (adopted 5 May 1988, entered into force 5 September 1992) ETS 128; CoE, Protocol Amending the European Social Charter (21 October 1991) ETS 035.

¹⁷⁷ CoE, Additional Protocol to the European Social Charter Providing for a System of Collective Complaints (adopted 9 November 1995, entered into force 1 July 1998) ETS 35.

¹⁷⁸ Originally, the committee was referred to as 'Committee of Experts', see CoE, European Social Charter, art 25. The role and composition of the European Social Committee was clarified by the 1991 Turin Protocol, see CoE, Protocol Amending the European Social Charter (21 October 1991) ETS 035, art 25. See also Carole Benelhocine, *The European Social Charter* (CoE, 2012) 39.

¹⁷⁹ 'Details of Treaty No.158: Additional Protocol to the European Social Charter Providing for a System of Collective Complaints' (CoE) <<https://www.coe.int/en/web/conventions/full-list/-/conventions/treaty/158>> accessed 11 June 2018. For more information on the 1995 Collective Complaints Protocol, see Harris and Darcy (2001) 16f. See also Markus Jager, 'The Additional Protocol to the European Social Charter Providing for a System of Collective Complaints' (1997) 10 *Leiden Journal of international Law* 69. More recently, see Robin R Churchill and Urfan Khaliq, 'Violations of Economic, Social and Cultural Rights: The Current Use and Future Potential of the Collective Complaints Mechanism of the European Social Charter' in Mashood A Baderin and Robert McCorquodale (eds), *Economic, Social and Cultural Rights in Action* (Oxford University Press, 2007).

Thus, Article 11 of the Revised Charter holds:

With a view to ensuring the effective exercise of the right to protection of health, the Contracting Parties undertake (...) to take appropriate measures designed inter alia: 1. to remove as far as possible the causes of ill-health; 2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health; 3. to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.

Apart from Article 11 of the Charters express or implicit references towards health are made in a number of other provisions of the legal texts, for instance, concerning health and safety at work,¹⁸⁰ the well-being of children and young persons,¹⁸¹ the health of pregnant women¹⁸² as well as of elderly persons.¹⁸³ In addition, references to health are made in Part I of the Charters, which outlines the underlying principles of the Charters. In concrete terms the Charters hold that '[e]veryone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable'.¹⁸⁴

The wording used in the ESC raises questions of which situations are covered by the right to health under the Charters' protection regime. In this context, clarifications are provided by the secretariat of the ECSR, which published an informational document outlining explanations on the scope of the right to health under the protection system of the ESC. Thus, the health-related provisions enclose far-reaching 'rights to enable persons to enjoy the highest possible standard of health attainable'.¹⁸⁵ The secretariat clusters these rights in two categories, namely 'measures to promote health' and 'health care provision in case of sickness'.¹⁸⁶ While the former category covers issues concerning prevention, education and awareness-raising, the regulation of public health and the right to health for specific groups like workers, children, women and elderly persons,¹⁸⁷ the latter deals with healthcare facilities and the access to healthcare.¹⁸⁸

¹⁸⁰ CoE, European Social Charter (Revised) art 3.

¹⁸¹ *ibid* arts 7 and 17.

¹⁸² *ibid* arts 8 and art 17.

¹⁸³ *ibid* art 23.

¹⁸⁴ CoE, European Social Charter (Revised) part I(11). For further references being made with regard to the 'right to safe and healthy working conditions', see also *ibid* part I(3).

¹⁸⁵ 'The Right to Health and the European Social Charter' (*ECSR Secretariat*, March 2009) <https://www.ilga-europe.org/sites/default/files/right_to_health_and_esc.pdf> accessed 15 June 2018.

¹⁸⁶ *ibid*.

¹⁸⁷ *ibid* 2-9.

¹⁸⁸ *ibid* 9f.

The right to health in prison, however, is not mentioned by the ECSR secretariat. This seems inconsistent to the explicit focus of the ECSR on vulnerable groups as described in an interpretative statement on Article 11 of the ESC. In the document the ECSR underlines that ‘[i]n assessing whether the right to protection of health can be effectively exercised, the Committee pays particular attention to the situation of disadvantaged and vulnerable groups’.¹⁸⁹ The fact that prisoners clearly fall within this category makes it surprising that there is no further express reference by the ECSR secretariat to the right to health in a prison context.¹⁹⁰ As shown in the following, such a commitment is also absent in the outcome documents of the ECSR supervisory mechanism.

Before analysing this supervisory mechanism, however, a striking fact, which underlines the wide acceptance of the health provisions mentioned by the CoE member states, must be noted. Most of the state parties to one or the other ESC consider themselves bound by the health-related Charters’ provisions.¹⁹¹ This is anything but self-evident given the *à la carte* approach inherent to the Charters’ ratification procedure. Accordingly, states that want to become a contracting party to one of the Charters do not have to ratify the documents as a whole. Apart from certain ‘hard core’¹⁹² provisions, listed in each of Charters,¹⁹³ states can rather choose which provisions they accept and they do not. On the one hand, this aims to increase the numbers of ratifications of the Charters by giving states the possibility to avoid unwanted obligations. On the other, it leads to a strong fragmentation of the socio-economic rights protection system within the CoE. It is disputed whether the cherry-picking of provisions must be understood as an obstacle or as a benefit.¹⁹⁴ In any case, the right to protection of health is

¹⁸⁹ ECSR, Conclusion 2005 – Statement of Interpretation Article 11 (2005) 2005_Ob_1-1/Ob/EN.

¹⁹⁰ See above 1.2.1.

¹⁹¹ ‘Reservations and Declarations for Treaty No.163 – European Social Charter (Revised)’ (CoE, 12 June 2018) <https://www.coe.int/en/web/conventions/full-list/-/conventions/treaty/163/declarations?p_auth=LIPzUD7E> accessed 12 June 2018; ‘Reservations and Declarations for Treaty No.035 – European Social Charter’ (CoE, 12 June 2018) <https://www.coe.int/en/web/conventions/full-list/-/conventions/treaty/035/declarations?p_auth=aov6egUg> accessed 12 June 2018.

¹⁹² Olivier De Schutter, ‘The Two Lives of the European Social Charter’ in Olivier De Schutter (ed), *The European Social Charter: A Social Constitution for Europe* (Bruylant, 2010) 16.

¹⁹³ Part III of the 1996 Revised Charter outlines the core provisions, namely arts 1, 5, 6, 7, 12, 13, 16, 19 and 20, see CoE, European Social Charter (Revised) part III(1)(a)-(c). The 1961 Charter mentions arts 1, 5, 6, 12, 13, 16 and 19, see CoE, European Social Charter, part III(1)(a)-(c). See for an explanation of the relatively complex *à la carte* approach, De Schutter (2010) 16f.

¹⁹⁴ For an overview on the different opinions of academics see Stefan Clauwaert, ‘The Charter’s Supervisory Procedures’ in Niklas Bruun, Klaus Lörcher, Isabelle Schömann and others (eds), *The European Social Charter and the Employment Relation* (Bloomsbury, 2017) 134. To give an example, Schlachter sees the ‘cafeteria system’ as negative indicator with regard to the level of protection of rights in the European Social Charter system, see Monika Schlachter, ‘The European Social Charter: Could It Contribute to a More Social Europe?’ in Nicola Countouris and Mark Freedland (eds), *Resocialising Europe in a Time of Crisis* (Cambridge University Press,

not listed as a mandatory provision for the ratification of the Charters. Hence, state parties may become party to the Charters without accepting Article 11. The fact that most of the countries still declared to be bound by Article 11 and the other health-related Charters' provisions underlines the wide-spread acceptance for the issue.¹⁹⁵

4.3 THE SUPERVISORY MECHANISM OF THE EUROPEAN COMMITTEE OF SOCIAL RIGHTS

Having given an overview on the implementation of the right to health in the European Social Charter framework, the quality of protection provided by it is now discussed. In general, there are two tools that enable the ECSR to monitor the ESC: the national reporting system and the collective complaints procedure. Both tools show certain strengths and weaknesses compared to the ECHR system. In the following the argument is made, however, that the shortcomings inherent to the ECSR supervisory mechanisms are too serious to guarantee for effective protection of the right to health, especially in the prison context.

4.3.1 The reporting system

Until the Collective Complaints Protocol entered into force in 1995, the only tool for the ECSR to monitor compliance with the ESC was the analysis of national reports drawn up by state parties. This reporting system is characterised by the regular submission of reports by the state parties to ESC. The Committee examines these national reports and issues conclusions on whether or not the national states comply with the ratified Charters' provisions. Thereafter, it is up to the CoM to ensure that states follow-up the ECSR conclusions. In case a state does not act upon the Committee's conclusions, after a certain period of time, the CoM can issue resolutions, followed by recommendation, calling the state to bring the situation into conformity.¹⁹⁶ However, the conclusions made by the ECSR following the examination of the

2013) 106. In contrast, De Schutter is 'doubtful (...) whether the à la carte approach has been an obstacle to the adequate functioning of the system', because only a 'handful' state parties have accepted all provisions of the European Social Charters. For him, the approach, hence, pays due regard to the hesitation of many states to ratify the Charters, see De Schutter (2010) 16f.

¹⁹⁵ The potential state parties have to declare by notification by which articles it considers itself bound, see CoE, European Social Charter (Revised) part III(3); CoE, European Social Charter, part III(3). For the up-to-date status of these declarations on the 1996 Revised Charter see 'Reservations and Declarations for Treaty No.163' (CoE). For the status of declarations on the 1961 Charter see 'Reservations and Declarations for Treaty No.035' (CoE).

¹⁹⁶ Régis Brillat, 'The Supervisory Machinery of the European Social Charter: Recent Developments and Their Impact' in Gráinne De Búrca and Bruno De Witte (eds), *Social Rights in Europe* (Oxford University Press, 2005) 32f.

national reports, as well as the CoM resolutions or recommendations, are not enforceable in the domestic legal systems but rather must be understood as ‘declaratory’.¹⁹⁷ This makes the reporting system significantly weaker than the procedures at the ECtHR, which is able to issue judgements binding for the ECHR state parties.

Even though neither the ECSR nor the CoM can set legally binding findings, admittedly, the former works very efficiently in issuing conclusions considering the state parties’ compliance with the provisions of the ESC. For example, altogether the Committee has issued more than 1000 conclusions with regard to Article 11 of the Charters alone, thereby dealing with far reaching aspects of the right to health in the CoE member states.¹⁹⁸

In contrast, the situation is very different with regard to the activities set by the CoM in the reporting system. For instance, the scholar Maša Marochini holds that ‘the biggest defect within the Reporting system is the CoM follow up procedure, or the lack thereof. (...) Not only does the CoM rarely issue recommendations, but even the adopted recommendations are very mild and brief’.¹⁹⁹ Indeed, to date the CoM has only issued 36 recommendations as follow-up of ECSR conclusions, with the last one even dating back to 2007, despite starting in 1993.²⁰⁰

Finally, with respect to the right to health, the situation is even worse. In total there are only two recommendations, both of which are outdated, dealing with Article 11 of the ESC. These are both on the application of the Charters’ provisions by Turkey. While the first recommendation, made in 1999, refers to the ECSR conclusion that ‘measures taken to reduce the particularly high rate of perinatal and infant mortality are not sufficient’,²⁰¹ the second, issued in 2002, focuses on ‘the manifestly inadequate budget for health care and the inadequacy

¹⁹⁷ For an overview on the reporting system see ‘Reporting System of the European Social Charter’ (CoE, 12 June 2018) <<https://www.coe.int/en/web/turin-european-social-charter/reporting-system>> accessed 12 June 2018. For a more detailed explanation see Benelhocine (2012) 44-50. See also Robin R Churchill and Urgan Khaliq, ‘The Collective Complaints System of the European Social Charter: An Effective Mechanism for Ensuring Compliance with Economic and Social Rights?’ (2004) 15(3) *European Journal of International Law* 417, 439. In addition, Churchill and Khaliq discuss the scope of obligation of the CoM to issue recommendations, see *ibid* 437-439.

¹⁹⁸ Up-to-date data is provided by the European Social Charter HUDOC system, see ‘Document Collections’ (HUDOC ESC, 13 June 2018) <<http://hudoc.esc.coe.int/>> accessed 13 June 2018.

¹⁹⁹ Maša Marochini, ‘Council of Europe and the Right to Healthcare – Is the European Convention on Human Rights Appropriate Instrument for Protecting the Right to Healthcare?’ (2013) 34(2) *Zbornik Pravni Fakultet Sveučilišta u Rijeci* 729, 752f. See also Churchill and Khaliq (2004) 455.

²⁰⁰ ‘Document Collections’ (HUDOC ESC).

²⁰¹ CoM, Recommendation on the Application of the European Social Charter by Turkey During the Period 1993-94 (4 February 1998) R ChS(98)4.

of equipment and health personnel [which] do not guarantee access for the population, notably children, to health care of a satisfactory quality in the whole country'.²⁰²

4.3.2 The collective complaints procedure

The effective introduction of the collective complaints procedure in 1998 supplemented the supervisory mechanism of the ECSR, which hitherto completely depended on national state reports. Alston describes the adoption of this procedure as '[t]he most significant innovation in the ECSR system'.²⁰³

Indeed, in comparison to the ECtHR procedures, some advantages can be identified. In fact, certain admissibility criteria are easier to fulfil for potential applicants of an ECSR complaints procedure. For instance, the ECHR asks applicants to be 'directly affected'²⁰⁴ by a violation of a Convention right. A so called *actio popularis*, which addresses general grievances in a state regarding a Convention right without the existence of any personal link, would be declared inadmissible.²⁰⁵ However, such a requirement is absent to the ECSR collective procedure. Non-governmental organisations and other organisations, which are allowed to file a collective complaint, hence do not necessarily have to be victim to the alleged violation. Moreover, there is no need to exhaust domestic remedies for the complaint to be admissible, which is the case at the ECtHR.²⁰⁶ Finally, the procedures before the ECSR are significantly faster than before the ECtHR, where, according to author Carole Benelhocine, it can take up to a decade after an application is lodged until the Court gives its judgement in a case.²⁰⁷

²⁰² CoM, Recommendation on the Application of the European Social Charter by Turkey During the Period 1995-1998 (Fifteenth Supervision Cycle – part II) (16 January 2002) RecChS(2002)1.

²⁰³ Philip Alston, 'Assessing the Strengths and Weaknesses of the European Social Charter's Supervisory System' in Gráinne De Búrca and Bruno De Witte (eds), *Social Rights in Europe* (Oxford University Press, 2005) 66.

²⁰⁴ CoE, European Convention for the Protection of Human Rights and Fundamental Freedoms, art 34.

²⁰⁵ ECtHR, 'Practical Guide on Admissibility Criteria' (2017) 12.

²⁰⁶ For an overview on the collective complaints procedure see 'The Collective Complaints Procedure' (CoE, 12 June 2018) <<https://www.coe.int/en/web/turin-european-social-charter/collective-complaints-procedure>> accessed 12 June 2018. For an analysis of the importance of the collective Complaints Procedure see Alston (2005) 66. Regarding the exhaustion of remedies see CoE, European Convention for the Protection of Human Rights and Fundamental Freedoms, art 35.

²⁰⁷ Benelhocine (2012) 52. In contrast, for Drzemczewski the 'heavy and slow' procedure of the ECSR is one of its 'four major weaknesses' along with the 'uncertainty as to the respective roles of the Committee of Independent Experts and of the Governmental Committee, the absence of actual participation of the social partners in the supervisory procedure and the lack of any significant political sanction as the outcome of the procedure', see Andrew Drzemczewski, 'Fact-Finding as Part of Effective Implementation: The Strasbourg Experience' in Anne F Bayefsky (ed), *The UN Human Rights Treaty System in the 21st Century* (Brill, 2000) 130.

These advantages, however, are overshadowed by serious shortcomings in the ECSR collective complaints system. First of all, it must be noted that the shorter duration of the proceedings before the ECSR evidently results from the fact that there are relatively small numbers of collective complaints brought before the Committee.²⁰⁸ Since the Collective Complaints Protocol entered into force in 1998, in total the ECSR has issued only 108 decisions on the merits of collective complaints. Regarding the protection of the right to health according to Article 11 of the Charters the number of decisions on the merits is significantly lower. Thus, so far only 12 decisions concerning Article 11 have been issued.²⁰⁹ These low numbers stand in contrast to the numerous conclusions made by the ECSR in the context of the reporting system of ESC, as described above.²¹⁰

Furthermore, as being already indicated by its name, the collective complaints procedure cannot be triggered by individuals. The collective nature of the complaints does not even allow for individual situations to be submitted at all, irrespective of whether a complaint is lodged by a legitimate organisation. Rather, a complaint must concern the general non-compliance of a state's practice or law with one of the Charters' provisions.

In addition, the number of ratifications of the 1995 Collective Complaints Protocol are anything but high. To date only 15 CoE member states have ratified the protocol and there are only 4 signatures not followed by ratification.²¹¹ This is an indicator for the ongoing scepticism throughout the CoE member states towards a more effective monitoring mechanism for the ECSR, which could be triggered by non-state actors.

Apart from these reasons, the most striking weakness of the procedure again lies with the fact that neither the decisions made by the ECSR as a result of a collective complaints procedure nor the resolutions or recommendations made by the CoM following the ECSR decisions, have any legally binding effects on the states and, hence, they are in no way enforceable.

²⁰⁸ Benelhocine (2012) 52.

²⁰⁹ 'Document Collections' (*HUDOC ESC*). The ECtHR on the other hand has issued more than 1.000 judgements in 2018 alone according to the ECtHR HUDOC search engine, 'Document Collections' (*HUDOC ECHR*).

²¹⁰ See above pp???

²¹¹ 'Chart of Signatures and Ratifications of Treaty 158: Additional Protocol to the European Social Charter Providing for a System of Collective Complaints' (*CoE*, 12 June 2018) <https://www.coe.int/en/web/conventions/full-list/-/conventions/treaty/158/signatures?p_auth=1T0U9fvb> accessed 12 June 2018.

4.4 INTERIM CONCLUSION: A CALL FOR THE EUROPEAN COURT OF HUMAN RIGHTS TO FILL THE GAPS

The right to health is strongly embedded in the normative framework of the ESC. Its scope must be understood broadly, covering various health-related issues, as reflected in the ECSR conclusions deriving from the reporting system rather than in its decisions resulting from collective complaints procedures. The broad interpretation did not prevent most of the CoE member states to give their consent to be bound by the Charters' health provisions. This remains true, even though states were not obliged to do so, due to the disputed à la cart approach used in the ratification regime of the Charters. This indicates that the right to health is of some concern for the CoE member states.

Taking the examinations made regarding the ECSR supervisory mechanism into account, one might argue that the Charters' social protection system is a paper tiger. However, this would be to underestimate the impact of the comprehensive outcomes of the ECSR monitoring system and its follow-up procedures. Regarding the latter, the role of the CoM recommendations within the Charters' supervisory system must always be kept in mind. In this context, while taking into account the low numbers of recommendations issued by the CoM, Régis Brillat, Special Adviser of the Secretary General of the Council of Europe for Ukraine, points out that the effectiveness of the ESC cannot be measured in terms of quantity of CoM recommendations. He appropriately clarifies that it is solely up to the ECSR to find violations of the Charter provisions. In contrast, recommendations are political documents which aim 'to remind states of their obligations to comply with a treaty they have ratified and take account of the conclusions of the body responsible for ruling on violations, which is the treat's judicial organ'.²¹²

Moreover, with respect to the work of the ECSR, the Committee is, indeed, very active when it comes to the issuing of conclusions. In the vast majority of the cases, these conclusions get accepted by governments, which make the changes necessary to secure compliance. In fact, Brillat is right when saying that 'the practice according to which states comply with the Committee's conclusions and decisions is becoming established practice, even though such an obligation is not explicitly written in the [ESC]'.²¹³ Evidently, this is also demonstrated in the

²¹² Brillat (2005) 33.

²¹³ *ibid.*

most recent ECSR activity report, which lists far reaching improvements made within the CoE member states.²¹⁴

Against this background, it seems plausible when Marochini heaps praise on the role of the ECSR in the collective complaints system, especially in cases concerning the right to health. Indeed, in comparison to the ECtHR system, the collective complaints procedure is ‘relatively new’ and that ‘the awareness of possible claimants of protection provided by the ECSR system is rising’.²¹⁵

Nevertheless, neither the comprehensive activities of the ECSR nor the advantages of the monitoring procedures, as described in this chapter, can mask the serious weaknesses, which are currently inherent to the human rights protection system provided by the ESC. Accordingly, the aim of the examinations at hand were never to say that no positive impact results from the Charters’ social rights protection system. Rather, it was to point out the evident lack of effective protection of the right to health under the system of the ESC, as reflected in the flaws of the ECSR supervisory mechanisms and its follow-up procedures. Therefore, the question arises: how does one fill these gaps of protection?

Marochini, for instance, is convinced that ‘the right to health and healthcare issues should be left for the ECSR mechanisms of protection to deal with’²¹⁶ and this remains true irrespective of the existence of the current problems inherent to the protection regime of the ESC. He is reluctant to look for solutions within the ECtHR system but rather suggests that ‘the CoE bodies should focus into improving the ECSR system and urge States to ratify the Collective Complaints Protocol as well as pressure the CoM to issue proper and concrete recommendations’.²¹⁷

²¹⁴ ECSR, ‘Activity Report 2016: European Committee of Social Rights’ (2017) 29-52. For past reports on the ECSR activities see --‘Activity Reports’ <<https://www.coe.int/en/web/turin-european-social-charter/activity-reports>> (CoE) accessed 15 June 2018.

²¹⁵ Marochini (2013) 757.

²¹⁶ *ibid.* In his overall argument the scholar mainly refers to ECSR (dec), *European Roman Rights Centre (ERRC) v Bulgaria* (18 October 2006) 31/2005.

²¹⁷ Marochini (2013) 757. Marochini further suggests that ‘instead of looking for a solution for those problems within the ECHR system, the CoE bodies should focus into improving the ECSR system and urge States to ratify the Collective Complaints Protocol as well as pressure the CoM to issue proper and concrete recommendations. Therefore, the right to health and healthcare issues should be left for the ECSR mechanisms of protection to deal with’, see *ibid.*

Admittedly, for the sake of increasing the level of human rights protection within the CoE on the long-term, there is no reason to reject this view. As already mentioned, at this time the CoE human rights system is strongly shaped by the categorisation of human rights. In state practice there is almost nothing that suggests the fostering of the establishment of a World Court of Human Rights in practice, an idea which is supported by some scholars.²¹⁸

However, the stubborn refusal to understand the ECtHR system as a supplement to the ESC protection regime has to be challenged. This is because one must not stand and watch, when there are apparent shortcomings in the protection of some of the most crucial human rights, like the right to health. Desirable improvements of the situation within the system of the ESC are likely to be lengthy and in the meanwhile certain standards must be guaranteed by a competent human rights body, like the ECtHR. At the time, the ECHR system provides significant advantages compared to the ESC and their protocols. First and foremost, judgements finding violations of Convention rights are binding for the contracting states and there is an obligation to execute them. Even though problems in practice regarding the execution of ECtHR judgements exist,²¹⁹ it does not change the fact that against the background of the deficits inherent to the non-binding ECSR monitoring system, the ESC only remain a ‘faint shadow of the Convention’.²²⁰ Thus, it is obvious that increasing the jurisprudence of the ECtHR concerning the right to health in general, and especially in a prison context, would increase the overall level of human rights protection within the CoE.

²¹⁸ Manfred Nowak, ‘On the Creation of World Court of Human Rights’ (2012) 7(1) National Taiwan University Law Review 257. For the drafting of a statute for a World Court of Human Rights see Julia Kozma, Manfred Nowak and Martin Scheinin, *A World Court of Human Rights – Consolidated Draft Statute and Commentary* (Neuer Wissenschaftlicher Verlag, 2013). An example of the manageable efforts made by governments towards the idea of a World Court of Human Rights is the Swiss Initiative to Commemorate the 60th Anniversary of the Universal Declaration of Human Rights see ‘Agenda for Human Rights: A Swiss Initiative’ (*humanrights.ch*, 8 December 2008) <<https://www.humanrights.ch/en/switzerland/foreign-affairs/io/un/agenda-human-rights>> accessed 19 June 2018. For Philip Alston’s argument against the establishment of such a World Court of Human Rights, see Philip Alston, ‘Against a World Court for Human Rights’ (2014) 28(2) *Ethics & International Affairs* 197.

²¹⁹ On the problem of non-implementation of judgements see for example Nils Muižnieks, ‘Non-Implementation of the Court’s Judgments: Our Shared Responsibility’ (*CoE Human Rights Commissioner*, 13 August 2016) <<https://www.coe.int/en/web/commissioner/-/non-implementation-of-the-court-s-judgments-our-shared-responsibility?desktop=true>> accessed 16 June 2018. See also CoM, *Supervision of the Execution of Judgments and Decisions of the European Court of Human Rights: 11th Annual Report of the Committee of Ministers 2017* (2018).

²²⁰ Maud De Boer-Buquicchio, ‘Welcome Address’ in Niko Johanson and Matti Mikkola (eds), *Reform of the European Social Charter: Seminar Presentations Delivered 8 and 9 February 2011 at the House of the Estates and the University of Helsinki* (Ministry for Foreign Affairs of Finland, 2011) 5.

The main counterargument against a stronger involvement of the ECtHR in social matters, like the health situation in a state, might be the alleged lack of jurisdiction of the Court regarding such matters. Indeed, the explicit scope of the ECHR merely covers traditional civil and political rights. As a traditional socio-economic right, the right to health would not fall in this category. The underlying fear of governments is that the ECtHR would, more and more, dictate how to organise their legislation with regard to its social matters, by interfering with policies, which fall within the most sensitive field of state sovereignty.²²¹ Nevertheless, the last part of this thesis now not only touches upon the replies of the Court to such sovereignty concerns, but also demonstrates how the right to health found its way into the jurisprudence of the ECtHR, having an impact on today's health protection standards, at least in a prison context.

²²¹ See below 5.1.1-5.1.3.

5 THE RIGHT TO HEALTH IN PRISON AND THE EUROPEAN COURT OF HUMAN RIGHTS: ABOUT AN INTEGRATED ENGAGEMENT

In the light of the previous chapters the focus now shifts towards an analysis of the ECtHR's jurisdiction related to the right to health in prison. The examinations follow a logical structure and hence, are designed along three major questions. First; does the ECtHR engage with socio-economic rights at all? If so; what is the situation like with the right to health in hospitals and other health services for the general public? And finally; what are the differences to the Court's engagement with the right to health in a prison context? This structure chosen aims to provide the final link to answer the overarching research questions of this thesis.

Accordingly, the first section addresses the ECtHR's engagement with socio-economic rights. It is demonstrated that the methods of interpretation applied by the Court do indeed open its doors for cases closely related to traditional socio-economic fields, albeit not without criticism. Next, the second section shows that the right to health outside of prison walls is indeed addressed by the ECtHR. Even though the judges in Strasbourg for a long time were reluctant to engage with the substantive dimension of issues related to the right to health, this has changed in more recent years. This evolution of the Court's approach as well as the current status quo are discussed. Finally, the right to health in prison is central to the third section of this chapter. Apart from a compact presentation of the case-law of the ECtHR regarding prisoners' health, the section further points to differences in the level of protection of health in prisons and in hospitals and other health services outside prison walls. It is argued that the Court does not only strongly engage with the right to health in prison, but it even puts prisoners in a privileged position with regard to the level of health guaranteed position compared to the general public.

5.1 THE COURT AND SOCIO-ECONOMIC RIGHTS

With a view to the explicit wording of the ECHR, as adopted in 1950, it is obvious that the Convention was designed to guarantee civil and political, rather than socio-economic rights. Consistently, the latter are not directly expressed in the 1950 Convention text. Since the scope of jurisdiction of the ECtHR is limited to the provisions provided by the ECHR, at first glance,

it seems plausible to argue that it is not for the Court to issue judgements regarding socio-economic rights, such as the right to health. Against this background the question arises; does the ECtHR engage with socio-economic rights at all? In the following section it is now demonstrated that there are indeed ways which enables the judges in Strasbourg to address socio-economic rights to a certain extent.

5.1.1 The explicit tradition

First of all, it must be noted that the first protocol to the ECHR in 1952 already introduced a few exceptions of the strict avoidance of socio-economic rights in the Convention text. These exceptions explicitly concern certain dimensions of the protection of property²²² as well as the right to education.²²³ With regard to the latter, the ECtHR case law also specifically deals with education in prison,²²⁴ albeit the scholar Laurens Lavrysen appropriately states that the Court fails to provide genuine substance to such a right.²²⁵

More importantly in the context of the right to health, the ECtHR has a long jurisprudential tradition to accept the interlinkage between certain civil and political rights and economic, social and cultural rights. The perhaps most cited case in this regard is the *Airey* case, dealing with the right to judicial separation in Ireland in the 1970s. Regarding the role of socio-economic rights, the Court put in a nutshell:

Whilst the Convention sets forth what are essentially civil and political rights, many of them have implications of a social or economic nature. The Court therefore considers (...) that the mere fact that an interpretation of the Convention may extend into the sphere of social and economic rights should not be a decisive factor against

²²² CoE, Protocol 1 to the European Convention for the Protection of Human Rights and Fundamental Freedoms (adopted 20 March 1952, entered into force 18 May 1954) ETS 9, art 1. For detailed information on the right to property in the ECHR see Monica Carss-Frisk, 'The Right to Property: A Guide to the Implementation of Article 1 of Protocol No. 1 to the European Convention on Human Rights' (*CoE Human Rights Handbooks*, 2001) <<https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=090000168007ff4a>> accessed 16 June 2018.

²²³ *ibid* art 2.

²²⁴ See for example ECtHR, *Velyo Velev v Bulgaria* (27 May 2014) 16032/07. For an overview of the Court's jurisprudence regarding the right to education in prison see 'Guide on Article 2 of Protocol No. 1 to the European Convention on Human Rights: Right to Education' (*ECtHR*, 30 April 2018) <https://www.echr.coe.int/Documents/Guide_Art_2_Protocol_1_ENG.pdf> accessed 16 June 2018, 9f.

²²⁵ Laurens Lavrysen, 'Education in Prison: Right to Education Only Protects Access in Case of "Existing" Educational Facilities (Velyo Velev v. Bulgaria)' (*Strasbourg Observers*, 13 June 2014) <<https://strasbourgobservers.com/2014/06/13/education-in-prison-right-to-education-only-protects-access-in-case-of-existing-educational-facilities-velyo-velev-v-bulgaria/>> accessed 16 June 2018.

such an interpretation; there is no water-tight division separating that sphere from the field covered by the Convention.²²⁶

This view is in accordance with the principles of interdependence and indivisibility of human rights, which were later also reaffirmed by the CESCR in its General Comment 9 on the Implementation of the ICESCR:

The adoption of a rigid classification of economic, social and cultural rights which puts them, by definition, beyond the reach of the courts would thus be arbitrary and incompatible with the principle that the two sets of human rights are indivisible and interdependent. It would also drastically curtail the capacity of the courts to protect the rights of the most vulnerable and disadvantaged groups in society.²²⁷

Furthermore, the broad interpretation of the ECtHR is reflected in the more recent view of the Office of the United Nations High Commissioner for Human Rights (hereafter OHCHR), which holds that ‘[a]ll human rights treaties contain provisions of direct relevance to economic, social and cultural rights’.²²⁸ The OHCHR continues to argue that every treaty, even the ICCPR, ‘apparently dealing exclusively with civil and political rights, in recognizing the rights to life, equal protection of the law and freedom of association, indirectly recognize components of economic, social and cultural rights’ and it points out that this was acknowledged by Courts in many jurisdictions.²²⁹

²²⁶ ECtHR, *Airey v Ireland* (9 October 1979) 6289/73, para 26.

²²⁷ CESCR, General Comment No. 9: The Domestic Application of the Covenant (3 December 1998) E/C.12/1998/24, para 10.

²²⁸ OHCHR, ‘Economic, Social and Cultural Rights: Handbook for National Human Rights Institutions’ (2005) 4.

²²⁹ *ibid.* To support its argument, apart from the *Airey* case, in its footnote the OHCHR refers to additional jurisprudence of the ECtHR regarding the existence of certain forms of social security benefits inherent to Article 6(1) of the ECHR. In this regard see ECtHR, *Feldbrugge v The Netherlands* (29 May 1986) 8562/79; ECtHR, *Deumeland v Germany* (29 May 1986) 9384/81. With respect to the application of such doctrines the OHCHR further lists cases, in the ICCPR context considered by the the Human Rights Committee, see HRC, *S. W. M. Broeks v The Netherlands* (9 April 1987) 172/1984; HRC, *L. G. Danning v The Netherlands* (19 July 1984) 180/1984; HRC, *F. H. Zwaan-De Vries v The Netherlands* (9 April 1987) 182/1984.

5.1.2 The integrated approach

The principles of interdependence and indivisibility are further fostered by an approach of the ECtHR which evolved in the end of the last century. Thus, the Court's so-called *integrated*²³⁰ approach to human right takes the division of human rights in the normative and institutional framework of the CoE into account and seeks to integrate the interpretation of civil and political rights and the interpretation of socio-economic rights. Hence, this approach limits the effects of the separation of human rights created by the adoption of the ECHR on the one hand and the European Social Charters, on the other. As pointed out by the academics Bernadette Rainey and Elizabeth Wicks along with the practitioner Clare Ovey '[the *integrated* approach] recognises that (...) the enjoyment of civil and political rights requires respect for and promotion of social rights, and (...) that social rights are not second best to civil and political rights'.²³¹ This view complies with the examinations made by Virginia Mantouvalou, Professor of Human Rights and Labour Law at the University College London, who identified two aspects, which reflect two different moral justifications for socio-economic rights. On the one hand, the *instrumental* aspect 'sees social rights as means for the effective protection of civil and political rights, and embraces the idea that the enjoyment of civil and political rights is rendered meaningless if social rights are neglected'.²³² On the other, the *substantive* aspect is characterised by 'the belief that social entitlements are as intrinsically valuable as fundamental civil and political rights are'.²³³ Analysing the *Sidabras and Džiautas* case,²³⁴ which concerned limitations on the employment of former KGB employees in Lithuania, Mantouvalou – in a remarkably clear way – provides evidence of the use of the *integrated* approach in the ECtHR jurisprudence.²³⁵

The integrated approach can be understood as extension of the so-called *evolutive* approach which has a long tradition in the ECtHR interpretation regime, first introduced in the *Tyrer* case.²³⁶ Proponents of the *evolutive* approach understand the ECHR as a

²³⁰ Martin Scheinin, 'Economic, Social and Cultural Rights' in Asbjørn Eide, Catarina Krause and Allan Rosas (eds), *Economic Social and Cultural Rights* (Kluwer, 2001) 32-38. The approach is also known as *holistic* approach, see Virginia A Leary, 'Lessons from the Experience of the International Labour Organisation' in Philip Alston (ed), *The United Nations and Human Rights: A Critical Reappraisal* (Oxford University Press, 1992) 590.

²³¹ Bernadette Rainey, Elizabeth Wicks and Clare Ovey, *Jacobs, White, and Ovey: The European Convention on Human Rights* (7th edn, Oxford University Press, 2017) 78.

²³² Virginia Mantouvalou, 'Work and Private Life: Sidabras and Džiautas v Lithuania' (2005) 30 *European Law Review* 573, 574.

²³³ *ibid.* Mantouvalou also 'convinced' Rainey, Wicks and Ovey, see Rainey, Wicks and Ovey, (2017) 78.

²³⁴ ECtHR, *Sidabras and Džiautas* (27 July 2004) 5540/00 and 59330/00.

²³⁵ Mantouvalou (2005) 574. In her argument Mantouvalou is strongly influenced by Waldron's moral justification of socio-economic rights' protection, see Jeremy Waldron, 'Liberal Rights: Two Sides of the Same Coin' in Jeremy Waldron (ed), *Liberal Rights: Collected Papers 1981-1991* (Cambridge University Press, 1993).

²³⁶ ECtHR, *Tyrer v The United Kingdom* (25 April 1978) 5856/72, para 31.

dynamic rather than a static document.²³⁷ A good example in the context of socio-economic right is again provided in the *Airey* case. The ECtHR ‘[being] aware that the (...) realisation of social and economic rights is largely dependent on the situation (...) reigning in the State in question’, noted that ‘the Convention must be interpreted in the light of present-day conditions (...) and [that] it is designed to safeguard the individual in a real and practical way as regards those areas with which it deals’.²³⁸ This passage not only entails the so-called living instrument doctrine, but even represents ‘one of the most dramatic illustrations of the application of the principle of effectiveness’.²³⁹ However, it must be noted that the *evolutive* approach, unsurprisingly, is not without debate. Apart from the fears described in the beginning of the section, admittedly, it was the ‘conservative and incoherent’²⁴⁰ work of the ECtHR itself which created doubts towards the approach.²⁴¹

5.1.3 The ongoing scepticism

Of course, for some this engagement of the ECtHR with social matters is a thorn in the flesh. Governments²⁴² and especially judges of national jurisdictions,²⁴³ regularly argue that social-

²³⁷ For details on the *evolutive* approach see for example David J Harris, Michael O’Boyle, Edward P Bates and others, *Harris, O’Boyle & Warbrick: Law of the European Convention on Human Rights* (Oxford University Press, 2014) 8-10.

²³⁸ ECtHR, *Airey*, para 26.

²³⁹ Rainey, Wicks and Ovey (2017) 76.

²⁴⁰ Mantouvalou (2005) 574.

²⁴¹ De Albuquerque points out the downside of the approach which ‘may now permit a regression in terms of human rights protection in Europe’ with regard to the Hassan case. See De Albuquerque (*UK Supreme Court*) <<https://www.supremecourt.uk/docs/speech-140212.pdf>> 5, accessed 28 June 2018; ECtHR (GC), *Hassan v The United Kingdom* (16 September 2014) 29750/09. See also Alastair Mowbray, ‘The Creativity of the European Court of Human Rights’ (2005) 5(1) *Human Rights Law Review* 57, 71.

²⁴² To give a representative example for a governmental position in the jurisprudence of the ECtHR, see the Russian government submissions regarding the right to a pension of a particular amount in ECtHR (dec), *Budina v Russia* (18 June 2009) 45603/05. Furthermore, in contrast to the position of the UK Conservative Party, which seek to repeal from parts of the UK human rights framework due to sovereign issues in relation to the living instrument doctrine see Sir Michael Tugendhat, ‘Fighting for Freedom? The Historic and Future Relationship Between Conservatism and Human Rights’ (Bright Blue, 2017) 74-80.

²⁴³ In the case of the United Kingdom, Lord Judge, the former Lord Chief Justice of England and Wales, in an interview with BBC Radio 4, expressed his doubts that the state parties to the ECHR intended to enable the ECtHR to dictate rather than just influence their social legislation. Reiterating the view of the former president of the ECtHR, Dean Spielmann, who, accordingly argues that this broad understanding of the Court’s competences derives from the Convention’s living instrument doctrine, states that ‘of course a convention is not a dead instrument, but [Spielmann’s view] means that legislation can be made by [ECtHR] judges on all sorts of societal issues. Binding legislation. And if that is the position then there is a very serious problem with sovereignty’, see ‘European Court of Human Rights “Risk to UK Sovereignty”’ (*BBC*, 28 December 2013) <<https://www.bbc.co.uk/news/uk-politics-25535327>> accessed 16 June 2018. In addition, for Lord Neuberger ‘the idea of courts overruling decisions of the UK parliament, as is substantially the effect of what the Strasbourg court and the Luxembourg court can do, is little short of offensive to our notions of constitutional propriety. All the more so, given that the courts concerned are not even British courts’, see Lord Neuberger, ‘Cambridge Freshfields Annual Law Lecture 2014’ (12 February 2014) para 28.

economic issues do not fall within the scope of the ECHR. In a remarkable speech by De Albuquerque, delivered at the Mansfield College, Oxford, the ECtHR Judge appropriately points out the claims made by such critiques, who deny that socio-economic rights are enshrined in the ECHR. According to De Albuquerque they would argue:

[H]uman rights are residual, civil liberties which serve only minorities, not the majority of citizens. The Convention is portrayed as the villains' charter, not as the bill of rights of the common man on the street. Furthermore, social rights are not human rights, not enforceable rights at all. Human rights only imply negative, not positive obligations and certainly not a budgetary cost. The transformation of the Convention into a disguised social charter betrays its nature.

Against the background of this debate on the separation of human rights, the Court is accused of extensive judicial activism when engaging with socio-economic rights. Any decision of the Court to examine the merits of complaints dealing with socio-economic matters is seen as threat to state sovereignty.²⁴⁴ Accordingly, it is argued that applications linked to such issues should be declared inadmissible by the ECtHR judges.²⁴⁵

All this criticism, however, does not undo the factual engagement of the Court with socio-economic rights in general. Accordingly, the examinations made in this section have shown that the ECtHR indeed regularly – albeit to a different extent – considers traditional social-economic rights in its jurisprudence. Thus, the first question raised in this chapter, namely if the ECtHR does engage with socio-economic rights at all can undoubtedly be answered positively. In this regard the right to health is no exception, given that by now it is deeply interlaced in the ECHR provisions and the interpretations of the ECtHR judges, as shown in the following.

²⁴⁴ For a critical analysis of the judicial activism of the ECtHR see Marc Bossuyt, 'Judicial Activism in Strasbourg' in Karel Wellens (ed), *International Law in Silver Perspective: Challenges Ahead* (Brill, 2015). In this context, in a speech delivered at the Mansfield College, Oxford, Judge De Albuquerque appropriately sums up the arguments drawn from the working methods of the Court by its critiques: '[J]udicial activism leads the Court to a mission creep. The Court's attempt to aggrandise itself is visible in the invention of new rights and the enlargement of its own powers. The Court's micro-management of cases threatens democracy and State sovereignty, since Governments lose control of the Convention and domestic authorities are side-stepped and discredited', see De Albuquerque (*UK Supreme Court*). See also Paul Mahoney, 'Judicial Activism and Judicial Self-Restraint in the European Court of Human Rights: Two Sides of the Same Coin' (1990) 57 *Human Rights Law Journal* 66.

²⁴⁵ See footnote 242.

5.2 THE COURT AND THE RIGHT TO HEALTH

After having demonstrated that the ECtHR does indeed engage with socio-economic rights, the second question raised in this chapter must be considered, namely; what is the situation like with the right to health in hospitals and other health services for the general public? To go *medias in res*, it must be reiterated that other than the right to education or the right to property, the right to health is all absent from the text of the ECHR and its protocols. Nevertheless, the Court deals indeed with cases which are closely linked to issues related to the right to health, especially within the scope of Articles 2 and 8 of the ECHR and somewhat in cases related to Article 3 of the ECHR.²⁴⁶ While the former articles – and especially Article 2 of the ECHR – are part of detailed discussions in this section, the latter is rather neglected. This is because in the context of health the relevance of Article 3 of the ECHR is mainly limited to a niche number of cases concerning the removal or expulsion of migrants and aliens.²⁴⁷ In the prison context, however, the article plays a significant role and hence is discussed in the last section of this thesis.²⁴⁸ At the same time, Article 8 of the ECHR is particularly important with regard to developments in the field of health and the environment.²⁴⁹ An examination of the issue, however, would go beyond the scope of this thesis.

5.2.1 The right to health as an implied right

The right to health must be understood as an ‘implied right’.²⁵⁰ This is because the ECtHR puts certain health-related obligations on the Convention states which derive from some of the Convention’s articles. These obligations might be of negative as well as positive nature. The Court’s jurisprudential basis of the well-established view in favour of the existence of such obligations can already be found in the *L.C.B.* judgement, issued in 1998. The case dealt with a series of failures of the state to warn of and monitor the impacts of nuclear tests in which the

²⁴⁶ For an overview of the comprehensive jurisdiction of the ECtHR in the context of health, see ‘Factsheet – Health’ (*ECtHR*, May 2018) <https://www.echr.coe.int/Documents/FS_Health_ENG.pdf> accessed 3 July 2018; ‘Thematic Report: Health-Related Issues in the Case-Law of the European Court of Human Rights’ (*ECtHR*, June 2015) <https://www.echr.coe.int/Documents/Research_report_health.pdf> accessed 3 July 2018.

²⁴⁷ An examination of these cases would go beyond the scope of this thesis. However, for an overview of the relevant case law in the given context see De Albuquerque (2017b) para 42f; Marochini (2013) 743-747. For a digression to the topic of migrants and terrorism see Alessia Vedano, ‘The Use and Abuse of the “Clash of Civilizations” Rhetoric’ (*Freedom from Fear Magazine*) <<http://f3magazine.unicri.it/?p=1533>> accessed 1 July 2018.

²⁴⁸ See below 5.3.1-5.3.2.

²⁴⁹ For a large number of cases regarding environment and health see ‘Factsheet – Environment and the European Convention on Human Rights’ (*ECtHR*, February 2018) <https://www.echr.coe.int/Documents/FS_Environment_ENG.pdf> 8-21, accessed 3 July 2018.

²⁵⁰ De Albuquerque (2017b) para 29. See also ECSR, Conclusion 2005 – Statement of Interpretation Article 11 (2005) 2005_Ob_1-1/Ob/EN.

applicant's father participated before his death.²⁵¹ The ECtHR held that Article 2 of the ECHR enjoins that states not only have 'to refrain from the intentional and unlawful taking of life', but even more they have to 'take appropriate steps to safeguard the lives of those within its jurisdiction'.²⁵² A similar argumentation was also used before with respect to Article 8 of the ECHR.²⁵³

In this context, the ECtHR also established principles related to states' obligations regarding the quality of health in a country. Originally deriving from the early view of the European Commission of Human Rights (EComHR),²⁵⁴ the Court most notably reiterated its approach in *Calvelli and Ciglio v Italy*. Amongst others, the case concerned the question whether procedural delays and a statute of limitations in the context of medical negligence of medical personnel in delivering a baby violates Article 2 of the ECHR. In spite of the fact that in the end no violation was found, the Court reiterated the theoretical principles regarding the standard of healthcare in a state:

The (...) positive obligations (...) require States to make regulations compelling hospitals, whether public or private, to adopt appropriate measures for the protection of their patients' lives. They also require an effective independent judicial system to be set up so that the cause of death of patients in the care of the medical profession, whether in the public or the private sector, can be determined and those responsible made accountable (...).²⁵⁵

5.2.2 The reluctance of the European Court of Human Rights

However, the examination of the ECtHR's jurisprudence shows that despite these well-established theoretical principles regarding the states' obligations, for a long time the judges in Strasbourg almost completely shied away from an in-depth engagement with substantive

²⁵¹ ECtHR, *L.C.B. v The United Kingdom* (9 June 1998) 23413/94, paras 10-20; 'Thematic Report' (ECtHR) 26.

²⁵² ECtHR, *L.C.B.*, para 36. Similarly, see also ECtHR (GC), *Calvelli and Ciglio v Italy* (17 January 2002) 32967/96, para 48.

²⁵³ See for example ECtHR, *Guerra and others v Italy* (19 February 1998) 14967/89, para 58; EComHR, *Association of Parents v The United Kingdom* (12 July 1978) 7154/75.

²⁵⁴ EComHR, *Mehmet İşiltan v Turkey* (22 May 1995) 20948/92.

²⁵⁵ ECtHR (GC), *Calvelli*, para 49. See also ECtHR, *Erdinç Kurt and others v Turkey* (6 June 2017) 50772/11, para 51; ECtHR, *Jurica v Croatia* (2 May 2017) 30376/13, para 84; ECtHR, *Mehmet Şentürk and Bekir Şentürk v Turkey* (9 April 2013) 13423/09, para 81; ECtHR (dec), *Fiorenza v Italy* (28 November 2000) 44393/98, para 4; ECtHR (dec), *Pastorino v Italy* (11 July 2006) 176407/02, para 3; ECtHR (dec), *Erikson v Italy* (26 October 1999) 37900/97.

clarifications with regard to the states' basic standards of healthcare.²⁵⁶ Accordingly, Judge Albuquerque rightly notes that although the ECtHR has indeed established obligations on the states the Court has most of the time relied on the procedural instead of the substantive limb of Article 2 of the Convention.²⁵⁷

A representative example for the reluctance of the ECtHR to engage with the substantive dimensions of health-related ECHR's provisions is its judgement on the merits in the famous *Cyprus v Turkey* case in 2001. The complex facts of the case concerned various claims of violations of Convention rights, linked to the Turkish invasion of Cyprus in the 1970s, which caused the persistent division of the island. With regard to the right to health, it was claimed that Greek Cypriots and other ethnicities had been denied access to adequate or available healthcare in the territories governed by the Turkish authorities, due to restrictions on the freedom of movement for the concerned.²⁵⁸

As appropriately pointed out by the scholar Lewis Graham, in the case two different issues rose under Article 2 of the ECHR. First, the judges had to deal with the issue of denied access to healthcare. In this context, using soft language, the Court established the path-breaking principle that 'an issue may arise under Article 2 of the Convention where (...) the authorities of a Contracting State put an individual's life at risk through the denial of health care which they have undertaken to make available to the population generally'.²⁵⁹

In a second step, the judges continued to address the issue of quality of healthcare provided in the Turkish territories, which was criticised by the applicant state. In this regard, however, the Court did 'not consider it necessary to examine (...) the extent to which Article 2 of the Convention may impose an obligation on a (...) State to make available a certain standard of health care'.²⁶⁰ Even though it can be argued that the use of the word 'extent' indicates that in general such an obligation exists, its degree remained uncertain,²⁶¹ given that in the end no violation of Article 2 of the ECHR was held.

²⁵⁶ For academics supporting this argument see for example Lewis Graham, 'The European Court of Human Rights and the Emerging Right to Health' (*Oxford Human Rights Hub Blog*, 11 May 2017) <<http://ohrh.law.ox.ac.uk/the-european-court-of-human-rights-and-the-emerging-right-to-health>> accessed 30 May 2018; Marochini (2013).

²⁵⁷ De Albuquerque (2017b) para 49.

²⁵⁸ ECtHR (GC), *Cyprus v Turkey* (10 May 2001) 25781/94, paras 13-55.

²⁵⁹ *ibid* para 219. See also Graham (2017).

²⁶⁰ *ibid*.

²⁶¹ Harris, O'Boyle, Bates and others (2014) 213.

Against this background, it can be argued that in *Cyprus v Turkey* the ECtHR indeed established a crucial principle addressing the Convention states' positive obligations with regard to the access to healthcare. Nevertheless, this principle remained lifeless and still had to be materialised. In addition, the same was true regarding the issue of quality of healthcare in the Convention states. Instead of clarifying the aforementioned principles reiterated in *Calvelli and Ciglio v Italy*, the Court remained completely silent on the substantive aspects of the level of health which states are obliged to provide.

In the years after *Cyprus v Turkey*, the ECtHR's regularly missed further opportunities to clarify which situations would fall within the substantive scope of Article 2 of the ECHR regarding health and the Court's reluctance to the issue remained. This was reflected in a number of applications, which were declared inadmissible²⁶² as well as in the *Hristozov* judgement, concerning the state's refusal to allow terminally ill cancer patients to use experimental medicine, where no violation of Article 2 of the ECHR was held.²⁶³

The latter case provides a good example for the reasoning of the ECtHR to decline its comprehensive engagement with health-related issues in a more substantive manner. *Hristozov v the Netherlands* rather demonstrates the ECtHR's tendency to grant a wide margin of appreciation to the Convention states in handling their health-related issues in general, accepting that 'States deal differently with the conditions and manner in which access to unauthorised medicinal products is provided'.²⁶⁴

Similarly, the margin of appreciation argument was stressed in *Sentges v The Netherlands* where a violation of Article 8 of the ECHR was claimed. The case concerned a severely disabled person, suffering from a disease that causes progressive degeneration of muscles, the loss of ability to work and might even lead to a lethal outcome. Despite this severe status of health, the applicant was denied a robotic arm by their health insurance. The ECtHR, declaring the application inadmissible, not only held that regard must be paid to the wide margin of appreciation of states, but rather stressed that this margin is even wider when the issue at stake is related to the allocation of limited resources of a state. Furthermore, the Court noted that

²⁶² ECtHR (dec), *Wiater v Poland* (15 May 2012) 42290/08; ECtHR (dec), *Budina*; ECtHR (dec), *Makuc and others v Slovenia* (31 May 2007) 26828/06; ECtHR (dec), *Pentiacova and 48 others v Moldova* (4 January 2005) 14462/03; ECtHR (dec) *Nitecki v Poland* (21 March 2002) 65653/01.

²⁶³ ECtHR, *Hristozov and Others v Bulgaria* (13 November 2012) 47039/11.

²⁶⁴ *ibid*, para 108. The judgement was not without criticism, see Judge Vincent A De Gaetano, 'Dissenting Opinion Joined by Judge Vučinić' in ECtHR, *Hristozov*, para 4.

given the states' familiarity with their healthcare systems, 'the national authorities are in a better position to carry out this assessment than an international court'.²⁶⁵ Finally, the Court reminded that each individual case always establish a precedent, at least to some extent.²⁶⁶ This seemingly discouraged the judges even more to engage with the issue.²⁶⁷ For these reasons, even though cases with a narrower margin of appreciation exist,²⁶⁸ the ECtHR, understandably' grant a significant margin of appreciation to states in substantive health-related cases.

5.2.3 The evolution of the Court's approach

Eventually, against the background of the aforementioned missed opportunities to illuminate the concrete substantive dimensions of health in a state, in 2013 the ECtHR started to set the ball rolling again. In *Şentürk and Şentürk v Turkey* the applicants respectively claimed that their wife and mother died due to a series of misjudgements by medical personnel at four different hospitals. The victim, Mrs Menekşe Şentürk, was heavily pregnant when she consulted the hospitals experiencing pain. While Mrs Şentürk was only examined by a midwife in the first two hospitals, in the third hospital the doctor only prescribed her medicines and sent her home. Since the pain did not cease, Mrs Şentürk's husband drove her to a fourth hospital where for the first time she was examined by a gynaecologist who took an ultrasound and discovered that her foetus was dead. In addition, Mrs Şentürk was informed that an urgent operation was needed to remove the child. However, before conducting the operation, according to the applicants, a deposition for the hospital to cover the costs of the surgery should have been paid. Since neither Mrs Şentürk nor her husband could pay the amount for the deposition immediately, she was transferred to another clinic without the attendance of any medical supervisor. She died on the way to this fifth hospital.²⁶⁹

²⁶⁵ ECtHR (dec), *Sentges v The Netherlands* (8 July 2003) 27677/02.

²⁶⁶ *ibid.*

²⁶⁷ In contrast to the wide margin of appreciation granted to states in general health-related situations, in the last section of this thesis it is demonstrated that the Court's view significantly differs when such situations occur in the more specific prison context, see below 5.3.2.

²⁶⁸ For an example of a narrower margin of appreciation with regard to preventive health care, which underlines the principle of effectiveness, see ECtHR, *Georgel and Georgeta Stoicescu v Rumania* (26 July 2011) 9718/03.

²⁶⁹ ECtHR, *Mehmet Şentürk and Bekir Şentürk*, paras 5-63. The case represents a range of cases before the ECtHR regarding the impact of poverty on human rights, see Laurens Lavrysen, 'Poverty and Human Rights' in Eva Brems, Christophe Van Der Beken and Solomon A Yimer (eds), *Human Rights and Development* (Brill, 2015).

Although there was criticism related to the judges' lack of empathy in the case,²⁷⁰ Graham is right stating that the case demonstrates the evolvement of the ECtHR's 'cautious approach'²⁷¹ to the substantive dimension of health in the Convention states. Indeed, by unanimously holding both a procedural and substantive violation of Article 2 of the ECHR, in *Şentürk and Şentürk v Turkey* for the first time the Court identified concrete situations which fall within the issues that 'may arise' regarding the refusal of access to healthcare under the abovementioned principle established in *Cyprus v Turkey*.²⁷² Even more importantly, the circumstances of the tragic death of Mrs Şentürk provide precedence also with regard to the quality of healthcare in a state. While the ECtHR in *Cyprus v Turkey* found it unnecessary to engage with the level of healthcare available, in *Şentürk and Şentürk v Turkey* the judges indeed addressed this substantive aspect by reiterating the principles described in the *Calvelli and Ciglio* case. Accordingly, the Court stated that 'the positive obligations imposed on the State by Article 2 of the Convention imply that a regulatory structure be set up, requiring that hospitals, be they private or public, take appropriate steps to ensure that patients' lives are protected'.²⁷³

As a result, one can argue that after the establishment and reaffirmation of ground-breaking, but theoretical principles regarding the Convention states' health-related obligations in a number of preceding cases, it needed the dramatic events underlying the *Şentürk and Şentürk* case to give a first materialised glimpse of what is might be the concrete substance of these principles in practice.

The new jurisprudential momentum created by the *Şentürk and Şentürk v Turkey* judgement, to date has led to the issuing of a handful of additional ECtHR judgements holding a violation of the substantive limb of Article 2 of the ECHR in health-related cases, albeit mostly limited to the individual circumstances of the concerned. The most recent case, *Kutsenko v Ukraine*, concerned the victim's de facto denial of access to healthcare in a hospital after allegedly having been tortured by police forces. The judges unanimously found a 'de facto denial of health care', since no medical action was taken after the gravely injured victim fell into a coma causing his

²⁷⁰ Saïla O Chaib, 'Mehmet Şentürk and Bekir Şentürk v. Turkey: The Court Could Have Shown More Empathy' (*Strasbourg Observers*, 24 May 2013) <<https://strasbourgobservers.com/2013/05/24/mehmet-senturk-and-bekir-senturk-v-turkey-the-court-could-have-shown-more-empathy/>> accessed 30 June 2018.

²⁷¹ Graham (2017).

²⁷² ECtHR, *Mehmet Şentürk and Bekir Şentürk*, para 88. See also ECtHR (GC), *Cyprus*, para 219.

²⁷³ ECtHR, *Mehmet Şentürk and Bekir Şentürk*, para 81. For the line of argumentation of the ECtHR with regard of the violation of the substantive limb of Article 2 of the ECHR see *ibid* paras 84-97. See also ECtHR (GC), *Calvelli*, para 49.

death the following day.²⁷⁴ Furthermore, in the *Elena Cojocaru v Romania* the ECtHR was confronted with the death of the applicant's daughter and her premature new-born due to medical negligence. Even though an emergency surgery was strongly recommended, a doctor refused to perform the operation. The victim was eventually transferred to a clinic about 150 kilometres away, where she died minutes after her surgery. Her baby died two days later. Again, a violation of the substantive limb of Article 2 ECHR was found, even though not without dispute.²⁷⁵

While both of these cases provide further evidence of what falls within the substantive limb of Article 2 of the ECHR in health-related situations, like in the *Şentürk and Şentürk* judgement, the judges focused on the individual circumstances of the case. However, there are indeed two more cases in which the judges in Strasbourg took a far broader approach by referring to structural problems inherent to a state's healthcare system in their assessments. Both cases concerned a lack of equipment, especially incubators, and effective coordination between the medical staff in hospitals with regard to the death of two babies in Turkey. In *Asiye Genç v Turkey*, for instance, the ECtHR considered the lack of place in the hospitals concerned as well as the insufficient quantity and quality of medical equipment in the region and held:

[T]he State had not taken sufficient care to ensure the smooth organisation and correct functioning of the public hospital service, and more generally of its system for health protection, and (...) the lack of places was not linked solely to an unforeseeable shortage of places arising from the rapid arrival of patients.²⁷⁶

In the end, for the Court the insufficient situation described 'was analogous to a denial of medical care such as to put a person's life in danger'.²⁷⁷

Similarly, in *Aydoğdu v Turkey*, after having demonstrated the medical negligence inherent to the facts of the case, the ECtHR did not stop its examinations at that point. Rather, the Court continued to take into account the notorious and chronic situations regarding the insufficient

²⁷⁴ ECtHR, *Nina Kutsenko v Ukraine* (18 July 2017) 25114/11, para 185.

²⁷⁵ ECtHR, *Elena Cojocaru v Romania* (22 March 2016) 74114/12. Given that the case was decided merely with regard to medical negligence rather than a deny of health care, Judge Sajó delivered a concurring opinion in which he disagreed with the finding of a violation of the substantive limb of Article 2 of the ECHR, see Judge András Sajó, 'Concurring Opinion' in *ibid*.

²⁷⁶ ECtHR, *Asiye Genç v Turkey* (27 January 2015) 24109/07, para 80.

²⁷⁷ *ibid* para 82.

equipment and shortage of place in the hospitals concerned and further considered the lack of coordination of the medical personnel.²⁷⁸ In the case the judges referred to the well-known *Osman* test.²⁷⁹ It held that the authorities responsible failed to take measures within the scope of their power, which could have prevented the risk for the life of the applicants' baby, but also for the lives of other new-borns in general. For the Court, the authorities could not have been unaware at the material time of the existence of such a real risk, due to the apparent of the shortcomings existing.²⁸⁰ Furthermore, the judges stated that the Turkish government was not able to demonstrate an disproportionate or even impossible burden which had hindered the imposition of preventive measures, neither with regard to operational choices made in terms of priorities nor resources.²⁸¹ Hence, it was found that the Turkish authorities had not sufficiently ensured the proper organisation and operation of the public health service in the region concerned. For these reasons, the Court finally concluded that in addition to the negligence attributable to the medical personnel, there was also a causal link established between the death of the baby and the structural problems in the health system prevalent at that time. Accordingly, such as in the case of *Asiye Genç*, the Court considered that the applicants' new-born was the victim of both medical negligence and structural deficits, a combination that tantamount to a deny of the access to healthcare.²⁸²

At this point, however, the uneven level of *mens rea* required by the ECtHR in assessing the responsibility of the medical personnel in the *Aydoğdu* and the *Şentürk and Şentürk* case is worth to be noted. Thus, in the latter the Court does not refer to the *Osman* test ('knew or ought to have known'),²⁸³ but rather sets a much higher threshold stating that the medical personnel at the relevant hospital was 'perfectly aware of the risk to the patient's health were she to be transferred to another hospital'.²⁸⁴ One can agree with Judge Albuquerque stating that the ECtHR's hesitancy in this regard is further compounded by the Court's 'oversimplification' of

²⁷⁸ ECtHR, *Aydoğdu v Turkey* (30 August 2016) 40448/06, para 84-87.

²⁷⁹ '[W]here there is an allegation that the authorities have violated their positive obligation to protect the right to life (...) to prevent and suppress offences against the person, it must be established to its satisfaction that the authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual or individuals from the criminal acts of a third party and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk (...)', see ECtHR (GC), *Osman v The United Kingdom* (28 October 1998) 23452/94, para 116.

²⁸⁰ ECtHR, *Aydoğdu*, para 87.

²⁸¹ This is would be a legitimate justification for a state according to the *Osman* test, see ECtHR (GC), *Osman*, para 116.

²⁸² ECtHR, *Aydoğdu*, para 87f.

²⁸³ See 5.2.3.

²⁸⁴ ECtHR, *Mehmet Şentürk and Bekir Şentürk*, para 96.

the different degrees of *mens rea* and that in fact ‘unconscious negligence, recklessness or wilful ignorance’, in some cases, may be as serious as ‘full awareness’ of a situation.²⁸⁵

5.2.4 The jurisprudential status quo of the right to health

In summary, in the light of the last sub-sections, one can identify two types of circumstances which trigger the responsibility of a state under the substantive limb of Article 2 of the ECHR. These ‘very exceptional circumstances’²⁸⁶ were recently listed clearly in *Lopes de Sousa Fernandes v Portugal*. The case concerned the death of a man following a nasal polyp surgery due to medical negligence of parts of the medical personnel and the following proceedings. The Court noted that, first, a substantive violation might be held in cases concerning a particular situation where a ‘patient’s life is knowingly put in danger by denial of access to life-saving emergency treatment’.²⁸⁷ This is the case, for instance, in *Şentürk and Şentürk v Turkey*, *Kutsenko v Ukraine* and *Elena Cojocaru v Romania* as explained above. The second type of exceptional circumstances, however, is demonstrated in the cases *Asiye Genç* and *Aydoğdu*. In such cases ‘a systemic or structural dysfunction in hospital services results in a patient being deprived of access to life-saving emergency treatment’.²⁸⁸ In addition, the *Osman* test has to be applied and thus its result must lead to the understanding that the state ‘knew about or ought to have known about that risk and failed to undertake the necessary measures to prevent that risk from materialising, thus putting the patients’ lives, including the life of the particular patient concerned, in danger’.²⁸⁹ With regard to this second structural category the ECtHR finally asks for three factors which must be met cumulatively to hold a substantive violation of Article 2 of the ECHR. Put in a nutshell, these factors are:

1. The existence of an act or omission which goes ‘beyond a mere error or medical negligence’, meaning that the responsible healthcare providers ‘deny a patient emergency medical treatment despite being fully aware that the person’s life is at risk if that treatment is not given’.²⁹⁰

²⁸⁵ De Albuquerque (2017b) para 58.

²⁸⁶ ECtHR (GC), *Lopes De Sousa Fernandes v Portugal* (19 December 2017) 56080/13, para 190.

²⁸⁷ *ibid* para 191.

²⁸⁸ *ibid*.

²⁸⁹ *ibid*.

²⁹⁰ *ibid* para 194. See also ECtHR, *Mehmet Şentürk and Bekir Şentürk*, para 104.

2. The existence of a ‘systemic or structural’ dysfunction, which ‘must not merely comprise individual instances’ where something went wrong or functioned badly.²⁹¹
3. The existence of ‘a link between the dysfunction complained of and the harm which the patient sustained.’²⁹² This dysfunction must be a result ‘from the failure of the State to meet its obligation to provide the effective functioning of a regulatory framework.’²⁹³

Overall, the decision to open the doors to potential examinations of structural failures in states’ health system, can be seen as the interim highlights in the evolution of the ECtHR’s approach towards a more extensive understanding of the substantive scope of Article 2 of the ECHR. However, this development is not undisputed, as demonstrated in the opinion of Judges Lemmens, Spano and Kjølbros concurring partly with the reasoning of the *Asiye Genç* judgement. The judges are indeed more reluctant to base their finding of a substantive violation of the provision on the structural deficits existing in Turkey at the material time. Accordingly, for the judges ‘[t]his case is not about a structural problem in the Turkish health care system revealing a dysfunctional system, but a tragic incident resulting from acts and omissions in the treatment of the applicants’ child’.²⁹⁴

In some cases, the Court does even backslide into the reluctance to engage too much with the substantive aspects of health-related cases. The *Lopes de Sousa Fernandes* case can be seen as a disappointing example in this regard. In finding a violation of Article 2 of the ECHR with regard to the provision’s procedural limb alone, the Court shied away from what according to Judge Albuquerque ‘could have been a tipping point’²⁹⁵ to increase the level of protection in the context of healthcare in hospitals. With regard to the second factor described above,

²⁹¹ ECtHR (GC), *Lopes De Sousa Fernandes*, para 195. See also ECtHR, *Aydoğdu*, para 87.

²⁹² ECtHR (GC), *Lopes De Sousa Fernandes*, para 196. See also ECtHR, *Aydoğdu*, para 87f; ECtHR, *Mehmet Şentürk and Bekir Şentürk*, para 96.

²⁹³ ECtHR (GC), *Lopes De Sousa Fernandes v Portugal* (19 December 2017) 56080/13, paras 196. ‘The regulatory duties thus encompass necessary measures to ensure implementation, including supervision and enforcement’, see *ibid* para 189.

²⁹⁴ Judge Paul Lemmens, Judge Robert Spano and Judge Jon F Kjølbros, ‘Concurring Opinion’ in ECtHR, *Asiye Genç*, para 3.

²⁹⁵ De Albuquerque (2017b) para 93.

Judge Georgios Serghides rightly notes in his partly dissenting opinion:

[I]n no situation, other than health-care situations, in which there is a serious risk threatening life and which triggers a substantive positive obligation on the part of the State to protect life, does the Court’s case-law require a systemic problem as a precondition for a possible violation of Article 2 of the Convention.²⁹⁶

Similarly, Judge Albuquerque, in his impressive partly concurring, partly dissenting opinion to the *Lopes de Sousa Fernandes* judgement, underlines that ‘the Court sets very different health-care standards for different groups of the population’²⁹⁷ especially pointing to imprisoned individuals. Indeed, as demonstrated in the following, the threshold for the finding of a substantive violation in the context of general healthcare in hospitals and other health services outside prisons is significantly higher and thus, harder to reach than within prison facilities.

5.3 THE COURT AND THE RIGHT TO HEALTH IN PRISON

Since the right to health is not explicitly mentioned in the ECHR, it does not come as a surprise that there are also no provisions addressing the health of prisoners contained in the Convention text. However, again a significant number of cases before the ECtHR exist which are closely linked to health-related issues in prisons. Comprehensive principles concerning various situations related to the prisoners’ health have been derived from these cases under Article 2 and 8 of the ECHR, and also especially under Article 3 of the ECHR. Today, the Court’s jurisprudence covers issues regarding the medical assistance for prisoners with various physical²⁹⁸ as well as mental health problems.²⁹⁹ It deals with disabled³⁰⁰ and elderly prisoners³⁰¹ as well as drug addicts³⁰² and addresses special issues, such as HIV treatment³⁰³ or

²⁹⁶Judge Georgios A Serghides, ‘Partly Dissenting Opinion’ in ECtHR (GC), *Lopes De Sousa Fernandes*, para 12.

²⁹⁷ De Albuquerque (2017b) para 54. For the right to health care in the specific context of children and persons with disabilities see *ibid* paras 39-41. For the specific context of migrants see *ibid* paras 42f.

²⁹⁸ ECtHR, *Dorneanu v Romania* (26 July 2007) 1818/02; ECtHR, *Nogin v Russia* (15 January 2015) 58530/08.

²⁹⁹ ECtHR (GC), *Murray v The Netherlands* (26 April 2016) 10511/10; ECtHR, *Slawomir Musial v Poland* (20 January 2009) 28300/06.

³⁰⁰ ECtHR, *Helhal v France* (19 February 2015) 10401/12; ECtHR, *Z.H. v Hungary* (8 November 2012) 28973/11.

³⁰¹ ECtHR, *Contrada v Italy* (11 February 2014) 7509/08; ECtHR, *Farbtuhs v Latvia* (2 December 2004) 4672/02.

³⁰² ECtHR, *Wenner v Germany* (1 September 2016) 62303/13; ECtHR (dec), *Marro and others v Italy* (8 April 2014) 29100/07.

³⁰³ ECtHR, *Martzaklis and others v Greece* (9 July 2015) 20378/13; ECtHR, *Kats and others v Ukraine* (18 December 2008) 29971/04.

other special therapies,³⁰⁴ diets,³⁰⁵ force-feeding³⁰⁶ and the forced administration of substances³⁰⁷ as well as overcrowding.³⁰⁸ It takes into account the monitoring of medical correspondence³⁰⁹ as well as the access to medical records³¹⁰ and even considers problems with regard to passive smoking.³¹¹ Furthermore, the Court refers to health when it comes to the question of release³¹² and also tries to provide guidance for preventive health measures.³¹³ This list of areas covered by the Court's jurisprudence cannot be seen as exhaustive. Its sole aim is to provide a glimpse of the great extent the ECtHR engages with health in the context of prison.

Against the background of this 'rich plethora'³¹⁴ of cases, some authors might tend to lose themselves in the sheer quantity of the ECtHR's jurisprudence when analysing the right to health of prisoners in the given context. However, the approach chosen for this last section of the thesis is a different one. It does not seek to demonstrate each and every single facet of prisoners' health-related rights highlighted in the jurisprudence of the ECtHR. Such examinations would not only go far beyond the scope of this thesis, but would even lack any innovative dimension. Accordingly, the jurisprudence of the Court regarding the individual topics mentioned above is already analysed in numerous works of academics as well as practitioners.³¹⁵ Not least, the ECtHR itself regularly sums up the most crucial of its judgements in a number of public documents, thereby providing an overview of its broad engagement with health in prison.³¹⁶

³⁰⁴ ECtHR, *Vladimir Vasilyev v Russia* (10 January 2012) 28370/05; ECtHR, *Kupczak v Poland* (25 January 2011) 2627/09.

³⁰⁵ ECtHR, *Ebedin Abi v Turkey* (13 March 2018) 10839/09; ECtHR, *Moisejevs v Latvia* (15 June 2006) 64846/01.

³⁰⁶ ECtHR (dec), *Rappaz v Switzerland* (26 March 2013) 73175/10; ECtHR, *Ciorap v Moldova* (19 June 2007) 12066/02.

³⁰⁷ ECtHR, *Bogumil v Portugal* (7 October 2008) 35228/03; ECtHR, *Jalloh v Germany* (11 July 2006) 54810/00.

³⁰⁸ ECtHR, *Florea v Romania* (14 September 2010) 37186/03; ECtHR, *Slawomir Musiał*.

³⁰⁹ ECtHR, *Szuluk v The United Kingdom* (2 June 2009) 36936/05.

³¹⁰ ECtHR, *I v Finland* (17 July 2008) 20511/03.

³¹¹ ECtHR, *Elefteriadis v Rumania* (25 January 2011) 38427/05; ECtHR, *Florea*.

³¹² ECtHR, *Gülay Çetin v Turkey* (5 March 2013) 44084/10; ECtHR, *Papon v France* (25 July 2002) 54210/00.

³¹³ ECtHR, *Florea*; ECtHR, *Poghosyan v Georgia* (24 January 2009) 9870/07.

³¹⁴ For the specific context of migrants see De Albuquerque (2017b) para 29.

³¹⁵ For example, see Rainey, Wicks and Ovey (2017); Harris, O'Boyle, Bates and others (2014); Alastair Mowbray, *Cases, Materials, and Commentary on the European Convention on Human Rights* (Oxford University Press, 2012).

³¹⁶ 'Factsheet – Prisoners' Health-Related Rights' (ECtHR, May 2018) <https://www.echr.coe.int/Documents/FS_Prisoners_health_ENG.pdf> accessed 15 May 2018; 'Factsheet – Detention and Mental Health' (ECtHR, June 2018) <https://www.echr.coe.int/Documents/FS_Detention_mental_health_ENG.pdf> accessed 1 July 2018; ECtHR, 'Thematic Report' (ECtHR).

The approach applied rather derives from the examinations made in the previous section. As indicated, there is a difference between the health-related standards set by the judges in Strasbourg when it comes to situations inside prison facilities and in hospitals and other health services for the general population. The focus now lies on this uneven approach of the Court. Thereby, the third question raised in this chapter is examined, namely; what are the differences in the Court's engagement with the right to health in a prison context to the protection of health in hospitals and health services outside prison walls? Before addressing this question, however, the section now demonstrates the obligation for states to ensure health in prison, given that this can be understood as an overarching principle with regard to the question at hand. In addition, a non-exhaustive overview of some of the most crucial principles governing the obligations for the Convention states with regard to health-related issues is given.

5.3.1 The states' duty to ensure health in prison

In contrast to the general public, imprisoned individuals are in a special position. The deprivation of their liberty makes them completely dependent on the state authorities in relation to a wide range of medical issues. Moreover, it is inherent to the nature of imprisonment that omissions and acts of authorities responsible are likely to have significantly greater impact on the individuals' psychological state of health.³¹⁷ Thus, it seems plausible that states have the responsibility to ensure the individuals' health in prisons. Amongst others, the existence of such a duty is supported by the views of the CoM³¹⁸ and the CPT³¹⁹ as well as at UN level.³²⁰ In addition, the duty's general existence is accepted in the field of academics.³²¹

³¹⁷ *ibid* 13. See also above 1.2.1.

³¹⁸ With regard to Rule 39 of the 2006 EPR the CoM in his commentary holds that '[w]hen a state deprives people of their liberty it takes on a responsibility to look after their health in terms both of the conditions under which it detains them and of the individual treatment that may be necessary. Prison administrations have a responsibility not simply to ensure effective access for prisoners to medical care but also to establish conditions that promote the well-being of both prisoners and prison staff. Prisoners should not leave prison in a worse condition than when they entered. This applies to all aspects of prison life, but especially to health care', see CoM, Commentary on Rec(2006)2. See also CoM, RES(73)5, rule 39; CoM, R(98)7.

³¹⁹ The CPT notes that '[a]n inadequate level of health care can lead rapidly to situations falling within the scope of the term "inhuman and degrading treatment"' of Article 3 of the ECHR, see CPT, CPT/Inf(93) 12, para 30.

³²⁰ For example, the UN Human Rights Committee already in 2002 stated that 'the State party by arresting and detaining individuals takes the responsibility to care for their life. It is up to the State party by organizing its detention facilities to know about the state of health of the detainees as far as may be reasonably expected. Lack of financial means cannot reduce this responsibility', see HRC, *Yekaterina Pavlovna Lantsova v The Russian Federation* (26 March 2002) 763/1997, para 9.2. In addition, the WHO suggests the existence of a duty of care for the relevant governments as well as prison authorities to cover at least the prisoners' basic needs. Amongst others, this duty derives from the entire dependence of the prisoners on the prison personnel. Additionally, despite possible restrictions on some of their human rights, in general prisoners retain all human rights other than their freedom, see Enggist, Møller, Galea and others (eds) (2014) 1f.

³²¹ For example, see Mariner and Schleifer (2013).

Analysing its jurisprudence, it can be seen that also the ECtHR addresses the responsibility of states to take care of the health of prisoners. Most notably, the Court has established its broad understanding of such states' duties in *Kudła v Poland*, a Grand Chamber judgement issued in 2000. The case concerned a prisoner who suffered from chronic depression and twice attempted to commit suicide. In this regard, the applicant complained about an alleged lack of adequate psychiatric treatment in prison. In its assessments regarding the violation of Article 3 of the ECHR the Court held:

[T]he State must ensure that a person is detained in conditions which are compatible with respect for his human dignity, that the manner and method of the execution of the measure do not subject him to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention and that, given the practical demands of imprisonment, his health and well-being are adequately secured by, among other things, providing him with the requisite medical assistance (...).³²²

Over time, this comprehensive understanding of the states' duties with regard to health in prison became a well-established part of the ECtHR's jurisprudence.³²³ In addition, in *Salman v Turkey*, concerning the death of a prisoner in custody, the Court explicitly underlined the vulnerable position of prisoners and states a duty to protect prisoners on the state authorities.³²⁴

The principles expressed in the *Kudła* imply a certain degree of adequacy of healthcare in prisons. For the Court, this is particularly important in assessing potential violations of Article 3 of the ECHR. Accordingly, a lack of adequate healthcare in prison might amount to an 'inhuman and degrading treatment'.³²⁵ Most recently, the Court summed up the principles applying to cases, where the adequacy of healthcare in prison is at stake, in its *Izyurov and Kukharchuk* judgement. The case concerned the belated diagnosis of the health status of two prisoners in Russia. Mr Izurov did not receive certain medical examinations and was not given the medication required. Furthermore, a cancer surgery necessary was delayed. Mr

³²² ECtHR (GC), *Kudła v Poland* (26 October 2000) 30210/96, para 94.

³²³ The approach expressed in *Kudła v Poland* was referred to in a large number of ECtHR judgements. For a recent example see ECtHR (GC), *Khlaifia and others v Italy* (15 December 2016) 16483/12, para 160. See also ECtHR (GC), *Stanev v Bulgaria* (17 January 2012) 36760/06, para 204; ECtHR (GC), *Paladi v Moldova* (10 March 2009) 39806/05, para 71; ECtHR, *Kalashnikov v Russia* (15 July 2002) 47095/99, para 95.

³²⁴ ECtHR (GC), *Salman v Turkey* (27 June 2000) 21986/93, para 99.

³²⁵ CoE, European Convention for the Protection of Human Rights and Fundamental Freedoms, art 3.

Kukharchuk, on the other hand, apart from claiming belated confirmation of his diagnosis, suffered from a lack of treatment by certain medicines prescribed, eventually causing the need for a liver transplant. In its judgement, noting that “‘adequacy’ of medical assistance remains the most difficult element to determine”,³²⁶ the ECtHR pointed towards two main criteria that states have to consider in providing adequate healthcare in prisons.

First, in assessing an alleged violation of Article 3 of the ECHR the Court requires ‘prompt and accurate diagnosis and care’ of the state authorities, which has to be supervised regularly and systematically if necessary.³²⁷ In addition, the diagnosis must involve ‘a comprehensive therapeutic strategy aimed at successfully treating the detainee’s health problems or preventing their aggravation’.³²⁸

Second, states have to respect the principle of equivalence of healthcare by providing for medical treatment in prisons ‘appropriate and comparable to the quality of treatment’ outside of prison walls.³²⁹ In this context, it is important to note that ‘this does not mean that each detainee must be guaranteed the same level of medical treatment that is available in the best health establishments outside prison facilities’.³³⁰

In addition, assessing ill-treatment of prisoners under Article 3 of the ECHR, the ECtHR examines whether such a treatment attains a minimum level of severity. This principle was already established in the Court’s jurisprudence in 1978 in its famous *Ireland v The United Kingdom* judgement. In this case the judges dealt with the *five techniques of interrogation*, which were used by British authorities in the context of the conflict between Ireland and Northern Ireland. Apart from the basic elements of torture, namely degree of intensity and the length of the suffering, the judges identified the ‘health condition of the person exposed’ to

³²⁶ ECtHR, *Izyurov and Kukharchuk v Russia* (28 June 2018) 1484/16 and 16504/16, para 8. See also ECtHR, *Khatayev v Russia* (11 October 2011) 56994/09, para 85.

³²⁷ ECtHR, *Izyurov and Kukharchuk*, para 8. See also ECtHR, *Pitalev v Russia* (30 July 2009) 34393/03; ECtHR, *Hummatov v Azerbaijan* (29 November 2007) 9852/03 and 13413/04, para 115; ECtHR, *Melnik v Ukraine* (28 March 2006) 72286/01, paras 104-106.

³²⁸ ECtHR, *Izyurov and Kukharchuk*, para 8. See also ECtHR, *Kolesnikovich v Russia* (22 March 2016) 44694/13, para 70; ECtHR, *Hummatov*, para 115.

³²⁹ ECtHR, *Izyurov and Kukharchuk*, para 8. See also ECtHR (GC), *Blokhin v Russia* (23 March 2016) 47152/06, para 109; ECtHR, *Cara-Damiani v Italy* (7 February 2012) 2447/05, para 66.

³³⁰ ECtHR, *Izyurov and Kukharchuk*. For more cases regarding a violation of Article 3 of the ECHR, for example, see ECtHR, *Sergey Antonov v Ukraine* (22 October 2015) 40512/13; ECtHR, *Hummatov*, paras 121f. For the discussion of the principle of equivalence of health care see also above 3.2.1.

alleged torture as one of the factors which further must be considered by the Court.³³¹ This underlines the Court's long-lasting recognition of health in the context of imprisonment, in cases concerning Article 3 of the ECHR.

Moreover, there are cases in which the ECtHR was confronted with the death of prisoners due to a lack of healthcare. For example, the *Dzieciak* case concerned a prisoner who was suffering from a severe heart disease and died after four years of pre-trial detention. Numerous failings of the state authorities were claimed, including the cancellation of an urgently needed operation, the applicant's placement in a part of the relevant prison without a medical wing and the prolongation of imprisonment despite the opinion of medical experts to the contrary. These shortcomings resulted in a substantive breach of Article 2 of the ECHR.

Another case, in which the judges held a substantive violation of Article 2 of the ECHR was *Çoşelav v Turkey*. The applicants' son claimed the Turkish authorities responsible for the suicide of their 16-year-old son, who was placed in an adult prison. The judgement demonstrates how the Court deals with cases concerning mental health conditions of prisoners.³³² In this regard, the ECtHR does not only consider the higher degree of vulnerability of mentally ill prisoners.³³³ Rather, it also considers three additional elements when assessing the compatibility of a prisoner's mental health with its imprisonment. In its *Slawomir Musiał v Poland* judgement the ECtHR described these criteria as '(a) the medical condition of the prisoner, (b) the adequacy of the medical assistance and care provided in detention, and (c) the advisability of maintaining the detention measure in view of the state of health of an applicant'.³³⁴ In the latter case, the judges found a violation of Article 3 of the ECHR, especially because the applicant concerned suffered from multiple chronic and severe mental disorders and yet was kept in different detention centres for healthy prisoners without constant psychiatric supervision.³³⁵ In addition, the Court addressed the issue of overcrowding in Polish prisons,

³³¹ ECtHR, *Ireland v The United Kingdom* (18 January 1978) 5310/71, para 162. For detail on the five techniques of interrogation (wall standing, hooding, subjection to noise and deprivation of sleep, food and drink) see also *ibid* para 96. For the latest judgement referring to the principle at hand see ECtHR, *Khani Kabbara v Cyprus* (5 June 2018) 24459/12, para 128.

³³² ECtHR, *Çoşelav v Turkey* (9 October 2012) 1413/07; ECtHR, *De Donder and De Clippel v Belgium* (6 December 2011) 8595/06.

³³³ For example, see ECtHR (GC), *Kudła*, para 99.

³³⁴ ECtHR, *Slawomir Musiał*, para 88.

³³⁵ *ibid* paras 89-94.

acknowledging that such conditions are particularly inappropriate for prisoners with mental disorders.³³⁶

Finally, the ECtHR also provides for jurisprudence regarding Article 8 of the ECHR regarding health-related areas in prison. In *Szuluk v The United Kingdom* the Court dealt with the monitoring by prison authorities of a prisoner's medical correspondence. After two operations before being discharged to prison, the applicant discovered that his correspondence with a medical supervisor outside the prison had been monitored by a prison medical officer. Holding a violation of Article 8 of the ECHR, the Court noted that 'there was an "interference by a public authority" with the exercise of the applicant's right to respect for his correspondence'.³³⁷

Against the large number of health-related cases in prison, the listing of these most crucial examples must be understood only as the peak of the ECtHR's jurisprudence in this area. In no way should these examinations be seen as exhaustive. As indicated in the introduction of the chapter, it rather aims to shed light on the main obligations states have to meet when managing healthcare in prisons. In any case, there is no doubt that from the Court's perspective the right to health does not stop in front of the prison gates. Quite the contrary, it is now argued that the ECtHR even grants prisoners a higher level of health protection than to the general public in hospitals and other health services outside prison walls.

5.3.2 The privileged protection of health in prison

The examination of the ECtHR jurisprudence shows that the Court does not only deal comprehensively with the right to health in prison, but so far it rather grants prisoners a higher level of health protection than individuals treated in hospitals or other health services outside prisons. This is demonstrated in the section at hand. The argument finds great support in the partly dissenting and/or concurring opinions respectively of two Judges of the ECtHR, who were actively involved in issuing the *Lopes de Sousa Fernandes* judgement. The majority's decision in the case to find a procedural violation of Article 2 of the ECHR alone, triggered the criticism of Judge Serghides and Judge Albuquerque, as mentioned before. The former deprecated the Court's hesitance to find a violation of the substantive limb of the provision,

³³⁶ 'In this connection the Court refers to the judgment of the Constitutional Court which held that the overcrowding in itself could be qualified as inhuman and degrading treatment and, if combined with additional aggravating circumstances, as torture (...)', *ibid* para 95. See also Jim Murdoch, *The Treatment of Prisoners: European Standards* (CoE, 2006) 209-212.

³³⁷ ECtHR, *Szuluk*, para 43.

albeit his reasoning remained relatively brief. The latter, Judge Albuquerque, however, included a detailed discussion on health in prisons in an impressive 94 paragraphs partly concurring and partly dissenting opinion to the case.³³⁸

One of the most crucial differences between the protection of health inside and outside of prisons can be seen with regard to the finding of substantive violations of ECHR provisions. As described above, for a long time the Court shied away almost completely to hold substantive violations of the provision in hospitals or other health services for the general public. This is notably demonstrated, for instance, by the aforementioned *Cyprus v Turkey* and *Calvelli and Ciglio v Italy* cases. Furthermore, as discussed, there are only a handful cases where the Court engages with the substantive limb at all and, for Judge Albuquerque, ‘when it does so, the Court only assesses structural deficits in the medical system’.³³⁹ Cases like *Asiye Genç v Turkey* and *Aydoğdu v Turkey* seem to support this statement, which, however, needs further discussion. This is because there are indeed cases, such as *Şentürk and Şentürk v Turkey*, *Kutsenko v Ukraine* as well as *Elena Cojocaru v Romania*, in which the judges in Strasbourg examine substantive aspects without referring to the structural dimensions of the case. Admittedly, such cases are rare, but the same could be said about jurisprudence in which structural issues are discussed by the ECtHR. Keeping the overall low number of such cases in mind, at this point it seems to be a slippery slope to make generalisations on the ECtHR’s work. Despite that tendencies in the Courts jurisprudence undisputedly exist, one should wait and see how the ECtHR deals with similar cases in the future.

Moreover, while these discussions refer to the level of health protected in hospitals and other health services outside prisons, the situation regarding ECtHR cases dealing with health inside prison facilities differs. As demonstrated there are indeed a large number of cases where the Court holds substantive violations of Convention provisions in the prison context. Moreover, the case-law is way more differentiated, guaranteeing a more comprehensive level of protection for the health of prisoners.

³³⁸ In his examinations Judge De Albuquerque also includes discussion of the health protection of servicemen, children, migrants and certain kind of employees. For the sake of this thesis, however, the focus is on the difference between the level of protection granted by the ECtHR in prisons on the one hand, and hospitals on the other health services for the general public on the other. See De Albuquerque (2017b) paras 38-43.

³³⁹ De Albuquerque (2017b) para 56.

In this regard Judge Albuquerque appropriately holds:

Since the required treatments and services for detained persons include the provision of essential drugs and primary health care, dentures, orthopaedic footwear, glasses, medication for chronic back pain, care by qualified staff, examination by specialists and follow-up care independent of the initiative being taken by the patient, it can be concluded that the minimum existential health care afforded to detainees is much higher than that afforded to the common man on the street.³⁴⁰

In addition, the ECtHR's application of different approaches on the *mens rea* of medical personnel is not limited to situations in hospitals, as described above with regard to the cases *Aydoğdu* as well as *Şentürk and Şentürk*. Indeed, the Court requires a higher threshold regarding the level of *mens rea* in cases related to prisons than in situations taking place in hospitals in the outside world. In this context, Judge Albuquerque points out that to trigger positive obligations under Article 2 of the ECtHR, for instance, '[n]egligence, carelessness, wilful ignorance, an error of judgement (...), or deficient coordination among health professions in the treatment of a detainee (...) are sufficient of themselves'.³⁴¹ With regard to the treatment of patients in ordinary hospitals, however, this is not the case.³⁴² In this regard the *Tarariyeva* case provides for a good example. It concerned a prisoner who suffered from severe health problems and died days after a surgery was conducted. The Court, inter alia, held a violation of Article 2 of the ECHR for a number of failures, such as a lack of consistent medical recording of his health status in prison, deficits of the medical examinations in the hospitals as well as flaws related to the surgery and a lack of equipment in the hospitals concerned.³⁴³ Similar cases in ordinary hospitals for the general public do not exist.

Another area in which the ECtHR's applies uneven standards in situations related to health is the assessment of the evidence available. In the context of hospitals and other health services outside prisons, the judges hardly ever dispute domestic findings of Courts, such as the causal links existing between the alleged misconduct of a medical authority and the harm for the

³⁴⁰ Judge De Albuquerque also provides a range of concrete examples for each of these subjects in his footnotes, see *ibid* para 54.

³⁴¹ De Albuquerque (2017b) para 57.

³⁴² *ibid* para 57.

³⁴³ ECtHR, *Tarariyeva v Russia* (14 December 2006) 4353/03, para 88.

patient concerned, the chain of evidence or the degree of knowledge of the authorities concerned and it regularly finds the domestic remedies sufficient.³⁴⁴ Judge Albuquerque is right that cases like *Elena Cojocaru v Romania* are a rare departure from the Court's practice.³⁴⁵

In cases related to prisoners' health, however, the situation is different. This can be seen, for instance, in *Makharadze and Sikharulidze v Georgia*. The case concerned a prisoner who died from a fatal form of multidrug-resistant tuberculosis in prison. It was claimed that the treatment of the Georgian authorities was not sufficient to adequately response to his medical needs. In contrast to the ECtHR's regular acceptance of evidence provided by the national Courts, the judges in Strasbourg this time indeed entered a discussion regarding the scientific facts provided. Thereby, they referred to guidelines provided by the WHO instead of findings of the national authorities.³⁴⁶

Finally, differences can also be identified with respect to the margin of appreciation granted by the ECtHR to Convention states regarding the level of medical treatment in prison facilities and ordinary hospitals. For instance, while in *Sentges v The Netherlands* a wide margin of appreciation was granted, especially because the issue at hand was linked to financial aspects of the states, budgetary consequences for states are not considered in health-related cases within prison facilities. Evidently, this has been demonstrated in a range of cases concerning living conditions in Ukraine prisons, where the Court stated that the economic problems faced by the country could not in any event explain or excuse the insufficient conditions of detention at that time.³⁴⁷ Against this background, it can be said that the ECtHR's margin of appreciation with regard to health-related cases in prison is narrower than in ordinary hospitals or other health services outside the prison.

³⁴⁴ ECtHR, *Sayan v Turkey* (11 October 2016) 81277/12, para 112; ECtHR (dec), *Balci v Turkey* (20 October 2015) 58194/10; ECtHR (dec), *De Santis and Olanda v Italy* (9 July 2013) 35887/11; ECtHR, *Tysiqc v Poland* (20 March 2007) 5410/03, para 119.

³⁴⁵ See above 5.2.3. See also De Albuquerque (2017b) para 55. For an example, where the ECtHR did not find the national remedies sufficient see ECtHR, *Oyal v Turkey* (23 March 2010) 4864/05.

³⁴⁶ ECtHR, *Makharadze and Sikharulidze v Georgia* (22 November 2011) 35254/07, paras 48 and 78-81. See for another example in the prison context ECtHR, *Brincat and others v Malta* (24 July 2014) 60908/11, 62110/11, 62129/11 and others, para 106.

³⁴⁷ ECtHR, *Kuznetsov v Ukraine* (29 April 2003) 39042/97, para 128; ECtHR, *Nazarenko v Ukraine* (29 April 2003) 39483/98, para 144; ECtHR, *Dankevich v Ukraine* (29 April 2003) 40679/98, para 144; ECtHR, *Poltoratskiy v Ukraine* (29 April 2003) 38812/97, para 148; ECtHR, *Aliiev v Ukraine* (29 April 2003) 41220/98, para 151; ECtHR, *Khokhlich v Ukraine* (29 April 2003) 41707/98, para 181.

Again, however, it would be daring to generalise this finding, given that there are cases such as *Aydođdu v Turkey*, in which the judges indeed accepted the review of the operational choices made in terms of priorities nor resources, as described above.³⁴⁸

5.4 INTERIM CONCLUSION: CLOSER AND CLOSER TO A RIGHT TO HEALTH

The last chapter of this thesis enshrines crucial findings of the research conducted. First of all, the judges in Strasbourg regularly fill gaps in the explicit normative framework provided by the ECHR with regard to socio-economic rights. By using the *integrated* approach, the Court found an effective tool to address a range of socio-economic rights. It is the well-established view of the ECtHR that some of these rights are implied in the civil and political provisions of the ECHR, which predominantly belong to the category of civil and political rights. In spite of the ongoing scepticism towards the ECtHR's judicial activism inherent to such an *evolutive* approach, the factual engagement of the Court with socio-economic rights in general is without doubt. This becomes evident in the light of this chapter, since the ECtHR indeed – albeit to different extents – considers traditional social-economic rights in its jurisprudence. Thereby, the Court gradually becomes more and more involved in the setting of protection standards in socio-economic areas, influencing far-reaching social matters within the state parties to the ECHR.³⁴⁹

In this context, this is also true with regard to the traditionally socio-economic right to health. Thus, as an implied right, it is deeply interlaced in the jurisprudence provided by the ECHR and in today's methods of interpretation of the ECtHR. The Court constantly develop their approach in dealing with cases related to the right to health. In this regard, its increased examinations of the substantive limb of Article 2 of the ECHR is a good example. In the beginning of this century, the ECtHR was still reluctant to assess such substantive issues with respect to health. The principles in *Cyprus v Turkey* remained lifeless for over a decade after their establishment. Accordingly, Harris, O'Boyle, Bates and Buckley emphasised that confirmation of the interpretation suggested in the *Cyprus* case 'would extend the guarantee of the Article 2 obligation to protect life in a way that would be in accord with national health care standards in

³⁴⁸ See above 5.2.3. De Albuquerque (2017b) para 59.

³⁴⁹ In this context, Arbour appropriately held in a speech given on the occasion of the opening of the judicial year of the ECtHR on 25 January 2008 that 'the techniques [of the ECtHR] are of real value to national judiciaries, whose constitutional documents are also often limited to listings of civil and political rights, which nevertheless seek to address issues of broader community concern in rights-sensitive fashion', see Louise Arbour's Speech in ECtHR, 'Annual Report 2008' (2009) 47.

European states and indirectly provide a partial, but welcome guarantee of the right to health'.³⁵⁰ Nowadays, Starting with *Şentürk and Şentürk* in 2013, followed by a handful of cases, this partial guarantee of the right to health is reality.

In the prison context, language in favour of a right to health is even stronger developed. This is because, over time, the ECtHR issued an impressive number of judgements dealing with various facets of prisoners' health. The Court acknowledges the duty of the states to protect the health of prisoners, in the light of their particular vulnerability, which is inherent to the nature of their imprisonment. The prisoners' complete dependence on state authorities, indeed, asks for the establishment of particular standards. Accordingly, the research conducted shows that the Court's case-law on health-related rights in prisons is far more elaborated than in hospitals or other health services outside prison walls. Against this background, one has to agree with Judge Albuquerque who stresses that prisoners hold a 'privileged status' regarding the protection of their health before the ECtHR.³⁵¹ These privileges, however, might lead to unsatisfying results for the general public. In this light, Judge Serghides is right in noting:

One should not distinguish health-care situations from other situations which trigger the substantive positive obligation of a State to protect the lives of individuals, since the crux of the matter should be the protection of life and not the situation from which the risk to life arises.³⁵²

Finally, it can be concluded that it would be exaggerated to talk about the right to health as being an autonomous right under the jurisdiction of the Court, whether inside or outside prison walls. Its absence from the express legislative framework of the Convention makes the right dependent on other provisions such as Article 2, 3 and 8 of the ECHR. However, it is true, as supported by Graham, that the language used by the Court in its jurisprudence is edging close to such a *right to health*.³⁵³ Against this background, the potential for future improvements is real, as – sadly – are the deficits existing in the some of the CoE member states' health systems.

³⁵⁰ Harris, O'Boyle, Bates and others (2014) 213.

³⁵¹ De Albuquerque (2017b) para 54.

³⁵² Serghides (2017) para 13.

³⁵³ Graham (2017).

CONCLUSION

In the introduction of this thesis two research questions are raised. First, it is asked; does the right to health in general and especially in a prison context, fall within the scope of jurisdiction of the European Court of Human Rights, despite it traditionally being a socio-economic right? And if so; to what extent does the European Court of Human Rights engage with the right to health in general and especially in the prison context? The examinations conducted give a clear answer to these questions.

The ECHR and its protocols provide jurisdiction for the ECtHR, which primarily covers traditionally civil and political rights. Socio-economic rights are hardly enshrined in the Convention text. The right to health, along with many other socio-economic human rights, is completely ignored in the explicit wording of the ECHR. Nevertheless, this does not prevent the judges in Strasbourg to address a wide range of socio-economic issues in their jurisprudence. By using progressive means of interpretation, the Court also opens its doors for an engagement with the right to health. While the ECtHR's reluctance regarding health-related issues in hospitals and other health services outside prisons is far from overcome, prisoners' health is indeed well-covered by the jurisprudence of the Court. Dealing with a wide range of health-related issues in prison, the engagement the ECtHR must be understood as comprehensive. Against this background, Judge Albuquerque is right:

In Europe, there was a time when the law did not enter prisons (...), when wardens (...) were untouchable gods while prisoners (...) were insignificant subjects. That time is long over for prisons (...). Regrettably, it is not yet over for hospitals. As the majority see it, the Convention should stay at the hospital door.³⁵⁴

The ECtHR's engagement with the right to health, especially in a prison context, is of utmost importance for the individuals' human rights protection. This is because, other protection mechanisms existing in the CoE human rights system, are insufficient to guarantee adequate and effective protection of prisoners' health. The shortcomings inherent to the monitoring system provided by the ESC and their protocols underline the need for the ECtHR to address health in prison.

³⁵⁴ De Albuquerque (2017b) para 93.

Of course, the judges in Strasbourg must always seek to achieve a balance between the gradual development of the Convention as a living instrument and the extent of its judicial activism. When it comes to the right to health, such judicial activism requires a high degree of sensitivity, given that the right often touches on issues closely related to state sovereignty. Therefore, it does not take much to feed criticism of an increase in engagement of the ECtHR with such issues. One can argue, however, that so far, the Court was successful in striking this balance and Louise Arbour, is right when she says:

[T]he Court has not hesitated to draw upon the interconnected nature of all rights to address many economic, social and cultural issues through the lens of – nominally – civil rights. The Court’s approach, for example, to health issues through the perspective of the right to security of the person – in the absence of a right to health as such – shows how rights issues can be effectively approached from various perspectives.³⁵⁵

In any case, it is time to overcome the ‘unnatural cleavage’³⁵⁶ between civil and political rights on the one hand, and socio-economic rights, on the other. An examination of the origins of the right to health shows that the need to guarantee the health of human beings goes beyond ideological boundaries. With regard to prisoners’ health, the traditional separation of human rights has already been partly overcome by the ECtHR. In practice, however, there is still a long way to go until the standards set out in the EPR and other international standard-setting documents are fully realised in the CoE member states. In the end, governments as well as societies have to understand that increased health of prisoners is a win-win for all. The ECtHR jurisprudence might help to achieve such improvements of health for prisoners and it even bears the potential to affect health system as a whole. Thereby, the Court is getting closer and closer towards the implementation of an autonomous right to health in prison and beyond.

³⁵⁵ *ibid.*

³⁵⁶ Louise Arbour (2009) 47.

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