

State Human Rights Obligations Regarding the Distribution of Scarce Health Resources

Comparative Legal Research

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Executive Summary

This report offers a comprehensive overview of case law concerning the rights to life, health, and non-discrimination in international, regional, and national systems. The focus is on States' positive obligations to protect the rights to life, health, and non-discrimination in the context of access to health care, denial of treatment, protection and prioritization of vulnerable populations, and allocation of scarce health and other resources.

International bodies and regional commissions have been generally more generous in the interpretation of the rights to life and health than the European Court of Human Rights. In the ECtHR jurisprudence, the limits to a successful claim are often determined by the scope of the State's positive obligations, the margin of appreciation allowed to States, the knowledge by the authorities of the circumstances that lead to violations of Article 2 ECHR, and the limitations on Court intervention in areas of State policy, including national health and resource allocation. Establishing a claim, in this context, based on the systemic dysfunctioning of the health care system is more likely under Article 2 than under other relevant heads, such as Article 8 ECHR.

Health considerations in some form permeate most of the cases examined. Of specific interest are jurisdictions that have an autonomous right to health within their constitutional or other fundamental rights framework, and those where the right to health enjoys derivative protection as an inherent, if implicit part of the right to life. The issue of inconsistent or uneven access to medicines and mismanagement has often triggered claims based on the rights to life, health, and non-discrimination, which are discussed in the wider context of persistent failure of health care systems for which the State is responsible. Access to health-related information is also identified as a further means for States to build a relationship of trust with the public. Lack of trust has thwarted the implementation of state-wide immunization programs, such as vaccinations, even when these are implemented equitably.

The interdependence of the three pillars – rights to health, life and freedom from discrimination – was evident throughout the research. Our findings suggest that a claim is more likely to be persuasive when it has considered the interrelation and combined application of these rights with reference to the specific factual scenario.

1. Right to Life

Overview

The purpose of this section is to present a comprehensive overview of claims of violation of the right to life initiated by individuals, organizations, or family members on behalf of the deceased in regional, international, and national legal systems. Claims offering insights on national vaccination programs, supply and distribution of drugs, and relevant policies are included. The factual circumstances identified here include allegations of State failure to fulfil positive obligations in relation to (i) allocation of scarce health resources, including lack of equipment, medical staff, and medicines; (ii) allocation of limited funding in the context of medical care and public health; (iii) denial of treatment on the basis of policy prescription or as a result of lack of resources, and systemic health care and hospital dysfunctioning; and separately (iv) the issue of the deference afforded by courts to the State decision-makers in this area.

The analysis allows for comparisons between regional and international systems and different national legal systems. Intermediate conclusions from these comparisons allows us to highlight the links between the rights to life, health, and non-discrimination.

1.1. International and Regional Systems

The right to life is protected in an array of international and regional human rights laws as the paramount and inherent right of all human beings without distinction. Different treaties contain similar wording, as regards protection of the rights to security, liberty, and integrity of a person in relation to the arbitrary deprivation of life. Article 3 of the Universal Declaration of Human Rights (UDHR) protects ‘everyone’s’ right to life,¹ and Article 6 (1) of the International Covenant on Civil and Political Rights (ICCPR) protects the ‘inherent right to life’ for all human beings.¹ Regionally, Article 4 (1) of the American Convention on Human Rights (the ‘Pact of San José’) protects every person’s ‘right to have his life respected (...) from the

1 ‘Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.’ International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171 (ICCPR) Article 6 (1).

moment of conception’,² while Article 4 of the African Charter on Human and People’s Rights (the ‘Banjul’ Charter) and Article 1 of the American Declaration of the Rights and Duties of Man (ADHR) refer to the protection of a person’s ‘integrity’ and ‘liberty and security’ respectively.³ Protection of the right to life should be afforded to all human beings equally,⁴ with strict thresholds clarifying derogation when allowed.

Article 2 (1) of the European Convention on Human Rights (ECHR) states that everyone’s ‘right to life shall be protected by law’, continuing in section (2) to set out the conditions for lawful derogation.⁵ The right to life under Article 6 ICCPR is a non-derogable right even in light of national or other emergencies, which is significant, especially in the context of the COVID-19 pandemic and rationing of scarce health resources. As we will see later in the analysis, the comments of the Human Rights Committee in General Comment No. 36 on Article 6 (ICCPR) and its jurisprudence, confirm that the ‘due diligence obligation’⁶ of States to protect the right to life under the ICCPR, includes addressing the prevalence of

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- 2 ‘Every person has the right to have his life respected. This right shall be protected by law and, in general, from the moment of conception. No one shall be arbitrarily deprived of his life.’ Organization of American States (OAS), American Convention on Human Rights (‘Pact of San José’), Costa Rica 22 November 1969.
 - 3 ‘Human beings are inviolable. Every human being shall be entitled to respect for his life and the integrity of his person. No one may be arbitrarily deprived of this right’; Organization of African Unity (OAU), African Charter on Human and Peoples’ Rights (‘Banjul Charter’), 27 June 1981, CAB/LEG/67/3 rev. 5, 21 ILM 58 (1982) Article 4, and ‘Every human being has the right to life, liberty and the security of his person’; Inter-American Commission on Human Rights (IACHR), American Declaration of the Rights and Duties of Man, 2 May 1948 Article 1.
 - 4 Note the repetition of the words ‘everyone’ and ‘every’.
 - 5 ‘Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary: (a) in defence of any person from unlawful violence; (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained; (c) in action lawfully taken for the purpose of quelling a riot or insurrection’; Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended by Protocols Nos. 11 and 14) (ECHR) (4 November 1950) Article 2 (2).
 - 6 UN Human Rights Committee (HRC), CCPR General Comment No. 36 (2019) On Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (3 September 2019), CCPR/C/GC/36 §§7, 21. See also Alessandra Spadaro, ‘COVID-19: Testing the Limits of Human Rights’, (2020) 11(2) European Journal of Risk Regulation 317.

life-threatening diseases, when these are reasonably foreseeable, and ensuring access to medical care.⁷ This indicates that issues arising from the prioritisation of limited health resources, such as vaccines to prevent a life-threatening disease (COVID-19), would be within the scope of this duty.

The following sections (1.1.1 – 1.1.3) analyse international and regional human rights instruments protecting the right to life. Section 1.1.1 on Article 6 ICCPR is followed by an analysis of Article 2 ECHR (s. 1.1.2) and an overview of additional regional systems (s. 1.1.3). Selected claims in which one or more of the following are at issue or constitute part of the factual matrix are introduced and discussed; these include the denial or inaccessibility of treatment, medicines, medical care, coverage of essential health care, allocation of scarce health or other resources, and the States' positive obligations to protect the right to life, especially for the most vulnerable population groups. This will allow for a comprehensive overview of the international and regional protections afforded to the right to life before continuing with the selected national jurisdictions in section 1.2.

1.1.1. International Covenant on Civil and Political Rights: Article 6

Article 6 (1) of the International Covenant on Civil and Political Rights (ICCPR)⁸ reads:

Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.

7 UN Human Rights Committee (HRC), CCPR General Comment No. 36 (2019) On Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (3 September 2019), CCPR/C/GC/36 §§ 21 ('reasonably foreseeable threat to life'), 25 ('necessary medical care and appropriate regular monitoring of their health'), and 26 ('prevalence of life-threatening diseases'). See also the comments of the HRC in *Toussaint v Canada* Communication No. 2348/2014 UN Doc. CCPR/C/123/D/2348/2014 (2018) discussed in 1.1.1.2.

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

The Human Rights Committee ('HRC') in General Comment No. 36⁹ describes the right to life as the 'supreme', non-derogable right,¹⁰ which must be protected in all circumstances, including national or public emergencies.¹¹ The right to life is an intrinsic right inherent in every human being, with an additional, instrumental value in so far as it is a prerequisite for the enjoyment of all other human rights.¹² It informs all human rights and takes its color from their application. Article 6 has both a negative and positive component, reflected in the obligations of the States both to refrain from interfering with the enjoyment of Article 6, and to take all necessary measures to protect it.¹³ The HRC underlines that Article 6 should not be interpreted narrowly.¹⁴ It protects individuals from all acts and omissions that could cause their unnatural, premature death, or prevent them from enjoying a life with dignity.¹⁵ States should respect and protect the right

9 General Comment No. 36 replaced General Comments No. 6 and No.14 adopted by the HRC at its sixteenth (30 April 1982) and twenty-third session (9 November 1984) respectively; UN Human Rights Committee (HRC), CCPR General Comment No. 36 (2019) On Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (3 September 2019), CCPR/C/GC/36.

10 See also Article 4 (2) ICCPR 'No derogation from Articles 6, 7, 8 (paragraphs I and 2), 11, 15, 16 and 18 may be made under this provision'.

11 UN Human Rights Committee (HRC), CCPR General Comment No. 36 (2019) On Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (3 September 2019), CCPR/C/GC/36, §2.

12 UN Human Rights Committee (HRC), CCPR General Comment No. 36 (2019) On Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (3 September 2019), CCPR/C/GC/36, §2.

13 UN Human Rights Committee (HRC), CCPR General Comment No. 36 (2019) On Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (3 September 2019), CCPR/C/GC/36, §§ 13, 18, 21.

14 UN Human Rights Committee (HRC), CCPR General Comment No. 36 (2019) On Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (3 September 2019), CCPR/C/GC/36, §3.

15 UN Human Rights Committee (HRC), CCPR General Comment No. 36 (2019) On Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (3 September 2019), CCPR/C/GC/36, §3.

to life under Article 6 from reasonably ‘foreseeable threats and life-threatening situations’ that could result in death.¹⁶

The right to life is significant for individuals and the society as a whole.¹⁷

States are expected to address general conditions in society that could threaten or undermine the enjoyment of the right by individuals.¹⁸

Therefore, States are expected to take measures designed to address the prevalence of life-threatening diseases, to ensure timely access to essential goods, such as health care, to enhance the efficiency of emergency health services, and to fight discrimination, including based on disability and disease, that hinders access to medical care.¹⁹ It is important, for purposes of this report, to note that States are expected to have disaster management plans to safeguard the operation of essential services in case of natural and human-made disasters that could affect the protection of the right to life.²⁰ It is worth noting that General Comment no.36 does not explicitly list

16 Although States may be in violation of Article 6 even death has not occurred; UN Human Rights Committee (HRC), CCPR General Comment No. 36 (2019) On Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (3 September 2019), CCPR/C/GC/36, §7.

17 UN Human Rights Committee (HRC), CCPR General Comment No. 36 (2019) On Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (3 September 2019), CCPR/C/GC/36, §2.

18 UN Human Rights Committee (HRC), CCPR General Comment No. 36 (2019) On Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (3 September 2019), CCPR/C/GC/36, §26.

19 UN Human Rights Committee (HRC), CCPR General Comment No. 36 (2019) On Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (3 September 2019), CCPR/C/GC/36, §26. In General Comment No. 6 (1982), replaced by General Comment No. 36 (2019), the HRC explicitly mentioned that States are expected to take all necessary steps to eliminate epidemics; UN Human Rights Committee (HRC), CCPR General Comment No. 6: Article 6 (Right to Life), (30 April 1982); §5. Although General Comment No. 36 does not refer to epidemics, it does refer to the State duty to address the general conditions in society that may threaten Article 6, including ‘the prevalence of life-threatening diseases such as AIDS, tuberculosis and malaria’; UN Human Rights Committee (HRC), CCPR General Comment No. 36 (2019) On Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (3 September 2019), CCPR/C/GC/36, §26.

20 UN Human Rights Committee (HRC), CCPR General Comment No. 36 (2019) On Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (3 September 2019), CCPR/C/GC/36, §26.

epidemics as an example of natural or human-induced disasters: the HRC mentions ‘natural and man-made disasters that may adversely affect the enjoyment of the right to life, such as hurricanes, tsunamis, earthquakes, radioactive accidents and massive cyberattacks’ that could disrupt essential services. That does not, of course, mean that COVID-19 could not be included as an example, especially considering its global impact, and particularly the disruption of essential services to which it led.²¹

Article 6 highlights that meaningful protection of the right to life goes hand in hand with the principle of non-discrimination. The HRC notes that the right to life must be protected ‘without distinction of any kind’, including disability, socio-economic status, and age.²² The States have a ‘heightened duty’ to protect the right to life for persons in liberty- restricting State-run facilities, such as mental health facilities,²³ and take all necessary protection measures to ensure equal enjoyment of Article 6 for people living with disabilities.²⁴ The HRC also links the protection of the right to life with access to ‘quality and evidence-based information and education’ in the context of reproductive health.²⁵ As discussed in subsequent sections of this report, a meaningful realisation of the right to health presupposes and relies on the existence and equal access to the necessary health- related

21 For a short exploration of the origins of COVID-19, see Kristian G Andersen and others, ‘The Proximal Origin of SARS-CoV-2’ (2020) 26 *Nature Medicine* 450.

22 UN Human Rights Committee (HRC), CCPR General Comment No. 36 (2019) On Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (3 September 2019), CCPR/C/GC/36, §61, 3.

23 UN Human Rights Committee (HRC), CCPR General Comment No. 36 (2019) On Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (3 September 2019), CCPR/C/GC/36, §25.

24 Including ensuring their access to essential facilities; UN Human Rights Committee (HRC), CCPR General Comment No. 36 (2019) On Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (3 September 2019), CCPR/C/GC/36, §24. See also arts 10 (Right to life), 12 (Equal recognition before the law), 14 (Liberty and security of person), and 25 (Health) of the Convention on the Rights of Persons with Disabilities; UN General Assembly (UNGA), Convention on the Rights of Persons with Disabilities: resolution / adopted by the General Assembly (24 January 2007), A/RES/61/106.

25 UN Human Rights Committee (HRC), CCPR General Comment No. 36 (2019) On Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (3 September 2019), CCPR/C/GC/36, §8.

educational resources, consistent dissemination of reliable scientific information, and combatting misinformation.²⁶

The emphasis of the HRC on the duty of States to address those wide-ranging social phenomena that could threaten or undermine the right to life is reflected in the listing of various conditions at paragraph 26, highlighting the socio-economic dimensions of Article 6.²⁷ Academic commentary has reflected on this, with Joseph²⁸ noting that the general conditions described by the HRC at paragraph 26, indicate that Article 6 not only protects the general right to live, but the specifically the right to live with ‘dignity’. These constitute the most onerous obligations under Article 6.²⁹ The HRC’s approach reveals the ‘significant permeation’ between Article 6 and those obligations flowing from the provisions of the International Covenant on Economic Social and Cultural Rights (ICESCR)³⁰ discussed later in this report. The relationship between Article 6 ICCPR and other international human rights instruments, and particularly Article 12 of the ICESCR, on

26 For the overlap of the right to health with the right to access health-related information see 3.5 Health research, information and communication in Council of Europe, Commissioner For Human Rights, *Protecting the Right to Health Through Inclusive and Resilient Health Care For All* (Council of Europe, 2021) 37; the comments by the Open Society European Policy Institute in the complaint to the European Committee of Social Rights; No. 204/2022 Open Society European Policy Institute (OSEPI) v Bulgaria (2022) §§61-64, and 72; and Article 11 (2) of the European Social Charter.

27 Also recall, the right to life is significant for individuals and the society as a whole; UN Human Rights Committee (HRC), *CCPR General Comment No. 36 (2019) On Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life* (3 September 2019), CCPR/C/GC/36, §2.

28 Sarah Joseph, ‘General Comment No. 36 (2018) on Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (HR Comm.)’ (2019) 58 (4) *International Legal Materials* 849.

29 Sarah Joseph, ‘General Comment No. 36 (2018) on Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (HR Comm.)’ (2019) 58 (4) *International Legal Materials* 849, 850.

30 With the ICESCR having broader socio-economic aspects than Article 6, which is confined to the socio-economic elements affects the right to life; Sarah Joseph, ‘General Comment No. 36 (2018) on Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (HR Comm.)’ (2019) 58 (4) *International Legal Materials* 849, 850.

the right to health, were also noted in the draft of General Comment 36 prepared by the rapporteurs Yuval Shany and Nigel Rodley.³¹

The comments of the HRC are not legally-binding, but they nonetheless provide authoritative guidance on the application of Article 6.³² This is of particular importance for those State parties which give precedence to international law over domestic legislation in their internal human rights arrangements.³³ In General Comment 36 the HRC has extended the socio-economic reach of Article 6, going beyond its own jurisprudence.³⁴ This is significant for the purposes of interpreting existing case law and building future arguments on the right to life under the ICCPR. By highlighting the interplay of Article 6 with wider international human rights law, the HRC advances a holistic and inclusive approach to human rights which is conducive to greater legal consistency and overcomes the ‘unfortunate isolationism’ of previous approaches.³⁵

31 ‘With regard to Article 6, paragraph 1: “Every human being has the inherent right to life”, issues may include: (a) The scope and nature of the duty to respect and ensure the right to life; (I) Relationship to other Articles of the Covenant that protect human life and the human person, e.g. 7, 9, 20; (II) Relationship to other international human rights instruments, e.g., Article 12 of the International Covenant on Economic, Social and Cultural Rights; (III) Protection against dangerous conduct not resulting in deprivation of life; CCPR/C/GC/R.36 §5.

32 Sarah Joseph, ‘General Comment No. 36 (2018) on Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (HR Comm.)’ (2019) 58 (4) *International Legal Materials* 849.

33 Article 5 (4) of the Constitution of Bulgaria gives precedence to international instruments over conflicting domestic legislation but not the Constitution, which remains the supreme law of the land; Article 5 (1). See also Christopher Harland, ‘The Status of the International Covenant on Civil and Political Rights (ICCPR) in the Domestic Law of State Parties: An Initial Global Survey through UN Human Rights Committee Documents’ (2000) 22 (1) *Human Rights Quarterly* 187. For the impact of ICCPR on State behaviour and influence on domestic law see Linda Camp Keith, ‘The United Nations International Covenant on Civil and Political Rights: Does It Make a Difference in Human Rights Behavior?’ (1999) 36 (1) *Journal of Peace Research* 95, 112-13

34 Sarah Joseph, ‘Extending the Right to Life Under the International Covenant on Civil and Political Rights: General Comment 36’ (2019) 19 (2) *Human Rights Law Review* 347, 367.

35 Sarah Joseph, ‘Extending the Right to Life Under the International Covenant on Civil and Political Rights: General Comment 36’ (2019) 19 (2) *Human Rights Law Review* 347, 367.

Proceeding in the spirit of General Comment No. 36 our analysis in the following reviews key underpinning factors affecting the right to life, including timely and equal access to health care, health-related education, scientific information, and other social phenomena specific to jurisdictions.

1.1.1.1. Applications of Article 6

The inclusive nature of Article 6 is evident in its application. A survey of jurisprudence on the right to life under the ICCPR between 1994 and 2020, indicates that Article 6 is invoked in a variety of contexts, including: 1) enforced disappearance³⁶ (*Serna v Colombia*³⁷; *Boathi v Algeria*³⁸); 2) capital punishment (*Yuzepchuk v Belarus*³⁹); 3) arbitrary deprivation of life while in State custody (*Ernazarov v Kyrgyzstan*⁴⁰; *Chaulagain v Nepal*⁴¹); 4) deportation that could pose a risk to life (*MB v Canada*⁴²); persecution,

36 '[W]hile the Covenant does not explicitly use the term "enforced disappearance" in any of its Articles, enforced disappearance constitutes a unique and integrated series of acts that represents continuing violation of various rights recognized in that treaty' *Serna v Colombia* Communication No. 2134/2012 UN Doc. CCPR/C/114/D/2134/2012 (2015) §9.4.

37 *Serna v Colombia* Communication No. 2134/2012 UN Doc. CCPR/C/114/D/2134/2012 (2015). The HRC found a violation of numerous Articles under the ICCPR, including of arts. 6, 7, 9, 16, and of art. 2 (3), read in conjunction with Articles 6, 7, 9 and 16; see §§9.1-10.

38 *Boathi v Algeria* Communication No. 2259/2013 UN Doc. CCPR/C/119/D/2259/2013 (2017); violation of art. 2 (3), read in conjunction with arts. 6 (1), 7, 9 and 16 regarding the victim, and of Article 2 (3) read in conjunction with art. 7 regarding the victim's mother and her family; see §7.11.

39 *Yuzepchuk v Belarus* CCPR/C/112/D/1906/2009. The HRC found a violation of arts. 6, 7, 9 (3), and 14 (1, 3 (e)); see §§8.6, 9, 10). Similarly, in *Grishkovtsov v Belarus* CCPR/C/113/D/2013/2010, a violation of arts. 6, 7, 9 (3), 14 (2, 3 (d) and (g)); see §§8.1-11) and in *Burdyko v Belarus* Communication No. 2017/2010 UN Doc. CCPR/C/114/D/2017/2010 (25 September 2015), a violation of arts. 6, 7, 9 (3), 14 (2, 3 (d) and (g)); see §§8.1-11.

40 *Ernazarov v Kyrgyzstan* CCPR/C/113/D/2054/2011. The HRC found a violation of arts. 6, 2 (3), and 7; see §§9.1-12.

41 *Chaulagain v Nepal* CCPR/C/112/D/2018/2010. The HRC found of a violation of arts. 6, 7, 9, and 10 all read in conjunction with art. 2 (3); see §§11.2-13.

42 *MB v Canada* Communication No. 2957/2017 UN Doc. CCPR/C/128/D/2957/2017 (2020). The communication was inadmissible under art. 2 of the Optional Protocol.

torture⁴³); 5) extrajudicial killings (*Hadji Hamid Japalali v The Philippines*⁴⁴); 6) State failure to investigate (i) disappearances (*SM v Bulgaria*⁴⁵) (ii) allegations of violations of the rights under the ICCPR (*Serna v Colombia*⁴⁶); 7) reproductive rights (*KL v Peru*⁴⁷), and recently, 8) climate change litigation (*Ioane Teitiota v New Zealand*⁴⁸).

43 The HRC in General Comment 36 underlines the duty of States parties to enact a protective legislative framework to prevent ‘all manifestations of violence’ including ‘intentional and negligent homicide, unnecessary or disproportionate use of firearms, [53] infanticide, [54] “honour” killings, [55] lynching, [56] violent hate crimes, [57] blood feuds, [58] ritual killings. [59], death threats, and terrorist attacks.’; UN Human Rights Committee (HRC), CCPR General Comment No. 36 (2019) On Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (3 September 2019), CCPR/C/GC/36, §20.

44 *Hadji Hamid Japalali v The Philippines* Communication No. 2536/2015 UN Doc. CCPR/C/125/D/2536/2015 (2019); violation of art. 6 (1) regarding the victims and violation of art. 2(3) read in conjunction with art. 6 (1) regarding the author; see §§7.4, 8.

45 *SM v Bulgaria* Communication No. 2100/2011 UN Doc. CCPR/C/117/D/2100/2011 (2016). The communication was inadmissible under art. 2 of the Optional Protocol.

46 ‘The Committee recalls its General Comment No. 31 (CCPR/C/21/Rev.1/Add.13), according to which a failure by a State party to investigate allegations of violations could in and of itself give rise to a separate breach of the Covenant’; *Serna v Colombia* Communication No. 2134/2012 UN Doc. CCPR/C/114/D/2134/2012 (22 September 2015) §9.6.

47 *KL v Peru* CCPR/C/85/D/1153/2003. The HRC considered the doctor’s statement that the complainant’s pregnancy exposed her to a life-threatening risk but decided not to make a finding on art. 6 (§§6.2 -6.3). See also the comments of the HRC in *Mellet v Ireland* CCPR/C/116/D/2324/2013: ‘the fact that a particular conduct or action is legal under domestic law does not mean that it cannot infringe Article 7 of the Covenant’ (at §7.4). This could be significant note to consider in applications of the ICCPR in jurisdictions with conflicting domestic legislation.

48 *Ioane Teitiota v New Zealand* Communication No. 2728/2016 UN Doc. CCPR/C/127/D/2728/2016 (2020). The HRC noted that ‘environmental degradation, climate change and unsustainable development constitute some of the most pressing and serious threats to the ability of present and future generations to enjoy the right to life (...) environmental degradation can compromise effective enjoyment of the right to life, and that severe environmental degradation can adversely affect an individual’s well-being and lead to a violation of the right to life.’ (§§9.4-9.5). Nevertheless, the majority did not find a violation of Article 6 (1). See however the comments of HRC member Vasilka Sancin (dissenting).

Considering the specific factual circumstances of the Bulgarian vaccine distribution scenario, as described by the Open Society European Policy Institute in the complaint submitted to the European Committee of Social Rights, the following section outlines complaints invoking or relying on Article 6 that could permit an argument by way of analogy.⁴⁹ These complaints were brought under the Optional Protocol to the ICCPR.⁵⁰ The focus is on (a) States' positive obligations to protect the right to life, both alone and in conjunction with the principle of non-discrimination,⁵¹ and on refusal of medical care, treatment, or medicines in the context of (b) liberty-restricting facilities and (c) deportation. Each of the selected claims includes a summary of the facts and the decision of the HRC; the claims are organised thematically.

1.1.1.2. Claims of Violation of Article 6

a) State's positive obligations to protect the right to life

In *Plotnikov v Russian Federation*,⁵² a period of hyperinflation had a significant effect on the cost of medicines and medical treatment (more than a 50% increase).⁵³ After failed attempts at the Swerdlowsk Regional Court (20 May 1993), the Moscow District Court (12 July 1993) and the Supreme Court (14 October 1993) at the domestic level, the applicant

49 Our findings rely on researching claims on the right to life in several case law databases, including the ones provided by the Centre for Civil and Political Rights, the ESCR-Net, and the Office of the United Nations High Commissioner for Human Rights.

50 See Article 2 'Subject to the provisions of Article 1, individuals who claim that any of their rights enumerated in the Covenant have been violated and who have exhausted all available domestic remedies may submit a written communication to the Committee for consideration.'; Optional Protocol to the International Covenant on Civil and Political Rights, GA res. 2200A (XXI), 21 UN GAOR Supp. (No. 16) at 59, UN Doc. A/6316 (1966), 999 UNTS 302, entered into force March 23, 1976.

51 See for instance the claim in *Toussaint v Canada* Communication No. 2348/2014 UN Doc. CCPR/C/123/D/2348/2014 (2018).

52 *Plotnikov v Russian Federation* Communication No 784/1997, UN Doc. CCPR/C/65/D/784/1997 (1999).

53 '[T]he inflation for industrial goods is between 10,000 to 20,000 per cent, but for medicine and medical treatment it reaches 25,000 even up to 80,000 per cent'; *Plotnikov v Russian Federation*, Communication No 784/1997, UN Doc CCPR/C/65/D/784/1997 (1999) §2.2.

notified the HRC that a State indexing law substantially reduced the value of his savings to the degree he could no longer purchase life-changing medicine:

*The author claims that his life is threatened because of lack of money for medicine, caused by a wrong indexing law regarding savings accounts, in violation of Article 6 of the Covenant.*⁵⁴

The HRC held the complaint inadmissible, noting that the arguments based on the occurrence of hyperinflation or the failure of the indexing law to mitigate the hyperinflation could not substantiate the claim.⁵⁵ Academic commentary notes that the chances of a claimant proving a violation of Article 6 based on socio-economic deprivation are slim.⁵⁶

In *Norma Portillo Cáceres v Paraguay*⁵⁷ the applicants claimed that the failure of the State to protect them from fumigation and toxic agrochemicals from nearby plantations violated their right to life under Article 6. The authors experienced severe symptoms such as dizziness, headaches, fever, stomach pains, vomiting, diarrhoea, coughing and skin lesions with the complainant's brother dying after exhibiting symptoms of pesticide poisoning, which was not an isolated case.⁵⁸

The HRC underlined that for at least five years before the complainants' communication, the State party had knowledge of the issues complained and the danger they posed to the inhabitants' life, but had taken no action.⁵⁹ The HRC underlined that States 'should take all appropriate measures to

54 *Plotnikov v Russian Federation* Communication No 784/1997, UN Doc CCPR/C/65/D/784/1997 (1999) §3.

55 *Plotnikov v Russian Federation* Communication No 784/1997, UN Doc CCPR/C/65/D/784/1997 (1999) §4.2.

56 Sarah Joseph, Jennifer Schultz, and Melissa Castan, *The International Covenant on Civil and Political Rights: Cases, Materials, and Commentary* (Oxford University Press 2004) 132-33.

57 *Norma Portillo Cáceres v Paraguay* Communication No. 2751/2016 UN Doc. CCPR/C/126/D/2751/2016 (2019).

58 *Norma Portillo Cáceres v Paraguay* Communication No. 2751/2016 UN Doc. CCPR/C/126/D/2751/2016 (2019) §§2.6, 5.9.

59 *Norma Portillo Cáceres v Paraguay* Communication No. 2751/2016 UN Doc. CCPR/C/126/D/2751/2016 (2019) §7.5.

address the general conditions in society that may give rise to threats to the right to life',⁶⁰ reiterating the positive obligations of the State under the ICCPR. The HRC highlighted the inclusive interpretation of Article 6, noting that a narrow interpretation is inadequate, finding a violation of Article 6.⁶¹

The diversity of the contexts which can trigger a claim under Article 6 confirms the significance and all-encompassing nature of the right to life. In *Florentina Olmedo v Paraguay*⁶² the complainant's husband (deceased) was part of an association of agricultural producers, supported by the largest trade organization in the area.⁶³ The victim participated in a demonstration which the police started to break-up with force.⁶⁴ The victim was shot in the back, and subsequently transferred to the Santa Rosa del Aguaray Health Centre. This was not equipped to treat him, and the victim was transferred two more times: to the San Estanislao District Hospital and then to the Asuncion Medical Emergency Hospital, where he died after surgery. The complainant noted:

[T]he first aid provided immediately after the shooting was inadequate, late and completely improvised. No measures had been taken to ensure that medical teams from the public emergency services were present at the site of the demonstration, if needed, to provide proper first aid to the wounded. More

60 *Norma Portillo Cáceres v Paraguay* Communication No. 2751/2016 UN Doc. CCPR/C/126/D/2751/2016 (2019) §7.3; UN Human Rights Committee (HRC), CCPR General Comment No. 36 (2019) On Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (3 September 2019), CCPR/C/GC/36, §26.

61 'The Committee takes note of the authors' claim that the events in this case constitute a violation by omission of Article 6 of the Covenant in respect of both Mr. Portillo Cáceres, who died while exhibiting symptoms of pesticide poisoning, and the authors themselves owing to the State party's failure to perform its duty to provide protection'; *Norma Portillo Cáceres v Paraguay* Communication No. 2751/2016 UN Doc. CCPR/C/126/D/2751/2016 (2019) §7.2.

62 *Florentina Olmedo v Paraguay*, Communication No. 1828/2008, UN Doc. CCPR/C/104/D/1828/2008 (2012).

63 *Florentina Olmedo v Paraguay*, Communication No. 1828/2008, UN Doc. CCPR/C/104/D/1828/2008 (2012) §2.1.

64 With shootings, beating, firearms, tear gas, and water cannons; *Florentina Olmedo v Paraguay*, Communication No. 1828/2008, UN Doc. CCPR/C/104/D/1828/2008 (2012) §§2.5-2.6.

*than 12 hours elapsed between the moment Blanco Dominguez was shot and his admission to hospital for proper medical treatment.*⁶⁵

The HRC reiterated that the States have a duty to protect the right to life not only against the criminal acts of others, but also from the arbitrary deprivation of life by State forces.⁶⁶ The HRC noted that the State had a duty to protect the demonstrators' lives, finding a violation of Article 6.⁶⁷

b) Denial of medical treatment and medicines in detention centers

In *Lantsova v Russia*,⁶⁸ the complainant's son (deceased) was a detainee in Matrosskaya Tishina, a pre-trial detention centre in Moscow. The complainant noted that her son was healthy when he entered the pre-trial detention centre, claiming that his death occurred as a result of extremely poor detention conditions, and denial of medical treatment despite repeated requests; the detainee received medical assistance only minutes before his death.⁶⁹ The 1994 report of the Special Rapporteur against torture, which was cited in the complaint, found that gross overcrowding at a number of detention centres in the Russian Federation, including Matrosskaya Tishina, was a detriment to health. It compounded the

65 *Florentina Olmedo v Paraguay*, Communication No. 1828/2008, UN Doc. CCPR/C/104/D/1828/2008 (2012) §3.3.

66 *Florentina Olmedo v Paraguay*, Communication No. 1828/2008, UN Doc. CCPR/C/104/D/1828/2008 (2012) §7.3.

67 *Florentina Olmedo v Paraguay*, Communication No. 1828/2008, UN Doc. CCPR/C/104/D/1828/2008 (2012) §7.5.

68 *Lantsova v Russia* Communication No. 763/1997, UN Doc. CCPR/C/74/D/763/1997 (2002).

69 *Lantsova v Russia* Communication No. 763/1997, U.N. Doc. CCPR/C/74/D/763/1997 (2002) §§2.2, 9.2 It is worth noting that denial of treatment in some circumstances could also amount to cruel and degrading behaviour. See the abusive practices in health care settings and policies in the 2013 report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (A/HRC/22/53); C. Denial of pain treatment at §§51-56.

existing inabilities of staff to provide health care and other essential services, and prevent the spread of infectious diseases:⁷⁰

*In most centres there was an extremely high incidence of tuberculosis and virtually all detainees had various forms of skin diseases.*⁷¹

The State responded by citing *inter alia* a lack of financial resources for adequately equipping the detention center.⁷² It is worth adding that the lack of beds in Matrosskaya Tishina was so severe that detainees had to take turns sleeping in the same beds.⁷³ The HRC noted that the duty of the State to organize its detention facilities and take all necessary measures to protect the health and lives of the detainees could not be limited by invoking a lack of financial resources. It found that Article 6 had been violated.⁷⁴ The claim in *Montecino v Chile*,⁷⁵ where the detainee was repeatedly transferred to different detention centers to protect his life and safeguard his security against continuous threats by inmates, could provide an example in the opposite direction. The HRC held that the author had not referred to other measures that should have been followed, and considering his repeated transfers, he had not substantiated his claim against the State. The HRC held the complaint inadmissible.⁷⁶

70 Question Of The Human Rights Of All Persons Subjected To Any Form Of Detention Or Imprisonment, In Particular: Torture And Other Cruel, Inhuman Or Degrading Treatment Or Punishment, Report of the Special Rapporteur, Mr. Nigel S. Rodley, submitted pursuant to Commission on Human Rights resolution 1994/37 E/CN.4/1995/34/Add.1 (16 November 1994) §41; see also the Report of the Special Rapporteur, Mr. Nigel S. Rodley, submitted pursuant to Commission on Human Rights resolution 1992/32 E/CN.4/1995/34 (12 January 1995) §513; *Lantsova v Russia* Communication No. 763/1997, UN Doc. CCPR/C/74/D/763/1997 (2002) §2.3.

71 Question of the Human Rights of All Persons Subjected to Any Form of Detention or Imprisonment, In Particular: Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Report of the Special Rapporteur, Mr. Nigel S. Rodley, submitted pursuant to Commission on Human Rights resolution 1994/37 E/CN.4/1995/34/Add.1 (16 November 1994) §41.

72 *Lantsova v Russia* Communication No. 763/1997, UN Doc. CCPR/C/74/D/763/1997 (2002) §6.4.

73 *Lantsova v Russia* Communication No. 763/1997, UN Doc. CCPR/C/74/D/763/1997 (2002) §7.3.

74 *Lantsova v Russia* Communication No. 763/1997, UN Doc. CCPR/C/74/D/763/1997 (2002) §9.2.

75 *Montecino v Chile* Communication No. 1504/2006, UN Doc. CCPR/C/94/D/1504/2006 (2008).

76 *Montecino v Chile* Communication No. 1504/2006, UN Doc. CCPR/C/94/D/1504/2006 (2008) §6.3-5.

Other claims in relation to the right to life illustrate that denial of medical care and medicines is common in detention centres, in addition to the degrading treatment, torture, and other violations of rights under the ICCPR. This was the case in *Sedhai v Nepal*⁷⁷ where according to statements, detainees in Chhauni Barracks, were not only denied food, water and sanitation, but also access to medicines.⁷⁸ The complainant (the victim's wife), claimed *inter alia* a violation of Article 6 arising from the failure of the State to take the appropriate measures to prevent her husband's disappearance, and the inadequacy of existing legal measures to prevent and remedy this.⁷⁹ The complainant specifically referred to the denial of medicines as part of a claim of violation of Article 10 of the ICCPR.⁸⁰ It is worth noting that the medicines would be used to treat wounds inflicted in the detention center.⁸¹ The HRC found multiple violations under the ICCPR, including a violation of Articles 6 and 10.⁸² Claims where denial of medical care, treatment, and medicines was part of the factual matrix also include the communications in *Marcel Mulezi v Democratic Republic of the*

77 *Sedhai v Nepal* Communication No. 1865/2009, UN Doc. CCPR/C/108/D/1865/2009 (2013).

78 *Sedhai v Nepal* Communication No. 1865/2009, UN Doc. CCPR/C/108/D/1865/2009 (2013) §2.6.

79 *Sedhai v Nepal* Communication No. 1865/2009, UN Doc. CCPR/C/108/D/1865/2009 (2013) §3.1.

80 'All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.'; International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171 (ICCPR).

81 See also the witness statements at §2.6, referring to denial of medicines, and to a detainee dying as a result of the injuries incurred at the detention centre; *Sedhai v Nepal* Communication No. 1865/2009, UN Doc. CCPR/C/108/D/1865/2009 (2013).

82 *Sedhai v Nepal* Communication No. 1865/2009, UN Doc. CCPR/C/108/D/1865/2009 (2013) §8.1- 11.

Congo,⁸³ *Khomidova v Tajikistan*,⁸⁴ *Vedeneyeva v Russian Federation*,⁸⁵ *Eshonov v Uzbekistan*,⁸⁶ *Sorifing Traore v Cote d'Ivoire*,⁸⁷ and *Njie Monika v Cameroon*.⁸⁸ References to the relevant parts of the claims are included in the footnotes.

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- 83 The detainee was 'unable to see a doctor' receiving medication eventually from the Médecins Sans Frontières (Doctors without Borders) visiting the detention camp. Also, after the complainant's arrest, soldiers seriously injured his wife at home, then refused her to travel to receive medical attention, resulting in her death. The HRC found multiple violations under the ICCPR, including a violation of Article 6, 7, and 10, specifically referring to the lack of medical attention; *Marcel Mulezi v Democratic Republic of the Congo* Communication No. 962/2001, UN Doc. CCPR/C/81/D/962/2001 (2004) §2.5- 2.6, and 5.3-5.4.
- 84 The detainee received no medical attention despite the severe injuries inflicted during his arrest and forced confession *Khomidova v Tajikistan* Communication No. 1117/2002 UN Doc. CCPR/C/81/D/1117/2002 (2004) §2.12. It is worth adding that the claim under Article 6 was relied on the imposition of the death penalty without the requirements of fair trial under Article 14 ICCPR to be met (see §§3.6 and 6.6).
- 85 The details of the medical treatment the complainant's son received for the tuberculosis and pneumonia he contracted during his detention in the overcrowded Moscow Pretrial Detention Centre No 2 were not examined further; the HRC agreed with the State that the complainant had not exhausted domestic remedies holding the claim inadmissible. For the conditions at the detention centre and the medical assistance the detainee received see §2.2-2.4 *Vedeneyeva v Russian Federation*, Communication No. 918/2000, UN Doc. CCPR/C/83/D/918/2000 (2005).
- 86 The detainee died despite receiving medical assistance, the independence of the medical practitioners was questioned; *Eshonov v Uzbekistan*, Communication No. 1225/2003, UN Doc. CCPR/C/99/D/1225/2003 (2010) §5.3.
- 87 The continuous lack of adequate medical attention to treat life-threatening injuries during detention was noted by the HRC in *Sorifing Traore v Cote d'Ivoire*, Communication No. 1759/2008, UN Doc. CCPR/C/103/D/1759/2008 (2011) §7.3. The HRC also noted that 'persons deprived of their liberty may not be subjected to any hardship or constraint other than that resulting from the deprivation of liberty' at §7.4. It is worth recalling the 'heightened duty' States must observe towards persons at liberty-restricting State-run facilities; UN Human Rights Committee (HRC), CCPR General Comment No. 36 (2019) On Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (3 September 2019), CCPR/C/GC/36, §25.
- 88 Unusual circumstances involving detention within the hospital facilities of Limbe Hospital and threats against life if the complainant left these premises; *Njie Monika v Cameroon*, Communication No. 1965/2010, UN Doc. CCPR/C/112/D/1965/2010 (2015) §2.4.

c) Access to medical treatment and deportation

In *Toussaint v Canada*,⁸⁹ the applicant, whose health had deteriorated to the extent that her life was threatened, was denied coverage to essential health care under the Federal Health Benefit Program (IFHP) because she did not fit into the immigration categories set out in the 1957 Order in Council (OIC); the complainant's exclusion from this coverage led to the deterioration of her already critical health status.⁹⁰ Medical evidence presented to the Federal Court was in support of the claim that exclusion from IFHP was a deprivation of the claimant's right to life. However, the Court held that the particular case was not contrary to Section 7 of the Canadian Charter of Rights and Freedoms, which protects the right to life.⁹¹ The Federal Court of Appeal upheld this decision, noting that while the complainant's life and health were significantly at risk, possibly triggering a violation of rights under the ICCPR, the 'operative cause' of this risk was the complainant's own decision to stay in Canada without legal status, for which the state was not responsible.⁹²

Following failed actions at the domestic level, the applicant in *Toussaint v Canada* submitted a complaint to the HRC. The HRC found a violation of Article 6, recalling General Comment 6 and noting that the right to life under Article 6 should not be construed narrowly.⁹³ It confirmed that states parties have the duty to:

*[P]rovide access to existing health care services that are reasonably available and accessible, when lack of access to the health care would expose a person to a reasonably foreseeable risk that can result in loss of life.*⁹⁴

89 *Toussaint v Canada* Communication No. 2348/2014 UN Doc. CCPR/C/123/D/2348/2014 (2018).

90 *Toussaint v Canada* Communication No. 2348/2014 UN Doc. CCPR/C/123/D/2348/2014 (2018) §§ 2.3-2.8, 11.2.

91 Section 7: Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice; *Toussaint v Canada* Communication No. 2348/2014 UN Doc. CCPR/C/123/D/2348/2014 (2018) § 2.10.

92 See *Toussaint v Canada (Attorney General)* 2011 FCA 213 (2011) [103]-[104], [110]; *Toussaint v Canada* Communication No. 2348/2014 UN Doc. CCPR/C/123/D/2348/2014 (2018) § 2.12.

93 *Toussaint v Canada* Communication No. 2348/2014 UN Doc. CCPR/C/123/D/2348/2014 (2018) §§ 11.3, 11.5.

94 *Toussaint v Canada* Communication No. 2348/2014 UN Doc. CCPR/C/123/D/2348/2014 (2018) § 11.3.

The case is also significant for its discussion of discrimination in the context of health care, see the discussion below at section 3.1.1.1.

In *SV v Canada*⁹⁵ the complainant had also raised the issue of denial of health care, treatment, and urgent medical assistance, based on immigration status under the IFHP by the Canadian authorities.⁹⁶ The HRC held the claim inadmissible since the complainant had not substantiated his arguments.⁹⁷

The complainant in *AHG v Canada*⁹⁸ had both physical and mental health conditions (diabetes and paranoid schizophrenia).⁹⁹ He had become homeless and was living in shelters. After committing assault with a weapon, he was detained by the Canada Border Services Agency who sought to deport him to Jamaica.¹⁰⁰ After failed attempts at the domestic level to resist this,¹⁰¹ the applicant filed a complaint at the HRC arguing that deportation to Jamaica would lead to violations of his rights under the ICCPR, including the right to life. Of particular interest are the comments regarding the insufficient availability of medical resources and the inaccessibility of treatment for the complainant's conditions.¹⁰² The medical system in Jamaica was described as being conditional on the

95 *SV v Canada* Communication No. 1827/2008, UN Doc CCPR/C/105/D/1827/2008 (2012).

96 *SV v Canada* Communication No. 1827/2008, UN Doc CCPR/C/105/D/1827/2008 (2012) §3.7.

97 *SV v Canada* Communication No. 1827/2008, UN Doc CCPR/C/105/D/1827/2008 (2012) §§8.1-8.8.

98 *AHG v Canada* Communication No. 2091/2011, UN Doc. CCPR/C/113/D/2091/2011 (2015).

99 *AHG v Canada* Communication No. 2091/2011, UN Doc. CCPR/C/113/D/2091/2011 (2015) §2.2.

100 *AHG v Canada* Communication No. 2091/2011, UN Doc. CCPR/C/113/D/2091/2011 (2015)§2.3-2.4. The HRC asked the State party not to deport the complainant (interim measures request), but the request arrived late; the complainant was deported earlier on the same day (29 August 2011)§1.3.

101 Including an appeal against the decision to deport him before the Immigration Appeal Division; an application to remain in Canada on humanitarian and compassionate grounds; an appeal of the negative decision before the Federal Court; and rejection of the application for judicial review; see *AHG v Canada* Communication No. 2091/2011, UN Doc. CCPR/C/113/D/2091/2011 (2015) §§2.4- 2.10.

102 *AHG v Canada* Communication No. 2091/2011, UN Doc. CCPR/C/113/D/2091/2011 (2015) §3.3.

patients having family support, and with particularly limited capacity in mental hospitals:

[There are] insufficient resources in Jamaica to treat persons with schizophrenia. Jamaica is moving towards a community-based mental health-care system, which presupposes that patients have family support. This assumption is extremely problematic for the author, who has no family support in Jamaica. Community group homes provide accommodation for deportees for 30 days. After that period, the individual may (a) if ill, be admitted to the mental hospital, which has very limited capacity and whose authorities are very reluctant to admit deportees; or (b) stay in a shelter. Most people in that situation end up on the streets after three months.¹⁰³

The complainant underlined that his physical and mental health would deteriorate following his deportation, which would inevitably lead to further endangerment of his life and to his social marginalization.¹⁰⁴ In addition to the claim of violation of Article 6, the complainant also claimed a violation of Articles 7 and 10 of the ICCPR, specifically referring to the quality and the lack of medical care and staff shortages at Bellevue Hospital at Kingston, Jamaica.¹⁰⁵ The State noted that a number of governmental and non-governmental organizations in Jamaica would be able to provide specialized care supporting that the complainant would

103 *AHG v Canada* Communication No. 2091/2011, UN Doc. CCPR/C/113/D/2091/2011 (2015) §3.3.

104 *AHG v Canada* Communication No. 2091/2011, UN Doc. CCPR/C/113/D/2091/2011 (2015)

§§3.2, 3.5, and 3.7. See also the reference to the report by the UN Special Rapporteur on torture and other degrading treatment in Jamaica, noting that people with mental illness in liberty-restricting facilities, are not held in psychiatric institutions but in separate wings in detention centres. The report specifically noted the lack of medical care and the damaging effect of the detention conditions for the physical and mental health of vulnerable persons; Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak (Mission to Jamaica) A/HRC/16/52/Add.3 (11 October 2010) §64.

105 Noting that for 800 patients 15 doctors and 150 nurses were available; *AHG v Canada* Communication No. 2091/2011, UN Doc. CCPR/C/113/D/2091/2011 (2015) §3.12.

not face a ‘real risk’ of violation of Articles 6 and 7.¹⁰⁶ It is worth noting the State’s argument that the positive obligations to protect the right to life do not include ensuring a specific level of health.¹⁰⁷ The complainant accepted this premise, noting that was not arguing that the right to life includes a positive obligation to ensure healthcare, and protection from poverty, and homelessness. Rather his case was that these circumstances within the specific country to which he was to be deported, would lead to a deterioration in his mental disability and an increased risk to his physical integrity and life.¹⁰⁸ The HRC held the claim under Article 6 inadmissible since the complainant had not substantiated his arguments.¹⁰⁹

Similar issues were considered in *WMG v Canada*¹¹⁰ regarding the deportation of a HIV- positive person to Zimbabwe, with the complainant alleging the unlikelihood of timely and efficient access to antiretroviral medicines in Zimbabwe and treatment for his tuberculosis.¹¹¹ The complainant noted the limited accessibility to HIV/AIDS treatment due to the extremely high rates of HIV/AIDS infections in the country. By 2009 less than half of the HIV/AIDS-infected population had access to the

106 *AHG v Canada* Communication No. 2091/2011, UN Doc. CCPR/C/113/D/2091/2011

(2015) §4.9. The States have an ‘obligation not to extradite, deport, expel or otherwise remove a person from their territory, where there are substantial grounds for believing that there is a real risk of irreparable harm, such as that contemplated by Articles 6 and 7 of the Covenant, either in the country to which removal is to be effected or in any country to which the person may subsequently be removed’; UN Human Rights Committee (HRC), General Comment No. 31 [80], The nature of the general legal obligation imposed on States Parties to the Covenant, 26 May 2004, CCPR/C/21/Rev.1/Add.13 §12.

107 ‘The right to life does not include a positive obligation to provide a home and to guarantee a certain level of health’; *AHG v Canada* Communication No. 2091/2011, UN Doc. CCPR/C/113/D/2091/2011 (2015) §6.7.

108 *AHG v Canada* Communication No. 2091/2011, UN Doc. CCPR/C/113/D/2091/2011 (2015) §7.5.

109 *AHG v Canada* Communication No. 2091/2011, UN Doc. CCPR/C/113/D/2091/2011 (2015) §9.5; the HRC continued to consider the claims under Articles 2 (3), 7, 17 and 23 (1) ICCPR, finding a violation of Article 7 (§§10.1-13).

110 *WMG v Canada* Communication No. 2060/2011, UN Doc. CCPR/C/116/D/2060/2011 (2016).

111 *WMG v Canada* Communication No. 2060/2011, UN Doc. CCPR/C/116/D/2060/2011 (2016) §§2.17, 3.2.

necessary treatment.¹¹² Existing shortages of essential laboratory supplies, medical staff, treatment, and an irregular supply of medicines, had been exacerbated by corruption and decisions taken based on drug availability, not clinical need.¹¹³ The complainant also noted the need for medical treatment for his wife and one of his children as they were also HIV-positive.¹¹⁴

The State responded, noting the complainant's criminal record. It rejected his comments concerning the unavailability or unaffordability of antiretroviral drugs,¹¹⁵ also noting the overall specific factors in the complainant's case which made it likely he would be able to access the necessary treatment.¹¹⁶ The HRC also considered the complainant's argument regarding the waiting list for the necessary antiretroviral treatment, and alleged lack of medical care.¹¹⁷ But it held that this relied predominantly on general information concerning the economic situation in Zimbabwe. Along with his decision not to undertake antiretroviral treatment while in Canada, this meant that it could not find a violation of his rights under the ICCPR.¹¹⁸ In its reasoning the HRC made clear that in future cases of this sort it would consider the particular characteristics

112 The Special Report - FAO/WFP CROP and Food Security Assessment (Mission to Zimbabwe, 2010) cited in the complaint, noted: 'By the end of 2009, 1.1 million Zimbabweans were living with HIV and 1,090 people were dying weekly of AIDS related illness, the main cause of mortality. Less than 50 percent of *people living with HIV* (PLHIV) requiring Anti Retroviral Therapy (ART) have access to it (Ministry of Health and Child Welfare)' at 28. *WMG v Canada* Communication No. 2060/2011, UN Doc. CCPR/C/116/D/2060/2011 (2016) §3.3.

113 *WMG v Canada* Communication No. 2060/2011, UN Doc. CCPR/C/116/D/2060/2011 (2016) §3.3.

114 *WMG v Canada* Communication No. 2060/2011, UN Doc. CCPR/C/116/D/2060/2011 (2016) §3.5.

115 '[S]uch medications can be purchased at pharmacies in Zimbabwe for about US\$30 per month or can be obtained for free at several institutions; those other more recent reports confirm the availability of those medications in Zimbabwe' *WMG v Canada* Communication No. 2060/2011, UN Doc. CCPR/C/116/D/2060/2011 (2016) §4.7.

116 His education level and business achievements; *WMG v Canada* Communication No. 2060/2011, UN Doc. CCPR/C/116/D/2060/2011 (2016) §4.7.

117 *WMG v Canada* Communication No. 2060/2011, UN Doc. CCPR/C/116/D/2060/2011 (2016) §7.4.

118 *WMG v Canada* Communication No. 2060/2011, UN Doc. CCPR/C/116/D/2060/2011 (2016) §7.4.

of the complainant, their education, family status, professional prospects, conduct, and consistency in the information they provide.

In *HS v Canada*,¹¹⁹ however, a case concerning the deportation of two Indian nationals, who alleged that they would face political persecution on their return,¹²⁰ the best interests of their children, who were Canadian citizens, did not seem to influence the decision. The HRC held the claim inadmissible as the applicants had not exhausted domestic remedies. They were entitled to apply to the Federal Court for judicial review of the decisions rejecting their asylum application, but on the advice on their counsel, they had not.¹²¹ HRC members José Manuel Santos Pais and Gentian Zyberi drafted a joint dissenting opinion, to the effect that the Canadian authorities had not sufficiently considered the best interests of the applicants' children.¹²² The latter offers some basis for including the best interests, including health interests of children in future complaints under Article 6, especially given the specific views on this topic expressed by the HRC in General Comment 36.¹²³

119 *HS v Canada* Communication No. 2948/2017, UN Doc. CCPR/C/125/D/2948/2017 (2019).

120 *HS v Canada* Communication No. 2948/2017, UN Doc. CCPR/C/125/D/2948/2017 (2019) §§3.1-3.5.

121 *HS v Canada* Communication No. 2948/2017, UN Doc. CCPR/C/125/D/2948/2017 (2019) §6.4.

122 *HS v Canada* Communication No. 2948/2017, UN Doc. CCPR/C/125/D/2948/2017 (2019) §§1-17.

123 'The duty to protect the right to life requires States parties to take special measures of protection towards persons in situation of vulnerability whose lives have been placed at particular risk because of specific threats (...) [this] may also include children' and 'Article 24, paragraph 1, of the Covenant entitles every child "to such measures of protection as are required by his status as a minor on the part of his family, society and the State." This Article requires adoption of special measures designed to protect the life of every child, in addition to the general measures required by Article 6 for protecting the lives of all individuals. [246] When taking special measures of protection, States parties should be guided by the best interests of the child, [247] by the need to ensure the survival and development of all children, [248] and their well-being. [249]'; UN Human Rights Committee (HRC), CCPR General Comment No. 36 (2019) On Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (3 September 2019), CCPR/C/GC/36, §§23, 60.

1.1.1.3. Discussion

It is worth highlighting a number of points regarding the HRC's approach to the positive obligations of States under Article 6 in the case law examined above.

First, in *Florentina Olmedo v Paraguay*¹²⁴ the HRC underlined that States have a duty to protect the lives of the persons in its territory, including from their own arbitrary application of force.¹²⁵ Following this, it can be argued, that since the right to life must be protected against the acts or omissions of State-controlled forces and bodies, it should also be protected against the negative consequences of unfounded or unreasonable State decisions and policies, including those in the context of health. Second, it is worth attending to the HRC's consideration of the burden of proof in claims under the ICCPR, and in particular the often unequal access to evidence that the author of a communication has compared to the State.¹²⁶ The HRC has emphasized that the burden of proof cannot rest solely on the complainant. Rather Article 4 (2) of the Optional Protocol implies that the State must investigate all allegations of violations of the ICCPR against its authorities in good faith.¹²⁷ Of course, the underpinning meaning and interpretation of a requirement of good faith may differ as between jurisdictions. (An analysis of this diversity is beyond the scope of the present report).

Furthermore, it is worth considering a point made at paragraph 85 of the 1994 Special Rapporteur's report cited in *Lantsova v Russia* (see 1.1.1.2 above).¹²⁸ States that place persons in health-damaging conditions, such as

124 *Florentina Olmedo v Paraguay*, Communication No. 1828/2008, UN Doc. CCPR/C/104/D/1828/2008 (2012).

125 *Florentina Olmedo v Paraguay*, Communication No. 1828/2008, UN Doc. CCPR/C/104/D/1828/2008 (2012) §7.3.

126 *Florentina Olmedo v Paraguay*, Communication No. 1828/2008, UN Doc. CCPR/C/104/D/1828/2008 (2012) §7.5.

127 *Florentina Olmedo v Paraguay*, Communication No. 1828/2008, UN Doc. CCPR/C/104/D/1828/2008 (2012) §7.5. See also Article 26 of the Vienna Convention on the Law of Treaties noting that 'Every treaty in force is binding upon the parties to it and must be performed in good faith'; No. 18232 concluded at Vienna on 23 May 1969, and the requirement of good faith in UN Human Rights Committee (HRC), General Comment no. 33, Obligations of States parties under the Optional Protocol to the International Covenant on Civil and Political Rights, 25 June 2009, CCPR/C/GC/33 §15, 19.

128 *Lantsova v Russia*, Communication No. 763/1997, UN Doc. CCPR/C/74/D/763/1997 (2002).

insalubrious detention centers, effectively subject these vulnerable persons to disease.¹²⁹ It follows that consistently omitting to ensure the availability of medical treatment and medicines (or to review the corresponding policy or framework for delivering these) to vulnerable population groups, particularly, but not only those located in State-controlled facilities (e.g., hospitals, prisons, immigration centers), would amount to actively and knowingly endangering their rights to life and health. As such there would be a strong claim that the State had failed to fulfil its positive obligations to protect the right to life under Article 6.

We can draw on this line of reasoning in considering the operation of ‘green corridors’ in the Bulgarian vaccine distribution scenario, as set out in the OSF’s complaint under the European Charter. In that case the authorities made access to vaccines against COVID- 19 conditional on the elderly and people with disabilities being able to travel (without specific assistance), to stand for hours, and to endure winter temperatures.¹³⁰ The authorities, therefore, made the COVID-19 vaccination conditional on not having the very vulnerabilities for which one should be prioritized. The elderly and the vulnerable were not simply overlooked. They were ‘de-prioritized’. Thus, the Bulgarian authorities, by consistently failing to ensure the vaccination of its most vulnerable population groups, effectively subjected them to COVID-19 infection and its grave, and in most circumstances irreversible, consequences.

Considering the interrelation between the right to life under Article 6 and the right to health protected in Article 12 ICESRC, it is worth noting the complainant’s comment at paragraph 3.9 in *AHG v Canada*.¹³¹ He argued that protection of his health would not only require access to effective medicines, but also long-term treatment plans for which family support

129 Question of the Human Rights of All Persons Subjected to Any Form of Detention or Imprisonment, In Particular: Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Report of the Special Rapporteur, Mr. Nigel S. Rodley, submitted pursuant to Commission on Human Rights resolution 1994/37 E/CN.4/1995/34/Add.1 (16 November 1994) §85.

130 See Complaint No. 204/2022 *Open Society European Policy Institute (OSEPI) v Bulgaria* (2022)§52.

131 *AHG v Canada* Communication No. 2091/2011, UN Doc. CCPR/C/113/D/2091/2011 (2015).

and involvement was necessary.¹³² This interdependence between family support and the protection of health within the penumbra of duties under the right to life is consistent with a holistic understanding of Article 6 which goes beyond bare accessibility, to include those factors which will enable effective access and take up of medicines. This inclusive reasoning has significant potential application in relation to pandemic and vaccine accessibility. First, it indicates the wide scope of the State duty to protect the right to life, which aligns with the comments of the HRC in General Comment 36 that Article 6 should not be narrowly construed (see above 1.1.1).¹³³ It follows that social, as well as medical factors vital for ensuring the life and health of relevant persons should be considered as included within the scope of the right. On that point, it is worth recalling the comment of the HRC that the States should address all general conditions in the society that could affect the right to life.¹³⁴ Therefore, in the specific context of vaccine prioritization for vulnerable population groups in Bulgaria, the State seems not only to have failed to protect the right to life for those most in need, but also to have wholly disregarded the essential social dimensions of its duty in that regard.

Having considered the interpretation of the State's positive obligation to protect the right to life in international law, we continue in the following sections to examine regional protections, beginning with Article 2 of the European Convention on Human Rights.

132 '[Family involvement] improves clinical and functional recovery and significantly reduces relapse rates'; *AHG v Canada* Communication No. 2091/2011, UN Doc. CCPR/C/113/D/2091/2011 (2015)§3.9.

133 UN Human Rights Committee (HRC), CCPR General Comment No. 36 (2019) On Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (3 September 2019), CCPR/C/GC/36, §3.

134 UN Human Rights Committee (HRC), CCPR General Comment No. 36 (2019) On Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (3 September 2019), CCPR/C/GC/36, §26.

Article 2 (1) on the European Convention on Human Rights (ECHR)¹³⁵ states:

*Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.*¹³⁶

The European Court of Human Rights ('the Court' or 'ECtHR') has noted that the rights under the ECHR should be 'practical and effective' not 'theoretical and illusory'¹³⁷ and this permeates the interpretation and implementation of the right to life under Article 2.¹³⁸ In *Giuliani and Gaggio v Italy*¹³⁹ the Court underlined the significance of Article 2 as one of the 'most fundamental provisions in the Convention' with no room for derogation in peacetime, as would otherwise be permitted by Article 15.¹⁴⁰ This fundamental character of Article 2 is evident in the substantive obligations imposed on States. Article 2 (1) raises the significant question of how States should respect and protect the right to life, which is a central focus of the analysis in this section.

1.1.1.4. The Obligations of the State

As noted in *LCB v the United Kingdom*¹⁴¹ Article 2 (1) not only requires the State to refrain from the intentional and unlawful deprivation of life (negative obligations), but also to take appropriate measures to safeguard it (positive obligations).¹⁴² The nature of States' positive obligations in this regard is twofold, consisting of (a) the duty to provide a regulatory

135 Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended by Protocols Nos. 11 and 14) (ECHR) (4 November 1950).

136 Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended by Protocols Nos. 11 and 14) (ECHR) (4 November 1950) art 2(1).

137 See *İlhan v Turkey*, ECtHR Application no. 22277/93 (2000) §91.

138 See also *McCann v the United Kingdom* ECtHR Application no. 18984/91 (1995) §146.

139 *Giuliani and Gaggio v Italy* ECtHR Application no. 23458/02 (2011).

140 *Giuliani and Gaggio v Italy* ECtHR Application no. 23458/02 (2011) §174.

141 *LCB v the United Kingdom* ECtHR Application no. 23413/94 (1998).

142 *LCB v the United Kingdom* ECtHR Application no. 23413/94 (1998) §36.

framework (procedural limb); and (b) the obligation to take preventive operational measures (substantive limb); the ECtHR considers each separately.¹⁴³ Accordingly, States' duty to protect the right to life under Article 2 (1) is not confined to deterring and restricting interference with individual life, but includes a set of positive steps to protect the lives of those within its jurisdiction.¹⁴⁴ In any given case, the Court will consider whether in the particular circumstances:

*[The] State did all that could have been required of it to prevent the applicant's life from being avoidably put at risk.*¹⁴⁵

It is worth noting that the Court's interpretation of the State's positive obligations does not include providing experimental treatment, even if this concerns patients who are terminally ill; *Hristozov v Bulgaria*.¹⁴⁶ For the purposes of this report, the spheres of health, clinical care, and public health raise significant questions of State responsibility in relation to the fair allocation of scarce health resources, including vaccines. The case law explored in the following sections allow for a comparative analysis of the application of the doctrine by the Court, setting the foundation for the interpretation of the right to life.

143 ECtHR, *Guide on Article 2 of the Convention – Right to life* (2021) §§10, 142.

144 *Centre for Legal Resources on behalf of Valentin Câmpeanu v Romania*, ECtHR Application no. 47848/08 (2014) §130.

145 *LCB v the United Kingdom* ECtHR Application no. 23413/94 (1998) §36. States' obligations are triggered whenever the right to life is at stake. *Centre for Legal Resources on behalf of Valentin Câmpeanu v Romania*, ECtHR Application no. 47848/08 (2014) §130.

146 *Hristozov v Bulgaria* ECtHR Application nos. 47039/11 and 358/12 (2012) §108.

1.1.1.5. Clinical Care

In the context of clinical care, the duty to protect the right to life under Article 2 includes setting up an effective and independent system to determine the cause of patients' deaths and ensure accountability; *Calvelli and Ciglio v Italy*;¹⁴⁷ *Šilih v Slovenia*¹⁴⁸. The Court has reiterated in numerous cases that:

*[The] positive obligations therefore require States to make regulations compelling hospitals, whether public or private, to adopt appropriate measures for the protection of their patients' lives.*¹⁴⁹

States are expected to take all appropriate measures for the protection of patients' lives in private and public hospitals, including the duty to ensure the functioning of the regulatory framework put in place.¹⁵⁰ Thus, in the context of health care, the positive obligations of the State under Article 2 include supervision, implementation, and enforcement of the regulatory framework.¹⁵¹ Deficiencies in the regulatory framework put in place by the State must be shown to have caused harm to patients.¹⁵² A mere indication that the regulatory framework was not functioning properly will not suffice; *Lopes de Sousa Fernandes v Portugal*.¹⁵³ Nawrot et al. reiterate the significance of State responsibility in the context of emergency

147 *Calvelli and Ciglio v Italy* ECtHR Application no. 32967/96 (2002) §49.

148 *Šilih v Slovenia* ECtHR Application no. 71463/01 (2009) §192.

149 *Calvelli and Ciglio v Italy*, ECtHR Application no. 32967/96 (2002) §49; *Vo v France* ECtHR Application no. 53924/00 (2004) §89; *Lopes de Sousa Fernandes v Portugal*, ECtHR Application no. 56080/13 (2017) §166; *Fernandes de Oliveira v Portugal* Application no. 78103/14 (2019) §105.

150 ECtHR, *Guide on Article 2 of the Convention – Right to life* (2021) §44.

151 *Lopes de Sousa Fernandes v Portugal*, ECtHR Application no. 56080/13 (2017) §189.

152 *Fernandes de Oliveira v Portugal* Application no. 78103/14 (2019) §107. See also the comments in *Gardner and Harris v Secretary of State for Health and Social Care* [2022] EWHC 967 (Admin) at [47] 'it is common ground that three key factors must be present in order for the Article 2 operational duty to apply: (1) a real and immediate risk to life; (2) actual or constructive knowledge of the State of the risk; (3) a sufficient connection or link with the responsibility of the State ("the Rabone criteria")'.

153 *Lopes de Sousa Fernandes v Portugal* ECtHR Application no. 56080/13 (2017) §188.

health care.¹⁵⁴ Inadequate implementation of the relevant legislative and regulatory frameworks as a cause of patient death have been found to be sufficient reasons for a finding that Article 2 has been breached; *Erikson v Italy*¹⁵⁵ and *Altuğ v Turkey*.¹⁵⁶

1.1.1.6. Public Health

In the context of public health policy, the acts or omissions of authorities, which have endangered an individual's life, may trigger a State's responsibility under Article 2; *Powell v the United Kingdom*.¹⁵⁷ That is especially the case where health care that is available to the population generally is denied to a particular individual; *Hristozov v Bulgaria*;¹⁵⁸ *Cyprus v Turkey*.¹⁵⁹ State responsibility under Article 2 has been engaged when health care authorities knowingly put a patient's life in danger by denying life-saving treatment (*Mehmet Şentürk and Bekir Şentürk v Turkey*¹⁶⁰) and where a patient's life was endangered due to systemic hospital dysfunction

154 Oktawian Nawrot, Justyna Nawrot, and Valeri Vachev, 'The Right to Healthcare During the Covid-19 Pandemic Under the European Convention on Human Rights' (2022) *The International Journal of Human Rights* 4.

155 *Erikson v Italy* ECtHR Application no. 37900/97 (1999), which started a 'line of jurisprudence in this area' see Oktawian Nawrot, Justyna Nawrot, and Valeri Vachev, 'The Right to Healthcare During the Covid-19 Pandemic Under the European Convention on Human Rights' (2022) *The International Journal of Human Rights* 16.

156 *Altuğ v Turkey* ECtHR Application no. 32086/07 (2015).

157 *Powell v the United Kingdom* ECtHR Application no. 45305/99 (2000); 'The Court accepts that it cannot be excluded that the acts and omissions of the authorities in the field of health care policy may in certain circumstances engage their responsibility under the positive limb of Article 2. However, where a Contracting State has made adequate provision for securing high professional standards among health professionals and the protection of the lives of patients, it cannot accept that matters such as error of judgment on the part of a health professional or negligent co-ordination among health professionals in the treatment of a particular patient are sufficient of themselves to call a Contracting State to account from the standpoint of its positive obligations under Article 2 of the Convention to protect life.'

158 *Hristozov v Bulgaria* ECtHR Applications nos. 47039/11 and 358/12 (2012) §106.

159 *Cyprus v Turkey* ECtHR Application no. 25781/94 (2001) §219.

160 *Mehmet Şentürk and Bekir Şentürk v Turkey* ECtHR Application no. 13423/09 (2013).

(*Aydoğdu v Turkey*¹⁶¹). The ECtHR characterised both of these cases as exceptional.¹⁶²

The contexts of clinical care and public health interrelate. Effective regulatory systems link to the overarching policies informing them, and the positive obligations of the States under Article 2 permeate both. However, the ways in which States may discharge their obligations under Article 2 are left to them to a considerable degree, as indicated from the following discussion on the margin of appreciation.

1.1.1.7. Margin of Appreciation

The ECtHR has reiterated that the choice of means for discharging the positive duty to protect the right to life under Article 2 lies with the State; *Brincat v Malta*.¹⁶³ This has been upheld consistently by the Court,¹⁶⁴ subject to the measures being effective in practice.¹⁶⁵ The discretion States enjoy in selecting the measures to fulfil their positive obligations is confirmed in the specific context of resource allocation. In *Lopes de Sousa Fernandes v Portugal*,¹⁶⁶ the Court stated:

*[I]t is for the competent authorities of the Contracting States to consider and decide how their limited resources should be allocated, as those authorities are better placed than the Court to evaluate the relevant demands in view of the scarce resources and to take responsibility for the difficult choices which have to be made between worthy needs.*¹⁶⁷

161 *Aydoğdu v Turkey* ECtHR Application No. 40448/06 (2016) §31. The Court referred specifically to the ‘operational choices to be made in terms of priorities and resources’ and ‘proper organisation and functioning’ of the hospital service at §87.

162 ECtHR, *Guide on Article 2 of the Convention – Right to life* (2021) §48.

163 *Brincat v Malta* ECtHR, Applications nos. 60908/11, 62110/11, 62129/11, 62312/11 and 62338/11 (2014) §§101 and 116.

164 The State may fulfil its positive obligations by other means even when it fails to do so under a specific measure in domestic law; *Ciechońska v Poland*, ECtHR Application no. 19776/04 (2011) §65.

165 ECtHR, *Guide on Article 2 of the Convention – Right to life* (2021) §204. The protections afforded to Article 2 must not be theoretical and illusory; *İlhan v Turkey*, ECtHR Application no. 22277/93 (2000) §91.

166 *Lopes de Sousa Fernandes v Portugal* ECtHR Application no. 56080/13 (2017).

167 *Lopes de Sousa Fernandes v Portugal* ECtHR Application no. 56080/13 (2017) §175.

States are required to take preventive operational measures to protect the right to life when they have knowledge of a specific threat to an individual life; *Osman v United Kingdom*.¹⁶⁸ A lack of resources will not absolve the State of liability for violating Article 2 when the requirement of knowledge of a threat to life is met in such cases; *Oneryildiz v Turkey*.¹⁶⁹ States are also obliged to protect the right to life in dangerous situations such as naturally-occurring hazards; *Stoyanovi v Bulgaria*.¹⁷⁰ Stubbins Bates comments that positive operational obligations include pandemic preparation: ‘once the actual or constructive knowledge [of a threat to life is acquired], the positive obligation is triggered’. This duty is subject to two limitations on this duty, i.e., (1) where the burden would be disproportionate and (2) the ‘choice of means’, i.e., the margin of appreciation on how the State will discharge its duty.¹⁷¹

The likely impact of resource constraints during a pandemic has been known to States since at least the pandemic influenza in 2017. There were also clear indicators of scarce health resources early in the COVID-19 pandemic, allowing time to address them before vaccine roll-out. It is worth noting that States commonly cooperate in combating the lack of health resources.¹⁷² Although it would be wrong to conclude that the margin of

168 *Osman v United Kingdom* ECtHR Application no. 87/1997/871/1083 (1998) §105.

169 *Oneryildiz v Turkey* ECtHR Application no. 48939/99 (2004) §107.

170 ‘[T]he authorities, knowing about the potential danger, are under obligations to respond with due regard to protection of the right to life.’; *Stoyanovi v Bulgaria* ECtHR Application no. 42980/04 (2010)§59.

171 See Elizabeth Stubbins Bates, ‘COVID-19 Symposium: Article 2 ECHR’s Positive Obligations – How Can Human Rights Law Inform the Protection of Health Care Personnel and Vulnerable Patients in the COVID-19 Pandemic?’ (OpinioJuris, 2020) accessed 25 May 2022.

172 Illustratively, see the initiatives of Team Europe and the EU vaccine sharing mechanism, the COVAX initiative and global cooperation in the development, production, and equitable access to vaccination against Covid-19. See also, the discussion in Fukunari Kimura and others, ‘Pandemic (COVID-19) Policy, Regional Cooperation and the Emerging Global Production Network’ (2020) 34(1) *Asian Economic Journal* 3, and in Ana Amaya and Philippe De Lombaerde, ‘Regional cooperation is essential to combatting health emergencies in the Global South’ (2021) 17 (9) *Globalization and Health*. See also the discussion on vaccine development and distribution in Mark Jit and others, ‘Multi-country Collaboration in Responding to Global Infectious Disease Threats: Lessons for Europe from the COVID-19 Pandemic’ (2021) 9 (100221) *The Lancet Regional Health – Europe*.

appreciation affords States *carte blanche* to ‘disregard their preventive operational obligations’ under Article 2¹⁷³ illustrations from selected case law may rebut this premise.

1.1.1.8. Claims of Violation of Article 2

The following cases include claims of violation of the right to life under Article 2, in circumstances where the lack of health resources, equipment, medicine, treatment, and hospital dysfunction, constituted a contributory or main factor causing the death of the victim. Claims where the ECtHR has commented on the margin on appreciation afforded to States in the allocation of scarce medical resources are also included. The cases are presented thematically, with a focus on (a) State’s positive obligations to protect the right to life, (b) chronic hospital dysfunctioning, including unreasonable or inadequate allocation of resources, and (c) access to life-saving treatment where the resources are limited.

a) Vulnerable populations and State’s positive obligations

In *Nencheva v Bulgaria*,¹⁷⁴ fifteen children and young adults with physical and mental disabilities in the Dzhurkovo care home died due to lack of medicines, health care, and basic supplies. A period of inflation led to a decline in the State’s income and the budget available for allocation to public bodies, including the Dzhurkovo hostel, which accommodated children with severe mental and physical disabilities.¹⁷⁵ The care home did not have a doctor, while it had only one medical officer and five nurses (one nurse per 20 children).¹⁷⁶ The authorities’ knowledge of the dire situation at the Dzhurkovo care home established a positive obligation to protect

173 Elizabeth Stubbins Bates, ‘COVID-19 Symposium: Article 2 ECHR’s Positive Obligations – How Can Human Rights Law Inform the Protection of Health Care Personnel and Vulnerable Patients in the COVID-19 Pandemic?’ (OpinioJuris, 2020) accessed 25 May 2022.

174 *Nencheva v Bulgaria* ECtHR Application no. 48609/06 (2013).

175 *Nencheva v Bulgaria* ECtHR Application no. 48609/06 (2013) §26, 4.

176 *Nencheva v Bulgaria* ECtHR Application no. 48609/06 (2013) §27.

the lives of the vulnerable children and young adults in State care.¹⁷⁷ The ECtHR described the events as a national tragedy emphasizing that the situation was neither sudden nor unforeseen.¹⁷⁸ It noted that the case went beyond the applicants' individual circumstances, being a question of wider public interest.¹⁷⁹ The Court found a violation of Article 2.

In *Centre for Legal Resources on behalf of Valentin Câmpeanu v Romania*¹⁸⁰ concerned a complaint submitted on behalf of Mr. Câmpeanu (deceased), who had been diagnosed with HIV and severe intellectual disability.¹⁸¹ As regards admissibility, it is worth noting that the ECtHR dismissed the government's assertion that the Centre for Legal Resources (CLR) had no standing. It noted that Mr. Câmpeanu was the direct victim as specified in Article 34 of the Convention and that the CLR could not satisfy the

177 'For there to be a positive obligation, it must be established that the authorities knew or should have known at the time that a given individual was under real and immediate threat in his or her life, and that they did not take, within their powers, the measures which, from a reasonable point of view, would undoubtedly have mitigated this risk' and 'that the authorities failed in their obligation to protect their children's right to life, it is essential to be convinced that the said authorities should have known about the time that there was a real risk to the lives of these children and that they did not take, within the limits of their powers, the measures which, from a reasonable point of view, would undoubtedly have mitigated this risk' *Nencheva v Bulgaria* ECtHR Application no. 48609/06 (2013) §108, 118.

178 *Nencheva v Bulgaria* ECtHR Application no. 48609/06 (2013) §122-123.

179 '[The case] involves a situation of danger for the lives of vulnerable persons entrusted to the care of the State, fully known by the authorities and can be described as a tragedy at the national level. This is therefore a question not only relating to the individual condition of the applicants, but relating to the public interest. Thus, the circumstances denounced go beyond the case of negligence by health professionals and the Court is of the opinion that, taking into account all the elements which have just been set out and the public interest to be protected, the national authorities had the obligation to take urgently appropriate measures to protect the lives of the children (...); *Nencheva v Bulgaria* ECtHR Application no. 48609/06 (2013) §122-123.

180 *Centre for Legal Resources on behalf of Valentin Câmpeanu v Romania* ECtHR Application no. 47848/08 (2014).

181 *Centre for Legal Resources on behalf of Valentin Câmpeanu v Romania* ECtHR Application no. 47848/08 (2014) §7.

requirements for being an indirect victim. However, it could act as his representative given the exceptional circumstances of this case:

[I]t should be open to the CLR to act as a representative of Mr Câmpeanu, notwithstanding the fact that it had no power of attorney to act on his behalf and that he died before the application was lodged under the Convention. To find otherwise would amount to preventing such serious allegations of a violation of the Convention from being examined at an international level, with the risk that the respondent State might escape accountability under the Convention as a result of its own failure to appoint a legal representative to act on his behalf as it was required to do under national law (...) Allowing the respondent State to escape accountability in this manner would not be consistent with the general spirit of the Convention.¹⁸²

The victim had been transferred between institutions, receiving inadequate or no medical treatment for his conditions.¹⁸³ Among these, the Court noted that a significant number of patients had died at the Poiana Mare Neuropsychiatric Hospital ('PMH'): eighty-one in 2003 and twenty-eight at the beginning of 2004.¹⁸⁴ The General Prosecutor's Office, in a letter addressed to the Ministry of Health had described the administrative deficiencies and overall conditions at PMH as follows:

[L]ack of heating in the patients' rooms; hypocaloric food; insufficient staff, poorly trained in providing care to mentally disabled patients; lack of

182 *Centre for Legal Resources on behalf of Valentin Câmpeanu v Romania* ECtHR Application no. 47848/08 (2014) §112. See also at §§103-104: '[T]he Convention institutions have held that special considerations may arise in the case of victims of alleged breaches of Articles 2, 3 and 8 at the hands of the national authorities. Applications lodged by individuals on behalf of the victim(s), even though no valid form of authority was presented, have thus been declared admissible. Particular consideration has been shown with regard to the victims' vulnerability on account of their age, sex or disability, which rendered them unable to lodge a complaint on the matter with the Court, due regard also being paid to the connection between the person lodging the application and the victim'; *Centre for Legal Resources on behalf of Valentin Câmpeanu v Romania* ECtHR Application no. 47848/08 (2014) §§103-104.

183 See in particular the transfers between the Cetate-Dolj Medical and Social Care Centre and Poiana Mare Neuropsychiatric Hospital; *Centre for Legal Resources on behalf of Valentin Câmpeanu v Romania* ECtHR Application no. 47848/08 (2014) §§8-22.

184 *Centre for Legal Resources on behalf of Valentin Câmpeanu v Romania* ECtHR Application no. 47848/08 (2014) §43-44 and 141.

*effective medication; extremely limited opportunities to carry out paraclinical investigations (...) all these factors having encouraged the onset of infectious diseases, as well as their fatal progression (...).*¹⁸⁵

As noted by the Special Rapporteur on the Right to Health, cited in the case, most of the deficiencies at PMH were linked to the lack of medical assistance due to mismanagement and insufficiency of resources.¹⁸⁶ The Court also noted that the PMH lacked the necessary equipment, facilities, and staff to provide treatment to the victim, who had received only sedatives and vitamins, effectively palliative measures only.¹⁸⁷ The Court also noted the serious shortcomings in the decision-making process of the medical authorities.¹⁸⁸ As in *Nencheva v Bulgaria*,¹⁸⁹ where the death of children could not be categorised as a ‘sudden event’, the Court emphasised that the governmental authorities had full knowledge of the appalling conditions and severe medical shortages at PMH. Notwithstanding this it had not acted, thus failing to fulfil its positive obligations to protect the right to life. The Court, therefore, found a violation of Article 2.¹⁹⁰

This was not the only occasion that the CLR had initiated proceedings against the PMH. In *Centre for Legal Resources on behalf of Miorița Malacu v Romania*,¹⁹¹ the scarcity of human and medical resources was also evident.

185 *Centre for Legal Resources on behalf of Valentin Câmpeanu v Romania* ECtHR Application no. 47848/08 (2014) §43. For the conditions at PMH see also §78.

186 Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt E/CN.4/2005/51/Add.1 (2 February 2005) §54; *Centre for Legal Resources on behalf of Valentin Câmpeanu v Romania* ECtHR Application no. 47848/08 (2014) §78.

187 *Centre for Legal Resources on behalf of Valentin Câmpeanu v Romania* ECtHR Application no. 47848/08 (2014) §138-139.

188 *Centre for Legal Resources on behalf of Valentin Câmpeanu v Romania* ECtHR Application no. 47848/08 (2014) §§142-144.

189 *Nencheva v Bulgaria* ECtHR Application no. 48609/06 (2013).

190 *Centre for Legal Resources on behalf of Valentin Câmpeanu v Romania* ECtHR Application no. 47848/08 (2014) §§142-144. We will see subsequently in the analysis the significance of the requirement of the knowledge not only in the ECtHR jurisprudence but also in additional regional systems.

191 *Centre for Legal Resources on behalf of Miorița Malacu v Romania* ECtHR Application no. 55093/09 (2009).

The CLR noted that for 440 patients at PMH there were five psychiatrists and six general practitioners, while more than one patient occupied the same bed.¹⁹² The CLR claimed that Article 2 had been violated in the cases of five patients. The parties reached a settlement.

The cases of *Nencheva v Bulgaria*,¹⁹³ and *Centre for Legal Resources on behalf of Valentin Câmpeanu v Romania*,¹⁹⁴ can be distinguished from that of *Evija Dumpe v Latvia*.¹⁹⁵ In the latter, the ECtHR held that, unlike in the two previous cases, the domestic authorities had not been aware of the conditions leading to the illness and ultimate death of the applicant's son while in State social care.¹⁹⁶ Given that, the authorities could not be held to have unreasonably endangered the lives of those in its care.¹⁹⁷ Since the applicant's son had died due to medical negligence, the Court also examined the effectiveness of the mechanisms put in place to respond to such cases.¹⁹⁸ Ultimately, the Court held the claim under Article 2 to be inadmissible for failure to exhaust domestic remedies.¹⁹⁹

In *Budayeva v Russia*²⁰⁰ the applicants claimed that the State failed to take the necessary measures to protect their lives from naturally occurring phenomena (recurring mudslides). These included a failure to maintain protective infrastructure and lack of public warning about the upcoming

192 *Centre for Legal Resources on behalf of Miorița Malacu v Romania* ECtHR Application no. 55093/09 (2009) §16.

193 *Nencheva v Bulgaria* ECtHR Application no. 48609/06 (2013).

194 *Centre for Legal Resources on behalf of Valentin Câmpeanu v Romania* ECtHR Application no. 47848/08 (2014).

195 *Evija Dumpe v Latvia* ECtHR Application no. 71506/13 (2018).

196 *Evija Dumpe v Latvia* ECtHR Application no. 71506/13 (2018) §56.

197 *Evija Dumpe v Latvia* ECtHR Application no. 71506/13 (2018) §56.

198 '[T]he applicant argued that her son, who suffered from several serious illnesses, died owing to the social care home's, in particular its medical staff's failure to provide him adequate medical care when his health condition deteriorated. Accordingly, the Court considers that the applicant's complaint pertains to medical negligence in the care provided to her son.'; *Evija Dumpe v Latvia* ECtHR Application no. 71506/13 (2018) §57.

199 *Evija Dumpe v Latvia* ECtHR Application no. 71506/13 (2018) §77.

200 *Budayeva v Russia* ECtHR Applications nos. 15339/02, 21166/02, 20058/02, 11673/02 and 15343/02 (2008).

disaster.²⁰¹ Considering the claim under Article 2, the Court noted that, in the context of dangerous activities relevant to this claim, there is an overlap between Article 2 and Article 8 ECHR. This had already been identified in its jurisprudence on planning and environmental matters, to the effect that the right to private and family life under Article 8 can be relied on in a claim regarding the protection of life.²⁰²

The Court commented on the frequency of mudslides in the area, showing that the authorities were reasonably expected to know of the increased risk and thus to take the necessary preventive steps to address the problem and make ‘advance arrangements’ for evacuation.²⁰³ A duty to inform the public of these risks was explicitly mentioned by the Court:

*In any event, informing the public about inherent risks was one of the essential practical measures needed to ensure effective protection of the citizens concerned.*²⁰⁴

The ECtHR acknowledged the wide margin of appreciation afforded to States as regards the discharge of their positive obligations under Article 2. Nonetheless, it noted on the facts that the State had taken no measures to protect the lives of the applicants.²⁰⁵ This led it to find that Article 2 had been violated.²⁰⁶ The decision of the Court was considered in the recent decision of the English and Welsh High Court in *Gardner and Harris v Secretary of State for Health and Social Care*.²⁰⁷

201 *Budayeva v Russia* ECtHR Applications nos. 15339/02, 21166/02, 20058/02, 11673/02 and 15343/02 (29 September 2008) §§124-127.

202 *Budayeva v Russia* ECtHR Applications nos. 15339/02, 21166/02, 20058/02, 11673/02 and 15343/02 (29 September 2008) §133.

203 *Budayeva v Russia* ECtHR Applications nos. 15339/02, 21166/02, 20058/02, 11673/02 and 15343/02 (29 September 2008) §152.

204 *Budayeva v Russia* ECtHR Applications nos. 15339/02, 21166/02, 20058/02, 11673/02 and 15343/02 (29 September 2008) §152.

205 *Budayeva v Russia* ECtHR Applications nos. 15339/02, 21166/02, 20058/02, 11673/02 and 15343/02 (29 September 2008) §156.

206 *Budayeva v Russia* ECtHR Applications nos. 15339/02, 21166/02, 20058/02, 11673/02 and 15343/02 (29 September 2008) §§158-160.

207 *Gardner and Harris v Secretary of State for Health and Social Care* [2022] EWHC 967 (Admin).

In *Fenech v Malta*²⁰⁸ the applicant claimed *inter alia* a violation of Article 2 due to the State's failure to protect his life during the COVID-19 crisis. A detainee in the Corradino Correctional Facility, he has one kidney only. His health status made him particularly vulnerable to the ramifications of COVID-19 were he to be infected.²⁰⁹ In this context, the unsanitary prison conditions, set out in the judgment, engaged the State's positive obligations to safeguard the right to life of vulnerable people.²¹⁰ In its decision of March 2022, the Court accepted the government's position that the applicant had not shown how these shortcomings had placed his life at real and imminent risk.²¹¹ The Court noted that although Article 2 could apply in COVID-19 related cases, the applicant had failed to show that State omissions or acts had put his life in real danger.²¹² Thus, the claim could not 'attract the applicability of Article 2'²¹³ and the Court upheld the Government's objection.²¹⁴

b) Allocation of resources and hospital dysfunctioning

In *Asiye Genç v Turkey*²¹⁵ a failure to ensure adequate neonatal care had led to the death of the applicant's son, who was deprived of emergency care and any form of treatment.²¹⁶ The applicant's son was born prematurely and experienced respiratory complications thereafter.²¹⁷ There was no neonatal unit in the Gümüşhane public hospital, where he was born, and he had to be transferred to the Karadeniz Teknik Üniversitesi Farabi public hospital which was located 110 km away and had no available places in its neonatal

208 *Fenech v Malta* ECtHR Application no. 19090/20 (2020).

209 *Fenech v Malta* ECtHR Application no. 19090/20 (2020) §§29 and 40.

210 *Fenech v Malta* ECtHR Application no. 19090/20 (2020) see §67.

211 *Fenech v Malta* ECtHR Application no. 19090/20 (2022) §§99, 104.

212 *Fenech v Malta* ECtHR Application no. 19090/20 (2022) §104.

213 *Fenech v Malta* ECtHR Application no. 19090/20 (2022) §106.

214 *Fenech v Malta* ECtHR Application no. 19090/20 (2022) §§107-108.

215 *Asiye Genç v Turkey* ECtHR Application no. 24109/07 (2015).

216 *Asiye Genç v Turkey* ECtHR Application no. 24109/07 (2015) §82.

217 *Asiye Genç v Turkey* ECtHR Application no. 24109/07 (2015) §§4-13.

intensive unit.²¹⁸ As a result he was transferred again to the Trabzon Medico-Surgical and Obstetrics Centre which had no incubators²¹⁹ and finally to Karadeniz Teknik Üniversitesi Farabi, where the doctors refused to admit the baby on the basis that there were no available neonatal places. Soon after the baby died in the ambulance.²²⁰ The question for the ECtHR was whether the domestic authorities ‘did what could have reasonably been expected of them’ in order to satisfying their positive obligations to protect the lives of those in their care.²²¹

The Court noted the circumstances that led to the death of the applicant’s son: a failure of coordination between hospitals, inability urgent to conduct medical examinations, lack of available places in the neonatal unit, and a shortage of essential equipment, in particular incubators, with some of the latter being out of order.²²² The Court noted that these circumstances showed that the State had not taken all necessary steps to ensure the ‘smooth organisation and correct functioning of the public hospital service, and more generally of its system for health protection’; the unavailability of places was not solely related to rapid arrival of patients, but indicated chronic hospital dysfunctioning.²²³ The Court held that both the failure to provide essential emergency care to the premature baby and the subsequent ‘insufficient nature’ of the investigation into the circumstances that led to his death violated Article 2.²²⁴

Similarly, in *Aydoğdu v Turkey*²²⁵ the Court held that the authorities must have been aware of the existing risk to the lives of multiple patients because of the chronic dysfunctions in the hospital. Notwithstanding that knowledge, they had failed to take appropriate steps to remedy the

218 *Asiye Genç v Turkey* ECtHR Application no. 24109/07 (2015) §§4-13.

219 *Asiye Genç v Turkey* ECtHR Application no. 24109/07 (2015) §§4-13.

220 *Asiye Genç v Turkey* ECtHR Application no. 24109/07 (2015) §§4-13.

221 *Asiye Genç v Turkey* ECtHR Application no. 24109/07 (2015) §75.

222 *Asiye Genç v Turkey* ECtHR Application no. 24109/07 (2015) §§1-7, 77, 80.

223 *Asiye Genç v Turkey* ECtHR Application no. 24109/07 (2015) §80.

224 *Asiye Genç v Turkey* ECtHR Application no. 24109/07 (2015) §87.

225 *Aydoğdu v Turkey* ECtHR Application no. 40448/06 (2016).

situation.²²⁶ The premature baby in this case, suffering from respiratory distress, required treatment with ‘intensive care incubators and neonatal mechanical ventilation systems’, which the Atatürk hospital did not have.²²⁷ The premature baby was transferred to the Behçet Uz Hospital, which lacked an available place in the intensive care unit.²²⁸ The Court referred specifically to the ‘operational choices to be made in terms of priorities and resources’ and ‘proper organisation and functioning’ of the hospital service.²²⁹ It held that the victim had died as a result of the lack of coordination of the health care personnel, the structural deficiencies of the hospital system, and the inaccessibility of treatment.²³⁰

It is worth noting the ECtHR’s interpretation of the positive obligations of the State as explained by the Court in *Nencheva*, discussed previously:

*Article 2 of the Convention may, in certain well-defined circumstances, impose a positive obligation on the authorities to take preventive practical measures to protect the individual against others or, in certain particular circumstances, against himself. However, this obligation must be interpreted in such a way as not to impose an unbearable or excessive burden on the authorities, bearing in mind, in particular, the unpredictability of human behavior and the operational choices to be made in terms of priorities and resources (...) For there to be a positive obligation, it must be established that the authorities knew or should have known at the time that a given individual was under real and immediate threat in his or her life, and that they did not take, within their powers, the measures which, from a reasonable point of view, would undoubtedly have mitigated this risk.*²³¹

In the factual circumstances of this case, the Government had not demonstrated how taking preventive measures ‘would have placed an

226 *Aydoğdu v Turkey* ECtHR Application no. 40448/06 (2016) §87.

227 *Aydoğdu v Turkey* ECtHR Application no. 40448/06 (2016).

228 *Aydoğdu v Turkey* ECtHR Application no. 40448/06 (2016).

229 *Aydoğdu v Turkey* ECtHR Application no. 40448/06 (2016) §87.

230 ‘[I]n particular for lack of a regulatory framework capable of imposing on hospitals rules guaranteeing the protection of the lives of premature children, including the applicants’ daughter’; *Aydoğdu v Turkey* ECtHR Application no. 40448/06 (2016) §87.

231 *Nencheva v Bulgaria* ECtHR Application no. 48609/06 (2013) §108, 118 (emphasis added).

unbearable or excessive burden in terms of the operational choices to be made in terms of priorities and resources'.²³² The Court found a violation of Article 2 on the basis of the failure of the State to ensure the smooth functioning of the public hospital service in the region of İzmir.²³³

In *Mehmet Şentürk and Bekir Şentürk v Turkey*²³⁴ the applicants' mother and wife, and the child she was carrying, died as a result of being unable to access emergency care due to what the Court described as a 'flagrant dysfunctioning of hospital departments';²³⁵ the emergency treatment was made conditional on payment prescribed by policy.²³⁶ The ECtHR underlined that it did not intend to rule *in abstracto* on the State's national health policy. Neither, however, could it absolve the national bodies from their responsibility to provide treatment to the patient.²³⁷ The Court underlined that when a State denies an individual health care which is available to the population in general, Article 2 may be triggered.²³⁸ It found that Article 2 had been violated in this case.

In *Ivanov v Bulgaria*,²³⁹ the applicants' daughter was diagnosed with acute myocarditis; she was transferred to the Burgas Multi-Profile Active Treatment Hospital. The hospital did not have a paediatric cardiology ward,²⁴⁰ or a functioning echograph.²⁴¹ The child's condition deteriorated, and she died two days after her first admission to the hospital. The applicants claimed that the hospital failed to provide their daughter with adequate treatment and medicines, that the staff was ill-equipped and insufficiently trained, and that they had failed to monitor the child's critical

232 *Aydoğdu v Turkey* ECtHR Application no. 40448/06 (2016) §87.

233 *Aydoğdu v Turkey* ECtHR Application no. 40448/06 (2016) §87.

234 *Mehmet Şentürk and Bekir Şentürk v Turkey* ECtHR Application no. 13423/09 (2013).

235 *Mehmet Şentürk and Bekir Şentürk v Turkey* ECtHR Application no. 13423/09 (2013) §97.

236 *Mehmet Şentürk and Bekir Şentürk v Turkey* ECtHR Application no. 13423/09 (2013) §95.

237 *Mehmet Şentürk and Bekir Şentürk v Turkey* ECtHR Application no. 13423/09 (2013) §95.

238 *Mehmet Şentürk and Bekir Şentürk v Turkey* ECtHR Application no. 13423/09 (2013) §88.

239 *Ivanov v Bulgaria* ECtHR Application no. 67320/16 (2020).

240 *Ivanov v Bulgaria* ECtHR Application no. 67320/16 (2020) §§1-12.

241 *Ivanov v Bulgaria* ECtHR Application no. 67320/16 (2020) §§1-12.

condition.²⁴² The Burgas Health Centre responded that the death had occurred due to insufficient equipment and organisational problems, as confirmed by the Ministry of Health and the Medical Audit Agency.²⁴³ The ECtHR was not satisfied that there had been a systemic hospital dysfunction,²⁴⁴ and reaffirmed the State's discretion in allocating public funds for health care. It concluded that there was no basis on which to hold the State directly liable for the death of the applicants' daughter under Article 2.²⁴⁵

Limited resources and life-saving treatment

In *Pentiacova v Moldova*,²⁴⁶ the applicants complained of the State's failure to safeguard their right to life under Article 2 by not providing the necessary medication for their condition (haemodialysis) or treatment. The limited financing of the Spitalul Clinic permitted only an insufficient number of treatment sessions per week.²⁴⁷ That the hospital could not cover all necessary medication in the period after 1997 due to budget cuts was also noted.²⁴⁸ The ECtHR commented on the wide margin of appreciation afforded to States in determining the allocation of limited State resources and public funds:

[T]he applicants' claim amounts to a call on public funds which, in view of the scarce resources, would have to be diverted from other worthy needs funded by the taxpayer. While it is clearly desirable that everyone should have access to a full range of medical

242 'The applicants complained under Article 2 of the Convention that the hospital in which their daughter had died had failed to provide her with adequate medical care. They alleged, in particular, that the hospital staff (a) had underestimated the child's diagnosis; (b) had not been properly equipped and trained, in particular for intensive care; (c) had not informed them of a possibility to transfer the child to a suitably equipped paediatric cardiology ward; (d) had failed duly to monitor the child's condition; (e) had not administered heart stimulating drugs or attempted pericardiocentesis; and (f) had given the child an inappropriate medicine (Cordarone)'; *Ivanov v Bulgaria* ECtHR Application no. 67320/16 (25 February 2020) §40.

243 *Ivanov v Bulgaria* ECtHR Application no. 67320/16 (2020) §§14-15.

244 *Ivanov v Bulgaria* ECtHR Application no. 67320/16 (2020) §50.

245 *Ivanov v Bulgaria* ECtHR Application no. 67320/16 (2020) §49-50.

246 *Pentiacova v Moldova* ECtHR Application no. 14462/03 (2005).

247 *Pentiacova v Moldova* ECtHR Application no. 14462/03 (2005) p.2-4.

248 *Pentiacova v Moldova* ECtHR Application no. 14462/03 (2005) p.2-4.

*treatment, including life-saving medical procedures and drugs, the lack of resources means that there are, unfortunately, in the Contracting States many individuals who do not enjoy them, especially in cases of permanent and expensive treatment.*²⁴⁹

The Court noted that the death of a person with chronic renal failure was not in itself proof of shortcomings in medical care.²⁵⁰ It noted that the applicants had failed to show that the lack of a specific drug or medical care in general had caused the death, finding the claim under Article 2 ill-founded.²⁵¹

The decision in *Pentiacova*, was considered again by the Court in *Wiater v Poland*.²⁵² The applicant there was diagnosed with narcolepsy and several other conditions (type 2 diabetes, hypertension, epilepsy, ischaemic heart disease) and had requested reimbursement of the cost of necessary drugs.²⁵³ He claimed that the State had failed to fulfil its obligations under Article 2 by omitting to take positive steps to safeguard his life. The ECtHR disagreed. It noted that the applicant had not been refused the health care generally available to the public in Poland, and that the ‘impossibility of public funding’ for a particular drug could not be considered a breach of Article 2.²⁵⁴ The Court repeated its comments in *Pentiacova* that:

*[W]hile it was clearly desirable that everyone should have access to a full range of medical treatment, including life-saving medical procedures and drugs, lack of resources meant that there were, unfortunately, many individuals in the Contracting States who did not enjoy them, especially in cases of permanent and expensive treatment.*²⁵⁵

The Court recalled that the margin of appreciation afforded to the State in the allocation of public funds in the context of health care and scarce resources is a wide one, holding the claim under Article 2 ill-founded.²⁵⁶

249 *Pentiacova v Moldova* ECtHR Application no. 14462/03 (2005) p.13.

250 *Pentiacova v Moldova* ECtHR Application no. 14462/03 (2005) p.15.

251 *Pentiacova v Moldova* ECtHR Application no. 14462/03 (2005) p.15.

252 *Wiater v Poland* ECtHR Application no. 42290/08 (2012).

253 *Wiater v Poland* ECtHR Application no. 42290/08 (2012) §37.

254 *Wiater v Poland* ECtHR Application no. 42290/08 (2012) §§38-39.

255 *Wiater v Poland* ECtHR Application no. 42290/08 (2012) §36; *Pentiacova v Moldova* ECtHR Application no. 14462/03 (2005) p.13-14.

256 *Wiater v Poland* ECtHR Application no. 42290/08 (2012) §§36-41.

The Court noted that the decision in *Nitecki* relied by the applicant did not in fact support his case.²⁵⁷

In *Nitecki v Poland*²⁵⁸ a pensioner claimed a violation of Article 2 after his application for a full refund of a life-saving drug (Rilutek) was rejected. The applicant had been diagnosed with amyotrophic lateral sclerosis (ALS). Without access to the specific drug, his untimely death was likely.²⁵⁹ Bydgoszcz Municipal Social Services responded to the applicant's request by citing the limited resources designated for the refund of drugs.²⁶⁰ The ECtHR noted that, considering the overall resources available to the applicant,²⁶¹ it could not be said that the State had failed to fulfil its positive obligations under Article 2.²⁶²

In response to the claim under Article 14, it is worth noting that the Court considered the difficult choices facing the State provided reasonable justification for differentiated treatment:

*The Court recalls that Article 14 only prohibits differences in treatment which have no objective or reasonable justification. However, the Court finds such justification to exist in the present health care system which makes difficult choices as to the extent of public subsidy to ensure a fair distribution of scarce financial resources. There is no evidence of arbitrariness in the decisions which have been taken in the applicant's case.*²⁶³

257 See also the decisions in *Z v Poland* ECtHR Application no. 46132/08 (2012), in which the court considered only the procedural limb of Article (§§76-77; no violation of Article 2), and the decision in *Hristozov v Bulgaria* ECtHR Application nos. 47039/11 and 358/12 (2012) regarding the refusal of experimental medical treatment to terminally-ill cancer patients; 'in the Court's view Article 2 of the Convention cannot be interpreted as requiring access to unauthorised medicinal products for the terminally ill to be regulated in a particular way (...) this matter remains within the competence of the member States' (§108; no violation of Article 2).

258 *Nitecki v Poland* ECtHR Application no. 65653/01 (2002).

259 *Nitecki v Poland* ECtHR Application no. 65653/01 (2002) p.4.

260 *Nitecki v Poland* ECtHR Application no. 65653/01 (2002) p.3.

261 Including a 70% (but not 100% as requested) refund for the specific drug, access to medical treatment, facilities, drugs, and public health service in Poland; *Nitecki v Poland* ECtHR Application no. 65653/01 (2002) p.5.

262 *Nitecki v Poland* ECtHR Application no. 65653/01 (2002) p.5.

263 *Nitecki v Poland* ECtHR Application no. 65653/01 (2002) p.5.

We can contrast the decision in *Nitecki* with the case of *Panaitescu v Romania*,²⁶⁴ concerning the treatment of a patient diagnosed with cancer, requesting the necessary drugs for his condition (Roferon and Avastin) free of charge and a refund for the medical costs he had incurred to date.²⁶⁵ It should be noted that according to national Law no. 189/2000, the applicant was entitled to free medication, a right that had been confirmed in the domestic courts.²⁶⁶

The ECtHR noted that acts or omissions of the State in the context of health care may trigger the protection of Article 2.²⁶⁷ Yet, by making ‘adequate provision for securing high professional standards among health professionals’, the State may have fulfilled its positive obligations.²⁶⁸ It held that the question to be addressed in this, and similar claims, is whether the State, in the particular circumstances, did all that could have been required ‘to prevent the applicant’s life from being avoidably put at risk by timely providing him with appropriate health care’?²⁶⁹ The deterioration of the applicant’s health alone does not suffice to make out a case if the relevant domestic authorities have taken reasonable medical measures to protect the right to life in a timely manner.²⁷⁰ The Court held that, on the facts in *Panaitescu*, this was not the case.

The applicant’s right to receive the necessary medication free of charge as prescribed by domestic law had been denied and his right to life and health hindered.²⁷¹ Considering the severity of the applicant’s illness, and the positive impact the medication had in fact when administered, the State authorities must have known that in its absence, the applicant’s life would be at risk.²⁷² The Court held that the State cannot cite the lack of resources

264 *Panaitescu v Romania* ECtHR Application no. 30909/06 (2012).

265 *Panaitescu v Romania* ECtHR Application no. 30909/06 (2012) §11-13.

266 *Panaitescu v Romania* ECtHR Application no. 30909/06 (2012) §31.

267 *Panaitescu v Romania* ECtHR Application no. 30909/06 (2012) §28.

268 *Panaitescu v Romania* ECtHR Application no. 30909/06 (2012) §28.

269 *Panaitescu v Romania* ECtHR Application no. 30909/06 (2012) §30.

270 *Panaitescu v Romania* ECtHR Application no. 30909/06 (2012) §30.

271 *Panaitescu v Romania* ECtHR Application no. 30909/06 (2012) §§32-34.

272 *Panaitescu v Romania* ECtHR Application no. 30909/06 (2012) §36.

or funds as an excuse to avoid its duties under Article 2.²⁷³ The State authorities had failed to protect the applicant's right to life by not providing the necessary medication free of charge and in a timely manner, as ordered by the domestic courts, in breach of the procedural limb of Article 2 (see 1.1.2.1).²⁷⁴

The issue of the positive obligations of the State under Article 2 was also considered in *Volintiru v Italy*,²⁷⁵ a case concerning poor hospital conditions and inadequate medical care which led to the death of the applicant's mother, and in *Le Mailloux v France*,²⁷⁶ where the applicant relied on Article 2 to claim that the State had failed to fulfil its positive obligations to protect the lives and the physical integrity of persons under its jurisdiction.²⁷⁷

1.1.1.9. Discussion

It is of interest to note the separate joint concurring opinion of Judges Lemmens, Spano and Kjølbro in *Asiye Genç v Turkey*²⁷⁸ discussed above (see 1.1.2.5(b)), who partially agreed with the reasoning of the ECtHR. For them, there was no reason to criticise the limited capacity of the hospital, or the number of incubators available.²⁷⁹ Article 2 does not require a specific standard of treatment and equipment, and these were difficult decisions which should in principle be left to States:

273 *Panaitescu v Romania* ECtHR Application no. 30909/06 (2012) §35.

274 *Panaitescu v Romania* ECtHR Application no. 30909/06 (2012) §§37-38.

275 *Volintiru v Italy* ECtHR Application no. 8530/08 (2008).

276 *Le Mailloux v France* ECtHR Application no. 18108/20 (2020).

277 At the domestic level, the applicant had intervened in an application to the the *Conseil d'État* (Council of State) requiring France to provide 'FFP2 and FFP3 masks to doctors and health professionals, surgical masks to patients and the general population, (...) provide protective equipment to patients and healthcare personnel and introduce mass screening'; *Le Mailloux v France* ECtHR Application no. 18108/20 (2020) §4 (unofficial translation from French). The case was dismissed by the interim judge. Before the ECtHR, the applicant specifically complained about restrictions to diagnostic tests. Although the application was inadmissible due to the failure of the applicant to satisfy the victim threshold test under Article 34 of the Convention, the case remains significant for the comments of the Court on the right to health (§9).

278 *Asiye Genç v Turkey* ECtHR Application no. 24109/07 (2015).

279 *Asiye Genç v Turkey* ECtHR Application no. 24109/07 (2015) §4.

*In general, Article 2 of the Convention cannot be interpreted as requiring a certain standard, level or quality of treatment and equipment in public hospitals. The capacity to provide treatment as well as the level of treatment and the quality of equipment is an area where States have to make difficult decisions taking into account a number of factors, including prioritisation of needs as well as the reality of limited financial resources.*²⁸⁰

The implication of this comment in the context of COVID-19 would be to narrow the scope of acceptable claims that Article 2 has been violated, as in the Bulgarian vaccine distribution scenario. The discretion afforded to States should be a question of degree, determined by paying close attention to the specific factual circumstances of a given case rather than blind acceptance of any State decision-making. This is particularly so where State decision-making has been shown to be obviously unreasonable or consistently in disregard of the need to protect public health, particularly as regards vulnerable population groups who are dependent on State provision of adequate care. In that light, the Court's reluctance to impute responsibility to the State in *Asiye Genç v Turkey*,²⁸¹ is difficult to justify given that there had been multiple transfers of a premature baby with an underlying urgent condition between hospitals, which all had inadequate, broken, or no equipment.²⁸²

Following the reasoning of the ECtHR in the case law explored above, it seems unlikely that the onerous obligations of the States to protect the right to life could be negated merely by invoking a lack of limited resources. The reasoning of the Court in *Panaitescu* is a testament to that. Yet, in analysing and submitting claims under Article 2, it is worth recalling that the margin of appreciation afforded to States in the allocation of limited health and other resources is a wide one, as is clear from the reasoning of the Court in *Wiater*. The Court will consider the specific factual circumstances of each case, with a particular focus on any positive measures already taken by the State in question, as well as their adequacy, duration, and quality.

²⁸⁰ *Asiye Genç v Turkey* ECtHR Application no. 24109/07 (2015) §4.

²⁸¹ *Asiye Genç v Turkey* ECtHR Application no. 24109/07 (2015).

²⁸² See also commentary on the margin of appreciation in ECtHR jurisprudence; George Letsas, 'Two Concepts of the Margin of Appreciation' (2006) 26 (4) *Oxford Journal of Legal Studies* 705; Jan Kratochvíl, 'The Inflation of The Margin of Appreciation by the European Court of Human Rights' (2011) 29 (3) *Netherlands Quarterly of Human Rights* 324.

It will assess whether the State has taken all steps within its power, which could be reasonably expected to protect the right to life of the persons in its jurisdiction. In its application of Article 2, the Court seems readier to hold a violation of the right to life where chronic hospital dysfunctioning can be proved as seen in *Asiye Genç* and *Aydoğdu*. Prior knowledge of enduring dysfunctions or shortcomings in its health and medical care system is significant in this regard. That is especially the case when steps available to States to protect the lives of the most vulnerable in society have not been followed, or where continuous failure persists.²⁸³

In the following section we examine selected case law on the right to life in other regional systems. These will yield further insights concerning the requirement of prior knowledge by the relevant authorities of conditions and system failures which lead to severe disease or death among vulnerable population groups.

1.1.2. Additional Regional Systems

Inter-American Court of Human Rights

In *Sawhoyamaxa Indigenous Community v Paraguay*²⁸⁴ the failure of Paraguay to recognise the land rights of an indigenous community forced its members to live in unsanitary conditions, with no access to medical treatment or health care.²⁸⁵ These conditions led in turn to numerous deaths as a result of the spread of disease (measles, pneumonia, tetanus, bronchitis, cachexia), the lack of medical treatment (for respiratory failure, fever, enterocolitis) and the inaccessibility of basic supplies and food (malnutrition was also cited as a cause of death). Children and the elderly were disproportionately affected. Of 46 deaths cited in the case,²⁸⁶ 32

283 See the comments by the Open Society European Policy Institute in the complaint to the European Committee of Social Rights highlighting the continuous failure of the Bulgarian authorities to protect the rights to life, health, health-related information, and non-discrimination of the most vulnerable population; No. 204/2022 *Open Society European Policy Institute (OSEPI) v Bulgaria* (2022) §42.

284 *Sawhoyamaxa Indigenous Community v Paraguay* Inter-American Court of Human Rights (Inter-Am Ct HR) (ser. C) No. 146 (2006).

285 *Sawhoyamaxa Indigenous Community v Paraguay* Inter-American Court of Human Rights (Inter-Am Ct HR) (ser. C) No. 146 (2006) §73(61-62).

286 *Sawhoyamaxa Indigenous Community v Paraguay* Inter-American Court of Human Rights (Inter-Am Ct HR) (ser. C) No. 146 (2006) §§ 62, 67.

were of individuals under 3 years and 5 were over 60.²⁸⁷ A description of conditions in the Sawhoyamaxa community included in the decision of the Inter-American Court of Human Rights (IACtHR) reveals the scale of exclusion from medical care and access to the most basic health resources:

*The members of the Community do not have a health post or center in their settlements and are rarely visited by health workers. Visits by health workers have been made without notice, for which reason only a few members of the Community were given medical care. The nearest medical center for the members of the Community to attend is the Hospital Regional de Concepción [Hospital Regional de Concepción] (Concepción Regional Hospital) located 46 kilometers away (from Santa Elisa settlement). According to the Paraguayan legislation, medical, dental, hospital, laboratory services and other medical procedures should be provided by the State to the members of the Indigenous Communities of Paraguay free of charge. However, when they are ill they generally resort to the traditional medicine or to “household remedies.” The greatest material obstacle the members of this indigenous community have to face in order to have access to medical care is the lack of financial means to travel to the hospitals and to buy medicines.*²⁸⁸

Denial of treatment to patients from the community who had been admitted to local hospitals was also noted.²⁸⁹ The Inter-American Commission on Human Rights, which filed the application for the consideration by the Court noted that the ‘provision of food and medical care’ by the State was evidently irregular and insufficient, and that the deaths of members of the community were preventable.²⁹⁰

287 *Sawhoyamaxa Indigenous Community v Paraguay* Inter-American Court of Human Rights (Inter-Am Ct HR) (ser. C) No. 146 (2006) §61-62. The Court did not consider all the cases in the list of the deceased. Some were omitted, because of predating the date when Paraguay accepted the jurisdiction of the Court (1993) (see §71) and cases that were not included in the petition (see §§69-72).

288 *Sawhoyamaxa Indigenous Community v Paraguay* Inter-American Court of Human Rights (Inter-Am Ct HR) (ser. C) No. 146 (2006) §73 (72); emphasis added.

289 *Sawhoyamaxa Indigenous Community v Paraguay* Inter-American Court of Human Rights (Inter-Am Ct HR) (ser. C) No. 146 (2006) §73 (74), see illustratively case studies (1), (4) and (8).

290 *Sawhoyamaxa Indigenous Community v Paraguay* Inter-American Court of Human Rights (Inter-Am Ct HR) (ser. C) No. 146 (2006) §145.

The question for the IACtHR was whether under these circumstances, the State had followed the necessary measures within the scope of its responsibilities to protect the right to life under Article 4 of the American Convention on Human Rights; measures that would be expected to prevent the risk imposed.²⁹¹ The Court rejected the so-called ‘joint responsibility’ argument made by the State, i.e. that members of the community who were ill had also a responsibility to attend medical centres to receive the necessary treatment and that community leaders were required to communicate such events to the relevant health authorities.²⁹² The Court concluded that the State had not fulfilled the necessary positive steps that were reasonably expected and within its powers to protect the right to life, in violation of Article 4 (1) of the American Convention.²⁹³

The IACtHR reached a similar conclusion in *Xákmok Kásek Indigenous Community v Paraguay*.²⁹⁴ Although the case was also decided on the basis of property rights, it is noteworthy that State-imposed conditions frustrated access to health care and medicine, threatening the community’s survival and causing deaths that were preventable. The Court emphasised that the right to life is fundamental, and a prerequisite for the enjoyment of all human rights: ‘Restrictive notions with regard to this right’ were therefore ‘not admissible.’²⁹⁵ It also reaffirmed the existence of both negative and positive dimensions of the State’s duty to protect the right to life. Interpretation of the scope of this duty in the inter-American system aligns with the reasoning of the ECtHR in the application of Article 2 as explored in the case law above (see 1.1.2). The IACtHR noted that:

291 *Sawhoyamaxa Indigenous Community v Paraguay* Inter-American Court of Human Rights (Inter-Am Ct HR) (ser. C) No. 146 (2006) §156.

292 *Sawhoyamaxa Indigenous Community v Paraguay* Inter-American Court of Human Rights (Inter-Am Ct HR) (ser. C) No. 146 (2006) §173.

293 *Sawhoyamaxa Indigenous Community v Paraguay* Inter-American Court of Human Rights (Inter-Am Ct HR) No. 146 (2006) §§178, 180. Article 4 states: ‘1. Every person has the right to have his life respected. This right shall be protected by law and, in general, from the moment of conception. No one shall be arbitrarily deprived of his life.’ Organization of American States (OAS), American Convention on Human Rights (‘Pact of San Jose’), Costa Rica 22 November 1969.

294 *Xákmok Kásek Indigenous Community v Paraguay* Inter-American Court of Human Rights (Inter-Am Ct HR) (ser. C) No. 214 (2010).

295 *Xákmok Kásek Indigenous Community v Paraguay* Inter-American Court of Human Rights (Inter-Am Ct HR) (ser. C) No. 214 (2010) §186.

*The Court has emphasized that a State cannot be held responsible for every situation that jeopardizes the right to life. Taking into account the difficulties involved in the planning and adoption of public policies and the operational choices that must be made based on priorities and resources, the positive obligations of the State must be interpreted in such a way that an impossible or disproportionate burden is not placed on the authorities. To give rise to this positive obligation, it must be established that, at the time of the facts, the authorities knew or should have known of the existence of a situation of real and immediate risk to the life of an individual or group of specific individuals, and that they did not take the necessary measures within their powers that could reasonably be expected to prevent or avoid that risk.*²⁹⁶

Adopting a similar stance to that taken in *Sawhoyamaya Indigenous Community*, the Court held that on the facts that the State had failed to take the appropriate measures to protect the right to life. It found that Article 4 (1) of the American Convention on Human Rights had been violated.²⁹⁷

1.2. National Jurisdictions

The following section introduces selected case law from national jurisdictions across the regions of Europe, the Americas, Asia, and Africa, which support or could inform analysis by analogy with the Bulgarian vaccine distribution scenario. The claims selected illustrate one or more of the following elements: (i) the allocation of scarce health and other resources and the discretion afforded to States by the courts in this context; (ii) a denial of or restriction on access to treatment because of poor, unreasonable, or irregular distribution of resources including health resources and medicines; (iii) policies in relation to lack of medical

²⁹⁶ *Xákmok Kásek Indigenous Community v Paraguay* Inter-American Court of Human Rights (Inter-Am Ct HR) (ser. C) No. 214 (2010) §188.

²⁹⁷ *Xákmok Kásek Indigenous Community v Paraguay* Inter-American Court of Human Rights (Inter-Am Ct HR) (ser. C) No. 214 (2010) §234. See also the Court's comments at §208, noting that it acknowledges the progress made by the State authorities, but that the measures taken remained 'transient' and 'temporary'. The Court specifically noted the the State had not ensured the 'physical or geographical access to health-care establishments' neither that the medical supplies and treatment available were adequate. Of interest is also the comment of the Court on the lack of health-related education that would be respectful to community traditions and practices; *Xákmok Kásek Indigenous Community v Paraguay* Inter-American Court of Human Rights (Inter-Am Ct HR) (ser. C) No. 214 (2010) §208.

equipment, staff, treatment, and medicines, that may result in a (possibly discriminatory) refusal of treatment. Claims that allow (iv) comparisons between national and international law on the right to life; (v) provide insights into the implementation of vaccination programmes; or (vi) offer possibilities for the identification of additional cases for future consideration, are also included.

1.2.1. Europe

Armenia

In EKD/0077/11/12 before the Armenian Court of Cassation, the applicant's son had allegedly contracted hepatitis B during treatment, leading to his death.²⁹⁸ The applicant, the legal successor to the victim, was initially unable to participate in the investigation into her son's death at the hospital where his condition deteriorated.²⁹⁹ The case offers insights into the procedural rights of the deceased with reference to their the victim's legitimate interests *post mortem*, an issue which has been raised in relation to the Bulgarian vaccine distribution scenario.³⁰⁰ The Court considered the duty of the State to carry out an effective investigation into the victim's death, including circumstances when governmental authorities are involved.

Applying the principles of the ECtHR under Article 2,³⁰¹ the Court ruled that no effective investigation had been carried out into the death of the victim.³⁰² The Court of Cassation also affirmed the duty of the State to take positive measures to protect the right to life under both Article 2 ECHR,³⁰³ and Article 15 of the Constitution of the Republic Armenia.³⁰⁴

298 EKD/0077/11/12 §§6-11.

299 EKD/0077/11/12 §18.

300 EKD/0077/11/12 §26.

301 EKD/0077/11/12 §31; See claims examined under Article 2 ECHR.

302 EKD/0077/11/12 §39.

303 EKD/0077/11/12 §31.

304 Article 15 of the Constitution of the Republic of Armenia states: 'Everyone shall have a right to life. No one shall be condemned to the death penalty or executed.'

England and Wales

In England and Wales, the courts have generally been reluctant to rule on policy decisions regarding the allocation of health budgets and scarce resources. In *R v Cambridge Health Authority, ex p B*,³⁰⁵ the Court of Appeal noted *inter alia* that the difficult decision of how limited resources are best allocated to the ‘maximum advantage of the maximum number of patients’ is not one for courts:

*I have no doubt that in a perfect world any treatment which a patient, or a patient's family, sought would be provided of doctors were willing to give it, no matter how much the cost, particularly when a life is potentially at stake. It would however, in my view, be shutting one's eyes to the real world if the court were to proceed on the basis that we do live in such a world. It is common knowledge that health authorities of all kinds are constantly pressed to make ends meet. Difficult and agonising judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients. That is not a judgment which the court can make. In my judgment, it is not something that a health authority such as this authority can be fairly criticised for not advancing before the court.*³⁰⁶

The National Health Service (NHS) Act 1977 (‘the NHS Act’) stipulates the duty of the State Secretary to promote a comprehensive health care system (not to ensure it; section 1 (1) NHS Act) to such extent as they deem

³⁰⁵ *R v Cambridge Health Authority, ex p B* [1995] 1 WLR 898 (CA).

³⁰⁶ *R v Cambridge Health Authority, ex p B* [1995] 1 WLR 898 (CA) at 906 (Sir Thomas Bingham MR as he then was).

necessary, reasonable, and appropriate (see section 3 (1) NHS Act).³⁰⁷ As Foster notes,³⁰⁸ this is not an absolute obligation. The English and Welsh courts will only intervene when the decision taken is irrational, which is a difficult threshold to establish.³⁰⁹ On the other hand, rationality of a decision is not made out where inflexible policies are adhered to.³¹⁰ As noted in *R v North West Lancashire Health Authority, ex p A*,³¹¹ health authorities cannot unreasonably restrict their discretion to allocate resources without considering the particular facts of each case and without acknowledging the possibility of exceptional circumstances.³¹² It is worth adding the comments of Buxton LJ, which indicate the courts' approach to such resource allocation cases:

A health authority can legitimately, indeed must, make choices between the various claims on its budget when, as will usually be the case, it does not have sufficient funds to meet all of those claims.

307 Section 1 (1) of the NHS Act 1977 states: (1) It is the Secretary of State's duty to continue the promotion in England and Wales of a comprehensive health service designed to secure improvement (a) in the physical and mental health of the people of those countries, and (b) in the prevention, diagnosis and treatment of illness, and for that purpose to provide or secure the effective provision of services in accordance with this Act. Section 3 (1) of the NHS Act 1977 states: (1) It is the Secretary of State's duty to provide throughout England and Wales, to such extent as he considers necessary to meet all reasonable requirements (a) hospital accommodation; (b) other accommodation for the purpose of any service provided under this Act; (c) medical, dental, nursing and ambulance services; (d) such other facilities for the care of expectant and nursing mothers and young children as he considers are appropriate as part of the health service; (e) such facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as he considers are appropriate as part of the health service; (f) such other services as are required for the diagnosis and treatment of illness.

308 Charles Foster, 'Simple Rationality? The Law of Healthcare Resource Allocation in England' (2007) 33 (7) *Journal of Medical Ethics* 404.

309 Charles Foster, 'Simple Rationality? The Law of Healthcare Resource Allocation in England' (2007) 33 (7) *Journal of Medical Ethics* 404, 405.

310 Charles Foster, 'Simple Rationality? The Law of Healthcare Resource Allocation in England' (2007) 33 (7) *Journal of Medical Ethics* 404, 405.

311 *R v North West Lancashire Health Authority, ex p A* [1999] EWCA Civ 2022, [2000] 1 WLR 977.

312 *R v North West Lancashire Health Authority, ex p A* [1999] EWCA Civ 2022, [2000] 1 WLR 977 at 992-93.

In making those decisions the authority can legitimately take into account a wide range of considerations, including the proven success or otherwise of the proposed treatment; the seriousness of the condition that the treatment is intended to relieve; and the cost of that treatment.

*The court cannot substitute its decision for that of the authority, either in respect of the medical judgments that the authority makes, or in respect of its view of priorities.*³¹³

This reasoning is reflected in *R (Ann Marie Rogers) v Swindon NHS Primary Care Trust*³¹⁴ with the prerequisite that the relevant authorities could reasonably envisage what these exceptional circumstances would be.³¹⁵

In *R (on the application of Condliff) v North Staffordshire Primary Care Trust*³¹⁶ Lord Toulson noted the difficult ethical and practical decisions the Primary Care Trust had to take in allocating limited resources as between the competing claims of different patients.³¹⁷ Lastly, in *Bull v Devon Area Health Authority*³¹⁸ the inadequate provision of medical staff and postnatal care was considered by the Court of Appeal. It noted that public authorities cannot necessarily escape liability by simply invoking a lack of funds. Mustill LJ noted that:

[H]ospitals such as the Devon and Exeter were in the dilemma of having to supply a maternity service, and yet not disposing of sufficient manpower to provide immediate cover, the more so since the small number of consultants and registrars had to deal with three different sites. They could not be expected to do more than their best, allocating their limited resources as favourably as possible

³¹³ *R v North West Lancashire Health Authority, ex p A* [1999] EWCA Civ 2022, [2000] 1 WLR 977 at 997.

³¹⁴ *R (Ann Marie Rogers) v Swindon NHS Primary Care Trust* [2006] EWCA Civ 392, [2006] 1 WLR 2649.

³¹⁵ *R (Ann Marie Rogers) v Swindon NHS Primary Care Trust* [2006] EWCA Civ 392, [2006] 1 WLR 2649 [62].

³¹⁶ *R (on the application of Condliff) v North Staffordshire Primary Care Trust* [2011] EWCA Civ 910, [2012] 1 All ER 689.

³¹⁷ *R (on the application of Condliff) v North Staffordshire Primary Care Trust* [2011] EWCA Civ 910, [2012] 1 All ER 689 [19], [47].

³¹⁸ *Bull v Devon Area Health Authority* [1993] 4 Med LR 117 (CA).

*(...) but there are other public services in respect of which it is not necessarily an answer to allegations of unsafety that there were insufficient resources to enable the administrators to do everything which they would like to do.*³¹⁹

This echoes the case law the ECtHR explored in previous sections (see 1.1.2.4). In *Panaitescu*, the ECtHR noted that the State cannot cite the lack of resources or funds as an excuse to avoid its duties under Article 2.³²⁰ Nevertheless, as noted by Foster,³²¹ and as reflected in ECtHR jurisprudence, positive obligations to protect the right to life cannot be interpreted as imposing a disproportionate burden on the relevant authorities; *Osman v United Kingdom*.³²² Courts in England and Wales will approach the question of allocation of limited resources with a ‘judicial realism’³²³ taking into account the relevant human, financial, and other resource-related considerations; see *R v North and East Devon Health Authority ex p Coughlan*.³²⁴

The European Convention on Human Rights is incorporated into domestic law in the UK through the Human Rights Act 1998. As such it is worth noting the following comments of Lord Hoffmann in *Matthews v Ministry of Defence*:³²⁵

*(...) human rights (...) certainly do not include the right to a fair distribution of resources or fair treatment in economic terms - in other words, distributive justice. Of course distributive justice is a good thing. But it is not a fundamental human right. No one looking at the legal systems of the member States of the Council of Europe could plausibly say that they treated distributive justice as a fundamental principle to which other considerations of policy or expediency should be subordinated.*³²⁶

³¹⁹ *Bull v Devon Area Health Authority* [1993] 4 Med LR 117 (CA) (emphasis added).

³²⁰ *Panaitescu v Romania* ECtHR Application no. 30909/06 (2012) §35.

³²¹ Charles Foster, ‘Simple Rationality? The Law of Healthcare Resource Allocation in England’ (2007) 33 (7) *Journal of Medical Ethics* 404, 405.

³²² *Osman v United Kingdom* ECtHR Application no. 87/1997/871/1083 (1998) §116.

³²³ Charles Foster, ‘Simple Rationality? The Law of Healthcare Resource Allocation in England’ (2007) 33 (7) *Journal of Medical Ethics* 404, 405.

³²⁴ *R v North and East Devon Health Authority ex p Coughlan* [2001] QB 213 (CA).

³²⁵ *Matthews v Ministry of Defence* [2003] UKHL 4, [2003] 1 AC 1163.

³²⁶ *Matthews v Ministry of Defence* [2003] UKHL 4, [2003] 1 AC 1163 at [26] (Lord Hoffmann).

These comments, along with the analysis of the case law in this section indicate that an argument based on the fair allocation of resources alone is likely to be frustrated by the doctrine of separation of powers applied in the English and Welsh courts, by the discretion afforded to the relevant authorities, and by the high threshold of irrationality applied.³²⁷ Returning to the statutory duty on executive authorities in the UK to promote an effective health care system, it is evident from the case law that a non-comprehensive health care service does not necessarily mean that there is a breach of sections 1 or 3 of the NHS Act. As the Court of Appeal has put it:³²⁸

*The truth is that, while he has the duty to continue to promote a comprehensive free health service and he must never, in making a decision under section 3, disregard that duty, a comprehensive health service may never, for human, financial and other resource reasons, be achievable. Recent history has demonstrated that the pace of developments as to what is possible by way of medical treatment, coupled with the ever-increasing expectations of the public, mean that the resources of the NHS are and are likely to continue, at least in the foreseeable future, to be insufficient to meet demand.*³²⁹

It is worth reading the comment underlined in this passage in tandem with the case law from international and regional systems explored in previous sections, which highlights the requirement of knowledge by the authorities

327 See also Foster commenting ‘A defensible decision is merely a rational one.’; Charles Foster, ‘Simple Rationality? The Law of Healthcare Resource Allocation in England’ (2007) 33 (7) Journal of Medical Ethics 404, 406.

328 *R v North and East Devon Health Authority ex p Coughlan* [2001] QB 213 (CA) at 230.

329 *R v North and East Devon Health Authority ex p Coughlan* [2001] QB 213 (CA) at 230 (emphasis added).

of conditions threatening to the right to life.³³⁰ As we have seen, courts will assess whether the relevant authorities knew of the (in some cases persistent) conditions that led to the claimants' death or deterioration in health. These two interrelated elements, i.e., disregard of duty, and knowledge of circumstances that could threaten persons' lives and health, are interrelated and, taken together are likely to reinforce a claim that the rights to life and health have been violated in this context.³³¹

Finally, it is important to consider the recent decision of the English and Welsh High Court in *Gardner and Harris v Secretary of State for Health and Social Care*.³³² The claim alleged a failure on the part of the Secretary of State to fulfil their positive obligation under Article 2 ECHR to avoid putting at risk the lives of vulnerable care home residents during the COVID-19 pandemic.³³³

The claimants alleged breaches of both the 'systems duty' (putting in place a legislative and administrative framework to protect the right to life) and the 'operational duty' (practical steps to protect individuals from specific

330 See also the requirement of knowledge as part of the three key factors to establish an operational duty under Article 2 as described by the defendants in *Gardner and Harris v Secretary of State for Health and Social Care* [2022] EWHC 967 (Admin) with which the court agreed: "it is common ground that three key factors must be present in order for the Article 2 operational duty to apply: (1) a real and immediate risk to life; (2) actual or constructive knowledge of the State of the risk; (3) a sufficient connection or link with the responsibility of the State ("the *Rabone* criteria"); at [47], [228]. See also the comments of Lord Dyson in *Sarjantson v Chief Constable of Humberside Police* [2013] EWCA Civ 1252; [2014] QB 411 at [22], that the decisions after *Osman* indicate that the ECtHR 'has not limited the scope of the Article 2 duty to circumstances where there is or ought to be known a real and imminent risk to the lives of identified or identifiable individuals'; it is sufficient that the relevant authorities know or should know that there are victims.

331 See Heywood, discussing allegations of systemic negligence and commenting on the link between individual medical error and systemic factors that have created the environment for it to occur; Rob Heywood, 'Systemic Negligence and NHS Hospitals: An Underutilised Argument' (2021) 32 (3) *King's Law Journal* 437.

332 *Gardner and Harris v Secretary of State for Health and Social Care* [2022] EWHC 967 (Admin).

333 *Gardner and Harris v Secretary of State for Health and Social Care* [2022] EWHC 967 (Admin) [151]. See also at [147] 'The claim was originally brought under ECHR Articles 2, 3, 8, and 14, at common law, under ss 19 and 29 of the Equality Act 2010 and under s 147 of the same Act, the public sector equality duty'. The Court noted that the Article 8 claim did not contribute to the analysis and thus, was not considered; claims brought under Article 3 and 14, ss 19 and 29 were not pursued before the Court; the focus was on Article 2.

dangers’).³³⁴ As regards the systems duty, the claimants argued that the facts were showed a breach of the positive obligations under Article 2 ECHR, even more clearly than those cases considered by the ECtHR such as *Budayeva v Russia* discussed above (see 1.1.2.5).³³⁵ On the present facts, it was alleged that the State had not only failed to take the necessary steps to protect the right to life, but had also introduced new dangers of infection with the coronavirus through its policy of discharging elderly hospital patients into care homes and its recommendation permitting staff to move between facilities.³³⁶ Of particular interest in the context of the Bulgarian vaccine distribution scenario is that care home residents were almost uniquely vulnerable due to being detained during the lockdown, highly susceptible to infection, and being subjected to a high level of State control, all of which endangered their lives.³³⁷ Nevertheless, the High Court held that there is no ‘clear and consistent line’ in the ECtHR jurisprudence holding that a State owes a duty to take all necessary steps to ‘avoid the real and immediate risk to life posed by an epidemic or pandemic to as broad and undefined a sector of the population as residents of care homes for the elderly’. On that basis it dismissed those elements of the claim based specifically on Article 2 ECHR.³³⁸ A parallel common law claim based on the irrationality of the discharge policies was successful. The failure to

334 *Gardner and Harris v Secretary of State for Health and Social Care* [2022] EWHC 967 (Admin) [152].

335 Citing *Budayeva v Russia* ECtHR Applications nos. 15339/02, 21166/02, 20058/02, 11673/02 and 15343/02 (2008).

336 *Gardner and Harris v Secretary of State for Health and Social Care* [2022] EWHC 967 (Admin) [155].

337 *Gardner and Harris v Secretary of State for Health and Social Care* [2022] EWHC 967 (Admin) [160].

338 ‘There is no clear and consistent line of Strasbourg authority which indicates that such a duty exists and we cannot be at all confident – indeed we gravely doubt – that the ECtHR would be willing to declare that it does. We should keep pace with the Strasbourg jurisprudence, but not run past it and disappear into the distance. The Defendants did not, in our view, owe the Article 2 operational duty for which the Claimants contend’; *Gardner and Harris v Secretary of State for Health and Social Care* [2022] EWHC 967 (Admin) [252]-[254].

require that asymptomatic patients admitted to a care home be subject to an isolation period was irrational.³³⁹

Ireland

The case of *In the matter of Article 26 of the Constitution and the Health (Amendment) (No.2) Bill 2004*,³⁴⁰ concerned the Health (Amendment) (No. 2) Bill 2004 which made amendments to the Health Act 1970 (s.53),³⁴¹ in relation to the in-patient charges, affecting specific groups of people, mostly elderly of limited means.³⁴² The Supreme Court held that the proposed amendments were not incompatible with the Constitution, noting:

*[A] requirement to pay charges of the nature provided for prospectively in the Bill could not be considered as an infringement of the constitutional right to life and the right to bodily integrity as derived from Article 40.3 of the Constitution.*³⁴³

339 '[T]he policy set out in each document was irrational in failing to advise that where an asymptomatic patient (other than one who had tested negative) was admitted to a care home, he or she should, so far as practicable, be kept apart from other residents for 14 days'; *Gardner and Harris v Secretary of State for Health and Social Care* [2022] EWHC 967 (Admin) [298]. For the claim on irrationality see also [150]. Of interest could be the statement of the claimants on the 'Breach of the duty of transparency, by misleading the public in stating that "from the start we've tried to throw a protective ring around our care homes" and "we brought in the lockdown in care homes ahead of the general lockdown" at [150].

340 *In the matter of Article 26 of the Constitution and the Health (Amendment) (No.2) Bill 2004* [2005] IESC 7 (Ir), [SC No 524 of 2004] (16 February 2005).

341 Section 53 of the Health Act 1970 states: (1) Save as provided for under subsection (2) charges shall not be made for inpatient services made available under section 52. (2) The Minister may, with the consent of the Minister for Finance, make regulations- (a) providing for the imposition of charges for in-patient services in specified circumstances on persons who are not persons with full eligibility or on specified classes or such persons, and (b) specifying the amounts of the charges or the limits to the amounts of the charges to be so made.

342 *In the matter of Article 26 of the Constitution and the Health (Amendment) (No.2) Bill 2004* [2005] IESC 7 (Ir), [SC No 524 of 2004] (16 February 2005) §§1-2.

343 *In the matter of Article 26 of the Constitution and the Health (Amendment) (No.2) Bill 2004* [2005] IESC 7 (Ir), [SC No 524 of 2004] (16 February 2005) §§5, 43.

and

*[I]t could not be an inherent characteristic of any right to in-patient services that they be provided free of charge, regardless of the means of those receiving them.*³⁴⁴

The case can be compared with expenses-related case law explored under Article 2 ECHR (see 1.1.2.5), where denial of funding of specific treatment (as in *Wiater*) or full refund for life-saving treatment (as in *Nitecki*) did not constitute a violation of Article 2.

Germany

In July 2020 the German Federal Constitutional Court granted an injunction compelling the legislature to act by introducing formal guidelines for the allocation of treatment for COVID-19.³⁴⁵ The complainants suffered from disabilities and underlying medical conditions, making them particularly susceptible to the risks of COVID-19.³⁴⁶ Absent such guidelines they feared that triage process would lead to them being excluded from lifesaving treatment in violation of their rights to life and health.³⁴⁷

344 *In the matter of Article 26 of the Constitution and the Health (Amendment) (No.2) Bill 2004* [2005] IESC 7 (Ir), [SC No 524 of 2004] (16 February 2005) §37. See also the comments of the Supreme Court at §41: ‘Counsel assigned by the court are correct in submitting that the doctrine of the separation of powers, involving as it does respect for the powers of the various organs of State and specifically the power of the Oireachtas to make decisions on the allocation of resources, cannot in itself be a justification for the failure of the State to protect or vindicate a constitutional right.’

345 *BVerfG, decision of the 3rd Chamber of the First Senate of July 16, 2020*, 1 BvR 1541/20.

346 *BVerfG, decision of the 3rd Chamber of the First Senate of July 16, 2020*, 1 BvR 1541/20, §2. For a definition of disability see Robert Koch Institute, *Health in Germany* (June 2008, Berlin) at 61: ‘A disability, as defined by the German Social Security Code (SGB IX – “The Rehabilitation and Participation of Disabled People”), exists when it can be said that in all probability a person’s physical function, mental ability or mental health will be impaired for longer than six months – compared to what would be typical for the person’s given age – resulting in an adverse effect on the person’s life in society. A person is deemed to be threatened with a disability when this adverse effect is to be expected. The normal symptoms of ageing do not constitute a disability as defined by SGB IX.’

347 *BVerfG, decision of the 3rd Chamber of the First Senate of July 16, 2020*, 1 BvR 1541/20, §§1-12.

Subsequently, in a full hearing of the substantive issues in the case the Constitutional Court ruled that the legislature had specifically violated Art. 3 Para. 3 Sentence 2 of the German Basic Law (*Grundgesetz*) which protects the rights of disabled persons:³⁴⁸

*Based on their complaint, the review conducted by the Court was limited to deciding whether the Basic Law imposes a duty on the legislator to take effective measures to ensure that no person is disadvantaged on the basis of disability in the event of pandemic-related shortages in intensive care resources, i.e. in triage situations. To date, the legislator has taken no such measures. This legislative inaction violates the duty to take action arising from the mandate of fundamental rights protection under Art. 3(3) second sentence Grundgesetz.*³⁴⁹

Latvia

The Constitutional Court of Latvia considered a claim of violation of the right to life because the lower instance courts³⁵⁰ had rejected the applicants' request for full reimbursement of medication costs for treating the rare Gaucher's disease; Case 2009-12-03.³⁵¹ The Court considered whether Article 93 of the Constitution of Latvia (stating that 'the right to life of everyone shall be protected by law') established rights that were broader in scope than Article 2 ECHR. The Court concluded that Article 93 did not encompass a right to receive medication free of charge.

1.2.2. Asia

India

In *Paschim Banga Khet Mazoor Samity v State of West Bengal*³⁵² the claimant was refused treatment at six State hospitals due to the unavailability of hospital beds or medical staff. The Supreme Court of India ruled that the

348 BVerfG, decision of the First Senate of December 16, 2021, 1 BvR 1541/20, see §1.

349 BVerfG, decision of the First Senate of December 16, 2021, 1 BvR 1541/20, see §87.

350 The Regional Court of Administrative Cases and the Department of Civil Cases of the Senate of the Supreme Court.

351 Case 2009-12-03 §3.

352 *Paschim Banga Khet Mazoor Samity v State of West Bengal* (1996) AIR SC 2426/ (1996) 4 SCC 37.

constitutional right to life under Article 21 of the Indian Constitution requires the State to protect the right to life³⁵³ irrespective of financial constraints.³⁵⁴ In this the Court drew on the (formally unenforceable) Directive Principles of Social Policy in the Constitution to determine the scope of the (enforceable) right to life. The ruling underlined that the right to life requires medical treatment that is timely (the Constitutional Court in South Africa discussed the Paschim decision in *Soobramoney v Minister of Health*³⁵⁵). In *People's Union for Civil Liberties v Union of India*,³⁵⁶ despite the availability of excess grain stocks, people starved to death in Rajasthan. The paradox of the availability of resources and the loss of life was a testament to the gross mismanagement of allocation of food. The Supreme Court ruled that the right to life under Article 21 of the Indian Constitution includes the right to food.³⁵⁷ The case was considered in *Laxmi Mandal v Deen Dayal Harinagar Hospital* (explored below) where the High Court discussed the interrelation between the rights to life, health, food, and access to health care.

In *Laxmi Mandal v Deen Dayal Harinagar Hospital*³⁵⁸ the High Court of Delhi considered two petitions by women who were denied treatment, including medicines.³⁵⁹ The High Court noted that the right to health is an

353 *Paschim Banga Khet Mazoor Samity v State of West Bengal* (1996) AIR SC 2426/ (1996) 4 SCC 37, §9.

354 *Paschim Banga Khet Mazoor Samity v State of West Bengal* (1996) AIR SC 2426/ (1996) 4 SCC 37, §16.

355 See §§18-20 of the Judgment in *Paschim Banga Khet Mazoor Samity v State of West Bengal*.

356 *People's Union for Civil Liberties v Union of India* Civil Original Jurisdiction, Writ Petition (Civil) No.196 of 2001.

357 See also Lauren Birchfield and Jessica Corsi, 'The Right to Life Is the Right to Food: People's Union for Civil Liberties v. Union of India & Others' (2010) 17 (3) Human Rights Brief 15. See also §25 'Article 21 imposes an obligation on the State to safeguard the right to life of every person. Preservation of human life is thus of paramount importance. The State cannot avoid their constitutional obligations in that regard on account of financial constraints.' Citing the decision in *Paschim Banga Khet Mazoor Samity v State of West Bengal* explored above.

358 *Laxmi Mandal v Deen Dayal Harinagar Hospital* WP(C) 8853/2008 (2010).

359 See *Laxmi Mandal v Deen Dayal Harinagar Hospital* WP(C) 8853/2008 (2010) §§28.3, 29.1-29.3.

‘inalienable component of the right to life’³⁶⁰ which can include the right to access public health facilities and a minimum standard of treatment.³⁶¹ The Court explicitly referred to Article 12 ICECSR and to General Comment No.14 on the right to health.³⁶² Of particular interest are the comments of the Court on the implementation of the government schemes that:

*Instead of making it easier for poor persons to avail of the benefits, the efforts at present seem to be to insist upon documentation to prove their status as “poor” and “disadvantaged”. This onerous burden on them to prove that they are the persons in need of urgent medical assistance constitutes a major barrier to their availing of the services.*³⁶³

This could be considered by way of analogy with the implementation of the vaccination programme in Bulgaria. In both cases the vulnerable in society are unreasonably burdened with proving that they are most in need of prioritisation in vaccination. The case also raised questions of discrimination, relevant to all of the themes considered in this report.

*Sandesh Bansal v Union of India*³⁶⁴ concerned an alarmingly high maternal mortality ratio which resulted from the high cost of health care, lack of medical personnel and health services in rural areas.³⁶⁵ Supplies to health centres, as well as the availability and access to vital services, treatments, medicines, and vaccines were all irregular.³⁶⁶ The High Court of Madhya Pradesh (Jabalpur) ruled that these failures of the public health system had resulted in preventable deaths in violation of Article 21 of the Constitution of India.³⁶⁷

360 See *Laxmi Mandal v Deen Dayal Harinagar Hospital* WP(C) 8853/2008 (2010) §20.

361 *Laxmi Mandal v Deen Dayal Harinagar Hospital* WP(C) 8853/2008 (2010) §§19-20.

362 *Laxmi Mandal v Deen Dayal Harinagar Hospital* WP(C) 8853/2008 (2010) §§22-23.

363 *Laxmi Mandal v Deen Dayal Harinagar Hospital* WP(C) 8853/2008 (2010) §48.

364 *Sandesh Bansal v Union of India* Writ Petition No. 9061/2008 (2012).

365 *Sandesh Bansal v Union of India* Writ Petition No. 9061/2008 (2012) §§10-11.

366 See *Sandesh Bansal v Union of India* Writ Petition No. 9061/2008 (2012) §21 ‘Infrastructure & Facilities Available’.

367 *Sandesh Bansal v Union of India* Writ Petition No. 9061/2008 (2012) §§10-11; 22. The case *Court on Its Own Motion v Union of India* WP 5913/2010 (2011) is considered in 2. The Right to Health.

1.2.3. Americas

Argentina

Regarding access to a specific reproductive treatment in *LEH v OSEP*,³⁶⁸ the Supreme Court of Justice noted that the right to life is not absolute. An entitlement to specific treatment (pre-implantation genetic diagnosis (PGD)) could not be ‘inserted’ into the law by the courts (Law 26.862 on assisted reproduction). The power to do so is exclusive to the legislature.³⁶⁹

Canada

A policy of excluding forms of in vitro fertilisation (IVF) under s.1 of the Canadian Charter of Rights and Freedoms was explored in *Cameron v Nova Scotia*.³⁷⁰ The Nova Scotia Court of Appeal noted that the aim of this policy was to provide ‘the best possible health care coverage to Nova Scotians in the context of limited financial resources’.³⁷¹ The Court affirmed that it would be ‘unimaginable that such a plural system could ensure that every individual would have an unlimited right to every known treatment’.³⁷² This also recalls the comments of the ECtHR in *Pentiacova* (see 1.1.2.5) noting that:

*While it is clearly desirable that everyone should have access to a full range of medical treatment, including life-saving medical procedures and drugs, the lack of resources means that there are, unfortunately, in the Contracting States many individuals who do not enjoy them, especially in cases of permanent and expensive treatment.*³⁷³

368 *LEH v OSEP* CSJ 003732/2014/RH001 (2015); unofficial translation in English provided by Lawyers Collective and partners for the Global Health and Human Rights Database.

369 This also recalls the decision in *Wiater*: the ECtHR held that the denial of funding for a specific drug did not constitute a violation of Article 2.

370 *Cameron v Nova Scotia* (Attorney General), 1999 NSCA 14 (CanLII).

371 *Cameron v Nova Scotia* (Attorney General), 1999 NSCA 14 (CanLII) §218.

372 *Cameron v Nova Scotia* (Attorney General), 1999 NSCA 14 (CanLII) §239.

373 *Pentiacova v Moldova* ECtHR Application no. 14462/03 (2005) p.13.

The Nova Scotia Court of Appeal commented on the significant ‘deference to the decision makers’ in this context,³⁷⁴ recalling our discussion on the wide margin of appreciation afforded to the States in the allocation of scarce medical resources in claims under Article 2 ECHR (see 1.1.2.4).

Additional cases in relation to the right to life that could be further explored include: *New Brunswick (Minister of Health and Community Services) v G(J)*³⁷⁵ regarding the State’s positive obligations under Section 7 of the Canadian Charter of Rights; *Allen v Alberta*³⁷⁶ and the comments of the Alberta Court of Appeal that Section 7 of the Canadian Charter of Rights does not provide a ‘freestanding right to healthcare’ can be noted;³⁷⁷ as well as the decision in *Chaoulli v Quebec (Attorney General)*³⁷⁸, and the comments of the Supreme Court on the right to life under the Quebec Charter of Human Rights and Freedoms.³⁷⁹

Bolivia

In Case108-2010-R, the Constitutional Tribunal of Bolivia ruled that the right to life and health of a minor living with HIV/AIDS were violated because of a failure to ensure access to the necessary antiretroviral drugs due to irregular supply.³⁸⁰ The Court reiterated the State’s duty to protect the rights to life and health against defective bureaucratic procedures or the exhaustion of resources.³⁸¹

374 *Cameron v Nova Scotia (Attorney General)*, 1999 NSCA 14 (CanLII) §237.

375 *New Brunswick (Minister of Health and Community Services) v G(J)* [1999] 3 SCR 46.

376 *Allen v Alberta* 2015 ABCA 277.

377 *Allen v Alberta* 2015 ABCA 277 [35], [52].

378 *Chaoulli v Quebec (Attorney General)* 2005 SCC 35, [2005] 1 SCR 791.

379 Section 1 of the Quebec Charter reads: ‘Every human being has a right to life, and to personal security, inviolability and freedom. He also possesses juridical personality.’

380 See Case108-2010-R at III.5; unofficial translation in English provided by Lawyers Collective and partners for the Global Health and Human Rights Database.

381 Case108-2010-R at III.5.

Guatemala

In the Constitutional Case No. 2605-2009 (2010), the Court ordered the Guatemalan Institute of Social Security to provide medical treatment to the patient, a minor, for the period when she was in a critical condition, so as to avoid endangering her rights to life and health.³⁸² In particular it is worth noting the comment of the Court that ‘the right to health implies that a person receive timely and effective medical attention’.³⁸³

Venezuela

The state’s failure to ensure sufficient budget allocation and medical staff resulting in violation of the right to life were also noted in *Programa Venezolano de Educación- Acción en Derechos Humanos (PROVEA) v Gobernación del Distrito Federal s/ Acción de Protección*.³⁸⁴ These cases concerned children who had died while waiting for surgery. The inadequate supply of drugs for necessary treatment was discussed in *López, Glenda v Instituto Venezolano de los Seguros Sociales (IVSS) s/ Acción de amparo*³⁸⁵ and in *Cruz del Valle Bermúdez v MSAS s/ amparo*.³⁸⁶ The latter case raises issues under both the right to life and the right to health.

382 ‘It is necessary that the Guatemalan Institute of Social Security provide the appropriate medicines and treatment in order to preserve the state of her health. Such services may not be denied to her, nor suspended, without a final judicial resolution that authorizes such suspension or denial, or until her critical health condition is resolved.’; Case No. 2605-2009 (2010) IV.

383 Case No. 2605-2009 (2010) III. Regarding the timely access to health care see also the comments of the HRC in General Comment No.36; UN Human Rights Committee (HRC), CCPR General Comment No. 36 (2019) On Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (3 September 2019), CCPR/C/GC/36, §26, and an illustration in ECtHR jurisprudence in *Panaitescu v Romania* ECtHR Application no. 30909/06 (2012) §30.

384 *Programa Venezolano de Educación-Acción en Derechos Humanos (PROVEA) v Gobernación del Distrito Federal s/ Acción de Protección* Expediente No 3174 (2001).

385 *López, Glenda v Instituto Venezolano de los Seguros Sociales (IVSS) s/ Acción de amparo* Expediente 00-1343 Sentencia No 487 (1999).

386 *Cruz del Valle Bermúdez v MSAS s/ amparo* Expediente N° 15789 Sentencia No 196 (1999).

1.2.4. Africa

South Africa

In *Soobramoney v Minister of Health (Kwazulu-Natal)*,³⁸⁷ due to limited resources, the Addington Hospital admitted only patients suffering from acute renal failure, who could be treated within a short period of time (four to six weeks).³⁸⁸ In light of this policy, the claimant, who suffered from chronic renal failure, was denied treatment.³⁸⁹ The claimant based his claim on s.27(3) ('no one should be refused emergency medical treatment') and s. 11 (the right to life) of the Constitution. The court held that the decisions of the policy-makers should be respected, especially in the context of budget allocation.³⁹⁰

*Minister of Health v Treatment Action Campaign (TAC)*³⁹¹ concerned government reluctance to distribute the anti-retroviral drug Nevirapine which could prevent thousands of deaths from the HIV/AIDS epidemic, even though the drug had been made freely available by the manufacturers. These restrictions had left thousands without treatment inevitably leading to loss of life.³⁹² The South African Constitutional Court ordered the Government to develop and implement a plan for the sustainable delivery of the anti-retrovirals across the country pursuant to s.27(1) and (2) of the Constitution.

387 *Soobramoney v Minister of Health (Kwazulu-Natal)* Case CCT 32/97 (1997).

388 *Soobramoney v Minister of Health (Kwazulu-Natal)* Case CCT 32/97; Nov 27, 1997, §3.

389 *Soobramoney v Minister of Health (Kwazulu-Natal)* Case CCT 32/97; Nov 27, 1997, §18.

390 *Soobramoney v Minister of Health (Kwazulu-Natal)* Case CCT 32/97; Nov 27, 1997, §59.

391 *Minister of Health v Treatment Action Campaign (TAC)* (2002) 5 SA 721 (CC).

392 See also Mark Heywood, 'Preventing Mother-to-Child HIV Transmission in South Africa; Background, Strategies and Outcomes of the Treatment Action Campaign Case against the Minister of Health' (2003) 19 (3) South African Journal on Human Rights 278.

Kenya

In *LN v Ministry of Health*,³⁹³ the Kenyatta National Hospital, due to limited resources and insufficient machines denied the Petitioners treatment for renal failure. The High Court of Kenya at Nairobi noted that the State has the duty to protect the right to life and health under Articles 26 (1) and 43 (1) respectively of the Constitution of Kenya.³⁹⁴ However, relying on the reasoning in *Soobramoney* (discussed above), and following Article 20 (5) of the Constitution, it held that the power to decide reasonably on the allocation of limited resources remained with the State. In this case the High Court found the steps taken reasonable.³⁹⁵ The Petitioners also unsuccessfully claimed discrimination under Article 27 (5).

In *Patricia Asero Ochieng v Attorney General*,³⁹⁶ the Petitioners, who were living with HIV/AIDS, claimed that the vaguely drafting of Section 2 of the Anti-Counterfeiting Act (2008), could be interpreted as allowing the State to seize antiretroviral drugs. They argued that this was in violation of Articles 26 (1) (right to life), 28 (human dignity) and 43 (health) of the Constitution of Kenya. The High Court of Kenya at Nairobi ruled that in this respect the Act threatened the constitutional rights to life and health,³⁹⁷ also noting that the right to health includes the right to access to affordable medicine:

The state's obligation with regard to the right to health therefore encompasses not only the positive duty to ensure that its citizens have access to health care services and medication but must also encompass the negative duty not to do anything that would in any way affect access to such health care services and

393 *LN v Ministry of Health* Petition No 218 (2013).

394 See at §67 'The state has a duty to make the necessary budgetary allocation, as well as to take the necessary legislative and policy measures, to ensure that the right to health is realized'; *LN v Ministry of Health* Petition No 218 (2013).

395 See *LN v Ministry of Health* Petition No 218 (2013) §§89-90.

396 *Patricia Asero Ochieng v Attorney General* Petition 409 of 2009.

397 See the comments of the Court that 'However, the right to life, dignity and health of people like the petitioners who are infected with the HIV virus cannot be secured by a vague proviso in a situation where those charged with the responsibility of enforcement of the law may not have a clear understanding of the difference between generic and counterfeit medicine.'; *Patricia Asero Ochieng v Attorney General* Petition 409 of 2009, §84; 87.

*essential medicines. Any legislation that would render the cost of essential drugs unaffordable to citizens would thus be in violation of the state's obligations under the Constitution.*³⁹⁸

The Court examined the constitutional right to life in relation to international agreements, including Article 12 ICESCR and General Comment No.14 of the Committee on Economic, Social and Cultural Rights.

2. Right to Health

Overview

In international human rights law, health is an inclusive notion, covering mental, physical, and social wellbeing. It is not, therefore, restricted to the absence of disease.³⁹⁹ By extension, the right to health is an inclusive right, which goes beyond safeguarding access to adequate and timely health care.⁴⁰⁰ The right to health depends on the realisation of other human rights and builds upon the underlying determinants of health, including access to safe nutrition, housing, environment, sanitation, health-related education, and participation.⁴⁰¹

However, as Paul Hunt, former Special Rapporteur on the Right to Health, has commented, the right to health has distinctive qualities that are not necessarily part of nor are secured through other rights.⁴⁰² A human

398 *Patricia Asero Ochieng v Attorney General* Petition 409 of 2009, §66

399 Constitution of the World Health Organization, UN Doc. E/155 (1946), preamble.

400 UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) §11.

401 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) §§3, 11; see also UN General Assembly (UNGA), Universal Declaration of Human Rights (10 December 1948), A/RES/217A (III) 25(1).

402 Paul Hunt, 'Interpreting the International Right to Health in a Human Rights-Based Approach to Health' (2016) 18 (2) *Health and Human Rights Journal* 109, 111.

rights-based approach to health,⁴⁰³ without an explicit reference to the international right to health, could undermine these distinct qualities.⁴⁰⁴ Thus, as will be seen in the selection of case law which follows, indirect or implicit protection of the right to health via other rights, is not always sufficient to achieve the goals on human rights in this context. That is especially the case in the exceptional circumstances imposed by a health emergency such as COVID-19, which demands the effective and equitable implementation of complex and costly health interventions.⁴⁰⁵ In the context of limited financial and other resources, what Hunt describes as the ‘operational and conceptual potential’ of the right to health, its distinctive contribution to the difficult decisions to be made is indispensable.⁴⁰⁶ Admittedly, the development of the right to health is an ongoing process, requiring and permitting adaption to new circumstances. ‘Its inherent openness (...) facilitates its own transformation’.⁴⁰⁷ This understanding of the right to health, as distinct, necessary, and dynamic permeates our analysis throughout this report.

The purpose of the following sections is to support the development of arguments on the right to health in relation to the Bulgarian vaccine distribution scenario. The analysis focuses on cases raising one or more of the following issues (i) inadequate or no access to medical treatment or medication, (ii) denial of treatment prescribed or facilitated by State policy, and (iii) the States’ positive obligations to protect the right to health and the measures they are expected to take in this context, with a special focus on vulnerable populations.

403 Hunt describes a ‘trend’ away from considering the right to health itself, and towards a more general approach to human rights and health since the early 1990s; Paul Hunt, ‘Interpreting the International Right to Health in a Human Rights-Based Approach to Health’ (2016) 18 (2) *Health and Human Rights Journal* 109, 122.

404 Paul Hunt, ‘Interpreting the International Right to Health in a Human Rights-Based Approach to Health’ (2016) 18 (2) *Health and Human Rights Journal* 109, 111.

405 Paul Hunt, ‘Interpreting the International Right to Health in a Human Rights-Based Approach to Health’ (2016) 18 (2) *Health and Human Rights Journal* 109, 111.

406 Paul Hunt, ‘Interpreting the International Right to Health in a Human Rights-Based Approach to Health’ (2016) 18 (2) *Health and Human Rights Journal* 109, 111.

407 John Harrington and Maria Stuttaford, ‘Introduction’ in John Harrington and Maria Stuttaford (eds), *Global health and human rights: Legal and philosophical perspectives* (Routledge 2010), 4.

2.1. International and Regional Systems

The right to health as recognised in the Constitution of the World Health Organization (WHO) encompasses the principles of non-discrimination and equality, emphasizing governments' responsibility for the health of their peoples, and requiring inter-state cooperation.⁴⁰⁸ Ensuring the highest attainable standard of health is a prerequisite for peace and security,⁴⁰⁹ and an indispensable right for the meaningful exercise and relations of other human rights.⁴¹⁰ This encompassing nature of the right to health is reflected in the provisions of numerous international and regional human rights law instruments. Illustratively, in Article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination,⁴¹¹ and Articles 11.1 (f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women.⁴¹²

In regional instruments, the right to health is protected by Article 16 of the African Charter on Human and People's Rights (the 'Banjul' Charter),⁴¹³ Article 10 of the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (the

408 Constitution of the World Health Organization, UN Doc. E/155 (1946), preamble.

409 Constitution of the World Health Organization, UN Doc. E/155 (1946), preamble.

410 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) §1.

411 'The right to public health, medical care, social security and social services'; UNGA, International Convention on the Elimination of All Forms of Racial Discrimination (21 December 1965), United Nations (UN), Treaty Series, vol. 660, p. 195.

412 See Article 11.1 (f) 'The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.' and 12 (1) 'States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.'; UNGA, Convention on the Elimination of All Forms of Discrimination Against Women (18 December 1979), UN, Treaty Series, vol. 1249, p. 13. See also Article 24 of the Convention on the Rights of the Child; UNGA, Convention on the Rights of the Child (20 November 1989), United Nations, Treaty Series, vol. 1577, p. 3.

413 Article 16 (1): 'Every individual shall have the right to enjoy the best attainable state of physical and mental health' and (2): 'States parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.' Organization of African Unity (OAU), African Charter on Human and Peoples' Rights (27 June 1981), CAB/LEG/67/3 rev 5, 21 ILM 58 (1982).

‘Protocol of San Salvador’),⁴¹⁴ Article 11 of the European Social Charter⁴¹⁵ and other instruments. The right to health is also protected in various national constitutions, which will be discussed later (see 2.2). First and foremost, as noted by the Committee on Economic, Social and Cultural Rights⁴¹⁶ is Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR).⁴¹⁷ This is the most comprehensive and well developed locus for the right to health in international human rights law and it is at the centre of our discussion in the following section.

2.1.1. International Covenant on Economic, Social and Cultural Rights: Article 12

Article 12 (1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR)⁴¹⁸ states that:

The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

Furthermore Section (2) of that Article requires States to safeguard the realisation of the right to health, referring explicitly in parts (c) and (d) to the prevention, control, and treatment of epidemics, and the creation of medical services available to all. Both the general provision and these specific elements are relevant to the Bulgarian vaccine distribution scenario.

⁴¹⁴ Article 10 (1): ‘Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being.’ With 10 (2) outlining the measures States are expected to adopt, including a. Primary health care (...); c. Universal immunization against the principal infectious diseases, and, d. Prevention and treatment of endemic, occupational and other diseases; Organization of American States (OAS), Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (16 November 1999), A-52.

⁴¹⁵ See Article 11 (3) to prevent as far as possible epidemic, endemic and other diseases; Council of Europe, European Social Charter (18 October 1961), ETS 35.

⁴¹⁶ CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) §2.

⁴¹⁷ CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) §2.

⁴¹⁸ UNGA, International Covenant on Economic, Social and Cultural Rights (16 December 1966), United Nations, Treaty Series, vol. 993, p. 3.

2.1.1.1. General Comment No. 14

The Committee on Economic, Social and Cultural Rights (hereafter ‘the Committee’ or ‘CESCR’) has confirmed in General Comment No.14 that States must respect, protect, and fulfil the right to health.⁴¹⁹ The obligation to ‘respect’ the right to health requires States to ‘refrain from interfering directly or indirectly with the enjoyment of the right to health’⁴²⁰ reflecting the negative obligations of the State as examined in our discussion of Article 2 ECHR on the Right to Life (see 1.1.2). It is worth noting that these obligations include the State’s duty to refrain from prohibiting or restricting preventive care, treatment and medicines.⁴²¹ The duties to ‘protect’ and ‘fulfil’ indicate the positive steps States must take in order to realise the right to health, including adopting appropriate ‘legislative, administrative, budgetary, judicial, promotional’ and additional measures.⁴²² These include securing ‘equal access to health care and health-related services provided by third parties’⁴²³ and giving sufficient recognition to the right to health in national policy, legal, and political systems.⁴²⁴

With reference to the particular context of COVID-19, it is important to note that States are also required to implement immunisation programmes against infectious diseases, ensuring a sufficient number of hospitals, clinics, other health facilities.⁴²⁵ They are expected to ensure the right of access to health facilities for all, to provide essential drugs, and to ensure

419 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) §16.

420 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) §16.

421 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) §34.

422 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) §16.

423 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) §35.

424 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) §36.

425 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) §36.

the equitable distribution of all health facilities, goods, and services.⁴²⁶ The four core elements of the right to health as illustrated by the Committee, namely, accessibility, availability, quality, and acceptability, are all closely interrelated with the principle of non-discrimination.⁴²⁷ The Committee notes that States must put in place urgent medical care systems to prevent epidemics and similar health hazards,⁴²⁸ reiterating the States' extraterritorial obligations to prevent transmissible diseases.⁴²⁹ States are expected to cooperate in the distribution and managements of resources, including medical supplies, highlighting both the individual and collective responsibility of the States to protect the right to health.⁴³⁰ The obligation of the States to co-operate on the international level is reflected in Article

426 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) §§43-44.

427 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) §35.

428 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) §16.

429 'Moreover, given that some diseases are easily transmissible beyond the frontiers of a State, the international community has a collective responsibility to address this problem.'; CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) §40.

430 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) §33.

2 (1) ICESCR,⁴³¹ General Comment 24,⁴³² and General Comment 3.⁴³³ Among the violation of States' obligations under Article 12 identified in General Comment No.14, are the failure to adopt a national health policy that ensures the right to health for everyone, misallocation of public resources which endangers the right to health, and the failure to remedy the inequitable distribution of health facilities across the country.⁴³⁴

As Special Rapporteur on the Right to Health, Paul Hunt has highlighted that international, and in some circumstances national law confirms that the right to the highest attainable standard of health is subject to 'progressive realization and resource availability'.⁴³⁵ States are obliged to take deliberate, concrete and targeted steps toward its realisation, and will not be judged by the same quantitative standard in recognition of their differing starting points as regards resources.⁴³⁶ However, he

431 'Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.'; UNGA, International Covenant on Economic, Social and Cultural Rights (16 December 1966), UN, Treaty Series, vol. 993, p. 3.

432 CESCR, General Comment No. 24 (2017) on State obligations under the International Covenant on Economic, Social and Cultural Rights in the context of business activities (10 August 2017), E/C.12/GC/24. See also Articles 55 and 56 of the UN Charter, reiterating that States should take separate and joint action to ensure the wellbeing, equal rights, and self-determination of peoples across nations; UN, Charter of the United Nations (24 October 1945), 1 UNTS XVI.

433 CESCR General Comment No. 3: The Nature of States Parties' Obligations (Art. 2, § 1, of the Covenant) Adopted at the Fifth Session of the Committee on Economic, Social and Cultural Rights, on 14 December 1990 (Contained in Document E/1991/23) §3.

434 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) §50.

435 UN General Assembly (UNGA), Implementation of General Assembly Resolution 60/251 Of 15 March 2006 Entitled "Human Rights Council" Report of The Special Rapporteur on The Right of Everyone to The Enjoyment of The Highest Attainable Standard of Physical and Mental Health, Paul Hunt, UN Doc. A/HRC/4/28 (17 January 2007) §59.

436 UN General Assembly (UNGA), Implementation of General Assembly Resolution 60/251 Of 15 March 2006 Entitled "Human Rights Council" Report of The Special Rapporteur on The Right of Everyone to The Enjoyment of The Highest Attainable Standard of Physical and Mental Health, Paul Hunt, UN Doc. A/HRC/4/28 (17 January 2007) §66.

was also clear that the equal treatment of individuals is of immediate application. The principle of non-discrimination is non-derogable, even in emergency circumstances, and it is not subject to progressive realisation.⁴³⁷ Furthermore, when it comes to resource availability, which is particularly relevant in the context of COVID-19 and vaccine distribution, States are expected to seek international assistance and cooperation to meet the obligations to protect the right to health.⁴³⁸

437 UN General Assembly (UNGA), Implementation of General Assembly Resolution 60/251 Of 15 March 2006 Entitled “Human Rights Council” Report of The Special Rapporteur on The Right of Everyone to The Enjoyment of The Highest Attainable Standard of Physical and Mental Health, Paul Hunt, UN Doc. A/HRC/4/28 (17 January 2007) §63.

438 UN General Assembly (UNGA), Implementation of General Assembly Resolution 60/251 Of 15 March 2006 Entitled “Human Rights Council” Report of The Special Rapporteur on The Right of Everyone to The Enjoyment of The Highest Attainable Standard of Physical and Mental Health, Paul Hunt, UN Doc. A/HRC/4/28 (17 January 2007) §§66-67.

Health facilities must be available (in sufficient quantity throughout the State) accessible (to everyone), acceptable (respectful to medical ethics, consent, culture), and of good quality scientifically and medically.⁴³⁹ This applies to the availability, accessibility, and acceptability of essential medicines, including vaccines.⁴⁴⁰ Essential medicines have to be (a) accessible in all parts of the country including urban and rural areas (b) affordable (c) accessible without discrimination of any kind and (d) accompanied by reliable information to patients and health professionals.⁴⁴¹ It is worth recalling the comment of the Special Rapporteur that, even with very limited resources, there is ‘much States can do to realize the right to the highest attainable standard of health’.⁴⁴² Of course, it must be recognised that States faced difficulties in protecting, respecting, and fulfilling their obligations to realise the right to health with the outbreak

439 UN General Assembly (UNGA), Implementation of General Assembly Resolution 60/251 Of 15 March 2006 Entitled “Human Rights Council” Report of The Special Rapporteur on The Right of Everyone to The Enjoyment of The Highest Attainable Standard of Physical and Mental Health, Paul Hunt, UN Doc. A/HRC/4/28 (17 January 2007) §§ 68, 69 71, 74, 75.

440 ‘States have to do all they reasonably can to make sure that existing medicines are available in sufficient quantities in their jurisdictions (...) within a framework of international assistance and cooperation, States are required to take effective measures to promote the development and availability of new drugs, vaccines and diagnostic tools for those diseases causing a heavy burden in developing countries (...) States not only have a duty to ensure that existing medicines are available within their borders, they also have a responsibility to take reasonable measures to ensure that much-needed new medicines are developed and thereby become available.’; UN General Assembly (UNGA), Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, UN Doc. A/61/338 (13 September 2006) §§47-48 (emphasis added).

441 UN General Assembly (UNGA), Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, UN Doc. A/61/338 (13 September 2006) §§49.

442 UN General Assembly (UNGA), Implementation of General Assembly Resolution 60/251 Of 15 March 2006 Entitled “Human Rights Council” Report of The Special Rapporteur on The Right of Everyone to The Enjoyment of The Highest Attainable Standard of Physical and Mental Health, Paul Hunt, UN Doc. A/HRC/4/28 (17 January 2007) §76. For the role of the Special Rapporteur see Paul Hunt and Sheldon Leader, ‘Developing and Applying the Right to the Highest Attainable Standard of Health: The Role of the UN Special Rapporteur (2002-2008)’ in John Harrington and Maria Stuttaford (eds), *Global health and human rights: Legal and philosophical perspectives* (Routledge 2010).

of COVID-19. But the detailed duties flowing from Article 12 ICESCR remained in force, nonetheless.

2.1.1.2. Article 12 in the Context of COVID-19

Shortages in essential COVID-19-related health resources, including medical care, diagnostic tests, oxygen, ventilators, and protective equipment posed enormous challenges to the right to health around the world.⁴⁴³ These difficulties added to existing national issues preventing access to health care services, such as the effect of structural adjustment programmes, austerity measures, and the related imposition of user fees.⁴⁴⁴ However, as Pūras et al. note, the right to health, its distinctive qualities,⁴⁴⁵ was capable of providing a framework for ensuring equal enjoyment of the highest attainable standard of health during the pandemic.⁴⁴⁶ This was made clear by CESCR in a statement of March 12, 2021.⁴⁴⁷ In it the Committee specifically addressed the implications of the right to health for access to vaccination against COVID-19.⁴⁴⁸ It reiterated that States have a ‘priority obligation’ to take all the appropriate steps and measures to guarantee, for all persons without discrimination, access to available vaccines to the maximum of their resources.⁴⁴⁹ This duty is supported and complemented by the corollary obligation of international

443 Dainius Pūras and others, ‘The Right to Health Must Guide Responses To COVID-19’ (2020) 395 (10241) *The Lancet* 1888.

444 Michael Thomson and others, ‘Structural Adjustment Programmes Adversely Affect Vulnerable Populations: A Systematic-Narrative Review of Their Effect on Child and Maternal Health’ (2017) 38(13) *Public Health Reviews*.

445 Paul Hunt, ‘Interpreting the International Right to Health in a Human Rights-Based Approach to Health’ (2016) 18 (2) *Health and Human Rights Journal* 109, 111.

446 Dainius Pūras and others, ‘The Right to Health Must Guide Responses To COVID-19’ (2020) 395 (10241) *The Lancet* 1888.

447 CESCR, Statement on universal affordable vaccination for COVID-19, international cooperation and intellectual property (12 March 2021), E/C.12/2021/1.

448 CESCR, Statement on universal affordable vaccination for COVID-19, international cooperation and intellectual property (12 March 2021), E/C.12/2021/1.

449 CESCR, Statement on universal affordable vaccination for COVID-19, international cooperation and intellectual property (12 March 2021), E/C.12/2021/1 §3.

cooperation between States in this context.⁴⁵⁰ Importantly, distribution and prioritisation at both the global and national levels should be based on medical needs, public health considerations, and scientific evidence, not on extraneous factors.⁴⁵¹ The CESCR noted that the exceptional challenges imposed by Covid-19 underlined the obligations of the States to contribute to the protection of the right to health globally and to cooperate in realising the rights protected under the ICESCR, with the primary goal of preventing deaths.⁴⁵² In the following we provide illustrations of the application of Article 12 in proceedings under the Optional Protocol to the ICESCR permitting individual complaints to the Committee. These confirm the significance of Article 12 for the protection of the right to health and its growing contribution to regional and national legal systems protecting people's health across jurisdictions.

2.1.1.3. Applications of Article 12

In *Merino Sierra v Spain*⁴⁵³ the authors claimed that both they and their deceased mother were victims of a violation of Article 12 (1) and (2) (d) (quality of health facilities and care) causing them severe and ongoing harm.⁴⁵⁴ The authors claimed that their mother had faced delays in obtaining treatment and had not received appropriate and timely medical treatment. Because of these delays, she had been unable to undergo surgery and had only been prescribed palliative care and painkillers. The complaint was held inadmissible as the alleged violations preceded the entry into

450 CESCR, Statement on universal affordable vaccination for COVID-19, international cooperation and intellectual property (12 March 2021), E/C.12/2021/1 §3.

451 CESCR, Statement on universal affordable vaccination for COVID-19, international cooperation and intellectual property (12 March 2021), E/C.12/2021/1 §§3, 5.

452 CESCR, Statement on universal affordable vaccination for COVID-19, international cooperation and intellectual property (12 March 2021), E/C.12/2021/1 §13.

453 *Merino Sierra and Juan Luis Merino Sierra*, CESCR, Communication No. 4/2014 UN Doc E/C.12/59/D/4/2014 (2016) §6.7.

454 Before this complaint, the authors had initiated actions at the Torremolinos Court of First Instance No. 1, the Málaga Provincial Court, the Supreme Court, and the Constitutional Court to no avail. They had also filed a complaint at the ECtHR (inadmissible under Articles 34 and 35 of the ECHR) and submitted a communication to the HRC, which informed the authors that they had not provide sufficient details on their case that could trigger their rights under the ICCPR.

force of the Optional Protocol to ICESCR for Spain.⁴⁵⁵ Of significance are the Committee's comments clarifying that a given infringement of the ICSECR (e.g., delayed treatment) cannot be held to extend in time simply because the consequences (e.g. ill health) of that specific infringement do.⁴⁵⁶ If the earlier decisions of the national courts had taken place after the entry into force of the Optional Protocol for the State party, then the claim would be likely to have been found admissible.⁴⁵⁷

In *SC and GP v Italy*⁴⁵⁸ the authors, whose access to a medical procedure (in vitro fertilisation) was predicated on the basis of ambiguous national legislation claimed that this fact meant that the State would not be able to ensure adequate physical and mental health. As such, they argued that the legal uncertainty had led to a violation of their rights under Article 12 ICESCR. Specifically, the authors claimed that the State had failed to take the appropriate steps to respect, protect, and fulfil the right to health under Article 12, and to refrain from limiting equal access to medical treatment for all persons.⁴⁵⁹ The complaint provides a good illustration of the failure of the State to meet its obligations and protect the right to health under Article 12 by enacting effective and sufficiently clear national legislation. The CESCR noted that the legal uncertainty created by the ambiguous law restricted the access to health treatment otherwise available in Italy, finding a violation of Article 12.⁴⁶⁰

455 *Merino Sierra and Juan Luis Merino Sierra*, CESCR, Communication No. 4/2014 UN Doc E/C.12/59/D/4/2014 (2016) § 6.7.

456 *Merino Sierra and Juan Luis Merino Sierra* Communication No 4/2014 UN Doc E/C.12/59/D/4/2014 (2016) § 6.7.

457 *IDG v Spain* Communication No. 2/2014, UN Doc E/C.12/55/D/2/2014 (2015) § 9.3; Zdzisław (Dzidek) Kędzia, 'Chapter 5: Social rights protection under the ICESCR and its Optional Protocol – the role of the Committee on Economic, Social and Cultural Rights' in Christina Binder, Jane Hofbauer, Flávia Piovesan and Amaya Úbeda de Torres (eds) *Research Handbook on International Law and Social Rights* 106.

458 *SC and GP v Italy* Communication No. 22/2017, UN E/C.12/65/D/22/2017 (2019).

459 *SC and GP v Italy* Communication No. 22/2017, UN E/C.12/65/D/22/2017 (2019) §3.8.

460 *SC and GP v Italy* Communication No. 22/2017, UN E/C.12/65/D/22/2017 (2019) §11.1.

Lastly, it is worth noting that Article 12 is often engaged to inform and support regional and national decisions on the right to health and is often discussed in comparison with regional, national, and other legislation as it will be seen in subsequent sections.⁴⁶¹

2.1.2. The health dimensions of the right to life in ICCPR

Our exploration of complaints made under the Optional Protocol to the ICCPR, concerning Article 6 of that Covenant, showed a clear interrelation between the right to life and health (see 1.1.1.1). Thus: we considered the health-related arguments in *Toussaint v Canada*,⁴⁶² where the applicant's health deterioration was considered in the context of her impending deportation; we noted the significance for enjoyment of the right to life of the inaccessibility of timely treatment for persons living with chronic conditions in *WMG v Canada*;⁴⁶³ and we discussed the links between the rights to life and health and the intertwined social and family dimensions in *AHG v Canada*.⁴⁶⁴ Health arguments were also seen to inform the reasoning of the HRC in *KL v Peru*,⁴⁶⁵ and *LMR v Argentina*⁴⁶⁶, and in *Mambu v Democratic Republic of the Congo*⁴⁶⁷ where the HRC requested that the complainant's state of health to be considered as part of the right to life analysis, and for all necessary medical care to be provided to prevent irreparable harm.⁴⁶⁸

461 See for example the decision of the African Commission on Human and People's Rights *SERAC and CESR v Nigeria*, with the Commission discussing the right to health under Article 16 (1) of the African Charter along with the obligations stipulated by Article 12 ICESCR of which Nigeria is a party; *Social and Economic Rights Action Center (SERAC) and the Center for Economic and Social Rights (CESR) v Nigeria* Communication No. 155/96, ACHPR/COMM/A044/1 (2002) §52.

462 *Toussaint v Canada* Communication No. 2348/2014 UN Doc. CCPR/C/123/D/2348/2014 (2018).

463 *WMG v Canada* Communication No. 2060/2011, UN Doc. CCPR/C/116/D/2060/2011 (2016).

464 *AHG v Canada* Communication No. 2091/2011, UN Doc. CCPR/C/113/D/2091/2011 (2015).

465 *KL v Peru* Communication No. 1153/2003 UN Doc. CCPR/C/85/D/1153/2003 (2005).

466 *LMR v Argentina* Communication No. 1608/2007 UN Doc. CCPR/C/101/D/1608/2007 (2011).

467 *Mambu v Democratic Republic of the Congo* Communication No. 2465/2014 UN Doc. CCPR/C/118/D/2465/2014 (2016).

468 *Mambu v Democratic Republic of the Congo* Communication No. 2465/2014 UN Doc. CCPR/C/118/D/2465/2014 (2016) §1.2.

Of course, these observations built on the comments of the HRC in General Comment 36, noting that the States should address the general conditions in society that could affect the right to life,⁴⁶⁹ and that the due diligence obligation of the States to protect the right to life under ICCPR, includes addressing the prevalence of life-threatening diseases, when these are reasonably foreseeable, and ensuring access to medical care.⁴⁷⁰

2.1.3. The health considerations in ECtHR jurisprudence

The ECHR does not explicitly guarantee the right to health. Such protection as it does afford must be identified indirectly through an analysis of the scope of other rights. It is evident from our examination of ECtHR case law (see 1.1.2) that the right to life, protected by Article 2 ECHR, can be linked with the right to health through the positive obligations of the States to protect the life of those within their territories. These included the claims in *Centre for Legal Resources on behalf of Valentin Câmpeanu v Romania*,⁴⁷¹ *Asiye Genç v Turkey*,⁴⁷² and *Şentürk v Turkey*,⁴⁷³ and other significant cases of insufficient medical care, in which the poor or unreasonable allocation of resources contributed to, or caused the death of the victim. To these we can add a few selected claims that do not fall within the scope of Article 2 but which also cast significant light on the State's positive obligations to protect the health of those within its jurisdiction. These claims are pursued most often under Articles 3, 8, and 14 ECHR.⁴⁷⁴

469 UN Human Rights Committee (HRC), CCPR General Comment No. 36 (2019) On Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (3 September 2019), CCPR/C/GC/36 § 26.

470 UN Human Rights Committee (HRC), CCPR General Comment No. 36 (2019) On Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (3 September 2019), CCPR/C/GC/36 §§ 21 ('reasonably foreseeable threat to life'), 25 ('necessary medical care and appropriate regular monitoring of their health'), and 26 ('prevalence of life-threatening diseases'). See also the comments of the HRC in *Toussaint v Canada* Communication No. 2348/2014 UN Doc. CCPR/C/123/D/2348/2014 (2018) discussed in 1.1.1.2.

471 *Centre for Legal Resources on behalf of Valentin Câmpeanu v Romani* ECtHR Application No. 47848/08 (2014).

472 *Asiye Genç v Turkey* ECtHR Application No. 24109/07 (2015).

473 *Şentürk v Turkey* ECtHR Application No. 13423/09 (2013).

474 Claims that raise issues of discrimination are included in 3. Prohibition of Discrimination.

Thus, in *Stanev v Bulgaria*⁴⁷⁵ (claims made under Articles 3, 5, 6, 8, and 13) the inadequate medical assistance and lack of treatment for those living in the Pastra social care home were noted by the ECtHR. The only treatment available to residents of the home was medication with no provision for therapeutic activities or other form of treatment.⁴⁷⁶ The Government argued that ‘the inadequate financial resources set aside for institutions of this kind formed the main obstacle’ for these conditions.⁴⁷⁷ The decision also referred to the domestic Court’s case law noting that under section 1(1) of the Bulgarian State and Municipalities Responsibility for Damage Act 1988:

[A]nyone whose health has deteriorated because bodies under the authority of the Ministry of Health have failed in their duty to provide a regular supply of medication may hold the administrative authorities liable and receive compensation (реш. No 211 от 27.05.2008 г. по гр. д. No 6087/2007, ВКС, V г. о.).⁴⁷⁸

The ECtHR held unanimously that there had been a violation of Articles 5, 6, and Article 3 alone, and in conjunction with Article 13.

In *N v The United Kingdom*⁴⁷⁹ the ECtHR held that the limited supply of the necessary medication to treat the applicant’s health condition (HIV) did not of itself prevent her expulsion to Uganda in according with UK immigration rules.⁴⁸⁰ The restricted supply and availability of antiretroviral drugs in Uganda was found to be the result of limited financial resources and the poor health care infrastructure in that country.⁴⁸¹ Despite the severe health difficulties and unavailability of treatment the applicant would face on her return, the Court reiterated the high threshold for finding that threats to health would amount to inhuman and degrading treatment

475 *Stanev v Bulgaria* ECtHR Application No. 36760/06 (2012).

476 *Stanev v Bulgaria* ECtHR Application No. 36760/06 (2012) §§80-81.

477 *Stanev v Bulgaria* ECtHR Application No. 36760/06 (2012) §§197-99.

478 *Stanev v Bulgaria* ECtHR Application No. 36760/06 (2012) §§62-67. The case could be considered together with the decision in *Zaharieva v Bulgaria* ECtHR Application No. 6194/06, regarding the interrupted supply of medicines.

479 *N v The United Kingdom* ECtHR Application No. 26565/05 (2008).

480 *N v The United Kingdom* ECtHR Application No. 26565/05 (2008) §12.

481 *N v The United Kingdom* ECtHR Application No. 26565/05 (2008) §19.

(i.e. ‘health exceptionality’)⁴⁸² holding there was no violation of Article 3.⁴⁸³ It is worth adding that in the context of deportation, the ‘exceptional circumstances threshold’ discussed in *N v The United Kingdom*, was not met even in circumstances when the applicant would not be able to access any treatment in the receiving country; see the decision by the UK Upper Tribunal (Immigration and Asylum Chamber), in GS (Article 3 - health - exceptionality) *India v Secretary of State for the Home Department*.⁴⁸⁴

The following section explores selected case law in additional regional systems, whose human rights instruments contain a self-standing right to health.⁴⁸⁵

2.1.4. Additional Regional Systems

African Commission on Human and People’s Rights

The African Commission on Human and People’s Rights (ACHPR), which ensures the regional protection and promotion of human rights in Africa, has contributed to the interpretation of the right to health despite academic

482 *N v The United Kingdom* ECtHR Application No. 26565/05 (2008) § 43; for the concept of ‘exceptionality’ in relation to allocation of drugs and other medical treatment see Amy Ford, ‘The Concept of Exceptionality: A Legal Farce?’ (2012) 20 (3) *Medical Law Review* 304. The Article also comments on the case of *R v North West Lancashire Health Authority, ex p A* [1999] EWCA Civ 2022, [2000] 1 WLR 977 and *R (Ann Marie Rogers) v Swindon NHS Primary Care Trust* [2006] EWCA Civ 392, [2006] 1 WLR 2649 discussed in part 1. The Right to Life B. National Jurisdictions (England and Wales). *N v The United Kingdom* ECtHR Application No. 26565/05 (2008) § 43; *D v The United Kingdom* ECtHR Application No. 30240/96 (1997) §§ 53-54 (‘in the very exceptional circumstances of this case’) emphasis added.

483 *N v The United Kingdom* ECtHR Application No. 26565/05 (2008) § 51.

484 *India v Secretary of State for the Home Department*, [2011] UKUT 35 (IAC). See also *N (FC) v Secretary of State for the Home Department* [2005] UKHL 31 at [86]-[90]: ‘The unmistakable conclusion to be drawn from this series of recent decisions is that the Court has adopted the clear stance that Article 3 is not breached by the return of an AIDS sufferer to his or her home country save in circumstances closely comparable to those in *D* itself.’ and ‘As already indicated, my clear understanding of the subsequent Strasbourg case law is that the Court has now adopted “a restrictive line”. It has not been prepared to grant “an absolute right for seriously ill persons to remain in the host country to get treatment, provided they had managed to set foot there.” The “very far-reaching” consequences of such a right would give rise to positive obligations which the Court has not thought it right to impose upon the Contracting States.’

485 See §§ 100-18; *Poblete Vilches et al v Chile*, IACtHR Series C 349 (2018).

commentary noting that ACHPR receives very few communications on economic, social, and cultural rights.⁴⁸⁶

In *Purohit and Moore v The Gambia*⁴⁸⁷ the complainants, acting on behalf of mental health patients detained at the psychiatric hospital Campama, submitted that the legislative framework regulating mental health in Gambia (with the “Lunatics Detention Act (LDA)” being the primary instrument) prohibited the enjoyment of the best attainable state of physical and mental health protected under Article 16 of the African Charter on Human and People’s Rights (hereinafter ‘the African Charter’).⁴⁸⁸ The ACHPR read into Article 16 the obligation of the States:

*[T]o take concrete and targeted steps, while taking full advantage of their available resources, to ensure that the right to health is fully realised in all its aspects without discrimination of any kind.*⁴⁸⁹

That was particularly the case as regards vulnerable groups of persons, such as mental health patients, who should be facilitated by special measures, as stipulated in Article 18(4) of the African Charter.⁴⁹⁰ It is worth recalling at this point the heightened duty expected of States to protect the rights of those in liberty-restricting State-run facilities as explored previously (see section 1.1.1 Article 6 ICCPR).⁴⁹¹

486 Manisuli Ssenyonjo, ‘Responding to Human Rights Violations in Africa Assessing the Role of the African Commission and Court on Human and Peoples’ Rights (1987–2018)’ (2018) 7 (1) International Human Rights Law Review 40.

487 *Purohit and Moore v The Gambia* Communication No. 241/2001, Sixteenth Activity report 2002–2003, Annex VII.

488 *Purohit and Moore v The Gambia* Communication No. 241/2001, Sixteenth Activity report 2002–2003, Annex VII §78.

489 *Purohit and Moore v The Gambia* Communication No. 241/2001, Sixteenth Activity report 2002–2003, Annex VII §84.

490 *Purohit and Moore v The Gambia* Communication No. 241/2001, Sixteenth Activity report 2002–2003, Annex VII §78–82.

491 UN Human Rights Committee (HRC), CCPR General Comment No. 36 (2019) On Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (3 September 2019), CCPR/C/GC/36, §25.

In *Free Legal Assistance Group v Zaire*,⁴⁹² communication 100/93 submitted by the Union Interafricaine des Droits de l'Homme (20 March 1993)⁴⁹³ alleged *inter alia* that the government's mismanagement of public finances had led to shortages of medicine and basic services.⁴⁹⁴ The government did not respond to the communication despite repeated requests.⁴⁹⁵ The ACHPR held the right to health under Article 16 of the African Charter⁴⁹⁶ included the responsibility to provide basic supplies and medicines, finding a violation of Article 16.⁴⁹⁷

Inter-American System of Human Rights Protection

As Basch et al. note, in a region that poses significant and persistent challenges to democratic values and human rights, the Inter-American System of Human Rights Protection (IASPHR), consisting of the Inter-American Commission on Human Rights (IACHR) and the Inter-American Court of Human Rights (IACtHR) can shape, protect, and promote fundamental freedoms.⁴⁹⁸ Despite criticisms over the

492 *Free Legal Assistance Group v Zaire* Communications (Joined) No. 25/89, 47/90, 56/91, 100/93 (1995). For the purposes of this report the focus is on Communication 100/93.

493 *Free Legal Assistance Group v Zaire* Communications (Joined) No. 25/89, 47/90, 56/91, 100/93 (1995) §44-45.

494 *Free Legal Assistance Group v Zaire* Communications (Joined) No. 25/89, 47/90, 56/91, 100/93 (1995) §4.

495 *Free Legal Assistance Group v Zaire* Communications (Joined) No. 25/89, 47/90, 56/91, 100/93 (1995) §44-49.

496 Article 16 of the African Charter states: '1. Every individual shall have the right to enjoy the best attainable state of physical and mental health. 2. State Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.' African Charter on Human and Peoples' Rights ('Banjul Charter') adopted 27 June 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 ILM 58 (1982) entered into force October 21, 1986.

497 *Free Legal Assistance Group v Zaire* Communications (Joined) No. 25/89, 47/90, 56/91, 100/93 (1995) §79. The right to life under Article 4 of the African Charter on Human and Peoples' Rights was considered in relation to arbitrary killings of students, see *Free Legal Assistance Group v Zaire* Communications (Joined) No. 25/89, 47/90, 56/91, 100/93 (1995) §62-63.

498 Fernando Basch and others, 'The Effectiveness of The Inter-American System of Human Rights Protection: A Quantitative Approach to its Functioning and Compliance With its Decisions' (2010) 7(12) Sur - International Journal on Human Rights 9.

effectiveness of the IASPHR and the degree of compliance with the decisions adopted within its framework,⁴⁹⁹ we can identify cases which have made a significant contribution to the development of the right to health in the region and beyond, and which have moreover possibilities for further application to the Bulgarian vaccine distribution scenario.

Inter-American Court of Human Rights

In *Poblete Vilches v Chile*,⁵⁰⁰ the lack of medical equipment, including ICU beds and ambulances, contributed to Chile failing to meet its obligations to protect the right to life. The case is significant for this section as the IACtHR declared an autonomous right to health in its judgment:⁵⁰¹

[T]his Court will rule for the first time on the right to health autonomously, as an integral part of the ESCER,⁵⁰² the Court will now proceed to verify its consolidation as a right that is justiciable in light of the Convention, by analyzing the following elements.⁵⁰³

The IACtHR set out the requirements for the fulfilment of the right to health by States, which are expected to ensure equal access to medical health care.⁵⁰⁴ The Court reviewed the international body of law on the

499 Fernando Basch and others, 'The Effectiveness of The Inter-American System of Human Rights Protection: A Quantitative Approach to its Functioning and Compliance With its Decisions' (2010) 7(12) Sur - International Journal on Human Rights 9, 10.

500 *Poblete Vilches et al v Chile*, IACtHR Series C 349 (2018).

501 See §100-18; *Poblete Vilches et al v Chile*, IACtHR Series C 349 (2018).

502 The economic, social, cultural and environmental rights based on Article 26 of the American Convention on Human Rights.

503 *Poblete Vilches et al v Chile*, IACtHR Series C 349 (2018) §105; emphasis added.

504 *Poblete Vilches et al v Chile*, IACtHR Series C 349 (2018) §123.

right to health, specifically referring to Article 12 ICESCR⁵⁰⁵ and General Comments 6 and 14.^{506 507}

In the subsequent case of *Cuscul Pivaral v Guatemala*⁵⁰⁸ the IACtHR confirmed that the right to health is an autonomous and justiciable right under Article 26 of the American Convention on Human Rights.⁵⁰⁹ The case concerned 49 people who had been living with HIV/ AIDS (of whom 15 were deceased), who had had only inconsistent, inadequate, or no access to anti-retroviral therapy.⁵¹⁰ Having considered Article 12 ICESCR and General Comment No.14,⁵¹¹ the IACtHR held that the State is required to ensure the permanent and uninterrupted health care, supply of drugs, diagnostic tests, and other medical and social support to protect the right to health.⁵¹² Regarding allocation of resources, the IACtHR took note of Article 21 of the Health Code in Guatemala, according to which the State is expected to allocate ‘the necessary resources for the public funding of the provision of health services’ obligatorily as a priority.⁵¹³ The cases considered in our discussion of the right to life (see 1.1.3) also raise considerations regarding the right to health, in particular access to medical and health care, medicine, and treatment; for example, see *Indigenous*

505 *Poblete Vilches et al v Chile*, IACtHR Series C 349 (2018) §114.

506 *Poblete Vilches et al v Chile*, IACtHR Series C 349 (2018) §128.

507 See also commentary on the case; Ángela Arenas Massa and others, ‘Sanctioning Chile’s Public Health Care System for Not Providing Basic Services to the Elderly: The Inter-American Court’s Poblete Vilches Ruling’ (2021) 23 (1) *Health and Human Rights Journal* 251; and the relevant section in Patricia Palacios Zuloaga, ‘Pushing Past the Tipping Point: Can the Inter-American System Accommodate Abortion Rights?’ (2021) 21 (4) *Human Rights Law Review* 899, 925-26.

508 *Cuscul Pivaral et al v Guatemala*, IACtHR Series C 359 (2018).

509 See *Poblete Vilches et al v Chile*, IACtHR Series C 349 (2018) § 106 ‘the right to health protected by Article 26 of the American Convention, the Court observes that the wording indicates that it is a right derived from the economic, social, educational, scientific and cultural standards contained in the OAS Charter’.

510 *Cuscul Pivaral et al v Guatemala*, IACtHR Series C 359 (2018) §121.

511 *Cuscul Pivaral et al v Guatemala*, IACtHR Series C 359 (2018) §§80, 106, 143.

512 *Cuscul Pivaral et al v Guatemala*, IACtHR Series C 359 (2018) §209-10.

513 *Cuscul Pivaral et al v Guatemala*, IACtHR Series C 359 (2018) §43.

*Community Yakye Axa v Paraguay*⁵¹⁴ in which the IACtHR considered Article 12 ICESCR and General Comment No.14.⁵¹⁵

Inter-American Commission on Human Rights

These decisions of IACtHR should be considered alongside a number of selected claims before the Inter-American Commission on Human Rights (IACHR), which constitutes the second branch of the Inter-American System of Human Rights Protection. Thus: the claim of violation of the rights to health and life in *Sindicato Nacional de Trabajadores del Ministerio de Salud de Ecuador* (National Union of Workers of the Ministry of Health of Ecuador), and the commentary on State's obligations and budget allocation in relation to the responsibility to ensure health care services; the health arguments in *Jorge Odir Miranda Cortez v El Salvador*,⁵¹⁶ and the *Amparo* action in *People living with HIV*. Lastly, *Ana Victoria Sanchez Villalobos v Costa Rica*⁵¹⁷ which considered the alleged violation of the right to health contained in Article 10 of the Additional Protocol to the American Commission on Human Rights (the "Protocol of San Salvador").⁵¹⁸

The right to health has also been considered before the IACHR in communications such as *Yanomami* (Brazil)⁵¹⁹ and *Amilcar Menéndez, Juan Manuel Caride* (Argentina).⁵²⁰

2.2. National Jurisdictions

At least 115 constitutions around the world protect the right to health or the right to health care.⁵²¹ As Heymann et al. note, to evaluate global protection of the right to health, we need to look more closely at national

514 *Indigenous Community Yakye Axa v Paraguay* IACtHR Series C 125 (2005).

515 *Indigenous Community Yakye Axa v Paraguay* IACtHR Series C 125 (2005) §166.

516 *Jorge Odir Miranda Cortez v El Salvador* IACHR Report No 29/11, Case 12.249 (March 20, 2009).

517 *Ana Victoria Sanchez Villalobos v Costa Rica* IACHR Report No. 25/04, OEA/Ser.L/V/II.122, doc. 5 rev. 1 (2004).

518 *Ana Victoria Sanchez Villalobos v Costa Rica* IACHR Report No. 25/04, OEA/Ser.L/V/II.122, doc. 5 rev. 1 (2004) §22.

519 *Yanomami* (Brazil) Case No 7615. Resolution No 12/85.

520 *Amilcar Menéndez, Juan Manuel Caride* (Argentina) Case No 11.670. Report No 03/01.

521 Office of the UN High Commissioner for Human Rights, *The Right to Health: Fact Sheet No. 31* (2008)10.

and constitutional guarantees.⁵²² It is worth adding that although several national constitutions protect the right to health, there is some variability as to the health rights protected; these can include the right to medical care, public health, and broader socio-economic rights underpinning the right to health.⁵²³ National constitutions and other laws can also differ in their specificity and degree of responsibility required from the State.⁵²⁴

2.2.1. Europe

Several national constitutions in Europe include a provision protecting the right to health in some form;⁵²⁵ Spain (art. 43); Italy (art. 32); France (Preamble and art.1); Portugal (art. 64); Bulgaria (art. 52); Greece (art. 21(3) ‘with special measures’ to protect vulnerable groups); Latvia (art. 111); Croatia (art. 58 ‘to health care’ and art. 69 ‘to health life’); Belgium (art. 23(2)); Netherlands (art. 22); Lithuania (art. 53); Hungary (art. XX (1)); Albania (art. 55); Romania (art. 34); and Poland (art. 68). Additionally, a number of jurisdictions rely on the right to health without an explicit recognition of the ‘right to health’ in their national legal systems. Of particular interest is the right to health in Germany, which has established criteria for its application by the Federal Constitutional Court; see the ‘Nikolaus decision’ (*Nikolaus-Beschluss*), which connects access to

522 Jody Heymann and others, ‘Constitutional Rights to Health, Public Health and Medical Care: The Status of Health Protections in 191 Countries’ (2013) 8 (6) *Global Public Health* 639, 640.

523 Jody Heymann and others, ‘Constitutional Rights to Health, Public Health and Medical Care: The Status of Health Protections in 191 Countries’ (2013) 8 (6) *Global Public Health* 639, 640.

524 Jody Heymann and others, ‘Constitutional Rights to Health, Public Health and Medical Care: The Status of Health Protections in 191 Countries’ (2013) 8 (6) *Global Public Health* 639, 650.

525 For a global survey of constitutional protections to the right to health and health care see Eleanor Kinney and Brian Alexander Clark, ‘Provisions for Health and Health Care in the Constitutions of the Countries of the World’ (2004) 37 (2) 285.

treatment with the right to life protected under Article 2 (2) of the Basic Law (*Grundgesetz*)).⁵²⁶

England and Wales

Although the UK does not include an explicit right to health in its law, it has incorporated the ECHR into domestic law. As a result, it is possible to rely on the provisions of the Convention indirectly to protect rights in and to health care as discussed above (see 2.1.3). In *MB v UCL Hospitals NHS Foundation Trust*,⁵²⁷ the Trust removed a patient from her bedroom in the hospital ward. The request was ‘urgent because the COVID-19 pandemic meant that the bedroom [was] urgently needed for other patients’. The Trust which ran the hospital noted that the patient could be safely discharged into adapted accommodation away from the risk of contracting COVID-19 and with a care package tailored her medical needs.⁵²⁸ The patient had multiple conditions, including post-traumatic stress disorder, Asperger’s syndrome, obsessive compulsive disorder, chronic migraine, fatigue, and functional neurological disorder.⁵²⁹ Her behaviour towards hospital staff had been described as threatening, intimidating, and verbally abusive.⁵³⁰ The claim was brought by the Trust to enforce its private rights as a property owner. The patient argued that requiring her to leave would amount to a violation of her rights under Articles 3, 8, and 14 ECHR.⁵³¹

⁵²⁶ See also Stefanie Ettelt, ‘Access to Treatment and The Constitutional Right to Health in Germany: A Triumph of Hope Over Evidence?’ (2020) 15 (1) *Health Economics, Policy and Law* 30. See also academic commentary exploring constitutional guarantees of access to essential medicines including vaccination; Katrina Pehudoff and others, ‘Essential Medicines in National Constitutions: Progress Since 2008’ (2016) 18 (1) *Health and Human Rights Journal*; Brigit Toebe, ‘Towards an Improved Understanding of the International Human Right to Health’ (1999) 21 (3) *Human Rights Quarterly* 661; Colleen Flood and Aeyal Gross, ‘Litigating the Right to Health: What Can We Learn from a Comparative Law and Health Care Systems Approach’ (2014) 16 (2) *Health and Human Rights Journal* 62.

⁵²⁷ *MB v UCL Hospitals NHS Foundation Trust* [2020] EWHC 882 (QB).

⁵²⁸ *MB v UCL Hospitals NHS Foundation Trust* [2020] EWHC 882 (QB) [2]-[3].

⁵²⁹ *MB v UCL Hospitals NHS Foundation Trust* [2020] EWHC 882 (QB) [6].

⁵³⁰ *MB v UCL Hospitals NHS Foundation Trust* [2020] EWHC 882 (QB) [10]-[11].

⁵³¹ *MB v UCL Hospitals NHS Foundation Trust* [2020] EWHC 882 (QB) [22].

The High Court, first noted that the patient's physical and mental health care could be satisfied by way of the new arrangements, which included 24-hour care.⁵³² The case is significant for the comments of Chamberlain J, who discussed the issue of the health authority's allocation of limited resources during the COVID-19 pandemic, and the competing interests at play:

*In some circumstances, a hospital may have to decide which of two patients, A or B, has a better claim to a bed, or a better claim to a bed in a particular unit, even ceasing to provide in-patient care to one of them to leave will certainly cause extreme distress or will give rise to significant risks to that patient's health or even life. A hospital which in those circumstances determines rationally, and in accordance with a lawful policy, that A's clinical need is greater than B's, or that A would derive greater clinical benefit from the bed than B, is not precluded by Article 3 ECHR from declining to offer in-patient care to B. This is because in-patient care is a scarce resource and, as Auld LJ put it in R v North West Lancashire Health Authority ex p. A [2000] 1 WLR 977, at 996, "[i]t is plain... that Article 3 was not designed for circumstances... where the challenge is to a health authority's allocation of finite funds between competing demands". Decisions taken by a health authority on the basis of finite funds are, in my judgment, no different in principle from those taken by a hospital on the basis of finite resources of other kinds. In each case a choice has to be made and, in making it, it is necessary to consider the needs of more than one person. The present situation does not involve a comparison of the needs of two identified patients. But the decision to withdraw permission for MB to remain in the Hospital is still a decision about the allocation of scarce public resources.*⁵³³

The case can be compared with the decision in *R (Ann Marie Rogers) v Swindon NHS Primary Care Trust*⁵³⁴ which concerned refusal of funding for treatment with Herceptin (unlicensed drug). The policy of the Trust had been to deny funding for treatment with an unlicensed drug unless the circumstances were exceptional. The appellant argued that the decision

532 *MB v UCL Hospitals NHS Foundation Trust* [2020] EWHC 882 (QB) [46].

533 *MB v UCL Hospitals NHS Foundation Trust* [2020] EWHC 882 (QB) [55]-57].

534 *R (Ann Marie Rogers) v Swindon NHS Primary Care Trust* [2006] EWCA Civ 392, [2006] 1 WLR 2649.

in her particular case had been irrational.⁵³⁵ The Court of Appeal agreed, noting that the policy would be rational if it were possible to envisage concrete circumstances in which such an exception could be made.⁵³⁶ If it were not possible to envisage such circumstances, then essentially, the policy amounted to a blanket refusal of treatment in all cases, and as such would be irrational.⁵³⁷ The Court agreed with the judge of first instance that the key issue of this case was not one involving the allocation of scarce resources, citing *R v Cambridge Health Authority ex p B* explored previously (see 1.2.1).

Belarus

The Constitutional Court of the Republic of Belarus, in Case -673/2011, considered whether the national law on “auxiliary reproductive technologies” was compatible with the Constitutional provisions on the right to health and access to treatment; see Article 45.⁵³⁸ The Court discussed *inter alia* the restrictions imposed on patients within a specific age group (i.e., over 50 years old) as regards access to surrogacy, concluding that the restrictions imposed by the new law were justified and compatible with the Constitution.

535 *R (Ann Marie Rogers) v Swindon NHS Primary Care Trust* [2006] EWCA Civ 392, [2006] 1 WLR 2649 [1].

536 *R (Ann Marie Rogers) v Swindon NHS Primary Care Trust* [2006] EWCA Civ 392, [2006] 1 WLR 2649 [62].

537 *R (Ann Marie Rogers) v Swindon NHS Primary Care Trust* [2006] EWCA Civ 392, [2006] 1 WLR 2649 [62].

538 ‘Citizens of the Republic of Belarus shall be guaranteed the right to health care, including free treatment at state health-care establishments. The State shall make health care facilities accessible to all of its citizens. The right of citizens of the Republic of Belarus to health care shall also be secured by the development of physical training and sport, measures to improve the environment, the opportunity to use fitness establishments and improvements in occupational safety’; Article 45 of the Constitution of the Republic of Belarus.

Bulgaria

In the Case 211 (*TDZ case*),⁵³⁹ the plaintiff alleged that the Ministry of Health in Bulgaria had failed to ensure an uninterrupted supply of a medication for cancer (Zoladex) resulting in permanent health damage (as a result of the necessary removal of the patient's ovaries). The Supreme Court of Cassation reaffirmed the decisions of the lower courts holding that the irregular supply of the drug constituted a violation of the officials' duty to protect the citizens' health.⁵⁴⁰ This case can be considered together with Case No 183/02.08.2010 (Case File No 146/2009; *Toshka Nikolova Bosheva v Minister of Health for the Republic of Bulgaria*) before the Commission for Protection Against Discrimination, which raises the significant question of medicine distribution in the context of discrimination,⁵⁴¹ as considered below (see 3.2.1).

Spain

In case 3015/2006,⁵⁴² which concerned distribution of the drug Rebetol, the Supreme Court ruled that the restrictions imposed by the General Directorate of Pharmacy and Chemical Products (GDPCP) had relied on economic and not health objectives. As such they amounted to a violation of the national law on medicines and health; Article 22 of the Law of Medicine.⁵⁴³

Secondly, analogies with the factual circumstances in Bulgaria during the pandemic can be drawn with the outbreak of measles in Granada and the

⁵³⁹ Decision No. 211 on Case No. 6087/2007.

⁵⁴⁰ Decision No. 211 on Case No. 6087/2007 p.5-6. See also 'irregular' and 'chaotic' supply of drugs p. 3.

⁵⁴¹ See p.2 'B. complaints that due to the shortage of the drug Arimidex®, provided in Bulgaria for the treatment of patients with cancer diseases, the quantities are not enough for everybody and in practice the drug is received by those who managed to go earlier on the scheduled days to receive it.' presenting a situation analogous with the 'green corridors' in the implementation of the vaccination programme during the COVID-19 pandemic; Unofficial translation in English provided by Lawyers Collective and partners for the Global Health and Human Rights Database.

⁵⁴² Case 3015/2006, STS 3015/2006 (May 9, 2006).

⁵⁴³ Unofficial translation in English provided by Lawyers Collective and partners for the Global Health and Human Rights Database.

low percentages of vaccination in case JCAG 362/2010.⁵⁴⁴ There the Court authorised the compulsory vaccination of children noting *inter alia* Section 43(2) of the Spanish Constitution which requires public authorities to protect public health with appropriate measures:

It is incumbent upon the public authorities to organize and watch over public health by means of preventive measures and the necessary benefits and services. The law shall establish the rights and duties of all in this respect.

An argument may be made, in relation to the Bulgarian vaccine distribution scenario, that authorities are required to act rationally in promotion of public health. The latter action includes the science-led distribution of needed medicines, whether on a voluntary or a compulsory basis.

2.2.2. Asia

India

The decision in *Paschim Banga Khet Mazoor Samity v State of West Bengal*,⁵⁴⁵ discussed previously in relation to the right to life (see 1.2.2), also raises significant points in relation to the right to health as regards the availability of and access to emergency medical treatment. The Supreme Court of India required the Governmental authorities to put in place a plan for primary health care with specific reference to access and provision of treatment during an emergency. We should also note the comments of the Supreme Court in *State of Punjab v Ram Lubhaya Bagga*⁵⁴⁶ that protecting citizens' health should be a priority for the Government and other authorities, and that protecting the right to life includes a responsibility to protect the right to health;⁵⁴⁷ reading Article 21 and 47 of the Constitution of India together.⁵⁴⁸

544 JCAG 362/2010 Decision No 362/10 (2010); Unofficial translation in English provided by Lawyers Collective and partners for the Global Health and Human Rights Database.

545 *Paschim Banga Khet Mazoor Samity v State of West Bengal* (1996) AIR SC 2426/ (1996) 4 SCC 37.

546 *State of Punjab v Ram Lubhaya Bag* (1998) 1 SCR 1120.

547 *State of Punjab v Ram Lubhaya Bag* (1998) 1 SCR 1120, §21.

548 *State of Punjab v Ram Lubhaya Bag* (1998) 1 SCR 1120, §21.

In *Premlata v Government of NCT Delhi*⁵⁴⁹ where the authorities failed to make life- saving (food) ration cards available and to take the necessary steps to secure the health of pregnant and lactating women, the court reaffirmed that the right to life under Article 21 of the Constitution of India encompasses the right to health. The reasoning of the High Court of Delhi follows that adopted in *State of Punjab*, discussed above, as regards protection of the right to health within the scope of the right to life (Article 21).

It is worth considering *Court on Its Own Motion v Union of India*.⁵⁵⁰ Following the death of a homeless woman while giving birth, the High Court of Delhi brought public interest litigation on its own motion, an innovative procedure developed by the Indian courts in the 1980s. An amicus brief filed by the Human Rights Law Network outlined failures to protect the right to health and instances of hospitals denying admission to homeless women in labour. The case raises issues under all three normative pillars that could contribute to analyses by analogy relevant to the Bulgarian vaccine distribution scenario.

The inclusion of the right to health within the scope of the constitutional right to life under Article 21 was also confirmed in *Laxmi Mandal v Deen Dayal Harinagar Hospital*⁵⁵¹ as discussed above in relation to the right to life (see 1.2.2) and in *Jaitun v Janpura Maternity Home*⁵⁵² which also referred to Article 12 ICESCR.⁵⁵³ It is also worth considering the decision of the High Court of Delhi in *Amit Ahuja v Union of India*⁵⁵⁴ regarding which specific categories of patients were permitted access to free treatment.

In *Mohd Ahmed (Minor) v Union of India*,⁵⁵⁵ a child with Gaucher Disease (rare genetic condition) requested free access to Enzyme Replacement Therapy (ERT), a life-saving drug which due to low demand had an

549 *Premlata v Government. of NCT Delhi* WP(C) 7687/2010 and CM APPL 6265/2011.

550 *Court on Its Own Motion v Union of India* WP 5913/2010 (2011).

551 *Laxmi Mandal v Deen Dayal Harinagar Hospital* WP(C) 8853/2008 (2010).

552 *Jaitun v Janpura Maternity Home* WP(C) 10700/2009.

553 *Laxmi Mandal v Deen Dayal Harinagar Hospital* WP(C) 8853/2008 (2010) §22.

554 *Amit Ahuja v Union of India* WP(C) 1507/2014 & CM APPL 3144/2014.

555 *Mohd Ahmed (Minor) v Union of India* WP(C) 7279/2013.

exceptional high price. The High Court of Delhi considered the right to health as enshrined in Article 25(1) of the Universal Declaration on Human Rights and Article 12 ICESCR, and as considered in General Comment No.14. On that basis it required the Government to provide ERT to the child free of charge, noting that the obligations to protect the right to health are non-derogable.⁵⁵⁶ The Court underlined again that Article 21 of the Constitution requires the Government to take all necessary steps to safeguard access to health care and health facilities, including access to life-saving drugs.⁵⁵⁷ The case also considers whether socio-economic deprivation is capable of leading to violations of the rights to life and health.⁵⁵⁸ The Court underlined that although the scope of protections for the rights to life and health needs to be determined with reference the resources available to the State, some rights are non-derogable with access to essential medicines being one of these.⁵⁵⁹ This is consistent with the reasoning of the CESCR in relation to the minimum core elements of the right to health in General Comment No.14.

2.2.3. Americas

There is widespread constitutional recognition of the right to health in the regions of Central and South America; Costa Rica (art. 46); Dominican Republic (art. 61); Suriname (art. 36); Ecuador (art. 32); Brazil (art. 196); El Salvador (art. 65); Panama (art. 109); Guatemala (arts. 93 and 94); Argentina (art. 42); Uruguay (art. 44); Barbados (art. 17.2.A); Haiti (art. 19); Venezuela (art. 83); Paraguay (art. 68); Bolivia (art. 35); Colombia (art. 49); Honduras (art. 145); Mexico (art. 4); Peru (art. 70); and Nicaragua (art. 59). See also the preamble to the Health Act in Canada, and academic commentary on the US Constitution in relation to a right to health care.⁵⁶⁰

556 *Mohd Ahmed (Minor) v Union of India* WP(C) 7279/2013 §67.

557 WP(C) 7279/2013 §68.

558 'Just because someone is poor, the State cannot allow him to die'; WP(C) 7279/2013 §86.

559 WP(C) 7279/2013 §87.

560 Kathleen Swendiman, 'Health Care: Constitutional Rights and Legislative Powers' (2010) CRS Report for Congress 2. See also the discussion on ensuring health equity through the 14th amendment and the Civil Rights Act; Scott Schweikart, 'How to Apply the Fourteenth Amendment to the Constitution and the Civil Rights Act to Promote Health Equity in the US' (2021) 23 (3) *AMA Journal of Ethics* 235.

Colombia

In *Sandra Clemencia Perez Calderon*⁵⁶¹ the plaintiffs (418 parents on behalf of their children) filed a *tutela*⁵⁶² against the Ministry of Health and the District Department of Health, claiming that their children's rights to life, health, and social security were violated (Articles 11, 44, and 49 respectively). The public authorities had not provided the necessary vaccination for meningococcal meningitis and meningitis free of charge, disproportionately affecting children and families of impoverished backgrounds.⁵⁶³

561 *Sandra Clemencia Perez Calderon* (Constitutional Court of Colombia) Case No. T-140800, Decision SU-225/98, (May 20, 1998).

562 A '*tutela*' is a constitutional injunction with the purpose of protecting fundamental rights when these could be threatened by an action or omission by any public authority; see Article 86 of the Constitution of Colombia.

563 *Sandra Clemencia Perez Calderon* (Constitutional Court of Colombia) Case No. T-140800, Decision SU-225/98, (May 20, 1998) §1. Article 11 states: 'The right to life is inviolate. There shall be no death penalty'; Article 44 states: 'The following are basic rights of children: life, physical integrity, health and social security, a balanced diet, their name and citizenship, to have a family and not be separated from it, care and love, instruction and culture, recreation, and the free expression of their opinions. They will be protected against all forms of abandonment, physical or moral violence, sequestration, sale, sexual abuse, work or economic exploitation, and dangerous work. They will also enjoy other rights upheld in the Constitution, the laws, and international treaties ratified by Colombia. The family, society, and the State have the obligation to assist and protect children in order to guarantee their harmonious and integral development and the full exercise of their rights. Any individual may request from the competent authority the enforcement of these rights and the sanctioning of those who violate them. The rights of children take precedence over the rights of others'; Article 49 states: 'Public health and environmental protection are public services for which the State is responsible. All individuals are guaranteed access to services that promote, protect, and rehabilitate public health. It is the responsibility of the State to organize, direct, and regulate the delivery of health services and environmental protection to the population in accordance with the principles of efficiency, universality, and solidarity; further, to establish policies for the provision of health services by private entities and to exercise oversight and control over them; and to establish the competences of the nation, territorial entities, and individuals, and to determine the shares of their responsibilities within the limits and under the conditions determined by law. Public health services will be organized in a decentralized manner broken down in accordance with levels of responsibility and with the participation of the community. The law will determine the limits within which basic care for all the people will be free of charge and mandatory. Every individual has the right to have access to the integral care of his/her health and that of his/her community.'

The Constitutional Court underlined the positive obligations of the States to protect the right to health and establish a free vaccination programme providing meningitis vaccines to children ('a marginalized and discriminated group'),⁵⁶⁴ in order to prevent death or severe health consequences:

*The difficult economic situation of their parents and the lack of coverage of public and private health services, have placed them within the category of the population that do not receive the abovementioned vaccination. While a substantial part of the youth population are protected against the risk represented by the contagion of pathogenic agents carriers of meningitis, the already-mentioned minors are not within the scope of security that society and the State have created to face this adversity.*⁵⁶⁵

The Court addressed the lack of a State policy to prevent children from getting infected, which was a 'grave omission' breaching the fundamental right to health.⁵⁶⁶ It is worth noting that the Court held that the State's duty to eliminate discrimination under Article 13 of the Constitution was linked

564 'The minors on whose behalf the positive action of the State is requested, action that consists in the enforcement of a vaccination program against a disease of an unusual gravity, are a marginalized and discriminated group'; *Sandra Clemencia Perez Calderon* (Constitutional Court of Colombia) Case No. T-140800, Decision SU-225/98, (May 20, 1998) §30.

565 *Sandra Clemencia Perez Calderon* (Constitutional Court of Colombia) Case No. T-140800, Decision SU-225/98, (May 20, 1998) §30. And at §31: 'The existence of a vaccine that prevents the acquisition of a disease of such gravity as meningitis, socially signifies a conquest that enables society to control at least one contingency that, if it occurs, has devastating effects on members of society. Social answers that represent a higher capacity to control the hostile environment that surrounds human life, acquire the form of basic goods that should be shared by everyone. This is especially possible when it is due to medical and technological advances. The availability of a vaccine to substantially reduce the risk of a disease such as meningitis – whose lethal characteristics have already been described in the background –, protects life and avoids mental and physical disability, and therefore becomes a basic need for the children.'

566 *Sandra Clemencia Perez Calderon* (Constitutional Court of Colombia) Case No. T-140800, Decision SU-225/98, (May 20, 1998) §35.

with and dependent on the protection of the right to health, in this case, through providing vaccines to all.⁵⁶⁷

Academic commentary had explored the judicialisation of the right to health in the Colombian courts. It has noted, from a procedural point of view, that the mechanism of *tutela* is predominantly used, with the number of such actions quadrupling in a period of ten years (1995-2005, Human Rights Ombuds Office Study).⁵⁶⁸ In *Luz Mary Osorio Palacio v Salud Coop*,⁵⁶⁹ the Constitutional Court of Colombia reviewed 22 *tutela* actions regarding violation of the right to health in diverse factual circumstances. Significantly the Colombian Constitutional Court declared the right to health to be a fundamental right, with positive and negative dimensions; i.e., it could be violated either by action or omission.⁵⁷⁰ It is worth noting the comments of the Court on the issue of elimination of health services:

[T]he limitations on the right must be reasonable and proportionate. In other words, although the benefit plan does not contain an infinite selection of services, the limiting of included health services must respect the principles of reasonableness and proportionality in a context of allocation of resources according to health priorities. It is therefore essential to carefully justify each

567 See also at §18 ‘In accordance with Article 13 of the Political Constitution, the “State (...) will take measures in favor of discriminated or marginalized groups”. It is the task of the Legislator, firstly, to order the policies that it considers as more adequate to provide for people that are in such a situation, and the means that allow them to assume the control of their existence. Usually, laws in this field impose upon the State the obligation to provide services. Since the distribution of goods and the promotion of opportunities for this part of the population imply expenses of public funds, the Legislator is competent to legislate on this matter.’

568 Daniel Alzate Mora, ‘Health Litigation in Colombia: Have We Reached the Limit for the Judicialization of Health?’ (2014) *Health and Human Rights Journal*. See also Everaldo Lamprea, ‘Colombia’s Right-to-Health Litigation in a Context of Health Care Reform’ (2013) in Aeyal Gross and Colleen Flood (eds) *The Right to Health at the Public/Private Divide: A Global Comparative Study* (Cambridge University Press 2014) 131; Katharine G Young and Julieta Lemaitre, ‘The Comparative Fortunes of the Right to Health: Two Tales of Justiciability in Colombia and South Africa’ (2013) 26 (1) *Harvard Human Rights Journal* 179.

569 *Luz Mary Osorio Palacio v Salud Coop* (Constitutional Court of Colombia, Second Panel of Review) CCC Judgment T-760/08, sec. 3. Decision T-760 of 2008 (July 31, 2008).

570 *Luz Mary Osorio Palacio v Salud Coop* Decision T-760 of 2008, §3.2.1. – 3.3.1.

*deletion as a measure that better allows for addressing new priorities in health, and not as a reduction in the reach of the right.*⁵⁷¹

The decision in *Luz Mary Osorio Palacio v Salud Coop* is considered a landmark in Columbian right to health jurisprudence, going beyond the specific issues raised by the *tutelas* examined in calling for the overall transformation of the national health system.⁵⁷² The contribution of the Colombian Constitutional Court in this regard can be considered together with relevant decisions in Central and South America.

Argentina

It is also worth considering the landmark decision regarding access to treatment and supply of medications in *Benghalensis Association v Ministry of Health and Social Action*⁵⁷³ (‘the *Benghalensis* Litigation’), the decision in *Viceconti v Ministry of Health and Social Welfare*⁵⁷⁴ regarding the lack of production of Candid 1 vaccine to prevent the epidemic of Haemorrhagic Fever, heard before the Federal Administrative Court of Appeals holding that the lack of vaccine production was a violation of the right to health under Article 12 ICESCR, and *Campodónico de Beviacqua, Ana Carina v Ministry of Health and Social Action – Secretariat of Health Programs and Bank of Neoplastic Drugs*⁵⁷⁵ before the Supreme Court of Justice regarding access and supply of life-saving drug to a child living with disability.

571 *Luz Mary Osorio Palacio v Salud Coop* Decision T-760 of 2008, § 6.1.1.2.2.

572 See also commentary on the contribution of the Colombian Court in Alicia Ely Yamin and Oscar Parra-Vera, ‘How Do Courts Set Health Policy? The Case of the Colombian Constitutional Court’ (2009) 6 (2) *Plos Medicine*.

573 *Benghalensis Association v Ministry of Health and Social Action* (National Supreme Court of Justice of Argentina) A. 186, XXXIV, June 1, 2000; CSJN, 1/6/2000, (2000-323-1339).

574 *Viceconti v Ministry of Health and Social Welfare* (Federal Administrative Court of Appeals of Argentina, Fifth Chamber) FACA Exp. 31 777/96 (June 2, 1998).

575 *Ana Carina v Ministerio de Salud y Acción Social – Secretaría de Programas de Salud y Banco de Drogas Neoplásicas* (Supreme Court of Justice of Argentina), C.823.XXXV (October 24, 2000).

Additionally, the case in *PA v Comisión Nacional Asesora para la Integración de las Personas Discapacitadas* (National Commission for the Integration of Disabled People).⁵⁷⁶ The Commission had argued that the claimant was not falling within the requirements of Law 24 901 to request medical coverage for treating her disabilities. The Supreme Court of Justice reversed the ruling of the Court of Appeal holding that Article 3 of Law 24 901 did not require the State to provide health coverage when the claimant had private health insurance.⁵⁷⁷

Ecuador

In *Mendoza v Minister of Public Health and the Director of the National AIDS-HIV-STI Program*,⁵⁷⁸ the applicants who were living with HIV/AIDS, were denied the drugs necessary for their triple antiretroviral treatment by a public hospital in violation of their rights to health and life. The Constitutional Court noted that the right to health forms part of the right to life, and that the State is required and expected to take all positive measures to ensure these rights; see Articles 3, 32, 45, 66 of the Constitution of Ecuador.

Mexico, Bolivia, Brazil, and Guatemala

In Mexico, the circumstances of the failure of the authorities to take all necessary steps to safeguard the patients' right to the highest attainable standard of health could be examined further with reference to the *amparo* action 1669/2012; Case "Special Care Unit 13" (Pabellón 13) regarding patients with HIV-AIDS brought against the National Institute of Respiratory Diseases (INER) and other authorities (AR 378/2014). Additionally, the health arguments in the decisions in Bolivia (Case 108-2010-R) and Guatemala (Case No. 2605-2009) discussed in 1.2.3 could be explored further.

⁵⁷⁶ *PA v Comisión Nacional Asesora para la Integración de las Personas Discapacitadas* (National Commission for the Integration of Disabled People) P 289 L RHE.

⁵⁷⁷ Victor Abramovich and Laura Pautassi, 'Judicial activism in the Argentine Health System: Recent Trends' (2008) 10 (2) *Health and Human Rights Journal* 53.

⁵⁷⁸ Constitutional Tribunal, 3ra. Sala, Ecuador, Resolution No. 0749-2003-RA.

In Brazil, three decisions would be worth consideration for further research and analysis: (1) *Municipality of Caxias do Sul v Vinicius Carpeggiani*,⁵⁷⁹ providing essential medications without cost to fulfil the rights to health and life, (2) Case ADPF 45 (2006) where the Brazilian Federal Supreme Court noted that realising the right to health goes hand in hand with the availability of resources, and (3) Case AI 839594/RS concerning fulfilling the constitutional right to health by providing surgery and essential medications.

Peru

In Peru, it is worth considering the case of *Azanca Alhelí Meza García*,⁵⁸⁰ in which the Constitutional Court ruled that the protection of the right to health should be upheld irrespective of financial resources, and that in doing so, the State would make a worthy ‘social investment’.⁵⁸¹ Additionally, the case in *RJSA Vda. de R*⁵⁸² where the patient’s parent argued that the discharge criteria had not been fulfilled for her daughter to leave the hospital, who was suffering from paranoid schizophrenia.⁵⁸³ The Court in its assessment considered among others, Article 25 UDHR, Article 12 ICESCR, and Article XI American Declaration of the Rights and Duties

579 AI 797349/RS, Federal Supreme Court.

580 *Azanca Alhelí Meza García* EXP. No. 2945-2003-AA/TC Lima, Peru.

581 See *Azanca Alhelí Meza García* EXP. No. 2945-2003-AA/TC at §35: ‘In this regard, this Court considers that even when the budget of the Republic is based on the principle of legality, and that the execution of expenses not approved in the Annual Budget Law is inadmissible, this is not an argument with sufficient force against to the threat or violation of rights, since it is the case that, without involving more resources than those already budgeted, they can be allocated prioritizing attention to specific situations of greater gravity or emergency, as in the instant case. Therefore, we believe that budget collection cannot be understood literally as an objective in itself, forgetting its condition as a means to achieve state objectives, in order to achieve maximum attention to the protection of citizens’ rights.’ and at §44: ‘It is important that the execution of the budget in social policies ceases to be seen as a mere expense and is rather thought of as a social investment for the sake of fulfilling a community goal. Only when all citizens enjoy minimum guarantees of well-being, will they be able to carry out their life plans satisfactorily and, consequently, provide a better contribution to society as a whole, thus achieving greater development as a country.’ (emphasis added).

582 *RJSA Vda. de R* [2007] 03081-2007-PA/TC, Lima, Peru.

583 *RJSA Vda. de R* [2007] 03081-2007-PA/TC, Lima, Peru §49.

of Man, ruling for the petitioner, and asking the hospital centre to provide the necessary medical treatment.⁵⁸⁴ Notably, there are qualifications to the protection of the Peruvian right to health as highlighted by the Court at paragraph 23:

*Notwithstanding the progressive nature of the right to health based on budget possibilities, it must be taken into account, in order to arrive at a valid ruling, that the enforceability of a social right always depends on three factors: a) the seriousness and reasonableness of the case; b) its connection with other fundamental rights; and, c) budget availability.*⁵⁸⁵

As Davies notes, the judgment of the Peruvian Constitutional Court in *Azanca* and in *RJSA*, relying on a human rights approach to protect and advance access to medicines is capable of application in other jurisdictions, and may provide a guide for States seeking to fulfil their obligations under Article 12 ICESCR.⁵⁸⁶

United States

In *James Pietrangelo II v Christopher Sununu*,⁵⁸⁷ the claimant challenged the constitutionality and legality of the vaccine allocation and phased distribution programme in New Hampshire. The latter had prioritised minority population groups disproportionately affected by COVID-19 based on scientific evidence. The case raises issues regarding the right to health in relation to allocation of vaccines and other scarce health resources, as well as non-discrimination under the Fifth and Fourteenth Amendments

584 *RJSA Vda. de R* [2007] 03081-2007-PA/TC, Lima, Peru §65.

585 *RJSA Vda. de R* [2007] 03081-2007-PA/TC, Lima, Peru §23.

586 ‘The jurisprudence of the Peruvian Constitutional Court shows that the court is taking full account of the right to health under the Constitution in cases relating to access to medicines and that its interpretation of the right is in line with the state’s obligations under Article 12 of the ICESCR. (...) These key decisions in Peru have been instructive in clarifying the state’s obligations in relation to the right to health, as well as navigating challenges such as resource constraints. Strengthening health provision is connected to resources, and the decisions make clear that the Constitutional Court acknowledges the progressive nature of health as a social right.’; Lowri Davies, ‘Advancing a Human Rights-Based Approach to Access to Medicines: Lessons Learned from the Constitutional Court of Peru’ (2022) *Health and Human Rights Journal*.

587 Case No. 21-cv-124-PB Opinion No. 2021 DNH 067.

of the United States Constitution, Title VI of the Civil Rights Act of 1964, 42 USC paragraph 2000d, and Title VI of Section 1557 of the Affordable Care Act, 42 USC paragraph 18116(a) (prohibition of discrimination). Further research could include the claim of inadequate treatment of injury in *Estelle v Gamble United States Supreme Court*⁵⁸⁸ which concerned the allocation of health resources in prisons.

2.2.4. Africa

South Africa

In *N v Government of Republic of South Africa*⁵⁸⁹ fifteen persons living with HIV/AIDS in Westville Correctional Centre (WCC), claimed that WCC denying them the necessary antiretroviral treatment necessary for their condition violated their rights to access to health care under s. 27 and 35 of the Constitution of South Africa. The applicants had to wait to pass stages of assessment and counselling sessions before being eligible to receive treatment. Pillay J held *inter alia* that the treatment available at WCC was unreasonable and therefore, unconstitutional.

In *Dudley Lee v Minister for Correctional Services*,⁵⁹⁰ regarding the failure of the Correctional Services to take the appropriate measures to prevent the claimant from contracting tuberculosis could be examined in analogy with the outbreak of a virus in relation to the positive obligations of the State. The Constitutional Court held that the right to medical care requires States to take positive steps and implement policies to prevent and mitigate the spread of infectious diseases. Note should also be made to the health arguments of the cases discussed in 1. Right to Life; *Soobramoney v Minister of Health (Kwazulu-Natal)*,⁵⁹¹ and *Minister of Health v Treatment Action Campaign (TAC)*.⁵⁹²

Of particular interest is the case in *Solidarity and Afriforum NPC v Minister of Health (3623/21)*, where the applicants challenged the constitutionality

588 429 US 97 (1976).

589 High Court of South Africa (Durban and Coast Local Division); 2006 (6) SA 543 (D) (S Afr).

590 [2012] ZACC 30.

591 Case CCT 32/97; Nov 27, 1997.

592 (2002) 5 SA 721 (CC).

and legality of the Government's vaccine distribution strategy, according to which the national government would be the only COVID-19 vaccine procurer. The applicants requested the interpretation of the constitutional right to health in the specific context of scarce medical resources during the COVID-19 pandemic and that private actors and provincial health authorities could procure, allocate, and administer vaccines subject to approach by the relevant health authority. The applicants withdrew the case against the Minister of Health in March 2021. The Health Justice Initiative (HJI) raised concerns over vaccine monopolies in the Global South taking precedence over the right to health.

Kenya

Along with the health arguments presented in *LN v Ministry of Health*,⁵⁹³ and *Patricia Asero Ochieng v Attorney General*⁵⁹⁴ discussed above in relation to the right to life (see 1.2.4), it is worth considering the decision in *Okwanda v Minister of Health and Medical Services*.⁵⁹⁵ There the High Court at Nairobi rejected the claim of an elderly petitioner for funding treatment for his life-threatening conditions. Specific reference was made to Article 12 ICESCR and General Comment No.14. The Court was not satisfied that the petitioner had provided enough evidence in support of their claim that the State had breached its constitutional obligations to protect the right to the highest attainable standard of health under Article 43(1) of the Constitution of Kenya.⁵⁹⁶

593 Petition No 218 of 2013.

594 Petition 409 of 2009.

595 *Okwanda v Minister of Health and Medical Services* Petition No. 94 of 2012 (2013).

596 *Okwanda v Minister of Health and Medical Services* Petition No. 94 of 2012 (2013) §19.

Zimbabwe

In *Attorney General v Tapela*⁵⁹⁷ regarding the government of Zimbabwe's refusal to cover the cost of anti-retroviral treatment (ARVs) for non-citizen prisoners,⁵⁹⁸ the Court of Appeal held this refusal was endangering the prisoners' rights to health and that the internal directive prescribing this policy was unlawfully discriminatory contrary to s.15 of the Constitution.⁵⁹⁹ The case confirms the justiciability of the right to health in this context with the Court noting that governmental authorities cannot justify derogation of their obligations solely on the basis of a lack of financial resources. The US case in *Estelle v Gamble United States Supreme Court*⁶⁰⁰ discussed previously in this section was considered.

Uganda

*Centre for Health, Human Rights and Development (CEHURD) v Attorney General*⁶⁰¹ concerned two women who had died because of multiple failures by the State to protect their rights to life and health. The applicants CEHURD, a health and human rights NGO, claimed that the government's insufficient budget allocation for the maternal care had resulted in a significant shortfall of needed and available mid-wives, medical practitioners, and essential health resources in contravention of Article 22 of the Constitution of Uganda which protects the right to

597 *Attorney General v Tapela* Civil Case No. CACGB-096-14 (2015).

598 *Attorney General v Tapela* '[P]rovision of free treatment to non-citizen prisoners suffering from ailments other than AIDS'; Civil Case No. CACGB-096-14 §15.

599 *Attorney General v Tapela* Civil Case No. CACGB-096-14 (2015) §77. Of interest are the Court's precautionary marks against reading socioeconomic rights into the Botswana Constitution at §83-86.

600 *Estelle v Gamble United States Supreme Court* 429 US 97 (1976).

601 *Center for Health Human Rights and Development (CEHURD) v Attorney General* Constitutional Appeal No. 1 of 2013 (2015); *Centre for Health Human Rights & Development & 3 Ors v Attorney General* Constitutional Petition 16 of 2011 (2012).

life.⁶⁰² Importantly, the Supreme Court distinguished its reasoning from earlier jurisprudence of the Ugandan Constitutional Court. It held that the reluctance to ‘interfere’ with government’s functions was constitutionally unfounded. The case concerned the insufficient supply and stock of essential medicinal products, and this was not a political question.

Comments

Concluding this section on national jurisdictions, it is worth noting that the litigation trends in Central and South America, India, and in South and West Africa are of particular interest. Many of the cases explored indicate that access to essential medicines can be closely linked to the realisation and protection of the right to health, mostly in Central and South America.⁶⁰³ Additional research with a sole focus on litigation trends and arguments engaged in middle- and low-income countries in these regions could be further developed and used to make comparisons with the interpretation of the right to health in Bulgaria.

2.3. Health and Information

In previous sections, we discussed illustrations and applications of the right to health in international, regional, and national systems. We observed the position and arguments put forward by State authorities in denying treatment, causing, or contributing to circumstances that are or could be harmful to the health of individuals. The factual scenarios explored highlight the interdependence of the right to life on the one hand and the protection of health on the other, and links of both with the principle of non-discrimination. We can note in summary that:

⁶⁰² *Center for Health Human Rights and Development (CEHURD) v Attorney General* Constitutional Appeal No. 1 of 2013 (2015); *Centre for Health Human Rights & Development & 3 Ors v Attorney General* Constitutional Petition 16 of 2011 (2012) at p.25. Article 22 Protection of right to life states: (1) No person shall be deprived of life intentionally except in execution of a sentence passed in a fair trial by a court of competent jurisdiction in respect of a criminal offence under the laws of Uganda and the conviction and sentence have been confirmed by the highest appellate court.

⁶⁰³ See Hans Hogerzeil and others, ‘Is Access to Essential Medicines as Part of the Fulfilment of the Right to Health Enforceable Through the Courts?’ (2006) 368 (9532) *The Lancet* 305.

The protection of the right to life naturally and inherently encompasses considerations of physical and mental health, which must be realised through policies, frameworks, and laws, that are non-discriminatory in their direct and indirect effects. Additionally, the right to health, like the right to life, depends and relies on the realisation of other human rights due to its inclusive nature and wide range of possible applications. An additional element flowing from the positive obligations of the State and permeating this relationship needs to be worth examining separately, namely public access to scientifically supported health information. This has two interrelated aspects: on the one hand the right of access to reliable health-related information and promotional programmes and, on the other hand, the combatting of misinformation. By ensuring the first the State can discharge its duty to combat the latter.

2.3.1. Health-related information

The right to health depends on the realisation of other human rights and builds upon the underlying determinants of health, including access to safe nutrition, housing, environment, sanitation, participation, information, and health-related education, as noted by the CESCR in General Comment No.14.⁶⁰⁴ The link between the right to health and health-related information and education was highlighted by the European Committee of Social Rights in its statement during the COVID-19 pandemic that:

*In line with Article 11 paragraph 2, [European Social Charter] States Parties must take all necessary measures to educate people about the risks posed by the disease in question. This entails carrying out public awareness programmes so as to inform people about how to mitigate the risks of contagion and how to access healthcare services as necessary.*⁶⁰⁵

The HRC has also linked the right to life with access to ‘quality and evidence-based information and education’ in the context of reproductive

604 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) §3, 11; see also UN General Assembly (UNGA), Universal Declaration of Human Rights (10 December 1948), A/RES/217A (III) 25 (1).

605 European Committee of Social Rights, ‘Statement of Interpretation on the Right to Protection of Health in Times of Pandemic’ (adopted by the Committee on 21 April 2020) 3.

health.⁶⁰⁶ In *Whelan v Ireland*,⁶⁰⁷ explored later (see 3.1.1.1), the HRC referred to the complainant's obstacles to access the necessary health care services and health information. The latter specifically concerned abortion-related information vital for the complainant's health given that her pregnancy was non-viable.⁶⁰⁸ At the regional level, similar examples include the comments of the Inter-American Court of Human Rights on the lack of health-related education that would be respectful to community traditions and practices in *Xákmok Kásek Indigenous Community v Paraguay*.⁶⁰⁹ At national level, similar concerns were raised regarding a vaccine-promotion campaign in Colombia, in *Sandra Clemencia Perez Calderon*.⁶¹⁰

It is worth highlighting, that in General Comment No.14, the duties to 'protect' and 'fulfil' the right to health, include adopting not only administrative, legislative, and judicial steps, but also 'promotional' measures.⁶¹¹ The CESCR notes that the duty to prevent epidemics and diseases requires establishing 'prevention and education programmes for behaviour-related health concerns' as well promoting 'social determinants of good health':⁶¹²

Further obligations include (...) promotion of medical research and health education, as well as information campaigns, in particular with respect to HIV/AIDS, sexual and reproductive health, traditional practices, domestic

606 UN Human Rights Committee (HRC), CCPR General Comment No. 36 (2019) On Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (3 September 2019), CCPR/C/GC/36, §8.

607 *Whelan v Ireland* Communication No. 2425/2014 UN Doc. CCPR/C/119/D/2425/2014 (2017).

608 *Whelan v Ireland* Communication No. 2425/2014 UN Doc. CCPR/C/119/D/2425/2014 (2017) §§7.5-7.6.

609 *Xákmok Kásek Indigenous Community v Paraguay* Inter-American Court of Human Rights (Inter-Am Ct HR) (ser. C) No. 214 (2010) §208.

610 *Sandra Clemencia Perez Calderon* (Constitutional Court of Colombia) Case No. T-140800, Decision SU-225/98, (1998) §4.

611 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) §16.

612 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) §§16, 17 ('health education').

*violence, the abuse of alcohol and the use of cigarettes, drugs and other harmful substances.*⁶¹³

and

*To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them.*⁶¹⁴

The comments of the CESCR in General Comment No.14 not only set out States' duties to design and conduct health-promotion campaigns and to ensure health education. They also indicate that States should nurture a culture of health education and information within the community as a distinct dimension and indivisible counterpart of the right to health. This allows a foundation of knowledge and information in relation to health to be built, which can then be adapted flexibly depending on the specific health challenge faced. By contrast it would seem highly unlikely that a community unaccustomed to accessing reliable health information or engaging with State-led health campaigns would be ready to do so for the first time during a global public health emergency, such as COVID-19. It is also unlikely that the community would trust the State in its public statements when these concern complicated scientific facts and when this is unusual, unexpected behaviour for State officials who have not engaged in informing the public about health concerns before.⁶¹⁵ Therefore, a lack of health information and public education can generate a lack of public trust, which will in turn hinder the implementation of state-wide treatment programmes, such as vaccinations, even when these are in place, and rolled-out equitably.

613 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) §36.

614 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) §44 (d).

615 And especially when corruption is a national problem. Corruption in the health sector is a major impediment to the fundamental right to health. Empirical evidence has shown that corruption can reduce immunisation rates, discourage the use of public health services, and increase waiting times at health clinics; Omar Azfar and Tugrul Gurgur, 'Does Corruption Affect Health and Education Outcomes in the Philippines?' (2008) 9 *Economics of Governance* 197. Bulgaria has one of the lowest rankings in the Rule of Law Index (2021).

It is this element of collaboration and mutual trust between State authorities and the public that appears to have been absent in the Bulgaria vaccine distribution scenario. As described by the Open Society European Policy Institute (OSEPI) in its complaint submitted to the European Committee of Social Rights of January 2022, the authorities failed to develop a communication strategy or launch a campaign to inform and encourage the public to get vaccinated, ignoring prompts by local think tanks to provide these services free of charge.⁶¹⁶ The failure of State authorities to promote the best available tool against the pandemic, namely vaccines against COVID-19, and thus to protect the lives and health of the Bulgarian public was exacerbated by the authorities' consistent failure to design and implement health promotion programmes aimed at chronic health problems in Bulgaria.⁶¹⁷ This was especially serious given

616 'It was not until early November 2021 that the Ministry of Health sought help from the Center for Analysis and Crisis Communications'; Complaint No. 204/2022 *Open Society European Policy Institute (OSEPI) v Bulgaria* (2022) §§64-66.

617 *State of Health in the EU: Bulgaria - Country Health Profile* (OECD 2021) 13, 16, 17, and 19.

that vaccine hesitancy⁶¹⁸ is a well-documented obstacle to vaccination in Bulgaria.⁶¹⁹

The lack of a COVID-19 awareness campaign in Bulgaria stands in contrast to the campaigns conducted in other European countries. For example, Greece launched a nation-wide public information campaign on COVID-19 prevention and disease control measures soon after reporting its first case in late February 2020.⁶²⁰ Recent surveys have indicated a high level of vaccine-acceptance among health professionals (physicians, pharmacists, dentists) in Central Greece. These findings link the absence of

618 For a definition of vaccine hesitancy see Noni E MacDonald, the SAGE Working Group on Vaccine Hesitancy, 'Vaccine Hesitancy: Definition, Scope and Determinants' (2015) 33 Vaccine 4161: 'Vaccine hesitancy refers to delay in acceptance or refusal of vaccination despite availability of vaccination services. Vaccine hesitancy is complex and context specific, varying across time, place and vaccines. It is influenced by factors such as complacency, convenience and confidence' at 4163.

619 Heidi Larson and others, *State of Vaccine Confidence in the EU 2018* (European Union 2018) 16; Adamos Hadjipanayis and others, 'Vaccine Confidence Among Parents: Large Scale Study in Eighteen European Countries' (2020) 38 (6) Vaccine 1505. See also Robb Butler, Noni E MacDonald, the SAGE Working Group on Vaccine Hesitancy, 'Diagnosing the determinants of vaccine hesitancy in specific subgroups: The Guide to Tailoring Immunization Programmes (TIP)' (2015) 33 (34) Vaccine 4176; discussing the application of a Tailoring Immunisation Programme (TIP) during the measles outbreak in Bulgaria (2009-2011), to combat low vaccination rates for what the *Tailoring Immunization Programmes (TIP): Outputs of pilot implementation in Bulgaria* (WHO 2015) described the 'vulnerable pockets of the Bulgarian population' at 5. See also Stoyan Vergiev and Denis Niyazi, 'Vaccine Hesitancy During the COVID-19 Vaccination Campaign: A Cross-Sectional Survey among Bulgarian University Students' (2021) 37 (3) Acta Microbiologica Bulgarica 122; Mark Muscat and others, 'The Measles Outbreak in Bulgaria, 2009-2011: An Epidemiological Assessment and Lessons Learnt' (2016) 21 (9) Euro Surveill. Last, Caudal and others, 'Vaccine Distrust: Investigation of the Views and Attitudes of Parents in Regard to Vaccination of Their Children' (2020) 78 (4) Annales Pharmaceutiques Françaises 294; Jhoys Landicho-Guevarra and others, 'Scared, Powerless, Insulted and Embarrassed: Hesitancy Towards Vaccines Among Caregivers in Cavite Province, the Philippines' (2021) BMJ Global Health 2021 6.

620 Georgia Kourlaba and others, 'Willingness of Greek General Population to Get a COVID-19 Vaccine' (2021) 6 (2) Global Health Research and Policy.

fear over vaccine safety with the information disseminated by public health authorities in Greece.⁶²¹

Nevertheless, empirical studies suggest that the Greek population was still more hesitant to receive the vaccine than other populations in Europe. Thus, the ‘vaccine-willingness’ rate in Greece was 57.7% compared to 76.9% in the UK.⁶²² Another study had noted that out of 7664 study participants across France, Italy, Portugal, Denmark, Germany, the UK, and the Netherlands, 73.9% were willing to get vaccinated, with the highest percentages of vaccine opposition to be found in France and Germany (10%).⁶²³ This trend is consistent with the level hesitancy among the Greek population regarding the influenza vaccine (H1N1) distributed in 2009.⁶²⁴

These findings indicate that even States which designed and implemented public information campaigns on COVID-19 prevention and mitigation measures early in the pandemic, as was the case in Greece, could still have gone further in seeking to build public trust in the context of a global health emergency.⁶²⁵ The evaluation of a country’s COVID-19 information campaign must take into consideration all population groups, particularly those which are distinctly vulnerable. Greece faced criticism for its delay in implementing information and vaccination campaigns targeted at asylum-seeking facilities, and in rolling-out vaccines to their residents. This was particularly significant given the evident vulnerability of the populations residing in overcrowded camps with unsanitary conditions and

621 See also ‘[O]ur results provide evidence that receiving vaccine-related information from the Greek Center for Diseases Control (E.O.D.Y.) could reduce the drivers of hesitancy and enhance the acceptability of COVID-19 vaccination’ Dimitrios Papagiannis and others, ‘Acceptability of COVID-19 Vaccination among Greek Health Professionals’ (2021) 9 (3) *Vaccines* (Basel) 200.

622 Rachael J Thorneloe and others, ‘Willingness to Receive a COVID-19 Vaccine Among Adults at High-Risk of COVID-19: a UK-Wide Survey’ (2020) *PsyArXiv*; Georgia Kourlaba and others, ‘Willingness of Greek General Population to Get a COVID-19 Vaccine’ (2021) 6 (2) *Global Health Research and Policy*.

623 Sebastian Neumann-Böhme and others, ‘Once We Have it, Will We Use It? A European Survey on Willingness to Be Vaccinated Against COVID-19’ (2020) 21 (7) *Eur J Health Econ* 977.

624 Georgia Kourlaba and others, ‘Willingness of Greek General Population to Get a COVID-19 Vaccine’ (2021) 6 (2) *Global Health Research and Policy*; Trang Nguyen and others, ‘Acceptance of a Pandemic Influenza Vaccine: A Systematic Review of Surveys of the General Public’ (2011) 4 *Infect Drug Resist* 197.

625 As noted previously, Bulgaria did not launch a relevant health campaign until much later in the pandemic.

the impossibility of social distancing within them.⁶²⁶ In Greece, persons unregistered by national health systems⁶²⁷ and pensioners returning from abroad⁶²⁸ also faced notable barriers to getting vaccinated against COVID-19. Low vaccination coverage for vulnerable population groups, such as children belonging to the Roma community, existed even before the pandemic.⁶²⁹ Greek national policies prescribing monthly fines for the unvaccinated in late 2021⁶³⁰ would also suggest a less than wholly successful information campaign. In effect the campaign's deficiencies were compensated for by penalising those vulnerable groups that it ought to have functioned to protect in the first place.

626 See Michela Pugliese, 'Euro-Mediterranean Human Rights Monitor - Greece's Discriminatory Vaccination Practices Render Asylum Seekers Seriously Vulnerable' (*Euro-Mediterranean Human Rights Monitor*, 2021) <<https://euromedmonitor.org/en/Article/4262/Greece's-discriminatory-vaccination-practices-render-asylum-seekers-seriously-vulnerable>> accessed May 30, 2022. See also 'In Greece, Thousands of Asylum-Seekers Are Waiting for the COVID-19 Vaccine' (*The World*, 2021) <<https://theworld.org/stories/2021-05-11/greece-thousands-asylum-seekers-are-waiting-covid-19-vaccine>> accessed May 30, 2022.

627 Tania Georgiopolou, 'Homeless, Migrants, Roma Without Access to Covid-19 Vaccination' (*Ekathimerini.com*, 2021) <<https://www.ekathimerini.com/news/261324/homeless-migrants-roma-without-access-to-covid-19-vaccination/>> accessed 21 May 2022.

628 'Ερώτηση Θ. Ξανθόπουλου: Εκτός Εμβολιασμών, Λόγω Έλλειψης ΑΜΚΑ, Οι Έλληνες Συνταξιούχοι Μετανάστες Του Εξωτερικού Που Διαβιούν Στη Χώρα-Ανάγκη Ένταξης Τους Στο Εμβολιαστικό Πρόγραμμα' (*Syriza.gr*, 2022) <<https://www.syriza.gr/Article/id/107404/Erwthsh-Th.-KSanthopoyloy:-Ektos-emboliasmwn-logw-elleipshs-AMKA-oi-Ellhnes-syntaksioychoi-metanastes-toy-ekswterikoy-poy-diabioyn-sth-chwra-Anagkh-entakshs-toys-sto-emboliastiko-programma.html>> accessed 26 May 2022.

629 Dimitris Papamichail and others, 'Low Vaccination Coverage of Greek Roma Children Amid Economic Crisis: National Survey Using Stratified Cluster Sampling' (2017) 27 (2) 318. The authors identified a deep gap between the vaccination of Greek Roma child population and non-minority child population. In their discussion, the authors proposed vaccination promotion and relevant social policies.

630 'Covid: Greece to Fine Over-60s Who Refuse Covid-19 Vaccine' (*BBC News*, 2021) <<https://www.bbc.com/news/world-europe-59474808>> accessed 30 May 2022. See also 'Covid: Quebec to Impose Health Tax on Unvaccinated Canadians' (*BBC News*, 2022) <<https://www.bbc.com/news/world-us-canada-59960689>> accessed 28 May 2022.

A detailed comparison of the information campaigns implemented in Greece and other European countries with the Bulgarian vaccine distribution scenario is beyond the scope

of this section. This brief analysis has been provided, rather, to clarify that States have the responsibility *gradually* to build up a relationship of trust and collaboration with the public, promptly and consistently sharing health-related information and providing the necessary educational resources to all population groups equally, in line with their international law commitments, as noted above.⁶³¹ This necessary trust and collaboration also confirms the social dimensions of health and the need for an inclusive, widely-framed understanding of the right to health to include its social and informational determinants. Providing fragmented information only in the aftermath of a pandemic seems highly unlikely to inform, educate, and incentivise the diverse communities of a State to get vaccinated. That is especially the case, since the COVID-19 pandemic was also characterised by an intensified flow of misinformation.⁶³²

3. Prohibition of Discrimination

Overview

Central to the protection of the rights to life and health is the prohibition of discrimination on any ground. Prohibition of discrimination along with equality before the law are overarching principles that inform and support

631 See also ‘COVID-19 has highlighted the importance of building trust in scientific research and public policy through well-conceived, adaptable health communication policies that ensure that new scientific knowledge is communicated rapidly, transparently and accurately in accessible formats’; Council of Europe, Commissioner for Human Rights, *Protecting the Right to Health Through Inclusive and Resilient Health Care for All* (Council of Europe, 2021) 37.

632 In a joint statement in 2020, several international organisations and bodies, including WHO, UN, UNICEF, and UNESCO, urged the States to ‘listen to their communities’ and empower them to ‘develop solutions and resilience against mis- and disinformation’; ‘Managing The COVID-19 Infodemic: Promoting Healthy Behaviours and Mitigating the Harm from Misinformation and Disinformation’ (*Who.int*, 2022) <<https://www.who.int/news/item/23-09-2020-managing-the-covid-19-infodemic-promoting-healthy-behaviours-and-mitigating-the-harm-from-misinformation-and-disinformation>> accessed 7 June 2022.

the protection of human rights.⁶³³ It is the ‘basic’ and ‘general’ nature of these principles that makes them relevant for the protection of all rights.⁶³⁴ Non-discrimination is an essential safeguard for the right to life and health. As noted by the HRC in General Comment No. 36, the right to life must be protected without distinction of any kind, including on the basis of disability and age.⁶³⁵ The HRC noted that:

*Legal protections for the right to life must apply equally to all individuals and provide them with effective guarantees against all forms of discrimination, including multiple and intersectional forms of discrimination. Any deprivation of life based on discrimination in law or fact is ipso facto arbitrary in nature.*⁶³⁶

In previous sections, and through the case law examined, we saw that the principle of non-discrimination is a prerequisite for protecting and respecting the right to health. We followed the comments of the Constitutional Court of Colombia in Judgment SU-225/98 that elimination of discrimination under Article 13 of the Constitution is dependent on the equal protection of the right to health (see 2.2.3). We also discussed the recent decision of the Federal Constitutional Court of Germany⁶³⁷ to the effect that the legislature had violated Art. 3 Para. 3 (Equality before the law) by failing to take the necessary steps ‘to ensure that no one, due to a disability, was not assigned essential treatment resources.’ (see 1.2.1)⁶³⁸ The right to health in the WHO constitution encompasses the principles of non-discrimination and equality,⁶³⁹ while the Committee on Economic, Social and Cultural Rights has underlined that States have a ‘priority obligation’ to take all the appropriate steps and measures to guarantee, for all persons without discrimination, the access to available vaccines to the

633 HRC, CCPR General Comment No. 18: Non-discrimination, 10 November 1989 §1.

634 HRC, CCPR General Comment No. 18: Non-discrimination, 10 November 1989 §3.

635 HRC, General Comment No. 36, Article 6 (Right to Life), 3 September 2019, CCPR/C/GC/35,§61.

636 HRC, General Comment No. 36, Article 6 (Right to Life), 3 September 2019, CCPR/C/GC/35, §61 (emphasis added).

637 *BVerfG, decision of the First Senate of December 16, 2021*, 1 BvR 1541/20, Rn. 1-131.

638 *BVerfG, decision of the First Senate of December 16, 2021*, 1 BvR 1541/20, Rn. 1-131.

639 Constitution of the World Health Organization, UN Doc. E/155 (1946), Preamble.

maximum of their resources.⁶⁴⁰

The following sections examine the international, regional, and national instruments which provide safeguards against discrimination. Selected claims of discrimination in the context of health care, resource allocation, and treatment will provide a practical illustration of these protections, bringing together the themes discussed in this report (right to life, health, non-discrimination) and highlighting their interdependence.

3.1. International and Regional Systems

3.1.1. International Covenant on Civil and Political Rights: Article 26

Article 26 of the International Covenant on Civil and Political Rights (ICCPR)⁶⁴¹ states:

All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

We should also note Article 3 ICCPR stating:

*The States Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all civil and political rights set forth in the present Covenant.*⁶⁴²

In General Comment No. 18 (non-discrimination), the HRC notes that the ICCPR does not include a definition of discrimination or what

⁶⁴⁰ CESCR, Statement on Universal Affordable Vaccination for COVID-19, International Cooperation and Intellectual Property (12 March 2021), E/C.12/2021/1 §3.

⁶⁴¹ International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171 (ICCPR).

⁶⁴² International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171 (ICCPR).

constitutes discriminatory conduct.⁶⁴³ But in line with the definitions noted in Convention on the Elimination of All Forms of Racial Discrimination (art. 1) and Convention on the Elimination of All Forms of Discrimination against Women (art. 1), the HRC notes that ‘discrimination’ should be understood to ‘imply any distinction, exclusion, restriction or preference which is based on any ground’, and which undermines the recognition and realisation ‘by all persons, on an equal footing’ of the rights protected under the Articles of the ICCPR.⁶⁴⁴

The principle of non-discrimination and equality in the ICCPR is seen in the Articles 2, 3, 4, 24, and 26. Articles 2 (1) and 3 provide an ancillary protection to individuals from discrimination, when this happens in relation to the enjoyment of their rights under ICCPR; a position similar to that of Article 14 ECHR in relation to the ECHR rights (see 3.1.2). Therefore, while Article 2 (1) provides an accessory right to non-discrimination, Article 26 is a ‘freestanding equality clause’ under the ICCPR.⁶⁴⁵ Under the Optional Protocol to the ICCPR,⁶⁴⁶ individuals subject to the jurisdiction of a State party to the ICCPR and to the Protocol, can submit a communication to the HRC for consideration.

In General Comment No. 18, the HRC noted that ‘not every differentiation of treatment will constitute discrimination, if the criteria for such differentiation are reasonable and objective and if the aim is to achieve a purpose which is legitimate under the Covenant’.⁶⁴⁷ Accordingly in *MSP-B v Netherlands*⁶⁴⁸ discussed below (see 3.1.1.1 (b)), the criteria for justifying a differentiated treatment were held to be reasonableness, legitimacy of aim,

643 HRC, CCPR General Comment No. 18: Non-discrimination, (10 November 1989) §§6-7.

644 HRC, CCPR General Comment No. 18: Non-discrimination, (10 November 1989) §§6-7.

645 See Dimitrina Petrova, *Article 7: The Equality and Non-Discrimination Provision Appendix E to the Report of the Global Citizenship Commission* (Open Book Publishers, 2016) 3.

646 See Article 2 ‘Subject to the provisions of Article 1, individuals who claim that any of their rights enumerated in the Covenant have been violated and who have exhausted all available domestic remedies may submit a written communication to the Committee for consideration.’; Optional Protocol to the International Covenant on Civil and Political Rights, GA res. 2200A (XXI), 21 UN GAOR Supp. (No. 16) at 59, UN Doc. A/6316 (1966), 999 UNTS 302, entered into force March 23, 1976.

647 HRC, CCPR General Comment No. 18: Non-discrimination, (10 November 1989) §13.

648 *MSP-B v Netherlands* Communication No. 2673/2015 UN Doc. CCPR/C/123/D/2673/2015 (2018).

and objectivity.⁶⁴⁹ This also recalls the tests for justifiably differentiated treatment developed by ECtHR. Under the latter, where discrimination per se has been established, a reasonable and objective justification for the differentiated treatment may be offered in justification, as in *Thlimmenos v Greece*,⁶⁵⁰ and *Molla Sali v Greece*⁶⁵¹ (see 3.1.2).⁶⁵²

3.1.1.1. Claims of Violation of Article 26

The general nature of the principle of non-discrimination which informs and supports the realisation of all human rights is seen from the diversity of the contexts in which it applies. A review of communications to the HRC made under the Optional Protocol reveals that Article 26 is engaged in a variety of contexts, including but not limited to discrimination on the basis of 1) religion (Opinion No. 42/2015);⁶⁵³ 2) deportation (*AAH v The Netherlands*⁶⁵⁴); 3) sexual orientation (*Kirill Nepomnyashchiy v Russian Federation*⁶⁵⁵); 4) marital status (*Sprenger v The Netherlands*⁶⁵⁶); 5) language

649 *MSP-B v Netherlands* Communication No. 2673/2015 UN Doc. CCPR/C/123/D/2673/2015 (2018) §§7.4-7.5.

650 *Thlimmenos v Greece* ECtHR Application no. 34369/97 (2000).

651 *Molla Sali v Greece* ECtHR Application no. 20452/14 (2020) §137. See also the relevant paragraphs in *ECSR Open Society European Policy Institute v Bulgaria* (complaint submitted 25 January 2022) §§ 85, 100.

652 Bulgaria failed to provide such an explanation. See *ECSR Open Society European Policy Institute v Bulgaria* (complaint submitted 25 January 2022) §§ 107, 110.

653 See Opinion No. 42/2015 concerning Irina Zakharchenko and Valida Jabrayliova (Azerbaijan) A/HRC/WGAD/2015 §44.

654 *AAH v The Netherlands* Communication No. 3104/2018 UN Doc. CCPR/C/124/D/3104/2018 (2019).

655 *Kirill Nepomnyashchiy v Russian Federation* Communication No. 2318/2013 CCPR/C/123/D/2318/2013 (2018).

656 *Sprenger v The Netherlands* Communication No. 395/1990 CCPR/C/44/D/395/1990 (1992).

(*Hervé Barzhig v France*;⁶⁵⁷ *Linder v Finland*⁶⁵⁸); 6) race (*RL v Canada*⁶⁵⁹); and 7) gender (*Purna v Nepal*⁶⁶⁰). Focusing on claims of discrimination under Article 26 in the context of access to health care, we can note the following set of cases, which are grouped thematically.

a) Reproductive health care

In *KL v Peru*,⁶⁶¹ the complainant was denied access to the necessary health and medical care following a diagnosis that she was carrying an anencephalic foetus. She had to carry to term a pregnancy whose outcome could only be fatal, and then suffered severe consequences to her mental health.⁶⁶² However, the HRC held that the complainant had not substantiated the claims of a violation of Articles 3 and 26, finding this part of the complaint inadmissible.⁶⁶³ In *LMR v Argentina*,⁶⁶⁴ the complainant, a minor with a mental disability, was raped and was found to be pregnant. Despite the fact that female rape victims with a mental disability had the right under Article 86.2 of the Criminal Code to terminate a pregnancy without requiring judicial authorization,⁶⁶⁵ the hospital was the subject of an injunction to desist from the procedure, issued by the juvenile court and confirmed by the Civil Court, which was overturned by the Supreme

657 *Hervé Barzhig v France* Communication No. 327/1988 UN Doc. CCPR/C/41/D/327/1988 (1991).

658 *Linder v Finland* Communication No. 1420/2005 UN Doc. CCPR/C/85/D/1420/2005 (2006).

The applicant claimed that he was discriminated on the basis of his origin and language and did not receive the necessary medical care in violation of Article 26 (§3.4). The HRC found the case inadmissible under Article 2 of the Optional Protocol to the ICCPR.

659 *RL v Canada* Communication No. 358/1989 UN Doc. CCPR/C/43/D/358/1989 (1991).

660 *Purna v Nepal* Communication No. 2245/2013 UN Doc. CCPR/C/119/D/2245/2013 (2017).

661 *KL v Peru* Communication No. 1153/2003 UN Doc. CCPR/C/85/D/1153/2003 (2005).

662 *KL v Peru* Communication No. 1153/2003 UN Doc. CCPR/C/85/D/1153/2003 (2005) §2.5.

663 *KL v Peru* Communication No. 1153/2003 UN Doc. CCPR/C/85/D/1153/2003 (2005) §5.3.

664 *LMR v Argentina* Communication No. 1608/2007 UN Doc. CCPR/C/101/D/1608/2007 (2011).

665 ‘The only requirements are that the disability should be diagnosed, that the victim’s legal representative should give consent and that the termination should be performed by a licensed physician.’; *LMR v Argentina* Communication No. 1608/2007 UN Doc. CCPR/C/101/D/1608/2007 §2.3.

Court of Justice of Buenos Aires.⁶⁶⁶ Despite the Supreme Court ruling in the claimant's favour, the hospital still did not perform the lawful abortion indicated and requested.⁶⁶⁷ The claimant was held to have been denied necessary reproductive and medical care, leading to significant physical and mental suffering.⁶⁶⁸ The HRC found a violation of Article 17, Article 2 (3) in relation to Articles 3, 7 and 17 and of Articles 7, 17 and 2 (3) in relation to Articles 3, 7 and 17 ICCPR.

In *Whelan v Ireland*⁶⁶⁹ the HRC found a violation of Article 26 in circumstances where the complainant was denied access to health care, health-related information, and medical advice in relation to her dying foetus, endangering her mental and physical health:

*[W]omen who choose to terminate a non-viable pregnancy must do so in reliance on their own financial resources, entirely outside of the public health care system. They are denied health insurance coverage for these purposes; (...) they are denied needed post-termination medical care and bereavement counseling. (...) The Committee recalls its General Comment No. 28, in which it states that “not every differentiation of treatment will constitute discrimination, if the criteria for such differentiation are reasonable and objective and if the aim is to achieve a purpose which is legitimate under the Covenant.”*⁶⁷⁰

The HRC considered the comment of the complainant that, unlike her, male and other patients in the State were not expected to disregard their health needs,⁶⁷¹ holding that the differentiated treatment in this case did not meet the requirements of 'reasonableness, objectivity and legitimacy

666 *LMR v Argentina* Communication No. 1608/2007 UN Doc. CCPR/C/101/D/1608/2007 (2011)§2.5, 2.6.

667 *LMR v Argentina* Communication No. 1608/2007 UN Doc. CCPR/C/101/D/1608/2007 (2011)§2.7.

668 *LMR v Argentina* Communication No. 1608/2007 UN Doc. CCPR/C/101/D/1608/2007 (2011)§3.1, 9.2.

669 *Whelan v Ireland* Communication No. 2425/2014 UN Doc. CCPR/C/119/D/2425/2014 (2017).

670 *Whelan v Ireland* Communication No. 2425/2014 UN Doc. CCPR/C/119/D/2425/2014 (2017)§7.10-7.11.

671 *Whelan v Ireland* Communication No. 2425/2014 UN Doc. CCPR/C/119/D/2425/2014 (2017)§3.9.

of purpose'.⁶⁷² The HRC noted its decision in *Mellet v Ireland*⁶⁷³ (also concerning a non-viable pregnancy) when considering the complainant's claim under Article 17 ICCPR.⁶⁷⁴

b) Immigration status and health care

In *MSP-B v Netherlands*,⁶⁷⁵ the complainant's daughter was diagnosed with a rare metabolic deficiency, which, without access to a ketonic diet, would result in a medical emergency in the form of brain damage, or death.⁶⁷⁶ The HRC rejected the complainant's claim that the State party had discriminated against her by denying her application for general child benefit based on residence status. It found that no violation of Article 26 had occurred.⁶⁷⁷ The HRC reiterated that not every differentiation in treatment will amount to discrimination. The complainant must show how the treatment in question does not meet the criteria of reasonableness, legitimacy of aim, and objectivity.⁶⁷⁸

Unlike in *MSP-B v Netherlands*, in *Toussaint v Canada*⁶⁷⁹ (considered above, see 1.1.1.2), the HRC found a violation of Article 26, where the complainant, suffering with life-threatening conditions was denied health care coverage because of her irregular immigration status. Her case did not fit the established categories in the Citizenship and Immigration

672 *Whelan v Ireland* Communication No. 2425/2014 UN Doc. CCPR/C/119/D/2425/2014 (2017)§7.12.

673 See *Whelan v Ireland* Communication No. 2425/2014 UN Doc. CCPR/C/119/D/2425/2014 (2017)§7.9; *Mellet v Ireland* Communication No. 2324/2013 UN Doc. CCPR/C/116/D/2324/2013 (2016).

674 Article 17 ICCPR states: 1. No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation. 2. Everyone has the right to the protection of the law against such interference or attacks.

675 *MSP-B v Netherlands* Communication No. 2673/2015 UN Doc. CCPR/C/123/D/2673/2015 (2018).

676 *MSP-B v Netherlands* Communication No. 2673/2015 UN Doc. CCPR/C/123/D/2673/2015 (2018)§2.1.

677 *MSP-B v Netherlands* Communication No. 2673/2015 UN Doc. CCPR/C/123/D/2673/2015 (2018)§§7.6, 8.

678 *MSP-B v Netherlands* Communication No. 2673/2015 UN Doc. CCPR/C/123/D/2673/2015 (2018)§§7.4-7.5.

679 *Toussaint v Canada* Communication No. 2348/2014 UN Doc. CCPR/C/123/D/2348/2014 (2018).

Canada guidelines.⁶⁸⁰ The complainant submitted that her exclusion from the health coverage on the basis of her immigration status was a ‘discriminatory distinction’ in violation of Articles 2 (1) and 26 ICCPR, especially considering her life-threatening status.⁶⁸¹ The State responded by arguing that differentiating between individuals with legal status and those illegally admitted to the country in allocating funding in the public health sector is not discriminatory. Legal residence is a ‘neutral, objective requirement’.⁶⁸² The HRC disagreed with this premise, noting that access to health care should be granted without discrimination of any kind, and that Article 26 ICCPR, unlike Article 2, protects against ‘discrimination in law or in fact in any field regulated and protected by public authorities’⁶⁸³ with no limitations in its scope. The HRC also noted General Comments no.18 (non-discrimination, discussed above), and no.15, which explicitly states that rights under ICCPR were protected for citizens and aliens equally.

This is a significant point, as States are often more reluctant to grant access to health care or health care coverage in the context of immigration law. Indeed in some States, such as the UK, denial of access to care is used as a tool to reduce overall levels of immigration (the so-called ‘hostile environment’ policy). But in *Toussaint*, the HRC confirmed the State’s duty to protect the right to life irrespective of immigration status, highlighting that the complainant’s health, right to life, and non-discrimination are inextricably linked. This suggests that the effective protection of each would be unlikely if considered in isolation. We can also see this focus on the interdependence of rights in the ECtHR jurisprudence on the right to non-discrimination in the following section.

680 *Toussaint v Canada* Communication No. 2348/2014 UN Doc. CCPR/C/123/D/2348/2014 (2018) §§ 2.3-2.8.

681 *Toussaint v Canada* Communication No. 2348/2014 UN Doc. CCPR/C/123/D/2348/2014 (2018) §3.2.

682 *Toussaint v Canada* Communication No. 2348/2014 UN Doc. CCPR/C/123/D/2348/2014 (2018) §§6.8, 11.6.

683 *Toussaint v Canada* Communication No. 2348/2014 UN Doc. CCPR/C/123/D/2348/2014 (2018) §11.7.

3.1.2. European Convention on Human Rights: Article 14

Article 14, ECHR Prohibition of Discrimination states:

The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

As underlined by the ECtHR in *Molla Sali v Greece*,⁶⁸⁴ *Carson v the United Kingdom*⁶⁸⁵ and briefly noted in the introduction to this section (see 3.1.1), Article 14 complements the substantive provisions of the ECHR and its Protocols. Article 14 therefore, does not prohibit discrimination as such, but rather discrimination in the enjoyment of the rights and freedoms set out in the ECHR.⁶⁸⁶ This is well-established in the ECtHR jurisprudence:

*According to the Court's well-established case-law, Article 14 complements the other substantive provisions of the Convention and its Protocols. It has no independent existence since it has effect solely in relation to the "enjoyment of the rights and freedoms" safeguarded by those provisions. Although the application of Article 14 does not necessarily presuppose a breach of those provisions – and to this extent it is autonomous – there can be no room for its application unless the facts in issue fall within the ambit of one of the latter provisions.*⁶⁸⁷

684 *Molla Sali v Greece* ECtHR Application no. 20452/14 (2020) §123.

685 *Carson v the United Kingdom* ECtHR Application no. 42184/05 (2010) §63.

686 This can be contrasted with Article 26 ICCPR which constitutes a freestanding protection against discrimination as discussed in 3.1.1 above. Protection from discrimination is also provided by Article E of the European Social Charter. The European Committee of Social Rights has stressed that the wording of Article E and Article 14 is 'almost identical'; ECSR *International Association Autism- Europe v France* (no. 13/2002 § 52). It is worth noting that although disability, medical vulnerability or age are not explicitly listed as grounds of discrimination under Article E, they are considered to be included in 'other status'; see ECSR *International Association Autism-Europe v France* (no. 13/2002

§§ 51-52) and comments on 'direct discrimination on the basis of age' for denying the benefits under Article 5 of the Charter; ECSR *International Federation of Associations of the Elderly (FIAPA) v France*, (no. 162/2018 §89). See also Directive 2000/78/EC, equal treatment between persons irrespective of age.

687 *Glor v Switzerland* ECtHR Application no. 13444/04 (2009) §45 (emphasis added).

There are two principles which can be drawn from this. On the one hand, a violation of Article 14 may be found even in the absence of an accompanying violation of a substantive right under the ECHR; *Carson v the United Kingdom*⁶⁸⁸; *Sommerfeld v Germany*.⁶⁸⁹ On the other hand, Article 14 must be read in conjunction with a substantive right; *Sidabras and Dziautas v Lithuania*⁶⁹⁰ ('[T]he application of Article 14 does not presuppose a breach of one or more of such provisions and to this extent it is autonomous'⁶⁹¹).

As explained in *Thlimmenos v Greece*,⁶⁹² Article 14 is violated when:

*States treat differently persons in analogous situations without providing an objective and reasonable justification (...) [and] when States (...) fail to treat differently persons whose situations are significantly different.*⁶⁹³

Following the reasoning of the ECtHR in *Thlimmenos v Greece*,⁶⁹⁴ and in *Molla Sali v Greece*,⁶⁹⁵ the first step in establishing discrimination is to confirm a difference in the treatment of persons in analogous situations who should be treated equally, or a failure to treat persons differently in disanalogous circumstances.⁶⁹⁶ Upon establishing the existence of discrimination, the burden falls on the respondent to provide a reasonable and objective justification to explain the discriminatory conduct under examination.

688 *Carson v the United Kingdom* ECtHR Application no. 42184/05 (2010) §63.

689 *Sommerfeld v Germany* ECtHR Application no. 31871/96 (2003).

690 *Sidabras and Dziautas v Lithuania* ECtHR Applications nos. 55480/00 and 59330/00 (2004).

691 *Sidabras and Dziautas v Lithuania* ECtHR Applications nos. 55480/00 and 59330/00 (2004) §38.

692 *Thlimmenos v Greece* ECtHR Application no. 34369/97 (2000).

693 *Thlimmenos v Greece* ECtHR Application no. 34369/97 (2000) §44.

694 *Thlimmenos v Greece* ECtHR Application no. 34369/97 (2000).

695 *Molla Sali v Greece* ECtHR Application no. 20452/14 (2020) §137.

696 See also the relevant paragraphs in *ECSR Open Society European Policy institute v Bulgaria* (complaint submitted 25 January 2022) §§85, 100.

The protection afforded by Article 14 is complemented by Article 1 of Protocol No. 12 to the Convention prohibiting discrimination in the enjoyment of any right established by law; a wider application than Article 14.⁶⁹⁷ Article 1 of Protocol No. 12 states:

1. *The enjoyment of any right set forth by law shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.*
2. *No one shall be discriminated against by any public authority on any ground such as those mentioned in paragraph 1. (emphasis added)*

Following this wording, and the ECtHR jurisprudence, Article 1 Protocol No. 12 introduces a general prohibition on discrimination, in the form of a ‘free standing right’ against discrimination; *Savez crkava “Riječ života” v Croatia*,⁶⁹⁸ *Sejdić and Finci v Bosnia and Herzegovina*.⁶⁹⁹ We could compare Article 1 Protocol No. 12 ECHR with Article 26 ICCPR (a ‘freestanding equality clause’), on the one hand, and Article 14 ECHR with Article 2 (1) ICCPR (an accessory right to discrimination) on the other.⁷⁰⁰ It is most useful to examine the application of Article 14 through selected case law in the following section.

697 ECtHR, *Guide on Article 14 of the European Convention on Human Rights and on Article 1 of Protocol No.12 to the Convention* (2021) §§19-20.

698 *Savez crkava “Riječ života” v Croatia* ECtHR Application no. 7798/08 (2011) §103.

699 *Sejdić and Finci v Bosnia and Herzegovina* ECtHR Applications nos. 27996/06 and 34836/06 (2009) §53.

700 See 3.1.1 above, also, Dimitrina Petrova, *Article 7: The Equality and Non-Discrimination Provision Appendix E to the Report of the Global Citizenship Commission* (Open Book Publishers, 2016) 3.

3.1.2.1. Applications of Article 14

a) Health and disability

Health-related discrimination manifests in a wide variety of situations. Illustrations include the claims in *Kiyutin v Russia*⁷⁰¹ where the applicant was denied a residence permit based on his positive HIV/AIDS status,⁷⁰² and in *IB v Greece*,⁷⁰³ where the applicant was dismissed from his position on the same grounds.⁷⁰⁴ In both cases the ECtHR found a violation of Article 14, (in conjunction with Article 8): discrimination existed based on the applicants' health status. The Court held that the State had overstepped its margin of appreciation, which is particularly narrow in relation to vulnerable groups.⁷⁰⁵ This is a significant observation, applicable to disability-related discrimination, which falls within the scope of Article 14 ECHR and Article 1 of Protocol No. 12.⁷⁰⁶ This narrowing of the margin of appreciation in cases of increased vulnerability was confirmed by the

701 *Kiyutin v Russia* ECtHR Application no. 2700/10 (2011).

702 *Kiyutin v Russia* ECtHR Application no. 2700/10 (2011) §64.

703 *IB v Greece* ECtHR Application no. 552/10 (2013) §81.

704 *IB v Greece* ECtHR Application no. 552/10 (2013) §10.

705 *Kiyutin v Russia* ECtHR Application no. 2700/10 (2011) §74. See also the comments of the Court in *IB v Greece* considering the decision in *Kiyutin*: 'In *Kiyutin*, the Court stated that if a restriction on fundamental rights applied to a particularly vulnerable group in society that had suffered considerable discrimination in the past, the State's margin of appreciation was substantially narrower and it must have very weighty reasons for imposing the restrictions in question (...) It added that, consequently, people living with HIV were a vulnerable group and that the State should be afforded only a narrow margin of appreciation in choosing measures that singled out this group for differential treatment on the basis of their HIV status'; §§ 79-81 (emphasis added).

706 'The Court considers that this case presents a dual example of differential treatment of people in comparable situations. As the list of grounds of distinction given in Article 14 is not exhaustive ("or other status"; see *Stec and Others*, cited above, § 50), there is no doubt that the scope of this provision includes discrimination based on disability. It remains to be seen whether the reasons for the difference of treatment were objective and reasonable.'; *Glor v Switzerland* ECtHR Application no. 13444/04 (2009) §80. See also ECtHR, *Guide on Article 14 of the European Convention on Human Rights and on Article 1 of Protocol No.12 to the Convention* (2021) §164.

ECtHR in *Glor v Switzerland*.⁷⁰⁷ There the Court noted that there is a ‘European and worldwide consensus on the need to protect people with disabilities from discriminatory treatment’, noting the Recommendation 1592 of the Council of Europe (2003) and the UN Convention on the Rights of Persons with Disabilities.⁷⁰⁸

In *Centre for Legal Resources on behalf of Valentin Câmpeanu v Romania*,⁷⁰⁹ the Centre for Legal Resources (CLR) submitted a complaint on behalf of Mr. Câmpeanu (deceased), who had been diagnosed with HIV and severe intellectual disability.⁷¹⁰ The victim had been transferred between institutions receiving inadequate or no medical treatment, ultimately dying at the Poiana Mare Neuropsychiatric Hospital (see 1.1.2.5 (a), 2.1.3).⁷¹¹ The ECtHR decided that it was unnecessary to examine Article 14. The dissenting minority noted the special protections and measures States are expected to take to protect the rights of persons with disability (*Jasinskis v Latvia*⁷¹²) stating that a violation of Article 2 in conjunction with Article 14 was evident in this case: It would be very difficult to find another case

707 *Glor v Switzerland* ECtHR Application no. 13444/04 (2009) §84. See also *Guide on Article 14 of the European Convention on Human Rights and on Article 1 of Protocol No.12 to the Convention* (2021) at §166: ‘In cases concerning disability, the States’ margin of appreciation in establishing different legal treatment for people with disabilities is considerably reduced’ citing the decision in *Glor*.

708 UN General Assembly (UNGA), Convention on the Rights of Persons with Disabilities: resolution adopted by the General Assembly (24 January 2007), A/RES/61/106; *Glor v Switzerland* ECtHR Application no. 13444/04 (2009) §53; See also the Recommendation 1592 (adopted by the Parliamentary Assembly of the Council of Europe on 29 January 2003) noting that some of the fundamental rights protected by the provisions of the ECHR and the European Social Charter, including the right to health and the right to be protected by social exclusion ‘are still inaccessible to many people with disabilities’; §2.

709 *Centre for Legal Resources on behalf of Valentin Câmpeanu v Romania* ECtHR Application no. 47848/08 (2014) §130.

710 *Centre for Legal Resources on behalf of Valentin Câmpeanu v Romania* ECtHR Application no. 47848/08 (2014) §7.

711 See in particular the transfers between the Cetate-Dolj Medical and Social Care Centre and Poiana Mare Neuropsychiatric Hospital; *Centre for Legal Resources on behalf of Valentin Câmpeanu v Romania* ECtHR Application no. 47848/08 (2014) §§8-22.

712 *Jasinskis v Latvia* ECtHR Application no. 45744/08 (2010).

examined by the Court in which the vulnerability of an applicant is based on so many grounds covered by Article 14 of the Convention.⁷¹³

The narrow margin of appreciation afforded to States in these circumstances, along with the heightened duty to protect the life of those with disabilities,⁷¹⁴ indicates that States have an even greater responsibility to ensure the rights of those with disabilities in the context of scarce health resources during a global health emergency.⁷¹⁵ It is because of the special status of people with disabilities that discriminatory treatment by States would require ‘very weighty reasons’ to be justified: *Guberina v Croatia*.⁷¹⁶ A difference in treatment based on age must also be objectively and reasonably justified: *British Gurkha Welfare Society v the United Kingdom*.⁷¹⁷ Discrimination based on disability (paraplegia) was also at issue in *Enver Şahin v Turkey*,⁷¹⁸ in relation to access to university premises. There the Court found a violation of Article 14 ECHR (in conjunction with Article 2 of Protocol No.1 on the right to education) noting that States are expected to take necessary measures to accommodate the applicant’s specific needs.⁷¹⁹

b) Access to treatment

In *Durisotto v Italy*,⁷²⁰ the applicant challenged the criteria of the Legislative Decree governing access to a specific treatment for his daughter’s degenerative cerebral illness. The applicant’s daughter had not met these criteria and alleged a violation of Article 2 in conjunction with Article 14. The ECtHR underlined the wide margin of appreciation

713 See the dissenting paragraphs at the end of the judgment: *Centre for Legal Resources on behalf of Valentin Câmpeanu v Romania* ECtHR Application no. 47848/08 (2014) §§1-4.

714 Compare with HRC, General Comment No. 36 (2018) On Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (30 October 2018) §25.

715 Actions in national jurisdictions discussed above (see 1.2.1), such as the recent decision of the Federal Constitutional Court of Germany could support this premise; *BVerfG, decision of the First Senate of December 16, 2021*, 1 BvR 1541/20, Rn. 1-131.

716 *Guberina v Croatia* ECtHR Application no. 23682/13 (2016) §73.

717 *British Gurkha Welfare Society v the United Kingdom* ECtHR Application no. 44818/11 (2016)§87.

718 *Enver Şahin v Turkey* ECtHR Application no. 23065/12 (2018).

719 *Enver Şahin v Turkey* ECtHR Application no. 23065/12 (2018) §§67-69.

720 *Durisotto v Italy* ECtHR Application no. 62804/13 (2014).

afforded to States in restricting access to experimental treatment, finding the claim inadmissible.⁷²¹

Although not a claim under Article 14, it is worth considering the decision in *Mouisel v France*⁷²² (Article 3), where the applicant prisoner was suffering from chronic lymphatic leukaemia and the State had not ensured or provided for an adequately equipped prison to protect his declining health:

*[T]he prison was scarcely equipped to deal with it, yet no special measures were taken by the prison authorities.*⁷²³

The ECtHR noted the obligation of the State to protect the health and wellbeing of vulnerable detained persons by providing the requisite medical assistance.⁷²⁴ Of interest is the policy of strict liability for damage sustained due to compulsory vaccinations of Hepatitis-B. This policy did not apply to the applicant's case, as it was only applicable to specific occupational groups none of which included him.⁷²⁵ There is a clear analogy here with the Bulgarian vaccine distribution scenario. It is also worth noting the comments of the Court that:

*Health, age and severe physical disability are now among the factors to be taken into account under Article 3 of the Convention in France and the other member States of the Council of Europe in assessing a person's suitability for detention.*⁷²⁶

721 See also Emmanuelle Rial-Sebbag and Alessandro Blasimme, 'The European Court of Human Rights' Ruling on Unproven Stem Cell Therapies: A Missed Opportunity?' (2014) 23 (1) Stem Cells and Development 39.

722 *Mouisel v France* ECtHR Application No. 67263/01 (2003).

723 *Mouisel v France* ECtHR Application No. 67263/01 (2003) §45.

724 *Mouisel v France* ECtHR Application No. 67263/01 (2003) §40. For the detention of elderly sick persons see *Papon v France* (no. 1) ECtHR Application no. 64666/01 (2001).

725 'On 3 October 2000 the applicant applied to the département of Haute-Garonne's Health and Social Affairs Department for acknowledgment of a vaccination-related accident, claiming that he had contracted cancer as a result of a hepatitis-B vaccination. On 24 October 2000 he received a reply from the Ethics and Law Office of the Ministry of Social Affairs and Solidarity informing him that strict liability could not be imposed on the State except for damage sustained as a result of the compulsory vaccinations provided for in the Public Health Code. Hepatitis-B vaccinations were compulsory only for certain occupational groups exposed to a risk of contamination, and the applicant did not belong to any such group'; *Mouisel v France* ECtHR Application No. 67263/01 (2003)§19.

726 *Mouisel v France* ECtHR Application No. 67263/01 (2003) §38.

The Court held a violation of Article 3.⁷²⁷

In *SH v Austria*⁷²⁸ (Articles 8 and 14) the claimants could not access treatment due to State policy, which raised issues of discrimination under Article 14. At issue was again the scope of the positive obligations of the State under the ECHR⁷²⁹ and the margin of appreciation afforded to States in the complex field of decisions with scientific, moral, and ethical considerations.⁷³⁰ Of particular note is the submission of the non-governmental organisations Hera ONLUS and SOS Infertilità Onlus, which argued that infertility should be addressed as a human health matter.⁷³¹ The Court held that the State had not gone beyond the margin of appreciation afforded in this context holding (13 to 4) that there was no violation of Article 8. Judges Tulkens, Hirvelä, Lazarova Trajkovska and Tsotsoria dissented. Their comments on the application of the margin of appreciation by the Court are significant:

Together with the European consensus, the margin of appreciation is thus the other pillar of the Grand Chamber's reasoning. This is sometimes described as wide or broad (see paragraph 97 of the judgment), and is sometimes referred to without any qualifying adjective (see paragraphs 106 and 115 of the judgment), thereby indicating a certain amount of hesitation as to the correct weight to be given to that concept and to the seriousness of the limitation in question. The result is that the Court's position is unclear and uncertain, or even opaque (...) The margin of appreciation goes hand in hand with European supervision. On the other hand, in a case as sensitive as this one, the Court should not use the

727 *Mouisel v France* ECtHR Application No. 67263/01 (2003) §§47-48.

728 *SH v Austria* ECtHR Application No. 57813/00 (2011).

729 *SH v Austria* ECtHR Application No. 57813/00 (2011) § 73. See also the discussion on the margin of appreciation in 1.1.2.4.

730 *SH v Austria* ECtHR Application No. 57813/00 (2011) § 73. See also the comments of the Court on the margin of appreciation in this context at § 97: 'Since the use of in vitro fertilisation treatment gave rise then and continues to give rise today to sensitive moral and ethical issues against a background of fast-moving medical and scientific developments, and since the questions raised by the present case touch on areas where there is not yet clear common ground among the member States, the Court considers that the margin of appreciation to be afforded to the respondent State must be a wide one (...) However, this does not mean that the solutions reached by the legislature are beyond the scrutiny of the Court.'

731 *SH v Austria* ECtHR Application No. 57813/00 (2011) § 74.

*margin of appreciation as a “pragmatic substitute for a thought-out approach to the problem of proper scope of review”.*⁷³²

The Court agreed unanimously that it was not necessary to examine Article 14 in conjunction with Article 8.⁷³³

c) Multiple discrimination, including European Union Law

Cases of multiple discrimination on the basis of age, health status, and other grounds, could contribute to the case study in Bulgaria.⁷³⁴ Illustrations of multiple discrimination on the basis of ethnic origin, gender, race, and other grounds with consequences for the applicants’ health include the case of *Ferenčíková v the Czech Republic*⁷³⁵ (forced sterilisation; reached settlement), *NB v Slovakia*⁷³⁶ (sterilisation; discrimination on the basis of race/origin and sex; no need to examine Article 14 separately) and *Anguelova v Bulgaria*⁷³⁷ (origin-based discrimination; no violation of Article 14 (6 to 1); see dissenting opinion of Judge Bonello). Cases of discrimination inside health care facilities (such as *NB v Slovakia*⁷³⁸; *IG v Slovakia*⁷³⁹), can allow an analysis by analogy.

732 *SH v Austria* ECtHR Application No. 57813/00 (2011) §11 of the joint dissenting opinion (emphasis added).

733 *SH v Austria* ECtHR Application No. 57813/00 (2011) §§115-120.

734 ‘Multiple discrimination is generally defined as discrimination on more than one protected ground’ see Sandra Fredman, *Intersectional discrimination in EU gender equality and non-discrimination law* (European Commission; European network of legal experts in gender equality and non-discrimination 2016) 51. See also Committee on the Elimination of Discrimination against Women, general recommendation No. 25, on art. 4 (1), of the Convention on the Elimination of All Forms of Discrimination against Women (2004); UN Convention on the Rights of Persons with Disabilities, Addressing the impact of multiple discrimination on persons with disabilities, and promoting their participation and multi-stakeholder partnerships for achieving the Sustainable Development Goals in line with the Convention UN Doc. CRPD/CSP/2017/2 (2017).

735 *Ferenčíková v the Czech Republic* ECtHR Application no. 21826/10 (2010).

736 *NB v Slovakia* ECtHR Application no. 29518/10 (2012).

737 *Anguelova v Bulgaria* ECtHR Application no. 38361/97 (2002).

738 *NB v Slovakia* ECtHR Application no. 29518/10 (2012).

739 *IG v Slovakia* ECtHR Application no. 15966/04 (2013).

Discrimination based on multiple grounds can be difficult to make out due to the different levels of protection and variety of legal instruments protecting each ground.⁷⁴⁰ The UN Convention on the Rights of Persons with Disabilities (CRPD),⁷⁴¹ explicitly recognises the issue of multiple discrimination in the text of the convention; according to a 2013 report by European Union Agency for Fundamental Rights it was the first international treaty to do so.

At the European level, protections against discrimination are contained in the Charter of Fundamental Rights of the European Union; Title III Equality: Article 20 (equality before the law), Article 21 (non-discrimination; with specific reference to age and disability), see also Article 25 (rights of the elderly), Article 26 (rights of persons with disability); Directive 2000/43/EC against discrimination on grounds of race and ethnic origin; Directive 2000/78/EC against discrimination at work on grounds of religion or belief, disability, age or sexual orientation; Directive OJ 2000 L 303/16 establishing a general framework for equal treatment in employment and occupation; and Directive Proposal (COM(2008)462) against discrimination based on age, disability, sexual orientation and religion or belief beyond the workplace. It is worth noting that the European Union (EU) is founded on the principle of equality (Article 2 TEU); the Union shall ‘combat social exclusion and discrimination’ (Article 3 (3); ex Article 2 TEU); see also Article 10 TFEU, the Union will ‘combat discrimination based on sex, racial or ethnic origin, religion or belief, disability, age or sexual orientation; also see Article 19 TFEU.⁷⁴²

740 European Union Agency for Fundamental Rights (FRA), *Inequalities and multiple discrimination in access to and quality of healthcare* (FRA 2013) 7.

741 UN General Assembly (UNGA), Convention on the Rights of Persons with Disabilities: resolution adopted by the General Assembly (24 January 2007), A/RES/61/106.

742 For academic commentary on the rights to health care in the European Union, its influence, and role see Jean McHale, ‘Fundamental Rights and Health care’ in Elias Mossialos, Govin Permanand, Rita Baeten and Tamara Hervey (eds) *Health Systems Governance in Europe: the Role of EU Law and Policy: Health Economics, Policy and Management* (CUP 2010) 282-314; and Miek Peeters, Martin McKee and Sherry Merkur, ‘EU Law and Health Professionals’ in Elias Mossialos, Govin Permanand, Rita Baeten and Tamara Hervey (eds) *Health Systems Governance in Europe: the Role of EU Law and Policy: Health Economics, Policy and Management* (CUP 2010) 589-634; Anniëk de Ruijter, *EU Health Law & Policy: The Expansion of EU Power in Public Health and Health Care* (OUP 2019).

Illustrations of relevant case law include disapplying a national provision that may contradict the principle of non-discrimination; *Dansk Industri* (C-441/14, 2016). Numerous cases before the Court of Justice dealing with discrimination on the basis of age, are found in the context of employment. Illustratively, EU law on an age limit of 65 years for commercial pilots justified on the ground of aviation safety (*Werner Fries v Lufthansa CityLine GmbH*, C-190/16, 2017); but not a blanket prohibition on pilots over 60 years old (*Prigge v Deutsche Lufthansa* C-447/09, 2011). There are also cases on the new and old Posted Workers Directive, (Directive 2018/957) and (Directive 96/71) respectively; *Hungary v European Parliament and Council* (Case C-620/18, 2020) and *Poland v European Parliament and Council* (Case C-626/18, 2020).⁷⁴³ Discrimination on the ground of disability is also found in the context of employment; *Sonia Chacón Navas v Eurest Colectividades SA* (C-13/05, 2006), and *Fag og Arbejde (FOA), acting on behalf of Karsten Kaltoft v Kommunernes Landsforening (KL), acting on behalf of the Municipality of Billund* (C-354/13, 2014).

At the national level, not every State has an explicit reference to multiple discrimination in its legislation.⁷⁴⁴ States making reference to multiple discrimination include Serbia ('discrimination against individuals on the basis of two or more personal characteristics (multiple or intersecting discrimination)'); Law on the Prohibition of Discrimination Article 13 (5)); Croatia (listed as one of the 'more serious forms of discrimination' in the Anti-discrimination Act, Article 6 (1), (2)); Greece (Law 3396/2011; Article 2); Bulgaria ('The bodies of state power (...) shall take priority measures (...) to equalize the opportunities of persons who are victims of multiple discrimination'; Protection Against Discrimination Act, Article 11(2)). See also the Italian Development Cooperation Disability Action

⁷⁴³ See also Pauline Melin, 'Overview of Recent Cases Before the Court of Justice of The European Union (September 2020-December 2020)' (2021) 23 (1) *European Journal of Social Security* 81.

⁷⁴⁴ For a detailed study on multiple and intersectional discrimination in the European Union see Sandra Fredman, *Intersectional discrimination in EU gender equality and non-discrimination law* (European Commission; European network of legal experts in gender equality and non-discrimination 2016). See also '1.5 National legislation: a patchy panorama'; European Union Agency for Fundamental Rights (FRA), *Inequalities and multiple discrimination in access to and quality of healthcare* (FRA 2013) 25.

Plan (2013); ‘the three-year Italian Development Cooperation plan should include this population among its top priorities, as it is often subject to multiple discrimination’ (1.1.c. at p. 15). The following section explores relevant case law in national jurisdictions in relation to access to health care, organised per region, also noting the constitutional protections against discrimination. As will be seen, the issue of discrimination in this context informs the previous discussion on the right to life and health, emphasising the interdependence of the three pillars examined in this report.

3.2. National Jurisdictions

3.2.1. Europe

Several national constitutions in Europe include a provision to protect the right to non-discrimination and equality in some form; Greece (art.5(2)); Bulgaria (art.6); Germany (arts. 3, 33(3) Basic Law); Ukraine (art. 24); Italy (art. 3); Czech Republic (art.3 of the Charter on Fundamental Rights and Freedoms; part of the Constitution); Hungary (art. XV (2)); Netherlands (art. 1); Slovakia (art.12(2)); Finland (art. 6); France (Preamble, art. 1); Poland (arts. 13, 25); Romania (arts. 4, 16); Serbia (art. 21(3)); Poland (art. 32); Montenegro (arts. 7, 8, 25); Spain (arts. 14, 16); Portugal (art. 13 (2)); Latvia (art. 91 of the Charter on Fundamental Rights and Freedoms; part of the Constitution); Austria (art. 7, art. 2 Basic Law); Sweden (Chapter 1, s.2, Chapter 2, s.12 of the Instrument of Government; part of the Constitution); Belgium (arts. 10, 11); Norway (art. 98); Croatia (art. 14); Cyprus (art. 28); Estonia (art. 12(1)); Turkey (art. 10); Macedonia (arts. 9, 54); Iceland (art. 40 (1)); Lithuania (art. 29); Luxemburg (art. 10bis for nationals); Malta (art. 45); and Slovenia (art. 14).

National law complements these high level norms with specific safeguards against discrimination in healthcare either explicitly e.g., see art. 1 of the Act on the Rights of Patients (Iceland), or implicitly in the provision for goods and services; see Equal Treatment Act (Lithuania), and Equal Status Acts 2000-2015 (Ireland).

England and Wales

*Cameron Mathieson, a deceased child (by his father Craig Mathieson) v Secretary of State for Work and Pensions*⁷⁴⁵ concerned regulations determining the period of allowance for people living with disabilities (the Disability Living Allowance (DLA)). The Secretary of State had suspended the DLA for the applicant's son, who suffered from several life-threatening conditions. The Supreme Court rejected an interpretation of the DLA, proposed by the State, that would exclude children in its application. Rather it found a violation of Article 14 in conjunction with Article 1 Protocol 1.⁷⁴⁶ It is worth noting the comments of Lord Wilson at [23], confirming that discrimination on any ground can occur within a single group (e.g., disabled persons) as much as between groups (e.g., able-bodied and disabled):

Decisions both in our courts and in the ECtHR therefore combine to lead me to the confident conclusion that, as a severely disabled child in need of lengthy in-patient hospital treatment, Cameron had a status falling within the grounds of discrimination prohibited by Article 14. Disability is a prohibited ground (Burnip v Birmingham City Council [2012] EWCA Civ 629, [2013] PTSR 117). Why should discrimination (if such it be) between disabled persons with different needs engage Article 14 any less than discrimination between a disabled person and an able-bodied person?

In *MB v UCL Hospitals NHS Foundation Trust* explored previously, the Trust sought to remove a patient from her bedroom in a hospital ward, making other arrangements for her treatment. The request was 'urgent because the COVID-19 pandemic meant that the bedroom was urgently needed for other patients' (see 2.2.1). Chamberlain J rejected the claim that the case raised an issue of discrimination based on disability, noting that denying those of the patient's requests which had no clinical basis (such as

⁷⁴⁵ *Cameron Mathieson, a deceased child (by his father Craig Mathieson) v Secretary of State for Work and Pensions* [2015] UKSC 47, [2014] EWCA Civ 286.

⁷⁴⁶ [2015] UKSC 47 [48].

a rainwater canopy for the front door) did not amount to discrimination.⁷⁴⁷ He noted:

*The decision to decline in-patient care to MB does not discriminate against her on the ground of her disabilities. The Hospital has treated her in the same way as a patient with different disabilities or with none: it has determined whether to continue to offer her in-patient care on the basis of her clinical need for such care. To the extent that this is itself discrimination against those, like MB, whose disabilities make them perceive a need for things (such as a rainwater canopy outside the front door) for which there is in fact no objective need, the discrimination would be justified even outside the context of a public health emergency. In the context of such an emergency, there is no prospect that a challenge based on Article 14 in these circumstances could possibly succeed.*⁷⁴⁸

Belarus

In the Case D-358/2009, the Constitutional Court of the Republic of Belarus considered the constitutionality of the law ‘On Making Alterations and Addenda to Certain Laws of the Republic of Belarus on Social Protection of the Disabled People’. The law aimed *inter alia* to secure rehabilitation programmes for people with disabilities. In the case that a person with disability or their representative confirmed and substantiated a voluntary renunciation of the rehabilitation programme, in full or in part, the relevant authorities would be released from their obligations under this law; Article 9.⁷⁴⁹ The Court held that said law compatible with the Constitution.

⁷⁴⁷ ‘Nor does reliance on Article 14, read with Article 3 or Article 8, take matters any further.; *MB v UCL Hospitals NHS Foundation Trust* [2020] EWHC 882 (QB) [60].

⁷⁴⁸ ‘*MB v UCL Hospitals NHS Foundation Trust* [2020] EWHC 882 (QB) [60].

⁷⁴⁹ ‘The Constitutional Court deems that such legislative approach will ensure the right balance of the state and individual interests, excludes the opportunity to abuse the disabled people’s right by a disabled person, his/her legal representative as well as by concerned state bodies, organisations and persons. In so doing will realise the principles of mutual responsibility, rationality and justice.’; Case D-358/2009 (2009) p.3-4.

Bulgaria

It is worth expanding on the case in *Toshka Nikolova Bosheva v Minister of Health for the Republic of Bulgaria*⁷⁵⁰ which came before the Commission for Protection against Discrimination, mentioned earlier (see 2.2.1). The proceedings were initiated by reason of art. 50 (1) of the Law for Protection against Discrimination. The claimant, who was diagnosed with cancer, could not access the life-saving drugs Arimidex and Herceptin.⁷⁵¹

She claimed that due to a shortage of the drugs, and ‘the lack of rhythm of delivery’, the quantities available did not cover all patients with cancer diseases. In practice, the drug was distributed on a first-come first-served basis:

*B. complains that due to the shortage of the drug Arimidex[®], provided in Bulgaria for the treatment of patients with cancer diseases, the quantities are not enough for everybody and in practice the drug is received by those who managed to go earlier on the scheduled days to receive it.*⁷⁵²

The claimant alleged that she was discriminated against compared to other cancer patients with the same condition whose ‘treatment was not interrupted due to shortage of prescribed drugs’.⁷⁵³ The Commission ruled that direct discrimination based on disability (see arts. 4 (1, 2) and 5 of the of the Law for Protection against Discrimination) had occurred against the claimant inviting the Minister to Health to remedy the irregular

750 *Toshka Nikolova Bosheva v Minister of Health for the Republic of Bulgaria* No 183/02.08.2010 (Case File No 146/2009); Unofficial translation in English provided by Lawyers Collective and partners for the Global Health and Human Rights Database.

751 ‘The complaint contains allegations for discrimination, resulting from the breach of the constitutionally set civil rights of plaintiff B., expressed in the lack of rhythm of delivery and shortage of the drugs Arimidex[®] and Herceptin[®] for treatment of all people suffering oncological diseases as she is, taking these drugs.’; *Toshka Nikolova Bosheva v Minister of Health for the Republic of Bulgaria* No 183/02.08.2010 (Case File No 146/2009) p.1 (emphasis added).

752 *Toshka Nikolova Bosheva v Minister of Health for the Republic of Bulgaria* No 183/02.08.2010 (Case File No 146/2009) at p.2.

753 *Toshka Nikolova Bosheva v Minister of Health for the Republic of Bulgaria* No 183/02.08.2010 (Case File No 146/2009) at p.2.

administration of drugs and medicine and respect the principles of non-discrimination and equality.⁷⁵⁴

France

In Decision no. 99-416 DC of July 23, 1999, a number of Articles of the law ‘Loi portant création d’une couverture maladie universelle’ (Act Creating Universal Health Coverage), including Articles 3 and 20, were challenged before the Conseil constitutionnel (Constitutional Council) for discriminating on the basis of income and creating unequal access to health care contrary to Article 2 of the Constitution, Article 6 of the Declaration of the Rights of Man and of the Citizen of 1789, and the ‘constitutional right to equal access to care’ deriving from the Preamble to the 1946 Constitution.⁷⁵⁵ The Council held that the legislature had the power under Article 34 of the Constitution of 1946 to determine how to meet its obligations to protect the right to health under the Constitution, including

754 ‘UPHOLDS the claim of T. N. B. and DECREES the interruption of the breach by applying adequate measures for timely and rhythmic administration of the drugs and medicine, necessary for her treatment (...)’; *Toshka Nikolova Bosheva v Minister of Health for the Republic of Bulgaria* No 183/02.08.2010 (Case File No 146/2009) at p.9 (emphasis added).

755 Decision no. 99-416 DC of July 23, 1999, §1-3. See the Preamble to the Constitution of 27 October 1946: ‘[The Nation] shall guarantee to all, notably to children, mothers and elderly workers, protection of their health, material security, rest and leisure. All people who, by virtue of their age, physical or mental condition, or economic situation, are incapable of working, shall have to the right to receive suitable means of existence from society’; see also Article 1 of the Declaration of the Rights of Man: ‘Men are born and remain free and equal in rights.’.

differentiating between groups.⁷⁵⁶ As a result Articles 3 and 20 were not in violation of the Constitution.

In Decision no. 180838 180839 180867, of April 30, 1997, Article 11 of the Ordinance of 24 April 1996 regulating health insurance was challenged by the 'l'Association nationale pour l'éthique de la médecine libérale' (the National Association for the ethics of liberal medicine) for violating the principle of equality and health protection. The question was whether Article 11 of the Ordinance of 24 April 1996 which stated that health insurance funding can be suspended for services that are not considered medically justified,⁷⁵⁷ contravened the principle of equality and whether Articles 17, 19, and 20 contravened the 'constitutional right to equal access to care' discussed above, deriving from the Preamble to the 1946 Constitution. The Conseil d'État (Council of State) held it did not.⁷⁵⁸

Belgium

The case Decision no. 2010-018f, of February 25, 2010, before the Constitutional Court of Belgium, concerned Article 1017 (2) of the Belgian Judicial Code and its compatibility with Articles 10 and 11 of the Belgium Constitution which guarantee equality before the law and protection from

⁷⁵⁶ See Decision no. 99-416 DC of July 23, 1999, §9: 'the principle of equality cannot impose on the legislator, when it strives, as in the present case, to reduce disparities in treatment in matters of social protection, to remedy all of the existing disparities concurrently' (emphasis added) and at §14: 'Considering that, while it is true that the conditions for compensating expenses incurred in respect of the additional protection of beneficiaries of universal health coverage are not the same depending on whether the choice of the persons concerned falls on a health insurance organization or on a supplementary social protection body, the resulting differences in treatment between bodies are the result of the difference in their situation with regard to the purpose of the law'. See also at §6: 'Considering, in particular, that it is at any time open to the legislator, ruling in the area reserved for it by Article 34 of the Constitution, to adopt, for the achievement or reconciliation of objectives of a constitutional, new terms and conditions, the advisability of which it is up to him to assess'.

⁷⁵⁷ 'If (...) the medical control service considers that a service mentioned in Article L. 321-1 is not medically justified, the Fund, after informing the insured, suspends the service'; Decision no. 180838 180839 180867, of April 30, 1997, p.3.

⁷⁵⁸ Unofficial translation in English provided by Lawyers Collective and partners for the Global Health and Human Rights Database.

discrimination.⁷⁵⁹ Article 1017 differentiated as between employees and public servants as regard the reimbursement of expenses connected with judicial complaints regarding social security benefits.⁷⁶⁰

3.2.2. Americas

Uruguay

The case of *Hernandez Gonzalez, Eliu Aquiliano v Executive State Power of the Ministry of Public Health*⁷⁶¹ before the Civil Appeals Court, 4th District, brings together the rights to health, life, and non-discrimination. The Court held that protecting public health should not be subject to ‘bureaucratic’ mechanisms referring to the application process for the supply of a drug (Cetuximab).⁷⁶² The drug was supplied to other patients with the same disease⁷⁶³ and the claimant successfully argued that this violated the principle of equality as guaranteed by Article 8 and 72 of the Constitution

759 Article 10 of the Constitution of Belgium (1831) states: ‘No class distinctions exist in the State.

Belgians are equal before the law; they alone are eligible for civil and military service, but for the exceptions that can be created by a law for particular cases. Equality between women and men is guaranteed.’; and Article 11: ‘Enjoyment of the rights and freedoms recognised for Belgians must be provided without discrimination. To this end, laws and federate laws guarantee among others the rights and freedoms of ideological and philosophical minorities’.

760 See at B.7 ‘the provision in question creates a difference in treatment between two categories of socially insured persons which is not reasonably justified’ Of interest are the comments of the court on health and disability insurance. Decision no. 2010-018f, of February 25, 2010B.5 and B.3.1.

761 *Hernandez Gonzalez, Eliu Aquiliano v Executive State Power of the Ministry of Public Health* Case 179/2011; Case No: 2-13.991/2011 (2011).

762 *Hernandez Gonzalez, Eliu Aquiliano v Executive State Power of the Ministry of Public Health* Case 179/2011; Case No: 2-13.991/2011 (2011) p.4.

763 *Hernandez Gonzalez, Eliu Aquiliano v Executive State Power of the Ministry of Public Health* Case 179/2011; Case No: 2-13.991/2011 (2011) III p.2. See at VI (p.4) ‘it must be necessarily agreed that it is an admitted fact that the MSP has been found to be supplying the same drug to other patients who suffer from the same disease as the plaintiff’ and ‘The convictive elements above leads the Court to conclude that the refusal of the [Ministry of Public Health] MSP to provide the medicine in this case is a flagrant violation of the principle of equality laid down in Articles 8 and 72 of the Constitution, derived from the basic principle of respect for human dignity, which imposes equal treatment to every person’.

of Uruguay.⁷⁶⁴ The same conclusion was reached in *Rodriguez, Allison v Executive Power of the Ministry of Public Health*.⁷⁶⁵

Canada

The Federal Court in *Laidlow v The Minister of Citizenship and Immigration*⁷⁶⁶ dismissed an application for judicial review of the decision of the Refugee Protection Board to remove the applicant to St. Vincent.⁷⁶⁷ The applicant claimed that his life would be at risk for lack of access to adequate health and medical care to treat his life-threatening condition;⁷⁶⁸ see also similar facts in *N v The United Kingdom*⁷⁶⁹ discussed previously (see 2.1.3.) The applicant challenged the compatibility of s. 97(1)(b)(iv) of the Immigration and Refugee Protection Act ('IRPA') with s. 7 (life, liberty and security of person) and s. 15 (non-discrimination) of the Canadian Charter of Rights and Freedoms. The Court found the comments of the Board that the health care system in St. Vincent was adequate, and that the applicant would not face discrimination in his medical treatment upon her removal, to be reasonable.⁷⁷⁰ The Court specifically considered the decision in *Toussaint*

⁷⁶⁴ Article 8 states: 'All persons are equal before the law, no other distinctions being recognized among them save those of talent and virtue.', Article 72 states: The enumeration of rights, duties, and guarantees made in this Constitution does not exclude others which are inherent in human beings or which are derived from a republican form of government.' The Court also considered Judgment No. 169/2011 noting that 'the health is a legally-protected right intimately linked to life, to the physical, moral and psychological integrity of a subject, to her/his quality of life, and to the development of his/her individuality. Before all, the right to health implies that a human being has a right to an adequate professional care, to care for it, to prevent illnesses, to find a place to be treated and to receive the necessary treatment for their recovery' *Hernandez Gonzalez, Eliu Aquiliano v Executive State Power of the Ministry of Public Health* Case Case 179/2011; Case No: 2-13.991/2011 (2011) (VI).

⁷⁶⁵ *Rodriguez, Allison v Executive Power* Case 169/2011; Case No: 2-13.991/2011 (2011).

⁷⁶⁶ *Laidlow v The Minister of Citizenship and Immigration* (2012) FC 144.

⁷⁶⁷ *Laidlow v The Minister of Citizenship and Immigration* (2012) FC 144 [38].

⁷⁶⁸ *Laidlow v The Minister of Citizenship and Immigration* (2012) FC 144 [3].

⁷⁶⁹ *N v The United Kingdom* ECtHR Application No. 26565/05 (2008).

⁷⁷⁰ *Laidlow v The Minister of Citizenship and Immigration* (2012) FC 144 [22]-[23].

v Canada (Attorney General) before the Federal Court,⁷⁷¹ (prior to the decision of the HRC, as explored in 1.1.1.2), noting the similarities with the case in *Laidlow* and the comments of Stratas JA assigning responsibility to the actions of the applicant.⁷⁷²

In *Covarrubias v Canada*,⁷⁷³ considered by the Court in *Laidlow*, the Federal Court of Appeal held that s. 97(1)(b)(iv) IRPA ('inability of that country to provide adequate health or medical care')⁷⁷⁴ should have a wide interpretation, and that a claimant must establish both a specific risk to their lives, and that this risk is not imposed because of inadequate health care of their home country.⁷⁷⁵ The decision in *Travers v Canada (Minister of Citizenship and Immigration)*⁷⁷⁶ followed the same line of reasoning; the claimant who was living with HIV/AIDS was found not to be at risk of suffering discrimination in his treatment upon his return to Zimbabwe.⁷⁷⁷

771 See *Toussaint v Canada* (Attorney General) 2011 FCA 213 (2011) [103]-[104], [110]; *Toussaint v Canada* Communication No. 2348/2014 UN Doc. CCPR/C/123/D/2348/2014 (2018) §2.12.

772 '[T]he appellant by her own conduct - not the federal government by its Order in Council - has endangered her life and health. The appellant entered Canada as a 2012 FC 144 (CanLII) Page: 15 visitor. She remained in Canada for many years, illegally. Had she acted legally and obtained legal immigration status in Canada, she would have been entitled to coverage under the Ontario Health Insurance'; *Toussaint v Canada* (Attorney General) 2011 FCA 213 (2011) [72], see also at [108].

773 *Covarrubias v Canada* 2006 FCA 365 (2006).

774 97 (1) states: 'A person in need of protection is a person in Canada whose removal to their country or countries of nationality or, if they do not have a country of nationality, their country of former habitual residence, would subject them personally' (...) (b) to a risk to their life or to a risk of cruel and unusual treatment or punishment if (...) (iv) the risk is not caused by the inability of that country to provide adequate health or medical care.' Immigration and Refugee Protection Act (SC 2001, c. 27).

775 Following the interpretation of the clause in *Housen v Nikolaisen* [2002] 2 SCR 235 [8], [33]; *Covarrubias v Canada* 2006 FCA 365 (2006) [21]-[21].

776 *Travers v Canada (Minister of Citizenship and Immigration)* 2006, 53 Imm LR (3d) 300 FCTD.

777 'Given the findings of the Board in this case that Mr. Travers would not face discrimination or persecution in his access to treatment in Zimbabwe (such as it is), I do not believe that he can bring himself within the protection of section 97 of the IRPA. Even in countries with the most deficient health care systems, there will usually be access to quality medical care for persons with the means to pay for it. [...]'; *Travers v Canada (Minister of Citizenship and Immigration)* 2006, 53 Imm LR (3d) 300 FCTD.

We can note the similarities in the approach of the State authorities in the above cases with the claims under Article 6 ICCPR discussed above (see 1.1.1.2 (c)).

United States

In *Alexander v Choate*,⁷⁷⁸ faced costs overruns, the state of Tennessee reduced the number of annual inpatient hospital days covered by its Medicaid budget (from 20 to 14).⁷⁷⁹ Medicaid recipients brought a class action on the basis of the discrimination that disabled persons would inevitably face, in violation of paragraph 504 of the Rehabilitation Act of 1973 (no person with disability should face discrimination in receiving federal financial assistance).⁷⁸⁰

The Supreme Court held unanimously that, as the measure did not have a discriminatory motive, it was ‘neutral’; reversing the judgment of the Court of Appeal:

*The 14-day rule challenged in this case is neutral on its face, is not alleged to rest on a discriminatory motive, and does not deny the handicapped access to or exclude them from the particular package of Medicaid services Tennessee has chosen to provide.*⁷⁸¹

As Persad notes, the decision permits for an equal allocation of resources among patients, even if this creates unequal outcomes for patients with disabilities.⁷⁸² The case in *James Pietrangelo II v Christopher Sununu*⁷⁸³ raises points on non-discrimination as noted in our discussion of the right

⁷⁷⁸ *Alexander v Choate* 469 US 287 (1985).

⁷⁷⁹ *Alexander v Choate* 469 US 287 (1985) I.

⁷⁸⁰ ‘[T]he proposed 14-day limitation on inpatient coverage would have a discriminatory effect on the handicapped. Statistical evidence, which petitioners do not Page 469 U. S. 290 dispute, indicated that in the 1979-1980 fiscal year, 27.4% of all handicapped users of hospital services who received Medicaid required more than 14 days of care, while only 7.8% of nonhandicapped users required more than 14 days of inpatient care.’ *Alexander v Choate* 469 US 287 (1985) I.

⁷⁸¹ *Alexander v Choate* 469 US 287 (1985) IV.

⁷⁸² Govind Persad, ‘Disability Law and the Case for Evidence-Based Triage in a Pandemic’ (2020) 130 *The Yale Law Journal* 26.

⁷⁸³ Case No. 21-cv-124-PB Opinion No. 2021 DNH 067.

to health (see 2.2.3) and could be considered along with the claims in *Olmstead v LC ex rel. Zimring*,⁷⁸⁴ *Estate of Cole v Fromm*,⁷⁸⁵ and *Henderson v Tanner*⁷⁸⁶ on the matter of resource allocation and disability.

3.2.3. Africa

Botswana

In *Tapela v Attorney General*⁷⁸⁷ the applicants, who were HIV positive, were refused access to Highly Active Antiretroviral Therapy (HAART) because they were not Botswanan citizens. The applicants successfully challenged the compatibility of the Presidential Directive Cab (5) of 2004, which provided for treatment to non-citizens but not those living with HIV/AIDS, with the Constitution of Botswana, s.4 (right to life) and s.15 (non-discrimination); see s.2.2.4. The case raises all of the main themes explored in this report and can be considered together with the South African case of *Khosa v Minister of Social Development*⁷⁸⁸ which concerned discrimination arising from exclusion of non-citizens from social entitlements.

784 527 US 581, 604 (1999).

785 941 F Supp 776, 784 (SD Ind 1995).

786 No CV 15-804-SDD-EWD, 2019 WL 885914.

787 *Tapela v Attorney General* (MAHGB-000057-14), BWHC 1 (2014); *Attorney General v Tapela* Civil Case No. CACGB-096-14 (2015).

788 *Khosa v Minister of Social Development* 2004(6) BCLR 569 (CC).

Conclusions

We noted previously that the protection of the right to life naturally and inherently encompasses considerations of physical and mental health, which must be delivered through policies, frameworks, and laws, which are non-discriminatory either directly or indirectly. We saw this relationship unfolding in a variety of contexts and legal frameworks in this report. The different response of national authorities and international bodies in some circumstances was noteworthy.

We followed the claimant in *Toussaint v Canada*⁷⁸⁹ failing at the domestic level but succeeding under Article 6 ICCPR. with the Federal Court of Appeal assigning the denial of health care coverage for a life-threatening condition to the claimant's choices, but the HRC construing the right to life widely allowing a holding that Article 6 had been violated. We saw the social dimensions of the interrelation of life and health with the complainant in *AHG v Canada*⁷⁹⁰ trying to prevent his deportation to Jamaica, commenting on the inevitable social marginalisation he would face as other deportees with mental health issues in Jamaica (the complainant was living with diabetes and paranoid schizophrenia).⁷⁹¹

Regionally, we followed the application of Article 2 ECHR and its health dimensions in the diversity of contexts it can arise, flowing from the all-inclusive nature of the right to life. In the ECtHR jurisprudence, the boundaries to the wide interpretation the right to life can take,⁷⁹² are defined by a number of factors, including (i) the scope of the State's positive obligations, (ii) the discretion afforded in discharging the duty to protect the lives of the people within its territory, (iii) establishing the knowledge

789 *Toussaint v Canada* (Attorney General) 2011 FCA 213 (2011); *Toussaint v Canada* Communication No. 2348/2014 UN Doc. CCPR/C/123/D/2348/2014 (2018).

790 *AHG v Canada* Communication No. 2091/2011, UN Doc. CCPR/C/113/D/2091/2011 (2015).

791 *AHG v Canada* Communication No. 2091/2011, UN Doc. CCPR/C/113/D/2091/2011 (2015)

§§3.2, 3.5, and 3.7. See sections 1.1.1.2 (c), and the discussion in 1.1.1.3.

792 Also recall the comments of the HRC in General Comment No. 36; UN Human Rights Committee (HRC), CCPR General Comment No. 36 (2019) On Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life (3 September 2019), CCPR/C/GC/36, §3.

by the relevant authorities of the particular circumstances that could lead to violations of Article 2, and (iv) the limitations of the Court to intervene in State policy areas, including national health policies.

These are not necessarily obstacles to a successful claim under Article 2. They are a challenge to show that the alleged violation of the right to life in the particular context of a case is continuous, consistently unremedied by the State, of such a degree, and with evident repercussions for the public health in the future. Thus, we followed the Court in *Şentürk v Turkey*⁷⁹³ noting that it did not intend to rule *in abstracto* on the State's national health policy, but it could not absolve the national bodies from their responsibility to provide treatment to the patient, in what it described was a 'flagrant dysfunctioning of hospital departments'.⁷⁹⁴ This decision was not the only one against Turkey in similar scenarios involving chronic dysfunctioning of public hospitals, non-coordination of health care personnel, and the consistent failure of the State authorities to take measures to protect the right to life despite knowing of the circumstances that may threaten it; *Asiye Genç v Turkey*,⁷⁹⁵ *Aydoğdu v Turkey*.⁷⁹⁶

It is worth recalling the comment of the Court in *Asiye Genç* that the unavailability of places in the hospital leading to the death of the applicant's son was not solely related to rapid arrival of patients but indicated chronic hospital dysfunctioning;⁷⁹⁷ violation of Article 2 was held. This suggests, that in a claim under Article 2, it is worth establishing that the issues arising, including denial of treatment or constructive denial of vaccination⁷⁹⁸ leading to death or severe disease, did not occur (solely) because of the increased patient intake, as was the case during the pandemic in many hospitals and medical centres globally, nor were isolated instances of health care failings; identifying and highlighting the chronic hospital dysfunctioning that may exist in these situations would strengthen an argument under Article 2.

793 *Mehmet Şentürk and Bekir Şentürk v Turkey* ECtHR Application no. 13423/09 (2013).

794 *Mehmet Şentürk and Bekir Şentürk v Turkey* ECtHR Application no. 13423/09 (2013) §§95-97.

795 *Asiye Genç v Turkey* ECtHR Application no. 24109/07 (2015).

796 *Aydoğdu v Turkey* ECtHR Application no. 40448/06 (2016).

797 *Asiye Genç v Turkey* ECtHR Application no. 24109/07 (2015) §80.

798 By creating all the circumstances making vaccination impossible in practice; e.g., in the example of 'green corridors' in the vaccination plan in Bulgaria.

The decision in *Ivanov v Bulgaria*,⁷⁹⁹ could support this premise. In that case, despite the hospital lacking a paediatric cardiology ward and a functioning echograph⁸⁰⁰ leading to the death of the applicants' daughter, and with the Burgas Health Centre noting that the death occurred due to insufficient equipment,⁸⁰¹ the Court was not satisfied that there was a chronic hospital dysfunction;⁸⁰² no violation of Article 2. The above align with the principles of finding a State directly liable for an individual's death due to deficient health care restated in *Lopes de Sousa Fernandes v Portugal*⁸⁰³ and cited in *Ivanov v Bulgaria*⁸⁰⁴:

*This is possible, exceptionally, either when (a) a patient's life has knowingly been put in danger through denial of access to life-saving emergency treatment, or when (b) a systemic or structural dysfunction in hospital services has resulted in a patient being deprived of access to life-saving emergency treatment and the authorities knew about or ought to have known about that risk and failed to take the necessary measures to prevent it from materialising.*⁸⁰⁵

799 *Ivanov v Bulgaria* ECtHR Application no. 67320/16 (2020).

800 *Ivanov v Bulgaria* ECtHR Application no. 67320/16 (2020) §§1-12.

801 *Ivanov v Bulgaria* ECtHR Application no. 67320/16 (2020) §14.

802 'But even if it is assumed that some forms of treatment would have given the child a better chance of survival but were not attempted because the hospital in Burgas was not sufficiently equipped and staffed to provide them, the resulting situation, though undeniably tragic for the child and her parents, cannot be seen as a systemic or structural dysfunction resulting from the State's failure to regulate the provision of healthcare. It must be emphasised in this connection that (a) the right to health is not as such among the rights guaranteed by the Convention or its Protocols, and that (b) the allocation of public funds in the area of healthcare is not a matter on which the Court should take a stand, since the competent authorities of the Contracting States are better placed to evaluate the relevant demands, take responsibility for the difficult choices which have to be made between worthy needs, and decide how their limited resources should be apportioned'; *Ivanov v Bulgaria* ECtHR Application no. 67320/16 (2020) §49. See also 'There is therefore no basis on which to hold the Bulgarian State directly liable under Article 2 of the Convention for the death of the applicants' daughter'; §§50-52.

803 *Lopes de Sousa Fernandes v Portugal* ECtHR Application no. 56080/13 (2017) §§186-196.

804 *Ivanov v Bulgaria* ECtHR Application no. 67320/16 (2020).

805 *Ivanov v Bulgaria* ECtHR Application no. 67320/16 (2020) §44; *Lopes de Sousa Fernandes v Portugal* ECtHR Application no. 56080/13 (2017) §§191-192 (emphasis added).

The Court noted that the dysfunctions must be systemic and structural, and not individual instances of failure, that there must be a link between the harm suffered and the dysfunction, and connected to the State's failure to regulate, which is interpreted broadly, as including supervision and enforcement of regulatory framework; *Ivanov v Bulgaria*,⁸⁰⁶ *Lopes de Sousa Fernandes v Portugal*.⁸⁰⁷

Attention should be paid to the authorities' knowledge of the specific circumstances that led to death or severe disease of population groups. We saw that the Court reached the same conclusion in *Nencheva v Bulgaria*,⁸⁰⁸ and in *Centre for Legal Resources on behalf of Valentin Câmpeanu v Romania*⁸⁰⁹ (violation of Article 2), where the authorities knew or must have known of the conditions and medical shortages at the Poiana Mare Neuropsychiatric Hospital and a different conclusion in *Evija Dumpe v Latvia*⁸¹⁰ (no violation of Article 2) where the authorities did not.⁸¹¹ The specific timeline of the State authorities' actions and omissions should also be evidenced and analysed in a claim under Article 2. The vulnerability of population groups living with disability or the elderly, duly acknowledged and supported by scientific evidence, would be a factor exacerbating this failure. We saw in *Budayeva v Russia*⁸¹² (violation of Article 2), that the Court made a detailed analysis of when the authorities knew or ought to have known of the continuous and increasing risk of mudslides in the area, including the number of warnings issued.⁸¹³ This line of analysis is also seen at the national level in *Gardner and Harris v Secretary of State for Health and Social Care* (England and Wales)⁸¹⁴ where *Budayeva* was considered.

806 *Ivanov v Bulgaria* ECtHR Application no. 67320/16 (2020) §45.

807 *Lopes de Sousa Fernandes v Portugal* ECtHR Application no. 56080/13 (2017) §§194-196.

808 *Nencheva v Bulgaria* ECtHR Application no. 48609/06 (2013).

809 *Centre for Legal Resources on behalf of Valentin Câmpeanu v Romania* ECtHR Application no. 47848/08 (2014).

810 *Evija Dumpe v Latvia* ECtHR Application no. 71506/13 (2018).

811 *Evija Dumpe v Latvia* ECtHR Application no. 71506/13 (2018) §56.

812 *Budayeva v Russia* ECtHR Applications nos. 15339/02, 21166/02, 20058/02, 11673/02 and 15343/02 (2008).

813 *Budayeva v Russia* ECtHR Applications nos. 15339/02, 21166/02, 20058/02, 11673/02 and 15343/02 (2008) §§147-149.

814 *Gardner and Harris v Secretary of State for Health and Social Care* [2022] EWHC 967 (Admin).

General claims solely relied on the failure of the State to provide medication free of charge, a specific number of treatments per week, or refund for previously incurred costs or the continuation of life-saving treatment, seem more unlikely to succeed as we saw in *Pentiacova v Moldova*,⁸¹⁵ *Wiater v Poland*,⁸¹⁶ and *Nitecki v Poland*.⁸¹⁷ The Court in these cases reiterated the discretion afforded to States as to how to allocate limited resources. If, on the other hand, a combination of factors exists, such as denial of treatment in breach of national law prescribing this treatment free of charge, the conclusion of the Court could differ as we saw in *Panaitescu v Romania*.⁸¹⁸

The reluctance of the courts to rule on providing a specific treatment, which is considered more a matter of policy and resource allocation, is evident in national jurisdictions; *LEH v OSEP* (Argentina),⁸¹⁹ *Cameron v Nova Scotia* (Canada),⁸²⁰ *LN v Ministry of Health* (Kenya),⁸²¹ *Soobramoney v Minister of Health* (South Africa).⁸²² The courts in India seem more eager to follow a different route in certain situations. We considered the comments of the High Court of Delhi in *Mohd Ahmed (Minor) v Union of India*,⁸²³ noting that although protection of the rights to life and health is understood to be within the available resources of the State, some rights are non-derogable, including access to essential medicines that are affordable.⁸²⁴ The right to health has been held as an autonomous justiciable right before the Inter-American Court of Human Rights in *Poblete Vilches v Chile*,⁸²⁵ and *Cuscul Pivaral v Guatemala*⁸²⁶, and an inalienable part of the right to life in *Laxmi*

815 *Pentiacova v Moldova* ECtHR Application no. 14462/03 (2005).

816 *Wiater v Poland* ECtHR Application no. 42290/08 (2012).

817 *Nitecki v Poland* ECtHR Application no. 65653/01 (2002).

818 *Panaitescu v Romania* ECtHR Application no. 30909/06 (2012).

819 *LEH v OSEP* CSJ 003732/2014/RH001 (2015); unofficial translation in English provided by Lawyers Collective and partners for the Global Health and Human Rights Database.

820 *Cameron v Nova Scotia* (Attorney General), 1999 NSCA 14 (CanLII).

821 *LN v Ministry of Health* Petition No 218 (2013).

822 *Soobramoney v Minister of Health* (Kwazulu-Natal) Case CCT 32/97 (1997).

823 *Mohd Ahmed (Minor) v Union of India* WP(C) 7279/2013.

824 *Mohd Ahmed (Minor) v Union of India* WP(C) 7279/2013 §87.

825 *Poblete Vilches et al v Chile*, IACtHR Series C 349 (2018).

826 *Cuscul Pivaral et al v Guatemala*, IACtHR Series C 359 (2018).

*Mandal v Deen Dayal Harinagar Hospital*⁸²⁷ and in *Jaitun v Janpura Maternity Home*.⁸²⁸

As noted in the academic literature, ‘the right to health cannot be reduced to a bare mechanism for reallocating resources to (or within) the health budget’.⁸²⁹ Its all-encompassing nature would prohibit such a narrow focus which would moreover undermine the distinct contribution to be made by the right to health.⁸³⁰ Of course, scarcity of resources is a real consideration, one acknowledged in ECtHR jurisprudence.⁸³¹ We noted the ‘judicial realism’⁸³² with which Courts in national jurisdictions may treat a question of allocation of resources, considering the human, financial, and additional matters; *R v North and East Devon Health Authority ex p Coughlan*.⁸³³ Yet, as noted previously, the State does not have *carte blanche*. Thus, the HRC found a violation of Article 6 ICCPR in *Lantsova v Russia*, noting that the State should take all necessary measures to protect the health and lives of the detainees could not be reduced by invoking a lack of financial resources.⁸³⁴ Similarly in *Panaitescu*, the ECtHR noted that the State cannot

827 *Laxmi Mandal v Deen Dayal Harinagar Hospital* WP(C) 8853/2008 (2010).

828 *Jaitun v Janpura Maternity Home* WP(C) 10700/2009. For academic commentary on the case see Jennifer Templeton Dunn and others, ‘The Role of Human Rights Litigation in Improving Access to Reproductive Health Care and Achieving Reductions in Maternal Mortality’ (2017) 17 (2) *BMC Pregnancy and Childbirth* 367.

829 John Harrington and Maria Stuttaford, ‘Introduction’ in John Harrington and Maria Stuttaford (eds), *Global health and human rights: Legal and philosophical perspectives* (Routledge 2010), 3.

830 Paul Hunt, ‘Interpreting the International Right to Health in a Human Rights-Based Approach to Health’ (2016) 18 (2) *Health and Human Rights Journal* 109, 111.

831 ‘[Steps] within the limits of their powers, the measures which, from a reasonable point of view, would undoubtedly have mitigated this risk’ *Nencheva v Bulgaria* ECtHR Application no. 48609/06 (2013) §108, 118.

832 Charles Foster, ‘Simple Rationality? The Law of Healthcare Resource Allocation in England’ (2007) 33 (7) *Journal of Medical Ethics* 404, 405.

833 *R v North and East Devon Health Authority ex p Coughlan* [2001] QB 213 (CA).

834 *Lantsova v Russia* Communication No. 763/1997, UN Doc. CCPR/C/74/D/763/1997 (2002) §9.2.

cite a lack of resources or funds as an excuse to avoid its duties under Article 2.⁸³⁵

Perhaps a broader margin of appreciation will be afforded to States due to the unprecedented public health emergency of COVID-19.⁸³⁶ Nonetheless, the emergency circumstances do not negate the duty to protect the lives and health of the most vulnerable population groups. The scope of the margin of appreciation may sometimes be undefined but it should not be used as a substitute for an analysis of the issues in question, or as a shield protecting governments from accountability instead of protecting people.⁸³⁷ Indeed a narrower degree of discretion should be afforded given the existing risks to the already vulnerable.⁸³⁸

It is worth adding a few notes on the discriminatory aspects of denial of treatment in care homes during the COVID-19 pandemic. Reports by Amnesty International based on open investigations into preventable deaths revealed the Europe-wide degree of discrimination, exclusion, and denial of treatment to elderly persons residing in care homes. The following notes provide a few illustrations.

835 *Panaitescu v Romania* ECtHR Application no. 30909/06 (2012) §35. For a different approach on the interpretation of the right to health in the context of resource scarcity see Keith J Syrett, ‘Evolving the Right to Health: Rethinking the Normative Response to Problems of Judicialization’ (2018) 20 (1) Health and Human Rights Journal 121.

836 See also the comments of Chamberlain J in *MB v UCL Hospitals NHS Foundation Trust*, that in the context of an emergency, referring to COVID-19: ‘to the extent that this is itself discrimination against those, like MB, whose disabilities make them perceive a need for things (...) for which there is in fact no objective need, the discrimination would be justified even outside the context of a public health emergency. In the context of such an emergency, there is no prospect that a challenge based on Article 14 in these circumstances could possibly succeed’ at [60]. See also 2.2.1.

837 See the comments of the dissenting minority in *SH v Austria* ‘the Court should not use the margin of appreciation as a “pragmatic substitute for a thought-out approach to the problem of proper scope of review”’; *SH v Austria* ECtHR Application No. 57813/00 (2011) §11 of the joint dissenting opinion (emphasis added).

838 See also the comments of the European Committee of Social Rights in *European Roma Rights Centre (ERRC) v Bulgaria* ECSR no. 151/2017, Resolution CM/ResChS (2019) at §§85-86 (cited below) which noted the ‘overall discrimination that Roma still suffer in accessing health care’ and the overall obstacles they face. The approach taken considers the deepening of an already disadvantaged social position.

In Spain, specifically in Catalonia and Madrid, the lack of protective equipment, PCR tests, and training for care home staff, in combination with repeated exclusion from hospital referrals resulted in ‘abandoning’ elderly residents in need of healthcare assistance.⁸³⁹ Additional reports for Italy,⁸⁴⁰ the United Kingdom,⁸⁴¹ Belgium,⁸⁴² and Sweden,⁸⁴³ portray similar findings. It is concerning that the overall picture is one of longstanding mistreatment, ageism, and discrimination against older people across Europe, which was intensified during the pandemic.⁸⁴⁴ Anand et al.⁸⁴⁵ underscore the degree of disregard for older persons’ human rights, including the right to life, non-discrimination, and prohibition of torture.⁸⁴⁶ The authors, who reviewed evidence on violation of older persons’ human rights in care homes in seven

839 Spain: Older People in Care Homes Abandoned During COVID19 Pandemic’ (*Amnesty International*, 2020) <<https://www.amnesty.org/en/latest/news/2020/12/spain-older-people-in-care-homes-abandoned-during-covid19-pandemic/>> accessed 15 May 2022.

840 Stefano Amore and others, ‘Impact Of COVID-19 On Older Adults and Role of Long-Term Care Facilities During Early Stages of Epidemic in Italy’ (2021) 11 *Scientific Reports* 12530; Diego de Leo and Marco Trabucchi, ‘COVID-19 and the Fears of Italian Senior Citizens’ (2020) 17 (10) *International Journal of Environmental Research and Public Health* 3572; ‘Fact Check: Were Elderly Italians Left to Die? And Is Socialized Health Care to Blame?’ (*Usatoday.com*, 2020) <<https://www.usatoday.com/story/news/factcheck/2020/03/20/fact-check-were-italians-left-die-socialized-medicine-blame-coronavirus/2887743001/>> accessed 18 May 2022.

841 ‘UK Government Failures Leave Older People “Abandoned to Die” In Care Homes During COVID 19 Pandemic’ (*Amnesty International*, 2020) <<https://www.amnesty.org/en/latest/news/2020/10/uk-older-people-in-care-homes-abandoned-to-die-amid-government-failures-during-covid-19-pandemic/>> accessed 19 May 2022.

842 ‘Belgium 2020 Archives’ (*Amnesty International*, 2020) <<https://www.amnesty.org/en/location/europe-and-central-asia/belgium/report-belgium/#endnote-2>> accessed 22 May 2022.

843 ‘Swedish Watchdog Finds Serious Failures in COVID Care at Nursing Homes’ (*Reuters*, 2020) <<https://www.reuters.com/Article/idUSKBN2841CG>> accessed 29 April 2022.

844 Estelle Huchet and Borja Arrue-Astrain, ‘The Fate of Europe’s Elderly Under Covid-19 Lock-down’ (*EUobserver*, 2020) <<https://euobserver.com/opinion/148637>> accessed 22 May 2022.

845 Janet Carter Anand and others, ‘The Covid-19 Pandemic and Care Homes for Older People in Europe - Deaths, Damage and Violations of Human Rights’ (2021) *European Journal of Social Work*.

846 Janet Carter Anand and others, ‘The Covid-19 Pandemic and Care Homes for Older People in Europe - Deaths, Damage and Violations of Human Rights’ (2021) *European Journal of Social Work* 2.

European countries between March and December 2020, argue that many of the deaths reported were preventable.⁸⁴⁷ Disturbing findings include prescribing care home residents a ‘palliative cocktail’ over the phone instead of supplementary oxygen.⁸⁴⁸ Gustafson, professor of geriatrics at Umea University described the practice as ‘active euthanasia’.⁸⁴⁹ In the UK, there was evidence of a blanket approach to DNARs forms (do not attempt resuscitation orders) to groups of residents,⁸⁵⁰ while Pio Albergo Trivulzio, one of the oldest care home in Milan is reported at the time of writing as being under investigation for manslaughter by the Italian authorities.⁸⁵¹

These are not isolated events solely caused by the recent pandemic. As described in the academic literature, COVID-19 revealed pervasive age-related discrimination in the health-care system.⁸⁵² Ageism, or age-related discrimination was well documented as leading to denial of treatment and inaccessibility to health care services,⁸⁵³ even before the pandemic.

847 The UK, Sweden, Spain, Ireland, Italy, Finland, and Estonia; Janet Carter Anand and others, ‘The Covid-19 Pandemic and Care Homes for Older People in Europe - Deaths, Damage and Violations of Human Rights’ (2021) *European Journal of Social Work* 2-3.

848 Janet Carter Anand and others, ‘The Covid-19 Pandemic and Care Homes for Older People in Europe - Deaths, Damage and Violations of Human Rights’ (2021) *European Journal of Social Work* 4; ‘Questions Raised About Sweden’s Covid-19 Policy on Nursing Homes’ (*BioEdge*, 2020) <<https://bioedge.org/uncategorized/questions-raised-about-swedens-covid-19-policy-on-nursing-homes/>> accessed 6 May 2022.

849 ‘Questions Raised About Sweden’s Covid-19 Policy on Nursing Homes’ (*BioEdge*, 2020) <<https://bioedge.org/uncategorized/questions-raised-about-swedens-covid-19-policy-on-nursing-homes/>> accessed 6 May 2022.

850 *United Kingdom: As if expendable: The UK Government’s Failure to Protect Older People in Care Homes During the COVID-19 Pandemic* (Amnesty International 2020) 25-26.

851 Ben Wedeman and Nicola Ruotolo, ‘Covid-19 Has Taken a Staggering Toll on a Whole Generation in Northern Italy’ (*CNN*, 2020) <<https://edition.cnn.com/2020/05/21/europe/italy-nursing-homes-deaths-intl/index.html>> accessed 6 May 2022. See also Adelina Comas-Herrera and others, ‘Mortality Associated with COVID-19 in Care Homes: International Evidence’ (2020) Article in *LTCcovid.org*, International Long-Term Care Policy Network, CPEC-LSE, last update 1st February 2021.

852 Sharon K Inouye, ‘Creating an Anti-Ageist Healthcare System to Improve Care for Our Current and Future Selves’ (2021) 1 *Nature Aging* 150.

853 E-Shien Chang and others, ‘Global Reach of Ageism on Older Persons’ Health: A Systematic Review’ (2020) 15 (1) *PLoS ONE*

In a 1999 study of more than nine thousand hospitalised patients, older patients were significantly more likely to be denied life-sustaining treatment compared to younger patients.⁸⁵⁴ Additional indications of age-based discrimination could include the exclusion of older people from COVID-19 clinical trials⁸⁵⁵ and the insufficient training of health care professionals in geriatrics.⁸⁵⁶ Discrimination within the same group (e.g., as between the elderly) is also possible and can have similarly deleterious effects on well-being and life chances. In the Bulgarian vaccine distribution scenario, the vague wording of Phase 3 of the vaccination plan enabled the nation's 'business class' to get vaccinated well ahead of when any rational allocation policy would have permitted this. If at least some of the members of this class were over 60 years old, and or living with underlying medical conditions, then discrimination had not only occurred on the basis of age, or disability, but also social status.

The factual circumstances of the Bulgarian vaccination plan during the COVID-19 pandemic, the overall health profile of the State, and its record in leaving existing inequalities in accessing health care services unremedied, suggests that there is persistent discrimination against

854 'For ventilator support, the rate of decisions to withhold therapy increased 15% with each decade of age' and 'older age was associated with higher rates of decisions to withhold ventilator support, surgery, and dialysis'; Mary Beth Hamel and others, 'Patient Age and Decisions to Withhold Life-Sustaining Treatments from Seriously Ill, Hospitalized Adults' (1999) 130 (2) *Annals of Internal Medicine* 116. See also 'Although criteria based on length of life and quality of life do not necessarily constitute direct discrimination, it may be argued that making decisions on this basis constitutes indirect discrimination in relation to age and disability. Indirect discrimination occurs when a criterion or practice would place a person at a comparative disadvantage to someone who did not share the protected characteristic'; Julian Savulescu and others, 'Equality or utility? Ethics and law of rationing ventilators' (2020) 125 (1) *British Journal of Anaesthesia* 10.

855 Helfand, Webb, and Gartaganis note that older persons are likely to be excluded from more than 50% of COVID-19 clinical trials raising significant questions on the efficacy, dosage, and side effects of the vaccine. Benjamin K I Helfand and others, 'The Exclusion of Older Persons from Vaccine and Treatment Trials for Coronavirus Disease 2019—Missing the Target' (2020) 180 (11) *JAMA Internal Medicine* 1546, 1547.

856 'In current medical training, physicians spend at least threefold increased time in pediatric compared with geriatric training, and the majority receive no formal training in geriatrics at all.'; Sharon K Inouye, 'Creating an Anti-Ageist Healthcare System to Improve Care for Our Current and Future Selves' (2021) 1 *Nature Aging* 150.

vulnerable populations. This can include people with physical and mental disabilities, Roma communities, the elderly, and persons with underlying medical conditions or chronic diseases. Discrimination against these populations may be indirect as well as direct. But in both cases it is of similarly deleterious effect. State authorities often create an untenable situation, hindered these individuals from protecting their rights to life and health, abandoning the duty to protect the most fundamental rights and transferring this burden to the most vulnerable of its peoples in violation of national and international commitments.

This has also been evident in cases before the European Committee of Social Rights; see *European Roma Rights Centre (ERRC) v Bulgaria*,⁸⁵⁷ and *European Roma Rights Centre (ERRC) v Bulgaria*.⁸⁵⁸ In the latter, the Committee unanimously found a violation of Article E in conjunction with Article 11 paragraph 1 of the European Social Charter regarding access to health insurance and maternity health care for Roma women.⁸⁵⁹ It is worth adding the Committee's response to the government's argument that the persons affected by alleged discrimination can follow legal avenues to assert their rights:

While this may be true in principle, (...) [i]n such cases, the authorities have a responsibility to support the persons concerned in order to overcome the barriers so that they can effectively assert their rights. Failing such a proactive approach on the part of the government, the rights and remedies are rendered illusory for the disadvantaged communities in question. This is all the more relevant and

857 ECSR complaint no. 46/2007, Resolution CM/ResChS (2010). See also *Follow-Up to Decisions on the Merits of Collective Complaints* (ECSR 2020): 3rd Assessment of follow-up: European Roma Rights Centre (ERRC) v. Bulgaria, Complaint No. 46/2007, decision on the merits of 3 December 2008, Resolution CM/ResChS (2010)1 at 30, 33.

858 ECSR no. 151/2017, Resolution CM/ResChS (2019).

859 ECSR no. 151/2017, Resolution CM/ResChS (2019).

*important where fundamental rights are concerned, especially the right to health and the conditions under which the enjoyment of that right is enabled.*⁸⁶⁰

The same reasoning applies to the purported availability of vaccination for older persons and persons with underlying medical conditions through the ‘green corridors’ scheme. In practice access via that route was impossible for such persons due to transportation difficulties, winter conditions, and other considerations which resulted in the young, able-bodied nationals being vaccinated before prioritised groups.⁸⁶¹

The issue of inconsistent or ‘unrhythmic’ access to medicines and mismanagement has often triggered claims relating to the rights to life, health, and non-discrimination. In *Toshka*,⁸⁶² the claimant was discriminated against compared to other cancer patients whose ‘treatment was not interrupted due to a shortage of prescribed drugs’.⁸⁶³ This case illustrates a situation analogous to the ‘green corridors’ in the Bulgarian vaccine distribution scenario, which effectively created a first-come first-served mandate. It is worth recalling that we also encountered the interruption and irregular supply of life-saving drugs in the Bulgarian *TDZ case*⁸⁶⁴ (see 2.2.1) and in claims under the ECHR against Bulgaria; see

860 ECSR no. 151/2017, Resolution CM/ResChS (2019) §84. See also the overall approach taken by the Committee: ‘Taking into account the overall discrimination that Roma still suffer in accessing health care, which has not been redressed during the 10 years following the ECSR’s decision in *ERRC v. Bulgaria* (Complaint No. 46/2007, op.cit.), (...) the overall lower health status of Roma reflected in official statistics, the higher amount of uninsured Roma as compared to the rest of the population and the difficulties in accessing public hospitals as a consequence of geographical distance and other barriers, the Committee considers that health care for Roma is inferior to that of the rest of the population (...) this constitutes indirect discrimination in violation of Article E in conjunction with Article 11§1 of the Charter’ at §§85-86.

861 Explained in detail in ECSR *Open Society European Policy Institute v Bulgaria* (complaint submitted 25 January 2022) §§ 22-24.

862 Discussing the ‘timely and rhythmic administration of the drugs and medicine, necessary for her treatment (...)’; *Toshka Nikolova Bosheva v Minister of Health for the Republic of Bulgaria* No 183/02.08.2010 (Case File No 146/2009) at p.9 (emphasis added).

863 *Toshka Nikolova Bosheva v Minister of Health for the Republic of Bulgaria* No 183/02.08.2010 (Case File No 146/2009) at p.2.

864 Decision No. 211 on Case No. 6087/2007.

Nencheva v Bulgaria,⁸⁶⁵ *Ivanov v Bulgaria*,⁸⁶⁶ and *Stanev v Bulgaria*⁸⁶⁷ also raising issues of lack of medicines, health care, and dysfunctioning (see 1.1.2.5). Considering the above, we would note a recurring dysfunction in ensuring a smooth, consistent and rhythmic supply of and access to essential medicines, treatment, and health care facilities in Bulgaria. This argument could be developed and evidenced further to support a claim that Bulgaria is continually and knowingly breaching its positive obligations to protect the rights to life, health, and non-discrimination to the detriment of the Bulgarian public.

Looking at the characteristics of the health system in Bulgaria, we can detect vulnerabilities known to the authorities that could have been addressed before the recent pandemic. These include low numbers of nurses,⁸⁶⁸ high levels of inpatient treatment, lack of health promotion programmes, uneven distribution of health workers, and inefficient allocation of funding to health care providers.⁸⁶⁹ Additionally, it is worth noting that almost half of all deaths in Bulgaria are related to behavioural risk factors, including unhealthy diets, smoking, and alcohol consumption.⁸⁷⁰ These are widely accepted as direct or indirect risk factors for severe disease or death from COVID-19, especially if combined.⁸⁷¹ As previously noted, the duty to prevent epidemics and diseases requires establishing ‘prevention and education programmes for behaviour-related health concerns’ and promoting ‘social determinants of good health’.⁸⁷²

865 *Nencheva v Bulgaria* ECtHR Application no. 48609/06 (2013).

866 *Ivanov v Bulgaria* ECtHR Application no. 67320/16 (2020).

867 *Stanev v Bulgaria* ECtHR Application No. 36760/06 (2012).

868 Together with Greece and Latvia, Bulgaria has one of the lowest densities of nurses; *State of Health in the EU: Bulgaria - Country Health Profile* (OECD 2021) 11.

869 *State of Health in the EU: Bulgaria - Country Health Profile* (OECD 2021) 13, 16, 17, and 19.

870 *State of Health in the EU: Bulgaria - Country Health Profile* (OECD 2021) 3.

871 See Mengyuan Dai and others, Influence of Cigarettes and Alcohol on the Severity and Death of COVID-19: A Multicenter Retrospective Study in Wuhan, China (2020) 11 *Frontiers in physiology*; XM Fang and others, ‘Combined and Interactive Effects of Alcohol Drinking and Cigarette Smoking on the Risk of Severe Illness and Poor Clinical Outcomes in Patients with COVID-19: A Multicentre Retrospective Cohort Study’ 2022 (205) *The Royal Society for Public Health* 6.

872 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) §16, 17 (‘health education’).

Bulgaria did not mitigate known vulnerabilities in its health system before and during the pandemic, consistently failing to protect its people's rights to life and health, permitting, if not constructing an environment where equal access to health care and vaccination was impossible. That was exacerbated Bulgaria's chronic failure to realise the rights to health-related information and educational programmes, contrary to the authoritative comments of the CESCR in General Comment No.14, paragraphs 3, 11, 16, 36, 44(d). Taken together, these issues could indicate a record of consistent failures by Bulgaria to directly or indirectly protect the rights to health, life, and non-discrimination for its most vulnerable populations. The specific claims of violations of rights during the COVID-19 pandemic against people with underlying conditions and the elderly could be placed in this wider context of a constant failure to discharge fundamental duties to the public.⁸⁷³

⁸⁷³ See also the Universal Periodic Review mechanism (UPR), established by the HRC in 2006 (A/RES/60/251) in which the HRC submits recommendations for supporting and enhancing the protection of the human rights for each UN Member State. In its 2020 report, the HRC included the recommendations of the CESCR that Bulgaria should ensure access to health care for all population groups without discrimination; the disparity between regions in relation to access to health care was concerning. Secondly, that Bulgaria should introduce specific measures for persons with mental health conditions and for the elderly; Report of the Office of the United Nations High Commissioner for Human Rights (Compilation on Bulgaria), UN Doc. A/HRC/WG.6/36/BGR/2 (27 February 2020) §34; CESCR, 'Concluding observations on the sixth periodic report of Bulgaria' UN Doc. E/C.12/BGR/CO/6 (29 March 2019) §§25-28, 42-43. See also the 2020 Country Reports on Human Rights Practices: Bulgaria Bureau of Democracy, Human Rights, and Labor, by the US Department of State (March 30, 2021) reporting that: 'NGOs accused the health minister of age discrimination, and a group of lawyers challenged in the court his May 13 order which provided for mandatory isolation and hospitalization of COVID-19 patients who were 60 and older. On May 19, the minister amended the order, removing that provision'.

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