Response to the consolidation and updating of the Provision of Health Services to Persons not Ordinarily Resident Regulations (NI) 2005

1. The Northern Ireland Human Rights Commission ('the Commission), pursuant to section 69(3) of the Northern Ireland Act 1998 reviews the adequacy and effectiveness of law and practice relating to the protection of Human Rights. In accordance with this function the following statutory advice is submitted to the Department of Health, Social Services and Public Safety ('the Department') on their proposals to consolidate and update the Provision of Health Services to Persons not Ordinarily Resident Regulations (Northern Ireland) 2005.

2. The Commission bases its position on the full range of internationally accepted human rights standards, including the European Convention on Human Rights, as incorporated by the Human Rights Act 1998, and the treaty obligations of the Council of Europe and United Nations systems. The relevant international treaties in this context include;

- The European Convention on Human Rights, 1950 ('ECHR') [UK ratification 1951];
- The European Convention on Social and Medical Assistance, 1953 ('ECSMA') [UK ratification 1954];
- The European Social Charter, 1961 ('ESC') [UK ratification 1962];
- The International Convention for the Elimination of Racial Discrimination, 1965 ('CERD') [UK ratification 1969];
- The International Covenant on Economic, Social and Cultural Rights, 1966 ('ICESCR') [UK ratification 1976];
3. The Commission recalls that section 24(1) of the Northern Ireland Act 1998 requires that all acts of the Department are compatible with Community law and the ECHR. In addition, section 26 of the Act also requires compliance with international obligations. The Commission, therefore, advises that the Department scrutinise these proposals for full compliance with international human rights standards.

**Introduction**

4. The Commission notes that the Department seeks to consolidate and restructure the Provision of Health Services to Persons not Ordinarily Resident Regulations 2005 (‘the 2005 Regulations’) to ensure access to health services is effective and not obstructed by conflicting laws and policies.

5. The Commission recognises the complexity of health care provision and welcomes the aim to provide legal certainty for both service providers and service users. The Commission emphasises the centrality of the principle of legal certainty from a human rights perspective. The Commission notes that this principle requires clarity be provided, so that affected individuals can ascertain what health services, goods and facilities they have access to and under what terms. In particular, this means that regulations must be clear, precise and foreseeable.

6. International human rights law provides a range of protections related to health care; including, for example, the right to the highest attainable standard or health (under ICESCR and UNCRC), the right to non-discrimination in the provision of health care services (under CERD, ICESCR, CEDAW and UNCRC) and the right of access to maternal health (under CEDAW and UNCRC).

7. The ICESCR is the central international treaty providing for the right to health. As with other economic, social and cultural rights, the ICESCR contains ‘a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights’.\(^1\) This represents a set of obligations, which require immediate implementation. The failure to fulfil those minimum core obligations will result in a violation of the respective right. The right to equality and non-discrimination forms part of the core obligation, in that all individuals must be able to exercise their rights free from

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discrimination. Special consideration must be given to vulnerable and marginalised groups.

8. At the same time, States must take steps to progressively realise those rights, using their maximum available resources. While this reflects the need for flexibility and taking resource constraints into account, progressive realisation ‘imposes an obligation to move as expeditiously and effectively as possible’ towards achieving full realisation of the rights set forth in the ICESCR.

9. The full range of international human rights standards which are referred to in the body of this response can be found at Appendix 1.

Analysis of the Proposals Contained in the Consultation Document

10. In January 2011, the Commission published a research paper entitled “Access Denied – Or Paying when you shouldn’t”, which considered the issue of access to publicly funded health care based on residency status. The research paper discusses the substantive right to health, principle of non-discrimination and legal certainty as applied by international human rights law.

11. The Commission has engaged with the Department on this issue for a number of years and welcomes the present consultation. The Commission notes that the consultation is proposal-based and the substantive text of any amendments to the current 2005 Regulations is not yet available.

12. The Commission wishes to make the following comments in relation to the proposals in the current consultation:

PROPOSAL B: EU Convention

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2 Article 2(1), ICESCR
13. The Commission understands that the revision of the 2005 Regulations will reflect the obligations under the EU Convention on Social and Medical Assistance.

14. The Commission recalls the duty of the Department to ensure that any amendments are compatible with European Union law, the ECHR and international human rights obligations pursuant to s.24 and 26 of the Northern Ireland Act 1998.

15. **The Commission advises the Department that any proposed amendments must be clear for both health care providers and service users in order to achieve legal certainty.**

PROPOSAL C: Legal Guardians

16. Article 2 UNCRC on non-discrimination contains the obligation to guarantee all the rights in the Convention without discrimination of any kind, ‘irrespective of the child’s or his or her parent’s or legal guardian’s race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status’.

17. The Commission welcomes the intention to ensure that the legal guardian of the child is given the same interpretation as the parent, in line with the UNCRC. While parents and legal guardians have primary obligations towards children under their guardianship, the Commission notes, however, that the UNCRC recognises children in their own right and vests them with special protection and rights that must be respected and guaranteed without discrimination. In particular, discrimination based on the parents’ or legal guardian’s status is prohibited.

18. **The Commission therefore advises that the Department take special consideration of the rights of the child and that all amendments are in conformity with the rights to health (article 24) and non-discrimination (article 2(1)), as well as in the best interests of the child (article 3(1)) enshrined in the UNCRC.**

PROPOSAL D: Unaccompanied children
19. It is recognised under this proposal that unaccompanied children would be entitled to free treatment under the current Provision of Health Services to Persons not Ordinarily Resident Regulations (NI) 2005 (‘2005 Regulations’). However, the Department proposes to frame the exemption around children in the care of social services.

20. The Commission notes the definition of a child under the UNCRC which covers all children up to the age of 18 \(^5\) and recalls the requirement to ensure that stateless and unaccompanied children are given the same access to services as nationals.\(^6\)

21. **The Department must fulfil its obligations under s.26 of the Northern Ireland Act 1998 and not act contrary to the UNCRC which recognises a child up to the age of 18. The Commission recommends that any amendment for unaccompanied children includes all children up to the age of 18, in line with the UNCRC.**

PROPOSAL E: Refugees

22. The 2005 Regulations exempt from charges those persons who have been accepted as a refugee or who have made a formal application under article 3(d). Proposal E intends to extend this exemption to ensure that any legal route by which an application is submitted to obtain refugee status will fall within this definition.

23. This is in line with the core obligation under ICESCR to provide health care services on a non-discriminatory basis for the most vulnerable and marginalised groups.\(^7\) States cannot deny or limit access to health care for non-citizens.\(^8\)

24. **The Commission welcomes the extension of the exemption for those seeking refuge in the UK. The Commission advises the Department to further reflect to**

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\(^5\) Article 1, UNCRC

\(^6\) UN Committee on the Rights of the Child, General Comment 6: Treatment of Unaccompanied and Separated Children outside their Country of Origin (2005) UN Doc. CRC/GC/2005/6, para 47

\(^7\) UN Committee on Economic, Social and Cultural Rights, General Comment 14: The Right to the Highest Attainable Standard of Health (2000) UN Doc. E/C.12/2000/4, para 43(a)

\(^8\) UN Committee on the Elimination of Racial Discrimination, General Recommendation 30: Discrimination against Non-citizens (2004) UN Doc. CERD/C/64/Misc.11/rev.3, para 36
ensure that women and children falling within this exemption are adequately protected in line with State obligations.

PROPOSAL G: Failed Asylum Seekers

25. The Commission notes that persons seeking asylum in the United Kingdom are exempt from health care charges during the application and appeal process. The Commission understands that failed asylum seekers, whose appeals process has been exhausted, may be eligible for financial support pursuant to s.4 or s.95 of the Immigration and Asylum Act 1999 (‘IAA’). This provides accommodation and subsistence support where the person is either destitute (s.95) or where they are co-operating with the UKBA in order to leave the UK (s.4).

26. The Commission recalls the recommendation of the ICESCR Committee for the UK government to review support and provision of essential services under s. 4 IAA. The Commission understands that such a review is outside the competence of the Department. However, it is within the competence of the Department to extend health care provision.

27. The Commission welcomes the extension of free health care services to those failed asylum seekers in receipt of s.4 IAA or s.95 IAA support.

28. However, not all failed asylum seekers will be detained or will be in receipt of s.4 or s.95 support. In this regard, the Commission advises that, for such failed asylum seekers, charging for health care services has the potential of pushing them into destitution. The State is under a positive obligation, pursuant to article 3 ECHR, to prevent all persons in their jurisdiction from falling into destitution to the extent that it would amount to inhuman and degrading treatment.10

29. The Commission also advises that, for this group of failed asylum seekers, a charge for health care services may represent a financial barrier. This has the potential

10 R. (on the application of Adam, Limbuela and Tesema) v. Secretary of State for the Home Department [2005] UKHL 66
to raise an issue in respect of the right to life (article 2 ECHR), whereby lack of access to health care on the grounds of finance may pose a serious threat to the life of the individual.

30. **The Commission advises that mechanisms must not be of a nature whereby they represent a barrier to accessing health care in a timely manner.** Equally, such procedures should not further burden health service providers.

31. **It is unclear how the Department plans to implement this proposal.** The Commission advises that any procedures must be clear for both service providers and service users so as to meet the requirements of legal certainty.

32. **The Commission further recommends that the Department ensure that children falling within this exemption have access to health care services.**

**PROPOSAL H: Emergency**

33. The Commission notes A&E services have been increasingly strained, due to the financial and procedural barriers in accessing primary health care which do not apply to emergency services. The current proposal aims to redirect patients more appropriately treated in primary care, where a charge would be levied, while taking those ‘genuinely without funds’ into consideration. The Department proposes to change the wording of the current legislation and limit the exemption to ‘treatment related to an accident or emergency’. However, the exact proposed rewording has not been provided, raising issues with regard to the principle of legal certainty and how the Department plans to ensure it meets the minimum core obligations.

34. The Commission notes the difficulty to substantively comment on this proposal without the new wording. The Commission would therefore welcome further information in this respect in order to comment comprehensively.

35. **The Commission advises that the Department take the following into account;**

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11 UN Committee on the Rights of the Child, Concluding Observations: UK (2002) UN Doc. CRC/C/15/Add.188, para 50(b)
36. **All individuals must have access to a minimum level of benefits that will enable them to acquire essential health care at the very least, as a minimum core obligation of the right to social security.** Simultaneously, this must be viewed in conjunction with the core obligations derived from the right to health, which require access to health facilities, goods and services on a non-discriminatory basis. The ICESCR Committee has also highlighted that special attention be afforded to individuals and groups that have traditionally faced difficulties in exercising their right to social security and thereby noted that “all persons, irrespective of nationality, residency or immigration status, are entitled to primary and emergency medical care”.14

37. With respect to emergencies, the European Committee of Social Rights has interpreted article 13(4) ESC to require emergency medical care to be “governed by the individual’s particular state of health”.15 **Emergencies should therefore be interpreted broadly in order to comply with the human rights obligations arising from the ESC.**

PROPOSAL I: HIV Treatment

38. The Commission notes that currently HIV treatment is not a service exempt from charges within the meaning of s.4 of the 2005 Regulations. Solely HIV diagnosis and counselling services are covered.16 The Department suggests three options to broaden the exemption. The Commission gives preference to the third option, which proposes the same exemption of providing HIV treatment for all overseas visitors as introduced in England in 2012.

39. Article 12(c) ICESCR contains the right to prevention, treatment and control of epidemic, endemic, occupational and other diseases. The ICESCR Committee has interpreted this

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15 Digest of the Case Law of the European Committee of Social Rights, 2008, p 104
16 s.4(5)(e), Provision of Health Services to Persons not Ordinarily Resident Regulations (NI) 2005
right to include sexually transmitted diseases, in particular HIV/AIDS.\textsuperscript{17} As a minimum obligation, it is therefore required to provide individuals effective access to such treatment and to take appropriate measures to best prevent and control the further spreading of HIV/AIDS within the jurisdiction.

40. With regard to children and adolescents, the CRC Committee emphasises the importance of providing equal access to HIV/AIDS treatment, care and support to children under the age of 18.\textsuperscript{18}

41. **The provision of HIV treatment for all would be a welcoming step towards providing effective access on a non-discriminatory basis, by minimising procedural barriers, as well as legal uncertainty for those individuals in need of treatment. Simultaneously, this measure would contribute significantly to the prevention and control of HIV within the jurisdiction.\textsuperscript{19}**

**PROPOSAL J: Primary Care**

42. The Commission recognises that the current system has created an anomaly, arising from the procedural barriers in accessing primary health care. The only way to access treatment, therefore, is through the emergency care services. As noted in proposal H, the Department aims to redirect individuals to primary care where more appropriate. While emergency care is provided free of charge, the Commission notes that this proposal intends to extend the exemption of primary care to only ‘some of the classes of persons categories’. It is indicated that treatment in a primary care setting would be subject to a charge and that amendments may be required to current legislation to identify the persons meeting the availability categories. However, the current proposals do not specify the details. The Commission therefore welcomes further information on which persons categories would be included in the exemption and what amendments to legislation would be proposed.

\textsuperscript{17} UN Committee on Economic, Social and Cultural Rights, General Comment 3: The Nature of State Parties Obligations (1990) UN Doc. E/1991/23, para 16

\textsuperscript{18} UN Committee on the Rights of the Child, General Comment 3: HIV/AIDS and Rights of the Child (2003) UN Doc. CRC/GC/2003/3, para 28

\textsuperscript{19} See in particular the Department of Health’s Guidance for the NHS ‘HIV treatment for overseas visitors’, which stated that the UK ‘amendment responds to the significant evidence on the benefits to public health of providing HIV treatment to all in clinical need. Left untreated, HIV presents a significant risk of transmission to people in the UK’.
43. The minimum core obligation of the right to health requires States to, at the very least; guarantee the provision of essential primary health care.\textsuperscript{20} This includes the obligation to provide individuals access to health facilities goods and services on a non-discriminatory basis, whereby vulnerable and marginalised groups must be afforded particular attention.\textsuperscript{21} The right to social security encompasses the right to access benefits, whether in cash or in kind, without discrimination in order to secure protection from financial barriers to health care.\textsuperscript{22} In that context, the ICESCR Committee specifically emphasises the right of “all persons, irrespective of nationality, residency or immigration status, (...) to primary and emergency medical care”.\textsuperscript{23}

44. The Commission notes that primary and emergency care represents the absolute minimum core that any State must afford to all individuals within its jurisdiction, without discrimination. In ensuring this right is guaranteed, States must remove procedural barriers to ensure timely and effective access to health care.\textsuperscript{24} The decision on whether an emergency or primary care setting would be most appropriate for a specific health condition, should be led by the individual’s state of health and right to receive timely access to appropriate health care.\textsuperscript{25} Prolonged periods of uncertainty regarding access to health care, will engage the right to health and rights protected by the ECHR.\textsuperscript{26}

45. The Commission advises primary care be regarded as a service exempt from charges, as is practice with respect to emergency care. By excluding certain classes


\textsuperscript{21} UN Committee on Economic, Social and Cultural Rights, General Comment 14: The Right to the Highest Attainable Standard of Health (2000) UN Doc. E/C.12/2000/4, para 43a

\textsuperscript{22} UN Committee on Economic, Social and Cultural Rights, General Comment 19: The Right to Social Security (2008) UN Doc. E/C.12/GC/19, para 2 and 22

\textsuperscript{23} UN Committee on Economic, Social and Cultural Rights, General Comment 19: The Right to Social Security (2008) UN Doc. E/C.12/GC/19, para 31 and 37


\textsuperscript{25} Digest of the Case Law of the European Committee of Social Rights, 2008, p 104

\textsuperscript{26} Tysiac v Poland, App. No. 5410/03, 2007, at 124
of people, the Department would not be ensuring its minimum core obligation and thus be acting in breach of s.26 of the Northern Ireland Act 1998.

Additional Comments

46. The Commission notes the discretion of the Health and Social Care Trust to write off debts incurred as a result of charges for health care with reference to unaccompanied children and asylum seekers. The Commission would welcome further information on how this discretion will be implemented given obligations to ensure that persons within the jurisdiction do not fall into destitution. Such discretion would need to be sufficiently clear and precise in order to meet the requirements of legal certainty.

47. The Commission welcomes the proposed extension of the exemption categories, recognising the increased vulnerability associated with their uncertain status in Northern Ireland. However, the Commission recalls that there are a number of identifiable vulnerable groups which are not subject to a current exemption, nor mentioned in the present consultation. These include:

   a) Roma/Gypsies/Travellers:

48. The Commission highlights concerns raised by the CERD Committee in relation to discrimination faced by “Roma/Gypsies/Travellers” in respect of, inter alia, their limited access to health services.27

49. The Commission notes the distinct challenges faced by each of these communities and recalls the requirement to give particular attention to vulnerable and marginalised groups. In doing so the Department must consider their specific needs and the barriers they face as a community to ensure they can effectively exercise their right to health.

50. The CEDAW Committee has also recommended that the UK take measures to address the issue of mortality in Traveller communities, "including the allocation of adequate resources to increase access to affordable health services, in particular

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pre-natal, post-natal and obstetric services, as well as other medical and emergency assistance”.

51. **The Commission advises the Department to consider how its proposals will impact upon Roma, Gypsy or Travelling communities given its obligations not to discriminate against these groups.**

   b) Pregnant women:

52. The Commission notes the special vulnerability of women who are pregnant and the requirement under international law to ensure that they have access to the appropriate medical care before, during and after childbirth. This is to be granted free of charge where necessary.

53. **Given the particular attention paid to pregnant women under international human rights jurisprudence, the Commission advises the Department to consider the compatibility of its proposals with Northern Ireland’s legal obligations.**

   c) Victims of violence/trafficking:

54. The Commission recalls the recommendation of the CEDAW Committee which urged the UK Government to reconsider the position on recourse to public funds for victims of violence. There may be a category of women, in Northern Ireland by virtue of a spouse or partner, with no self-standing right to reside or remain and which do not fall within the categories of asylum-seeker/refugee. **The Commission advises the Department to ensure that this category of vulnerable women is covered by the proposals to ensure compliance with international obligations.**

55. The Commission notes the position of persons who have been trafficked into Northern Ireland; their vulnerability and lack of access to resources. **The Commission advises that the Department consider how this category of persons will be able to access health care services, given that they may have increased needs given serious trauma.**

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28 UN Committee on the Elimination of Discrimination Against Women, Concluding Observations: UK (2008) UN Doc. CEDAW/C/UK/CO/6, para 294
29 Article 12(2), Convention on the Elimination of Discrimination against Women
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Appendix 1

Applicable International Human Rights Standards

Right to the highest attainable standard of health:

56. The ICESCR, Article 12, provides;

1. the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

   a. The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
   b. The improvement of all aspects of environmental and industrial hygiene;
   c. The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
   d. The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

57. The State is thus required, under article 12(2)(d), to assure medical service and medical attention in the event of sickness to all persons. The Committee on Economic, Social and Cultural Rights (‘ICESCR Committee’) has interpreted this as requiring “the provision of equal and timely access to basic preventative, curative, rehabilitative services and health education; regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level”.

58. The ICESCR Committee has identified that States have certain core obligations which are necessary in order to ensure the minimum protection of the rights under the ICESCR.

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59. In respect of the right to health, these ‘core obligations’ include the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalised groups”.\textsuperscript{33} Furthermore, the Committee considers the provision of reproductive, maternal and child health care to be of high importance.\textsuperscript{34}

60. There is an additional requirement upon States to provide health care facilities for those who do not have sufficient means and to prevent discrimination in the provision of core health care services.\textsuperscript{35}

61. The ICESCR Committee recalls that even where there are tight constraints on resources, the most vulnerable members of society must be protected.\textsuperscript{36}

**Right to Social Security:**

62. The right to social security is linked to the enjoyment of the highest attainable standard of health, and is also protected by international human rights law. Article 9 of ICESCR provides that;

\textit{The State Parties to the present Covenant recognise the right of everyone to social security, including social insurance.}

63. The ICESCR Committee has explained that article 9 encompasses the right to access benefits, in cash or in kind, to secure protection from financial barriers to health care.\textsuperscript{37}

64. The ICESCR Committee also states that non-nationals should be able to access non-contributory schemes for access to health care, and any restrictions upon such access must be both proportionate and reasonable.\textsuperscript{38} The Committee further requires that “all persons, irrespective of nationality, residency or immigration status, are entitled to primary and emergency medical care”.\textsuperscript{39}

\textsuperscript{33} UN Committee on Economic, Social and Cultural Rights, General Comment 14: The Right to the Highest Attainable Standard of Health (2000) UN Doc. E/C.12/2000/4, para 43(a)

\textsuperscript{34} Ibid, para 44(a)

\textsuperscript{35} Ibid, para 19


\textsuperscript{37} UN Committee on Economic, Social and Cultural Rights, General Comment 19: The Right to Social Security (2008) UN Doc. E/C.12/GC/19, para 2 and 22

\textsuperscript{38} Ibid, para 37

\textsuperscript{39} Ibid
Non-discrimination:

65. Equal and non-discriminatory access to health care facilities, goods and services must be guaranteed, in order to meet core human rights obligations. By virtue of articles 2(2) and 3, as interpreted by the ICESCR Committee, the ICESCR prohibits discrimination on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status, and civil, political, social or other status. The present consultation raises issues in respect of a number of these grounds such as national and social origin or other status.

66. The ICESCR Committee has emphasised that States have an immediate obligation to "refrain from denying or limiting equal access for all persons, including (...) detainees, minorities, asylum seekers and illegal immigrants to preventative, curative and palliative health services".40

67. The ICESCR also includes an obligation to pay specific regard to individuals without sufficient means. In particular, this requires states to prevent discrimination in the provision of health care and health services to such individuals, especially with respect to the core obligations.41

68. The ICESCR Committee has further emphasised that even where there are tight constraints on resources, the most vulnerable members of society must be protected.42

69. While the broadest prohibition of discrimination with regard to the right to health is contained in the ICESCR, the non-discriminatory enjoyment of human rights is guaranteed by other general and specific provisions enshrined in the ECHR, ICCPR, ICERD, CEDAW and UNCRPD.43 Some of these focus on particular groups.

70. The Committee on the Elimination of Racial Discrimination ('CERD Committee') recalls that human rights are to be enjoyed by all persons and that States are under an obligation "to guarantee equality between citizens and non-citizens in

40 Ibid, para 34
43 Article 14, ECHR; Article 26, ICCPR; Article 2(2), ICESCR; Article 1(1), CERD; Article 1, CEDAW; Article 5, UNCRPD
the enjoyment of these rights to the extent recognised under international law”. The CERD includes specific reference to the right to public health, medical care, social security and social services on a non-discriminatory basis.

71. Any differential treatment based on citizenship or immigration status will constitute discrimination under the CERD unless it is applied pursuant to a legitimate aim and is proportional to the achievement of that aim. In this respect, the CERD Committee requires that the implementation of legislation does not have a discriminatory effect on non-citizens. In particular, the CERD Committee requires that the rights of non-citizens to an adequate standard of physical and mental health be respected, by ensuring that they are not denied or limited in their access to preventative, curative and palliative health services.

72. The issue of multiple discrimination, often faced by non-citizens and in particular their children and spouses, should also be afforded special consideration. The ICESCR Committee has thereby required States to give heightened attention to individuals and groups, which have traditionally faced difficulties in exercising their rights. These include, inter alia, refugees, asylum-seekers, returnees and non-nationals.

73. The CEDAW Committee has also outlined that women in especially difficult circumstances, such as women refugees, should receive adequate protection and health services which include trauma treatment and counselling.

Children’s Rights:

74. Article 24 UNCRC provides that all children up to the age of 18, as a specific category, have the right to the highest

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45 Article 5(e)(iv), CERD
47 Ibid., para 7
48 First discussed by CERD in their Concluding Observations of Uruguay (2001) UN Doc. CERD/C/304/Add.78, para 36
49 Ibid., para 8
50 UN Committee on Economic, Social and Cultural Rights, General Comment No. 19, The right to social security, (Art. 9), 23 November 2007, para 31
51 UN Committee on the Elimination of Discrimination Against Women, General Comment 24: Article 12, Women and Health (1999) para 16
attainable standard of health. The Committee on the Rights of the Child (‘CRC Committee’) confirms that children are entitled to health services which include “prevention, promotion, treatment, rehabilitation and palliative care”.

75. Primary care must thereby be available in “sufficient quantity and quality, functional, within the physical and financial reach of all sections of the child population”. Article 2(1) UNCRC contains the prohibition of discrimination, obliging States to respect and ensure the rights of the Convention to each child within their jurisdictions, “irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status”. In combination with the principle of the best interests of the child, which is to be the primary consideration in all actions or decisions affecting children, the Commission wishes to highlight that all children within the jurisdiction must be able to access health care in their own right.

76. The CRC Committee has further emphasised that the “lack of ability to pay for services, supplies or medicines should not result in the denial of access” to health care. This involves measures such as abolishing user fees and implementing health-financing systems, which do not discriminate against women children on the basis of their inability to pay.

77. Article 24 UNCRC also includes a requirement to ensure that stateless and unaccompanied children are given the same access to health care as nationals.

Maternal Health:

78. International human rights law recognises the position of pregnant women, protecting their need for particular assistance and access to health care. The ICESCR Committee considers that the provision of reproductive, maternal and

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52 UN Committee on the Rights of the Child, General Comment 15: The Rights of the child to the enjoyment of the highest attainable standard of health (2013) UN Doc. CRC/C/GC/15, para 25
53 Ibid
54 Ibid, para 114
55 See also UN Committee on the Rights of the Child, General Comment 6: Treatment of Unaccompanied and Separated Children outside their Country of Origin (2005) UN Doc. CRC/GC/2005/6, para 47
child health care are important elements of the right to health.\textsuperscript{56}

79. ICESCR requires the State to reduce the stillbirth-rate and infant mortality,\textsuperscript{57} which the Committee understands as requiring the State to take measures that “improve child and maternal health, sexual and reproductive services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information”.\textsuperscript{58}

80. The CEDAW, Article 12(2), states;

\begin{quote}
States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.
\end{quote}

81. States are required, as a minimum core obligation, to provide appropriate services in connection with pregnancy. These services should be provided free where necessary given the risk of death or disability which may arise from pregnancy-related causes.\textsuperscript{59}

82. The UNCRC also requires the State to ensure appropriate pre-natal and post-natal healthcare for mothers.\textsuperscript{60} The CRC Committee notes the “obligation to ensure universal access to a comprehensive package of sexual and reproductive health interventions should be based on the concept of a continuum of care from pre-pregnancy, through pregnancy, childbirth and throughout the post-partem period”.\textsuperscript{61}

\textbf{Applicable Regional Human Rights Standards:}

\textbf{European Social Charter, 1961:}

\begin{itemize}
\item \textsuperscript{56} UN Committee on Economic, Social and Cultural Rights, General Comment 14: The Right to the Highest Attainable Standard of Health (2000) UN Doc. E/C.12/2000/4, para 43(b)
\item \textsuperscript{57} Article 12(2)(a), ICESCR
\item \textsuperscript{58} UN Committee on Economic, Social and Cultural Rights, General Comment 14: The Right to the Highest Attainable Standard of Health (2000) UN Doc. E/C.12/2000/4, para 14
\item \textsuperscript{59} UN Committee on the Elimination of Discrimination Against Women, General Comment 24: Article 12, Women and Health (1999), para 27
\item \textsuperscript{60} Article 24(2)(d), UNCRC
\item \textsuperscript{61} UN Committee on the Rights of the Child, General Comment 15: The Rights of the child to the enjoyment of the highest attainable standard of health (2013) UN Doc. CRC/C/GC/15, para 53
\end{itemize}
83. The European Committee of Social Rights (‘ECSR’) has recognised the complementarity of the ESC with the ECHR in respect of the right to health; given the fundamental value of dignity under both the ESC and ECHR and that “health care is a prerequisite for the preservation of human dignity”.

84. Article 11 provides for the right to protection of health and states;

*With a view to ensuring the effective exercise of the right to protection of health, the Contracting Parties undertake, either directly or in cooperation with public or private organisations, to take appropriate measures designed inter alia:

- to remove as far as possible the causes of ill-health;
- to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;
- to prevent as far as possible epidemic, endemic and other diseases.*

85. The ECSR has further concluded that the scope of the ESC, in relation to health care, extends also to non-nationals;

*the Parties to the Charter (in its 1961 and revised 1996 versions) have guaranteed to foreigners not covered by the Charter rights identical to or inseparable from those of the Charter by ratifying human rights treaties – in particular the European Convention of Human Rights – or by adopting domestic rules whether constitutional, legislative or otherwise without distinguishing between persons referred to explicitly in the Appendix and other non-nationals. In so doing, the Parties have undertaken these obligations.*

86. Article 13 provides for the right to social and medical assistance and states that;

*With a view to ensuring the effective exercise of the right to social and medical assistance, the Contracting Parties undertake:

1. to ensure that any person who is without adequate resources and who is unable to secure*
such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition;

2. to ensure that persons receiving such assistance shall not, for that reason, suffer from a diminution of their political or social rights;

3. to provide that everyone may receive by appropriate public or private services such advice and personal help as may be required to prevent, to remove, or to alleviate personal or family want;

4. to apply the provisions referred to in paragraphs 1, 2 and 3 of this article on an equal footing with their nationals to nationals of other Contracting Parties lawfully within their territories, in accordance with their obligations under the European Convention on Social and Medical Assistance, signed at Paris on 11th December 1953.

87. The ECSR has interpreted article 13(4) to require emergency medical care to be “governed by the individual’s particular state of health”.\(^{63}\)

88. The ECSR has commented that the system for granting assistance must be universal and based on the grounds of need. Additional or specific benefits may be provided for vulnerable categories of persons. However, “a condition in respect of length of residence in the country or part of its territory (as distinct from a condition in respect of stay or presence) is not in keeping with article 13(1)”.\(^{64}\)

89. The ECSR concludes that persons without adequate resources should be able to obtain the care required by their medical condition free of charge. However, the ECSR has determined that it is not within their competence to define what care should be covered.\(^{65}\)

**European Convention on Human Rights (ECHR):**

90. The ECHR does not include a substantive right to health. However, health care related issues may fall within the scope of the Convention by engaging one of the following protections: the right to life (article 2), the prohibition of

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\(^{63}\) Digest of the Case Law of the European Committee of Social Rights, 2008 p104

\(^{64}\) Ibid, p98

\(^{65}\) Ibid, p99
torture, inhuman and degrading treatment (article 3), the right to privacy and family life (article 8) in conjunction with the prohibition of discrimination (article 14).

91. The rights and freedoms contained within the ECHR are to be enjoyed without discrimination on the basis of immigration status, pursuant to article 14. Article 14 must engage another Convention rights as it cannot be relied upon alone.

92. As highlighted above, the principle of legal certainty is central to individuals’ effective enjoyment of their Convention rights. Thereby, definitions, regulations and procedures must be sufficiently clear and foreseeable to provide certainty to the individual in order to determine what entitlements are available and how these can be effectively accessed.

93. In *Tysiak v Poland*, the E Ct. HR scrutinised the available procedures and mechanisms with regard to determining the lawfulness of an abortion and held that the measures in place were not effective and had ‘created for the applicant a situation of prolonged uncertainty’. The E Ct. HR found a violation of the applicant’s right to private and family life, under Article 8.

94. In a health care context, this principle extends to both individuals accessing their rights and the service providers responsible for ensuring those rights are guaranteed. In particular, legal certainty must be ensured with regard to the provision of health care as required by the minimum core obligations. A lack of clear guidance as to which health goods and services can be accessed under which circumstances, will engage the right to health.

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66 *Tysiak v Poland*, App. No. 5410/03, 2007, at 124
67 See for example *Re Family Planning Association* [2004] NICA 38 on the provision of guidance to achieve legal certainty